An exploration of the factors that influence how asylum seeking or refugee women access preventive healthcare, using cervical screening as a case study.

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Abstract

Background

Forced migration has become an issue of great political, economic, and humanitarian importance. It is estimated that there are 30.1 million asylum seekers and refugees globally. Since 2000, Glasgow has been a dispersal city for asylum seekers and refugees and hosts one of the largest numbers of asylum seekers of any local authority in the U.K. Asylum seekers and refugees in Scotland are entitled to universal healthcare at all stages of the asylum process. However, there are known inequalities in access, particularly for women. Asylum seeker and refugee women have poorer health outcomes than economic migrant and host country populations. There is a specific gap in the literature with regards to asylum seeker and refugee women's preventive sexual healthcare needs, out with pregnancy and maternal care. Therefore, this thesis aimed to address this gap.

Aim

To identify and explore the factors that influence how asylum seeking and refugee women access preventive healthcare, using cervical screening as a case study. This aim was addressed by three research questions: 1) What discourses are constructed in the UK's print media around asylum seekers, refugees, and health? 2) How do these discourses affect asylum seeking and refugee women's and health care workers perceptions of this population's deservingness for preventive healthcare? 3) What are the barriers and facilitators, identified by asylum seeker/refugee women, community workers and primary care healthcare workers, with regards to the identification of candidacy, the assertion of this candidacy and the provision of cervical screening to women who are asylum seekers and refugees?

Methods

A multiple qualitative approach was taken, with newspaper analysis, focus group and individual interviews. Data collection and analysis were underpinned by the theory of candidacy. Intersectionality was a conceptual lens with which to interpret more fully the data generated.

The newspaper analysis covered the years 2008-2013. Newspapers were purposively selected to represent the breadth of the U.K. and Scottish national newspapers, in terms of political alignments and readership demographics. Articles were included if they focussed on asylum seekers or refugees in the U.K. and if >50% of the story focused on health of healthcare. A pro-forma was used to collect data on article tone; migrant group; and themes such as health access and healthcare spending. NVivo 10 software was used to organise the data and it was then analysed using both content and thematic analysis.

The second study involved semi-structured individual and focus group interviews. A purposive sampling approach was taken, and interpreter services were used as required. 17 asylum seeking and refugee women, 2 community workers and 7 primary healthcare workers were interviewed. The focus group of asylum seeking and refugee women was recruited through a community group, as were the two community workers. Individual asylum seeker and refugee interviews

were recruited through a flyer advertisement placed with the Scottish Refugee Council and through contacts of the focus group. Healthcare workers were recruited by contacting practices who were known to care for asylum seekers and refugees. These interviews were coded using NVivo 10 software and analysis facilitated using the One Sheet of Paper (OSOP) approach.

Findings

198 newspaper articles were included. Despite left-wing and local publications being more positive and sympathetic in their construction of deservingness for asylum seekers and refugees to seek healthcare, the volume of articles from right-wing publications which portrayed asylum seekers and refugees as undeserving outweighed these. This created a hostile tone, constructing migrants as a threat to resources, to the health of others and to British culture.

The hostile environment created by both newspaper constructions of deservingness and the asylum system was internalised by asylum seekers and refugee women. This affected their presentation at services. Being female and an asylum seeker creates an intersection of vulnerability and acts as a barrier to accessing preventive healthcare. This is worsened by the intersection of other identities such as language, culture, educational level, religious beliefs and socioeconomic status.

Healthcare workers shared frustrations that they had little influence over the asylum system as they realised the effect this was having on their patients. They also acknowledged the impact of the hostile environment but took little personal responsibility about how to combat this within their own service. However, a key finding in this thesis was that if the offer for cervical screening was encouraging, informed, supportive, and empowering, it would be more likely accepted.

Conclusion

This thesis found that asylum seeking, and refugee women operate within a hostile environment and have many intersecting factors which make them particularly vulnerable when accessing healthcare. However, if they are given the correct support both within healthcare and in the community, they are keen to seek preventive sexual healthcare, such as cervical screening. Recommendations from this thesis include widening the availability of clinics, to include drop in, evening and weekend periods; encourage community organisations to signpost for cervical screening; further training for primary healthcare workers in working with this population, recording data, and increase awareness of their role in reducing health inequalities for this population.

This thesis critiqued how candidacy, intersectionality, and deservingness work together as theories. Through using these theories together, a more nuanced understanding was achieved, particularly around the impact of structural and system inequalities affecting health access for this group. This thesis offers an advancement of the Mackenzie (2012) figure of candidacy to show the direct relationship of intersecting structural and system factors on individual interactions in healthcare, in addition to the impact of deservingness discourses.

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Author's declaration

All the work reported in this thesis was designed, conducted, analysed, and written up by the author (please note Anna Black was previously Anna Matthews).

The following prizes have been awarded based on material contained in this thesis:

- Distinguished Paper of the Year 2019. O'Donnell K, Isaacs A, Black A. Health in a hostile environment. Migration as a structural determinant of health for refugees and asylum seekers. North American Primary Care Research Group Annual Meeting, Toronto, 2019.

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Acronyms

The following acronyms are used in this thesis

Acronym	Explanation
EU	European Union
FGM	Female Genital Mutilation
GP	General Practitioner
HPV	Human Papilloma Virus
NHS	National Health Service
RCGP	Royal College of General Practitioners
SCCRS	Scottish Cervical Call Recall System
SRC	Scottish Refugee Council
SVPRS	Syrian Vulnerable Persons Resettlement Scheme
U.K.	United Kingdom
UKBA	United Kingdom Border Agency
WHO	World Health Organisation

Chapter 1 Introduction and Background

1.1 Introduction

Over the past three decades forced migration has become an issue of great political, economic, and humanitarian importance. Figures from the end of 2020 estimate that around 82.4 million people were forcibly displaced globally, which equates to 1 in every 95 people on earth having fled their home due to conflict or persecution (UNHCR, 2022) It is estimated that 30.1 million of these people were asylum seekers or refugees (UNHCR, 2022). Many of these are women, migrating for economic, family, and humanitarian reasons.

Asylum seeker and refugee women have poorer health outcomes than migrant and host country populations (Heslehurst *et al.*, 2018; Davidson *et al.*, 2022). Women in the asylum system also tend to face additional challenges to that of men, which exacerbates these poor health outcomes. Therefore, women's health and access to health care is a global issue and the barriers facing particularly vulnerable groups of women, such as asylum seekers and refugees, in accessing healthcare is of interest globally in academia, policy making and practice. With regards to asylum seeking and refugee women's sexual and reproductive health there is a recognised gap in the literature, with less understanding of issues regarding access to preventive sexual healthcare, compared with pregnancy and maternal health (Davidson *et al.*, 2022)

Therefore, this thesis considers asylum seeking and refugee women's access to primary preventive healthcare in Glasgow, using cervical screening as a case study. It explores the discourses which surround this: in policy; in newspapers; and the lived experiences of women, primary healthcare workers and community workers. The concept of deservingness and the theories of candidacy and intersectionality inform this study.

This chapter provides context by describing the U.K. asylum system and the hostile environment it creates, within which asylum seeking and refugee women have to operate, including when they are navigating and accessing healthcare. The history of asylum seekers and refugees in Scotland, in particular Glasgow, will be described (Section 1.3) as this is the location that the women who are

interviewed as part of this thesis live. After that Section 1.4 will focus on the specific vulnerabilities that women face in the asylum system and socially. From this broader context, Section 1.5 will introduce the entitlements for healthcare in Scotland for asylum seeking and refugee women and the concept that these can be eroded by the hostile environment created by the asylum system and wider discourses in the media. Section 1.6 will explain why cervical screening was chosen as the case study in this thesis, to bring together all of these wider aspects of health access and further explore the barriers and facilitators to healthcare for this population. The aim and research questions are introduced in Section 1.7, followed by description of the structure of the thesis in Section 1.9. Finally, definitions which will be used throughout the thesis are set out.

1.2 The U.K. Asylum System

In 2019 0.6% of the U.K.'s total resident population was made up of people who originally came to the U.K. to seek asylum, 20% of whom had sought asylum between 2014-2019 (Walsh, 2020). Around 74% of asylum applicants in 2019 were male and 26% were female, the majority of female applicants were between 18-49 years old (Home Office, 2019). Although there was some variation in the most common countries of origin for asylum seekers and refugees in the U.K., Iran, Iraq and Syria were often in the top five because of war and conflict in those countries (Home Office, 2019; Walsh, 2020).

On review of asylum applications, between 2015-2017, only 35% were granted by the U.K. Home Office at initial application, which is low compared to other European Union (EU) countries initial decisions, such as Ireland (85% success rate), Switzerland (89%) and Luxembourg (71%) (Eurostat, 2019; Home Office, 2019). Following appeal to the Courts service, the total grant rate increased to 53%-54% (Home Office, 2019; Walsh, 2020). Initial asylum decisions for men and women are the same but there has been a consistently higher number of successful appeals by women (Asylum Aid, 2011; Home Office, 2021). This casts doubt on the validity of initial decisions and whether women, in particular, are simply not believed by the Home Office (Asylum Aid, 2011; Refugee Council, 2020). Amnesty International U.K., found that credibility assessments by United Kingdom Border Agency (U.K.B.A) officials were unreliable, often not based on

facts and failed to focus on the individual merits of each claim with an unreasonable expectation of proof being placed on applicants which led to 20% of decisions to refuse asylum being overturned on appeal (Amnesty International U.K., 2004). A follow up Amnesty International report in 2013 found that this had increased to 25% of decisions being overturned on appeal and Right to Remain highlighted the issue of credibility assessments continuing to be flawed in 2018, demonstrating this to be a consistent problem over 14 years (Amnesty International UK, 2013; Right to Remain, 2018). There is also evidence that if individuals were given support from non-government agencies during their appeals it improved the decisions reached by up to 84% (Glasgow City Council, 2019).

There are different types of permission to stay in the U.K., with different time frames. Since 2005, refugee status with permission to stay in the U.K. has had a median duration of 5 years, after which individuals must apply for an extension or another type of settled status (Refugee Council, 2020). Subsidiary protection is given to individuals who are in need of international protection but do not fulfil the definition of a refugee (UNHCR, 2020). The U.K. will often term this Humanitarian Protection and usually applicants are given no more than 3 years of 'discretionary leave to remain' (UNHCR, 2020). These short time frames are recognised as causing stress, lack of stability and inhibit future planning by the individuals affected (Refugee Council, 2020). Wait times for asylum decisions, another source of instability, have also increased in recent years, in 2014 87% of applications received an initial decision within 6 months, compared with 20% in 2019 (Walsh, 2020).

Asylum seekers are one of the most deprived groups in the U.K. (Scottish Refugee Council, 2013; Refugee Council, 2022). Section 95 support is the financial support awarded to asylum seekers awaiting a decision and is much lower than that provided through the mainstream benefits system: £39.63 per week for food, clothing and toiletries (Baillot and Connelly, 2018; Glasgow City Council, 2019; U.K. Government, 2020). Standard rates of benefit support are typically below poverty thresholds and asylum seeker support is lower than this (The Children's Society, 2012; Asylum Matters, 2018). In addition, asylum seekers are not allowed to work and therefore cannot lift themselves or their family out of poverty (The Children's Society, 2012; Asylum Matters, 2018;

Refugee Action, 2020). Those who are on section 4 support, which is a benefit given to some refused asylum seekers, receive an even lower support than section 95 (Doyle, 2008; Commons Library Briefing, 2021). Doyle et al (2008) found that 68% of asylum seekers on section 4 support were unable to buy food and 73% were experiencing hunger. Asylum Matters (2018) reported that this has not improved, with the level of support given in 2018 meaning that a single asylum seeker will be living 74% below the relative poverty line and a family will be 63% underneath it. This will have worsened still as the U.K. Government's 2021 review of the financial support to asylum seekers and refugees gave only an increase of 17 pence per day (Refugee Council, 2022).

The Home Office expects refused asylum seekers to leave the U.K., but many are unable to leave. Reasons include: a lack of travel documents; their country of origin not cooperating with return; or being unwilling due to safety fears (Amnesty International UK, 2006; Lewis, 2007; City of Sanctuary UK, 2022). Refused asylum seekers are consequently frequently forced into destitution for years (City of Sanctuary UK, 2022). This leads to an increased vulnerability and reliance on charities, support networks, friends and religious organisations (Lewis, 2007; Refugee Action, 2019). This thesis does not focus on issues of destitution or detention of asylum seekers in U.K. immigration centres, as it is out with the scope of the research question but recognises destitution as a lived experience and real threat to those living in the asylum system.

1.3 Asylum Seekers and Refugees in Scotland: A Brief History

Following the U.K. Asylum and Immigration Act (1999), a 'no choice' dispersal policy for asylum seekers was introduced. The aim of the policy was to relieve the pressure on London and the South East of England, by providing alternative housing for asylum seekers arriving into the U.K. after April 2000 (Barclay *et al.*, 2003). Glasgow City Council participated in the dispersal scheme, as the only asylum dispersal area in Scotland, and continues to be so.

In 2001, 5.5% of the population of Glasgow was from a minority ethnic community (Sim and Bowes, 2007). Since December 2004 Glasgow has been one

of the largest hosts of asylum seekers of any U.K. local authority (3,807 or 60 per 10,000 residents in December 2020)(Commons Library Briefing, 2021). 2011 census data showed Springburn in Glasgow to have 2,360 African residents, compared to 322 in 2001 (Sim and Bowes, 2007; Simpson, 2014). Scotland delayed its census until 2022, due to the covid pandemic, so an update on ethnic minority populations living in Scotland is awaited. However, U.K. asylum data shows that the asylum applications lodged in June 2020-June 2021 showed the five countries with the highest number of applications to be Iran, Albania, Eritrea, Sudan and Iraq (Home Office, 2021). Although Glasgow specific data is not currently available, the nationalities of asylum seekers in Glasgow can be expected to follow the national trend.

Initially in Glasgow, asylum seekers were housed in surplus, poor condition, usually multi-storey, local authority housing in deprived areas of the city, where there were already established issues such as unemployment, low-income and limited access to community services for all residents (Sim and Bowes, 2007). Refugees have the same right to choice of housing as the U.K. population but asylum seekers do not (Netto and Fraser, 2009). Initially most asylum seekers were accommodated in North Glasgow, which was the most concentrated area of deprivation in Glasgow (Roshan, 2005). Scant consideration was given as to how asylum seekers were grouped in Glasgow, therefore they were rarely housed next to people of a similar nationality and were far away from existing ethnic minority groups (Sim and Bowes, 2007; Wren, 2007). This limited the potential for informal support groups and made it difficult to access culturally sensitive services, as these were located in other parts of the city (Wren, 2007). Asylum seekers often felt unsafe in their neighbourhoods, particularly at night (Roshan, 2005). Asylum seekers were also more likely to have bigger families which could not be easily accommodated within the housing stock in Glasgow and the available housing was often suboptimal with problems such as damp (which can worsen health conditions such as asthma) (Roshan, 2005; Mulvey, 2009).

Most of the accommodation used had previously been empty and required some upgrading, which led to tension within the local community due to the overall lack of resources (Mulvey, 2009). There was a widespread feeling at the time that local communities, support organisations and wider services, such as health and education, had not been adequately prepared or communicated to by

Glasgow City Council about the arrival of asylum seekers, their service needs and the impact on 'host' communities (Sim and Bowes, 2007; Wren, 2007; Mulvey, 2009). Glasgow City Council's asylum support team was only set up once dispersal was occurring (Mulvey, 2009). Voluntary organisations took on most of the responsibility for supporting asylum seekers in Glasgow and mobilised quickly to do this (Sim and Bowes, 2007; Wren, 2007).

In more recent years there has been a move away from accommodation provision in Glasgow being led by the public and third sector and instead being awarded by the Home Office to private contractors, for example Mears Group and Serco (GLIMER, 2019). This has led to accommodation being pushed even more into low cost housing in peripheral areas of Glasgow city (GLIMER, 2019). As the accommodation contracts are now held privately and these private companies are accountable to the Home Office only and not local authorities, Glasgow City Council has less control to plan for or act on these impacts (GLIMER, 2019; Scottish Refugee Council, 2022). Examples of this were seen during the Covid pandemic when the Mears group made the decision to move asylum seekers from long-term accommodation to hotel accommodation at the start of the first lockdown, which further isolated individuals and adversely affected mental health (Brooks, 2020; Scottish Refugee Council, 2022).

Politically, asylum and refugee policies are a mix of reserved and devolved policies (Mulvey, 2009). The protection of borders, including immigration and asylum are reserved matters under the control of the U.K. Government, whereas most social policy, affecting asylum seekers and refugees, such as education, interpreting, policing, housing, legal aid and health are devolved matters controlled by the Scottish Government (The Scottish Government, 2017). These can be argued to be many of the essential services required to support asylum seekers and refugees, however, they can be hampered by the wider asylum process Differences have arisen around issues such as dawn raids and detention in Scotland, which have been protested widely about in Scotland, including in a stand-off, in May 2021, between local residents and Home Office officials leading to the release of two men that the Home Office were attempting to detain (Mulvey, 2009; Garton, 2021). Also in 2020, the Scottish Elections (Franchise and Representation) Act 2020 was passed which allows refugees to vote in Scottish elections, the first being the Scottish Election 2021. Scotland is

the only country in the U.K. to have done this. This begins to illustrate some of the differences in how asylum seekers and refugees are dealt with in the two Government systems.

1.4 Women in the Asylum System

Women are more likely to seek asylum because of gender based violence or persecution, such as forced marriage, domestic violence, female genital mutilation (FGM), marital rape, sexual violence, forced abortion etc (Asylum Aid, 2011; Dudhia, 2020). Persecution has been defined in U.K. courts as serious harm plus the failure of state protection (Hathaway, 1991; Asylum Aid, 2011). For gender based violence this can be difficult to prove as it is often perpetrated by non-state actors such as a spouse, family or community members and therefore they must show beyond doubt the inadequacy of state protection (Asylum Aid, 2011). It is estimated that more than three quarters of women seeking asylum have experienced gender based violence, either by private individuals or the state, for example by soldiers, prison guards or the police (Dudhia, 2020).

Disclosing gender-based violence is a very sensitive matter especially if a women is traumatised, afraid, ashamed or fearful about disclosing information (Asylum Aid, 2011). However, non-disclosure or late disclosure can have a hugely negative effect on asylum claims. Women's claims will also be frequently deemed inadequate if information is not accurate and chronologically given, which can often be difficult in traumatic circumstances (Asylum Aid, 2011; Women for Refugee Women, 2021). Often there is no continuity of case worker, a lack of childcare facilities, a lack of staff training on gender based violence, interviews are not always private and often interpreters and staff are male, all of which can make disclosure more difficult (Asylum Aid, 2011; Sassetti, 2017; Lombardi, 2020).Women are vulnerable in detention centres in the U.K., with evidence of abuse, discrimination and humiliation in these settings, in addition to a lack of healthcare and the detrimental effects of detention (Zimmerman, Kiss and Hossain, 2011; Harris, 2015; Sassetti, 2017) Even out with detention or if claiming asylum with their spouse, women can be vulnerable. Their claims are often originally linked to their husband's claims, therefore may lack individual

detail about them and can leave them vulnerable if they leave the relationship (Asylum Aid, 2011; Baillot and Connelly, 2018).

Once dispersed through the asylum system, women may face isolation and are often in charge of dependents (Stewart, 2012). Women are also more vulnerable when faced with poverty. Poverty has been documented as a specific risk factor for sexual violence, with women living on less than £10,000 per year being three times more likely to report being raped compared to women from households with an income greater than £20,000 (Refugee Council, 2012b). The situation is particularly acute for women left destitute if their asylum claims have been denied, who cannot return to their country due to fear of persecution or lack of protection as they are at high risk of violence, illegal work, begging or entering into exploitative relationships or sex work to survive (Refugee Council, 2012b; Dudhia, 2020).

It has been argued that gender should be considered in the context of gender role expectations, family circumstances, occupational opportunities, education, legislative powers, historical, cultural and religious factors, all of which intersect and are affected by socioeconomic position (Hunt and Batty, 2009). To acknowledge this, this thesis utilizes intersectionality (see Chapter 2 Theory to consider women who are asylum seekers and refugees in Glasgow in their various contexts and not look at gender solely as an isolated issue.

1.5 Asylum Seeker/Refugee Entitlement to Healthcare in Scotland

As discussed in Section 1.3, the asylum process is a reserved, U.K. Government issue, whilst health and social care policies are devolved issues (The Scottish Government, 2020). Scotland allows free healthcare, both primary and secondary care, on the same basis as it does for all its citizens to anyone who is a refugee, has applied for asylum, has been refused asylum but is appealing or has been refused asylum and is waiting for the Home Office to make arrangements for their return home, through the CEL09 policy (The Scottish Government, 2010; NHS Inform, 2018). Refugees may need to pay, like other Scottish citizens, for some dental and eye care but asylum seekers who are

receiving support or are refused do not need to pay for any healthcare (NHS Inform, 2018).

The key difference between the policy in Scotland compared to England is that in England only refused asylum seekers in receipt of section 4 benefits are entitled to free secondary care (Public Health England, 2014; NHS Inform, 2018). For refused asylum seekers who are not in receipt of section 4 decisions on entitlement to treatment are at the discretion of the secondary care provider (Public Health England, 2014; NHS Inform, 2018).

The Lancet Commission 2018 recommends that equitable access to universal health coverage needs to be provided by governments to migrant populations regardless of age, gender or legal status (Abubaker *et al.*, 2018). This is in keeping with Scotland's health entitlement policy. However, the intersection of various statuses such as the wider hostile environment, gender, race, language, religion, immigration, poverty, isolation, unemployment and education contribute to inequities in healthcare accessibility, particularly for vulnerable groups, such as asylum seekers and refugees (Weerasinghe, 2012; British Medical Association, 2019; Kang et al., 2019; Babatunde-Sowole *et al.*, 2020; Farrington, 2020; Crawshaw *et al.*, 2021). These barriers shall be explored in this thesis through the case study of cervical screening.

1.5.1 Shaping Views of Deservingness

Within this thesis the wider hostile environment and its impact on healthcare access will be explored through the impact of the asylum process on women and the impact that newspaper discourses have on the feelings of deservingness for healthcare both by asylum seeking and refugee women who are seeking healthcare and those who are providing it.

Newspapers are powerful in forming and informing public opinion (Sparks, 1995). It can be argued that even if not a regular newspaper reader, everyone will come into contact with the news and the opinions formed from it, through discussions with friends, family or colleagues (Boeva, 2016). They have a key influencing role in perceptions of deservingness for particular populations by

encouraging audiences, both emotionally and intellectually, towards a particular vision or viewpoint (Sargent, 2012; Perna, 2018; Anahi Viladrich, 2019) Newspapers are known to be political and often support one particular political party and worldview (Rooney, 2010). For groups such as asylum seekers and refugees, whom much of the public will never come into personal contact with, newspapers will 'at the very least provide a framework for debate' (Pearce and Stockdale, 2009 pg 143). The internalisation of these discourses and debate may affect an individual's perceptions of deservingness and can alter the attitudes of healthcare workers (Larchanché, 2012).

1.6 Justification for Cervical Screening as a Case Study

Cervical screening was chosen as the platform with which to explore the complex factors, described above, that affect healthcare access for asylum seeking and refugee women. The reason for the specific choice of cervical screening will be described in this section.

There has been a growing awareness in the European Union (EU) of the importance of women's sexual and reproductive rights (Morgan, 2016; Davidson *et al.*, 2022). Human, sexual and reproductive rights have been shown to be at particular risk in vulnerable groups of women such as migrants, asylum seekers and refugees (Morgan, 2016; Davidson *et al.*, 2022).

In the past much research and policy making around migrant health has focused on the threat of 'imported diseases' to the host population, such as TB or HIV (WHO, 2010; Zimmerman, Kiss and Hossain, 2011; Yun *et al.*, 2012; Meltzer *et al.*, 2018). However, it is known that, world-wide, non-communicable chronic diseases are the greatest cause of death and are considered as important to migrant populations morbidity (WHO, 2010). Cancer, for example, is a rapidly growing crisis in low and middle income countries, where the burden of disease is undergoing an epidemiological shift from infectious disease to chronic, non-communicable diseases (Ginsburg *et al.*, 2017). Without a shift in focus to non-communicable disease the burden of these will worsen for migrant groups through poor access to preventive services and disrupted care (Abubaker *et al.*, 2018; Meltzer *et al.*, 2018)

This makes the case for the importance of asylum seekers and refugees having access to robust primary care services, developing preventive care health literacy and supporting community-based interventions such as screening (Cooper *et al.*, 2012; Abubaker *et al.*, 2018).

Cervical cancer screening provides an interesting case study for the purpose of exploring how women who are asylum seekers/refugees access preventative medicine. Cervical cancer is a possibility for all women, especially those who are sexually active, irrespective of ethnicity. Refugees are shown to be more likely to be diagnosed with later stage cervical cancer than host populations (World Health Organization, 2018). This reinforces the importance of cervical screening uptake as early diagnosis saves lives and reduces treatment costs (World Health Organization, 2018)

The NHS in Scotland runs a Cervical Screening Programme which invites all women aged 25 to 64 years old to attend cervical screening, which is in keeping with the age of most women seeking asylum in the U.K. (see Section 1.4). This is known as the Scottish Cervical Call Recall System (SCCRS). The screening procedure itself is known as a smear test and is usually performed by a Practice Nurse or General Practitioner (GP).

Therefore, cervical screening is an appropriate lens through which to explore how women who are asylum seekers and refugees access preventive medicine in primary care. It has clear parameters already set in place by the health care system and as women are invited it is not an ad-hoc or solely individually motivated attendance.

1.7 Aim and Research Questions

The overall aim of this thesis was to:

> Identify and explore the factors that influence how asylum seeking and refugee women access preventive healthcare, using cervical screening as a case study.

The exploration of this aim has a particular focus on how candidacy is formed and maintained between asylum seeking women and health professionals. It is also informed by intersectionality. As will be discussed in the next chapter there are multiple influences on the construction of candidacy. This study has, therefore, considered both the individual relationship between women and their healthcare provider, and the impact of wider discourses of deservingness in the media.

Addressing the aim was broken down into three research questions:

1. What discourses are constructed in the UK's print media around asylum seekers, refugees and health?

2. How do these discourses affect asylum seeking and refugee women's and health care workers perceptions of this population's deservingness for preventive healthcare?

3. What are the barriers and facilitators, identified by asylum seeker/refugee women, community workers and primary care healthcare workers, with regards to the identification of candidacy, the assertion of this candidacy and the provision of cervical screening to women who are asylum seekers and refugees?

1.8 Definitions used within this Work

Many of the definitions around migration, asylum seekers, refugees and ethnic communities are complex, often used interchangeably, regularly debated and frequently changed. Therefore, the purpose of this section is to provide clarity around the definitions decided upon in this thesis. Throughout the thesis it will be highlighted where there is any difficulty with definitions or where they are used ambiguously.

This thesis is primarily focused on the healthcare experiences of female asylum seekers and refugees in Glasgow. However, at times it will draw on the literature surrounding migrant health more generally, as this is unavoidable due to the frequent inter-changeability of terms.

It is acknowledged at this point in the thesis that attempts to categorise heterogenous groups of people into different types of migrants, such as: asylum seekers, refugees, economic migrants, undocumented/irregular and illegal migrants, are limited in capturing the complex social dynamics of human movement and the needs or perspectives of the people who are moving (Abubaker *et al.*, 2018; Crawley and Skleparis, 2018). It is also important to recognise that before, during and after any movement, the categorisation of people may change (Abubaker *et al.*, 2018). For example, people seeking safety from conflict may initially have moved due to economic reasons, as resources are often insufficient in areas of war, but then later apply for asylum (Abubaker *et al.*, 2018).

1.8.1Migrant, Refugee and Asylum Seeker Definitions

In international terms there is no legal definition of a migrant and it encompasses a wide range of reasons for movement (IOM, 2019). However, the International Organization for Migration defines a migrant as,

> ‘An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students.’(IOM, 2019)

An asylum seeker is defined as,

> ‘a person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded’ (Refugee Council, 2020).

When an asylum seekers application has been concluded favourably, they are given refugee status. A refugee is defined as,

> ‘A person 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 as a result of such events, is unable or, owing to such fear, is unwilling to return to it.' (United Nations, 1951)

Therefore, a refused asylum seeker is,

> 'a person whose asylum application has been unsuccessful and who has no other claim for protection awaiting a decision' (Refugee Council, 2020).

1.8.2 Terms Used to Describe Communities

The communities which asylum seekers and refugees migrate into are described differently across the literature. The most common terms are indigenous, host or local community.

Again, none of these terms are perfect. Indigenous has overlap with indigenous peoples such as the Maori, Aboriginal and Torres strait Islanders. It is not felt to be appropriate for describing majority communities which asylum seekers and refugees move into, as they have a very different history, profile and needs (Johnson *et al.*, 2019).

Local community feels restrained by geography and has connotations of only including those in close vicinity.

Therefore, the term host community or population will be used in this thesis. It is imperfect, as it gives the perception that asylum seekers, refugees and migrants are guests being hosted, but for the purposes of this thesis it does not overlap with other marginalised groups terms or have limitations in terms of location.

1.8.3 Definition of Culture

At various points throughout this thesis the importance of culture will be referenced. This is a nebulous term and for the purpose of this thesis the definition of culture provided in the UCL-Lancet 2018 Commission on Migration and Health will be used (Abubaker *et al.*, 2018):

> 'Culture can be outlined as a linked group of customs, practices, and beliefs jointly held by individuals, social networks, and groups. These

> factors help define who they are, where they stand in relation to those within and beyond the group and give meaning and order to life. Anthropologists describe culture as “a process through which ordinary activities and conditions take on an emotional tone and a moral meaning for participants”; this definition includes perceptions, beliefs, and practices related to health, suffering, and disease. Culture is thus never static but evolves in relation to a range of social, economic, and political factors, and experiences of individuals and groups.' (Abubaker et al., 2018, pg 2617)

Individual identity can be argued to be partly formed through culture. Therefore, living as a migrant, of any categorisation, and migration as a journey requires multiple occasions where individual and collective cultural challenge may occur and adaptation may be needed (Bhugra and Becker, 2005; Abubaker *et al.*, 2018; Prinz, 2019). This, in combination with ever changing labels, such as asylum seeker, refugee, undocumented migrant, illegal immigrant, changes in socioeconomic status, changing locations and experiences all challenge and change identity (Abubaker *et al.*, 2018).

1.9 Structure of the Thesis

To address the aim of this thesis and the research questions outlined above, this thesis will provide an initial broad context within which asylum seeking and refugee women access primary healthcare and then focus down on the specific identification and negotiation of candidacy for cervical screening.

Chapter 1, the introduction chapter above, provided the context of the U.K. asylum system, within which women who are asylum seekers and refugees must operate.

Chapter 2: Theoretical Underpinning, presents candidacy theory. The theoretical underpinning is presented as the second chapter of this thesis as it informed the structure of how the thesis is written and underpinned the methods and analysis. In addition to candidacy theory, intersectionality has been used as a lens with which to appreciate and consider the complexity of factors involved in asylum seeking and refugee women’s lives, decision making, feelings of deservingness, healthcare needs and access. This is also addressed in this chapter.

Chapter 3: Literature Review: Asylum Seeker and Refugee Healthcare and Access, explores literature around asylum seeker and refugee's health needs, behaviours, and access to health, including how asylum seekers and refugees develop health literacy in the U.K. It also considers wider issues such as wider policy protection for health entitlement and what is already known in the literature about the more subtle discourses of deservingness in the mainstream media which can affect healthcare access.

Chapter 4: Literature Review: Cervical Screening for Asylum Seeking and Refugee Women, focuses on access for cervical screening specifically, including the most likely barriers to participation in the cervical screening programme.

Chapter 5: Methods, describes the multiple methods used in this study, including media analysis, individual qualitative interviews, focus groups and thematic analysis.

Chapter 6: Health Media Analysis, is the first findings chapter of the thesis. It considers how the theme of health is portrayed in U.K. newspapers in connection to asylum seeker and refugee groups.

Chapter 7: Operating Conditions, presents the findings from the qualitative interviews about the operating conditions within which women present for healthcare and make decisions about attending for cervical screening. These included the effect of newspaper discourses, community contexts, asylum status, gender, and organisational structures and cultures.

Chapter 8: Micro-Level Candidacy Negotiations, focuses down in detail on the findings from the qualitative interviews around the identification of candidacy for cervical screening and the steps taken to assert this within the health system. It pays particular attention to the dynamic relationship between asylum seeking and refugee women and their health care provider in negotiating this.

Chapter 9: Discussion, reflects upon this thesis as a whole; presents the key findings and its contribution to knowledge; and considers the usefulness of the theoretical underpinning. Finally, there are recommendations for policy, clinical practice, and research.

Chapter 2 Theory

2.1 Introduction

Chapter 1 introduced the context within which asylum seeking and refugee women operate in Glasgow, when seeking healthcare. This chapter provides an overview of the theoretical underpinning of this thesis.

Two main theories informed this research: candidacy and intersectionality. Candidacy provided a framework for the design of this thesis and intersectionality provided a lens through which to view the findings. They were chosen as they allow the wider context of the hostile environment created by both the asylum system and media discourses, the impact of migration, structural inequalities, and intersecting identities to be linked to what happens in individual interactions with healthcare.

The advantages of combining intersectionality and candidacy in this thesis will be explored in this chapter and how used together they promoted an enhanced understanding of the notion of deservingness, and a deeper knowledge of the barriers and facilitators experienced by both women seeking and health care workers providing preventive sexual healthcare.

2.2 Definition of Candidacy

Candidacy is a theoretical framework which explores how individuals identify themselves as at risk of a disease or eligible for a health intervention, a ‘candidate’, and then explores the process of how they identify and approach appropriate or accessible services, navigate those services and in the process, assert their candidacy (Davison, Davey Smith and Frankel, 1991; Dixon-Woods *et al.*, 2006). Importantly, candidacy also pays attention to the role played by the health care professional, in particular the way in which they may judge the deservingness of the individual for the service. As it encompasses individual health beliefs, the relationship with the service provider, structural barriers and facilitators to care, it is a useful framework in health research, as it acknowledges that healthcare access is a dynamic process and exposes the

weaknesses within it (Dixon-Woods *et al.*, 2006; Koehn, 2009; Mackenzie *et al.*, 2012; Methley *et al.*, 2016)

2.2.1 Background Literature Exploring the Concept of Candidacy

The concept of candidacy was first raised by Davison, Davey Smith and Frankel, (1991) to understand how individuals assessed their risk factors for cardiovascular disease and, hence, identified themselves as a candidate for the disease. Davison, Davey Smith and Frankel (1991) and Hunt *et al.* (2000) described this notion of candidacy as "lay epidemiology", as through routine observations of illness and death, made by an individual within their social network, workplace and from other sources such as the media, snippets of information are pieced together regarding a disease. The data and information that is informally and perhaps subconsciously gathered is then put together to build a profile of the person they would consider to suffer from or be at risk from a specific disease. This person is then deemed a 'candidate'(Davison, Davey Smith and Frankel, 1991). An individual will then calculate their own personal risk of disease by making comparisons between themselves and the candidate to define whether themselves or people they know are also candidates for the disease in question (Davison, Davey Smith and Frankel, 1991; Pfeffer, 2004).

While this was a helpful way of conceptualising an individual's view of disease and risk, it did not address how individuals' might then use this information in order to access services, nor did it consider the social interactions between patients and health care professionals. Dixon-Woods *et al.* (2006) model of candidacy addresses access to care. Developed initially to understand how underserved populations accessed health care, it considers the process that an individual goes through to act upon their identified candidacy and navigate systems in order to assert their candidacy (Dixon-Woods *et al.*, 2006). It also recognised that determining eligibility or candidacy for healthcare services is a collaborative process and therefore both the patient and healthcare worker should be considered part of the candidacy process (Dixon-Woods *et al.*, 2005). This can be taken further to allow power relationships to be explored (Koehn, 2009; Methley *et al.*, 2016; Chase *et al.*, 2017).

> 'Candidacy describes how people's eligibility for healthcare is determined between themselves and health services. It is a continually negotiated property of individuals, subject to multiple influences arising from both people and their social contexts and from macro-level influences on allocation of resources and configuration of services' (Dixon-Woods et al., 2006, pg 10)

It is the Dixon-Woods model of candidacy that is being used in this thesis as it moves past the initial identification of candidacy to include engagement with services, which is needed to answer the research aim and questions in this thesis. It has also been used to understand access to services across a range of groups and conditions, both in health and more widely, and can be helpful in identifying intervention targets within services (Mackenzie *et al.*, 2012; MacKenzie *et al.*, 2014; Methley *et al.*, 2016). It has been used in a variety of ways throughout the literature, including: assessment of breast cancer screening in low income women (Klassen *et al.*, 2008); contrasting experiences of help-seeking and access to care in cancer and heart disease (Macdonald *et al.*, 2016); access to the emergency department (Nugus and Braithwaite, 2010), access to primary mental health care for 'hard to reach groups' (Kovandžić *et al.*, 2011); the use of candidacy in determining eligibility for obesity referrals in primary care (Blane, Macdonald and O'Donnell, 2020); and pertinent to this study candidacy was used by Chase *et al.*(2017) to consider the gap between entitlement and access for asylum seekers in Montreal. Therefore, candidacy has a great scope within research for understanding access, utilisation of services and the relationships between individuals and professionals.

2.2.2 Candidacy Framework

Dixon-Woods *et al.* (2006) candidacy framework consists of seven defined steps which are shown in Figure 1.[1]

[1] Permission and licence (no 1127606-1) have been granted from Blackwell Publishing to reproduce Figure

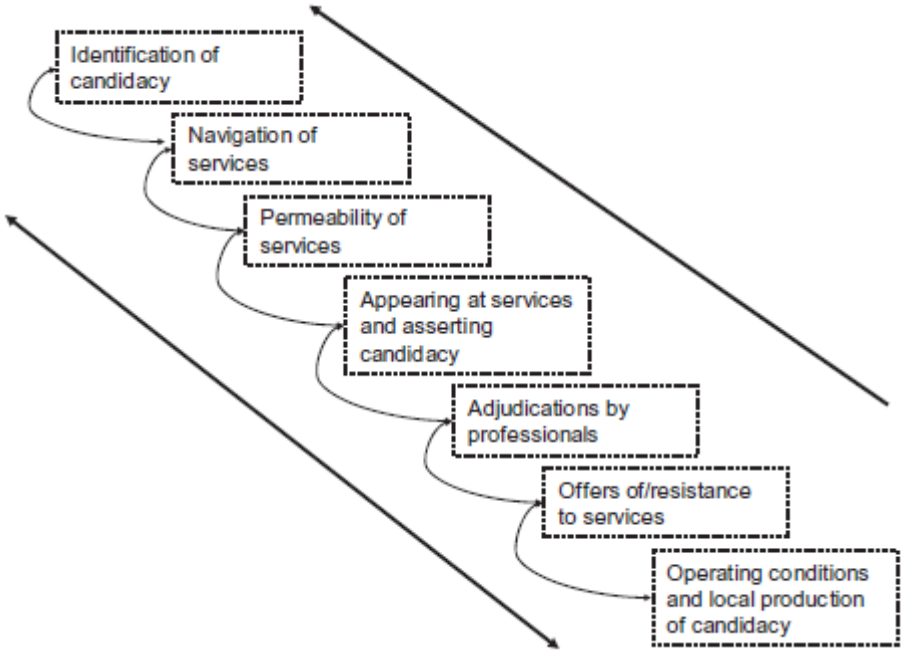

Figure 1: Dixon- Woods et al (2006) Candidacy Framework. From Mackenzie et al (2012)-'Negotiating the Candidacy Journey for Health Services- an extrapolation from Dixon-Woods et al 2006'

These steps refer to the personal identification of candidacy and the subsequent process of asserting this candidacy (Dixon-Woods *et al.*, 2006).

First an individual must identify themselves as a suitable or "worthy" candidate for a service. As described in Section 2.2.1 this often relies on 'lay epidemiology', collected from social networks, observations of illness and mass media (Davison, Davey Smith and Frankel, 1991). Individuals must then identify and navigate appropriate services, identifying the most suitable or permeable services to access. Factors which affect this navigation include awareness of the services that are offered, eligibility for the service, feelings of deservingness, cultural alignment of the service, being in a position to physically access services and overcoming practical problems, such as transport or rigid working patterns (Dixon-Woods *et al.*, 2006; Mackenzie *et al.*, 2012; Chase *et al.*, 2017).

Once the service has been accessed and the individual is within the health system, negotiations must then be made between the individual and the health care provider (Dixon-Woods *et al.*, 2006). Therefore, candidacy at this point is a two-sided negotiation between the patient and healthcare provider. The professional judgements surrounding the candidacy being presented can at this point often allow or halt the continued progression of candidacy (Dixon-Woods *et*

al., 2006). This can also include judgement from other workers in the healthcare system who are integral to healthcare delivery, and often create a chain of access, such as the role of receptionists as gatekeepers, experiences with interpreters, secondary care health workers and the wider multi-disciplinary team, such as health visitors (O'Donnell *et al.*, 2007; Kovandžić *et al.*, 2011; Armenta and Sarabia, 2020). The judgements that are made are recognised to depend on multiple factors including local resources and perceptions by the health professional of deservingness (Hughes and Griffiths, 1997; Chase *et al.*, 2017).

Once a professional judgement has been made that the individual is a candidate, an offer will be made for referral to a service or management of a condition, which can be accepted or resisted by the individual (Dixon-Woods *et al.*, 2006). Finally, the influence of the local context in which health care and the encounter was situated can also influence the ability of professional to make offers and for individuals to act on those (Dixon-Woods *et al.*, 2006; Mackenzie *et al.*, 2012; Blane, Macdonald and O'Donnell, 2020).

There are three main criticisms of the Dixon-Woods (2006) original candidacy model. First, although presented in a linear fashion, candidacy is a more fluid concept, with each step in the candidacy "journey" interacting and influencing each other, a process acknowledged by Dixon-Woods and colleagues (Dixon-Woods *et al.*, 2005, 2006) and also in a later critique by Mackenzie *et al.* (2012). A second issue is that whilst someone may identify themselves as a candidate for a service, other life circumstances may impede the assertion of this candidacy, for example identifying as a candidate for refuge from domestic violence may be impeded by an individual's identity as a loyal partner or not identifying as a victim (MacKenzie *et al.*, 2012). The multiple identities experienced by individuals during their presentation and negotiation of health systems is not explicitly addressed in the Dixon-Woods (2006) model of candidacy (MacKenzie *et al.*, 2012). Finally, whilst Dixon-Woods et al (2006) acknowledged operating conditions and structural processes within the steps of candidacy, they were somewhat understated and mostly recognised at the local level, such as resources and availability of services, in addition to being at the end of a linear process (MacKenzie *et al.*, 2012; Methley *et al.*, 2016). MacKenzie *et al* (2012), however, contended that these operating conditions are vital, as an individual's

identification of candidacy is 'structurally, culturally, organisationally and professionally constructed' (page 806). Therefore, the candidacy framework was refined by Mackenzie and colleagues to more explicitly surround the Dixon-Woods *et al*. (2006) candidacy framework by meso-and macro-level factors incorporating wider structural, political, cultural and societal influences on the candidacy process, which also allows a wider exploration of power relationships (MacKenzie *et al*., 2012).

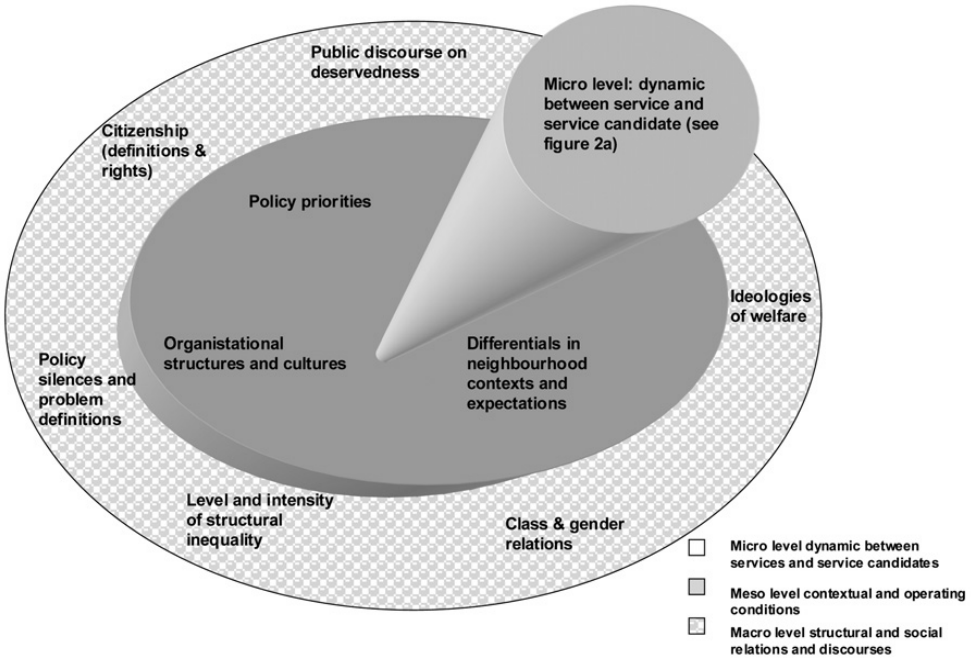

Figure 2: Macro- Meso- and Micro-Influences on Candidacy (MacKenzie et al 2012)[2]

Within this suggested figure the individual and their engagement with health or non-health care services is at the centre operating at the micro-level (MacKenzie *et al*., 2012). However, as acknowledged above, these individual identifications and negotiation of candidacy are not made in isolation. They are surrounded by multiple structural and contextual factors which are dynamic and can affect an individual simultaneously. The macro-and meso-levels are separated as such to represent the different distances between the individual and these influences. For example, neighbourhood contexts are much closer to the experience of the individual than high level ideologies of welfare, however this is not in any way a

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ranking of their importance, which may be fluid depending on different situations. Every level influences the other and by incorporating all these levels into research the exploration of candidacy is deeper and more meaningful.

Therefore, the candidacy figure presented by MacKenzie *et al.* (2012) was the preferred framework for this thesis. The micro-level is the Dixon-Woods (2006) framework which is explained above. The macro-and meso-levels which surround it in Figure 2 presented by MacKenzie et al (2012) are outlined next.

2.2.2.1 Macro-Level: Structural, Social Relations and Discourses

The outermost layer of the MacKenzie *et al.* (2012) candidacy figure incorporates the widest operating conditions within which individuals identify and negotiate candidacy. They extend far out-with the healthcare system and include national policy, structural inequalities, citizenship, gender, class, ideologies of welfare and public discourse on deservingness.

These wider operating conditions can be argued to be linked closely back to the concept of deservingness discussed in Section 1.5.1 and which will be further explored in Section 3.6 and 3.7. National policies, diminishing resources affecting welfare and public discourses on deservingness all begin the social construction of who is deserving of services, which will filter through the meso- and micro-levels potentially suppressing the assertion of candidacy (MacKenzie *et al.*, 2012). Perceptions of deservingness can be internalised by the individual, thereby limiting self-advocacy, and also by the health care worker who may, inadvertently, have the ideal candidate in their mind, and thus the yardstick by which they measure deservingness (MacKenzie *et al.*, 2012; Chase *et al.*, 2017).

The macro-level, although appearing to be removed from the individual interactions between individual and healthcare worker, actually wields considerable power in the micro-level decision making as the dynamics between the individual and healthcare worker are shaped by wider social values and notions of deservingness (MacKenzie *et al.*, 2012). National policy silences, punitive policies and the creation of a hostile environment through media discourses (further explored in Sections 3.4, 3.5 and 3.6) are important in the identification of candidacy formation and can suppress candidacy, as they reinforce individuals sense of being less than the host society (MacKenzie *et al.*,

2012; Chase *et al.*, 2017). For example, citizenship definitions and rights are a component of the macro-level of candidacy. In the case of asylum seekers, they are vulnerable due to the instability of their asylum status which may lead to them avoiding seeking healthcare, especially if they have experienced negative interactions previously (Chase *et al.*, 2017).

In this way the macro-level of candidacy helps the researcher consider power dynamics, a wide range of stakeholders and the structures and process which are out with the individual and healthcare provider interactions (Chase *et al.*, 2017).

2.2.2.2 Meso-Level: Contextual Local and Organisational Operating Conditions

Within the meso-level an individuals' identification and negotiation of candidacy may be affected by local policy priorities and organisational structures and cultures. This may include organisation of health services, including general practice, and how health care professionals' view individual's entitlement to health care. It has overlap with the final, local contexts step of the micro-level of candidacy.

It also incorporates differences in neighbourhood contexts and expectations. Communities can have their candidacy suppressed if they are not considered as deserving as others, which can lead to services not being provided to those most in need (Mackenzie *et al.*, 2012). Healthcare providers may often be put under pressure from meso-level factors, such as health board budgeting or resource allocation which then creates a tension with regards to enacting these local policies whilst also meeting individual service users' expectations.

When considering access to health care for asylum seekers, it is the meso-level where some tension may become apparent between reserved and devolved government responsibilities for asylum seekers and refugees, including confusion around entitlement to healthcare. For example, as discussed in Section 1.5, there are differences in entitlement, with a fuller entitlement to healthcare being available in Scotland. However, this may cause confusion at the micro-level of candidacy negotiation and may not always be obvious in the wider U.K. policy or newspaper discourses which are observed in the macro-level.

2.2.2.3 Candidacy as a Journey

Candidacy assertion and navigation is a process not a single event (MacKenzie *et al.*, 2012). It was a good choice of theory for this thesis as it allowed the researcher to follow asylum seeker and refugee women in their journeys to and through services (MacKenzie *et al.*, 2012; Methley *et al.*, 2016).

The candidacy figure (Figure 2) presented by Mackenzie *et al.*(2012) allows this journey to be further expanded by including other actors in the journey, such as the state, the media and institutions. The influences of the different macro-, meso- and micro-levels in the candidacy figure are fluid and often interlink.

Issues may be revisited in the journey across different levels which can sometimes lead to repetitive behaviours in the candidacy process or unresolved candidacy journeys (MacKenzie *et al.*, 2012; Chase *et al.*, 2017). An example of this would be asylum seekers attending the GP on multiple occasions with recurrent psychosomatic symptoms which may lead to an unresolved candidacy journey as there may not be any suitable referral pathways, treatment options or outcomes, because the issue lies in the macro-level of candidacy with the stress of the asylum system. Therefore, the problem is created by a structural factor that is resistant to the solutions offered by individual services (MacKenzie *et al.*, 2012). This has the potential to then suppress future candidacy assertions, as each experience of candidacy identification and assertion affects how future illness or candidacy identifications are managed (Chase *et al.*, 2017). The same can be said for each step of the micro-level of candidacy as the experience of each encounter or step may also aid or depress future expressions of candidacy (Dixon-Woods 2006). As MacKenzie (2012 pg. 13) describes, the candidacy process is ‘dynamic, contingent and long-term’ in its nature.

By following individuals and professionals through the journey of candidacy, the theory also allows exploration of how barriers to access have been affected over time (Mackenzie *et al.*, 2012; Chase *et al.*, 2017). This is particularly helpful for research involving those going through the asylum process as it is an unstable and constantly changing process so candidacy may be halted, delayed, or enhanced by intervening events which can be captured when it is considered as a journey and not a single event.

The second half of this chapter will describe intersectionality, which was used a lens through which to view candidacy in this thesis. Section 2.4 will then summarise how these two theories complement each other.

2.3 Intersectionality

2.3.1 Definition of Intersectionality

Intersectionality is a sociological theory with roots in black feminist research (Bowleg, 2012). There is still debate as to how to define intersectionality but in its most basic terms intersectionality is a theory, concept, framework or way of 'seeing' the world which acknowledges that we all have many intrinsic factors and characteristics, such as race, gender and economic status, influencing our life, both positively and negatively (Bowleg, 2012). It provides critical insight that 'race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but rather as reciprocally constructing phenomena that in turn shape complex social inequalities.' (Collins, 2015).

Key to intersectionality is the way in which it is also concerned with looking at structural factors inherent within institutions and in society which interact with individual characteristics and act as drivers of both inequality and formation of power within these multiple categories (Collins, 2000; Kapilashrami, Hill and Meer, 2015). These factors affect how we all function in the world and are treated by the society which we live in. Intersectionality is concerned with the power relation and social inequalities that occur at the intersections of these factors (Bowleg, 2012). The factors considered in intersectionality are described by some authors as categories and others as identities. For this thesis the term identities have been chosen. Neither term is perfect in its description, but it was felt by AB that identity is more self-selected, whereas categories sound prescribed. Therefore, intersectionality can be defined as follows,

> 'theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, socioeconomic status, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression

> (i.e. racism, sexism, heterosexism, classism) at the macro social-structural level.' (Bowleg, 2012, p 1267)

2.3.2 Background Literature Exploring the Concept of Intersectionality

The first documented mention of the concept of intersectionality was within the "Ain't I a woman?" speech by Sojourner Truth, a freed black slave, at the 1851 Ohio Women's Convention (Women's Rights National Historic Park, 2017), in which she recognised that the treatment of women as a group was not equal. Whilst all women suffered inequality, black women suffered a further level of subordination that white American women of the time were not subject to (Bowleg, 2012; Women's Rights National Historic Park, 2017). Therefore, the intra-group (with reference to women as the group) oppressions black women at this time suffered compared to white women were due to the intersection of race and gender.

In the 1990's, the term intersectionality was coined by Kimberle Crenshaw to describe these differences within women as a group (Crenshaw, 1991). Whilst exploring the relationship between identity politics and violence against women of colour Crenshaw observed that the 'problem with identity politics is… that it frequently conflates or ignores intragroup differences' (Crenshaw, 1991). She argued that an intersectional approach could capture more wholly the effect of intersecting factors such as race and gender in black women's lives in ways that could not be captured by looking at these factors separately, thus recognising and exploring that being both a woman and black they may be doubly discriminated against (Crenshaw, 1991). The importance of intersectionality has since received international recognition, helping researchers and policymakers to move beyond a siloed focus on issues such as racial inequality to incorporate other categories that intersect and enhance inequalities (Collins, 2015; UNHCR: The UN Refugee Agency, 2018; Hankivsky and Jordan-Zachery, 2019).

> 'intersectional injuries occur-when multiple disadvantages or conditions interact to create a distinct and compound dimension of disempowerment'(United Nations Division for the Advancement of Women, Office of the High Commissioner for Human Rights and United Nations Development Fund for Women, 2000, p9)

Within the U.K., however, research into the impacts of disadvantaged health inequalities has focused more on the relationship between social class/socioeconomic status and health rather than race, as is the case in America (Salway *et al.*, 2010; Collins, 2015; Kapilashrami, Hill and Meer, 2015). Ingelby (2012) contends that in European health equity literature the term social determinants almost always equate to solely socio-economic determinants, ignoring other factors, particularly ethnicity and migration status. A similar argument is made in relation to women's health research where it is argued that gender is given priority over other key determinants of inequality (Hankivsky *et al.*, 2010). Hankivsky *et al.* (2010), warns that by allowing gender to become the overriding category in women's health research, researchers run the risk of further excluding and marginalising populations of women from this research. Intersectionality challenges this one-dimensional approach to provide 'a more complex understanding of identity, social position and inequality in the social determinants of health' (Kapilashrami, Hill and Meer, 2015 pg 1).

Therefore, whilst socioeconomic status, class, gender or race should be included within the identities explored when using intersectionality, no single identity should be forced to dominate as they will not always be equally salient, depending on what is being studied (Walby, Armstrong and Strid, 2012; Collins, 2015). Identities should be examined in a non-hierarchical fashion and analysed carefully within the environment studied as identities are fluid and dynamic in different situations (Hancock, 2007; Walby, 2007; Bowleg, 2012; Ingleby, 2012; Walby, Armstrong and Strid, 2012)

American and Australian research has historically embraced intersectionality more than U.K. based and European research (Ingleby, 2012; Kapilashrami, Hill and Meer, 2015). However, it has increasingly become more recognised within U.K. research, for example in the works of authors such as Rollock (2014), Kapilashrami, Hill and Meer (2015), Piacentini *et al.* (2019) and Nazroo (2003). It is also becoming more recognised in the work of social care practitioners and is informing practice. For example Community Care Inform, an education site for social workers, has produced a guide for practitioners in using an intersectional approach in initial meetings with young people (Davis and Marsh, 2020), as has the Equality Network, who have produced and provided training on including

intersectionality when providing services for people who identify as lesbian, gay, bisexual and transgender (LGBT) (Equality Network, 2021).

2.3.3 Use of Identities in Intersectionality

Intersectionality traditionally focused on the triad of female gender, race and class, in keeping with the feminist roots of the theory (Davis, 2008). There have therefore been scholarly debates within the field of intersectionality about the importance of moving beyond this traditional triad to include other identities. Hancock (2007) suggested that intersectionality has an important place when exploring all types of inequality where two or more axes of oppression are likely to be at play and should not be limited to solely feminist research. Other authors have discussed the importance of the inclusion of other identities, such as migration status, ethnicity, sexual identity, sexual behaviour, disability status, poverty, age and education (Bowleg, 2012; Ingleby, 2012; Springer, Hankivsky and Bates, 2012). The absence of data from such areas such as those mentioned above can oversimplify explanations of inequality (Bowleg, 2012) and ignore the connections and reinforcement between multiple forms of inequality (Ingleby, 2012). For these reasons the potential for intersectionality within migration research is increasingly recognised (Anthias, 2008, 2012; Ingleby, 2012; Viruell-Fuentes, Miranda and Abdulrahim, 2012; Piacentini *et al.*, 2019). Examples where intersectionality has been used to explore refugees experiences include Erez, Adelman and Gregory, 2009; Yacob-Haliso, 2016; Koirala and Eshghavi, 2017; Zavratnik and Krilic, 2018; Taha, 2019; Tschalaer, 2020. Therefore, there is precedent to move beyond the scope of the traditional triad, to include migration status for example, to obtain as full a picture within this thesis as possible.

Within intersectionality individuals are not simplified to only one identity or another such as homosexual or female, woman or black (Bowleg, 2012); or in the case of this thesis asylum seeker or refugee. It is recognised that combined identities such as gender, religion, ethnicity and socioeconomic status will have also shaped their experiences (Collins, 2015). There may also be intra-group differences (Ingleby, 2012). For example, individuals are categorised as asylum seekers for legal purposes but they may have nothing else in common apart from this label (Leudar *et al.*, 2008).

Anthias (2008) argues that migrant groups may have experienced multiple fluid identities depending on their location, she terms this translocational positionality. Translocational positionality accepts that migration is a movement in the context of physical place but also incorporates dislocations and relocations of identities which are influenced by the national context of where they physically are (Anthias, 2012). These national contexts often lead to social positioning of identities as desirable or undesirable, linking back to notions of deservingness, as will be explored further in Section 3.5, and producing inequalities (Anthias, 2012). Therefore, the key benefit of the notion of translocation is the recognition of the importance of the context within which identities are formed and the importance of looking out with individual experiences to the wider discourses, practices and structures which can affect identity formation and subsequent inequalities in different locations (Anthias, 2008, 2012). This links in with the macro-level of candidacy and the internalisation of deservingness based on these macro level contexts, such as the construction of a hostile environment for asylum seekers and refugees.

Translocational positionality also acknowledges the existence of contradictory and shifting social identities where an individual might be in a position of dominance and subordination simultaneously in different spaces (Anthias, 2012). An example of this may be that an asylum seeker in the U.K. may identify as a lower socioeconomic class than they would have been in their country of origin, which will alter their experiences in the U.K. However, there may be an expectation from family in their country of origin that they are in a better socioeconomic position and will be able to send money home to their family. Expression of different identities may also be fluid or certain identities expressed more strongly, even when in one location, as they can be influenced by memories, traditions and symbolic ties to both their country of origin and the country they have migrated to (Anthias, 2008). Women in particular are often the keepers of culture, taking responsibility in passing down traditions to their children (Anthias, 2012).

Therefore, intersectionality should allow the researcher and the research participants to look at the group being studied, in this case asylum seeking and refugee women, and realise what the group encompasses and the differences within it (Crenshaw, 1991). This should help to avoid crude categorisation of

groups, which can lead to missing important intra-group differences (Kapilashrami, Hill and Meer, 2015).

Figure 3 illustrates how different individual identities create intersections, leading to the concept that ‘classes are always gendered and racialised and gender is always classed and racialised and so on.’ (Anthias, 2008 p 13). Hunt and Batty (2009) argued that gender should never be studied in isolation from social class and ethnicity, as it has consequences for life opportunities and health. Identities therefore intersect which can create interlocking oppressions and are therefore best understood in relational terms rather than in isolation from one another (Collins, 2015). Migration status has been added to this diagram to demonstrate this as an identity affecting asylum seekers and refugees, which may intersect with other identities (such as being an asylum seeker and a women) to create different and specific vulnerabilities. More identities can be added if they emerge throughout the research.

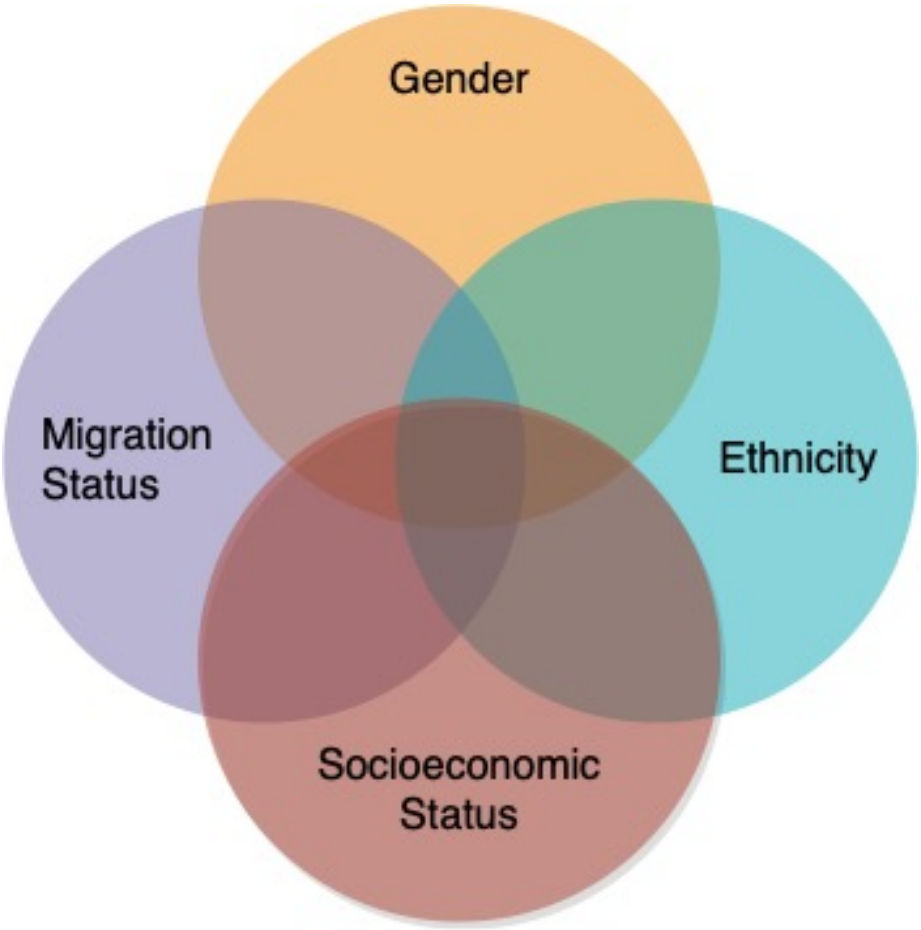


Figure 3: The Intersections of Identities

Intersectionality research should be focused on analysing what occurs at the intersection of the identities (Hankivsky *et al.*, 2010). This is important for both refugee and migrant women who are particularly vulnerable to race and gender discrimination, whilst also facing language and socioeconomic barriers, in addition to the background of anti-migration policies contributing to negative rhetoric and stereotyping (United Nations Division for the Advancement of Women, Office of the High Commissioner for Human Rights and United Nations Development Fund for Women, 2000). For example, if an asylum-seeking woman is a victim of domestic violence, her gender may appear to be the most important identity within this situation, however due to the intersection of her gender and migration status she may have less ability to gain freedom from the situation, as her asylum claim may be linked to that of her spouse. Therefore, it is not the prominence of one identity but the intersection of gender and migration status that determines her vulnerability and experience of inequality

at this point. Cultural identities, roles and responsibilities can also intersect with gender and race to make it difficult for women to confront gender discrimination within their own communities, as shown by the example below.

> 'Racism within the dominant culture makes it more difficult for immigrant women to confront gender discrimination within their own communities as immigrant communities frequently exert more pressure on women to maintain their traditional roles and to prevent patriarchal norms as "binding" elements for their community as a response to racism.' (United Nations Division for the Advancement of Women, Office of the High Commissioner for Human Rights and United Nations Development Fund for Women, 2000)

Identities should be largely identified by the research participants, allowing identities of importance to emerge and not be super-imposed by the researcher, with awareness that it cannot be assumed that all individuals will have had similar experiences within the same identity (Crenshaw, 1991; Bowleg, 2012).

Depending upon the context of the research, further stratification of the identities may be necessary (Kapilashrami, Hill and Meer, 2015). This is particularly the case when researching migration, as identities may have a more global context, or have changed in their meaning or importance during the migration journey, or between countries (Anthias, 2008, 2012; Kapilashrami, Hill and Meer, 2015). In this way identities constitute starting points for exploration in research, rather than the end point of analysis (Collins, 2015).

2.3.4 Structure, Power and Politics and Their Importance to Intersectionality

Intersectionality focuses beyond individuals to acknowledge the way in which systems, structures and institutions may oppress some groups within society, but privilege others (Crenshaw, 1991; Collins, 2015; Kapilashrami, Hill and Meer, 2015). An example of this would be white privilege, where there is an unearned dominance in society due to being white: as while racism limits the life chances of ethnic minority groups, it bolsters the opportunities afforded to the white population and, although white people face adversity, their life trajectory will not have been hampered by their race (Eddo-Lodge, 2020). Hence, by considering what is created at the intersection of different categories, we can

examine how this intersection can simultaneously oppress and privilege different groups at the same time (Hankivsky *et al.*, 2010).

Identities are experienced within political and social systems, which can often intensify intra-or inter-group inequalities (Collins, 2000; Bauer, 2014). A clear example, of relevance to this work, would be the situating of migrant women within the U.K. asylum process which makes them increasingly vulnerable, as discussed in Section 1.4. Therefore, intersectionality moves beyond the individual causes of health inequality to consider 'how these individual multiple identities intersect with multiple-level social inequalities at the macro structural level' (Bowleg, 2012).

Crenshaw (1991) discusses that issues of intersectionality are present in the media also and are often evidenced by the stories which the media chooses to present. For example the media often tackles issues such as rape and violence differently depending upon the victim's race (Crenshaw, 1991) or as will be discussed in Section 3.6 the tone of threat that is often used when discussing asylum seekers and refugees. With regards to gender policy Crenshaw (1991) discusses that these are often made by individuals or groups who are disconnected from the issues which the policies are trying to address and therefore will be limited in their usefulness.

> 'It is specifically political: the narratives of gender are based on the experience of white, middle class women, and the narratives of race are based on the experience of Black men.' (Crenshaw, 1991 p1298)

Whilst Crenshaw (1991) uses the example of gender policy similar examples can be shown for asylum seekers and refugees, who (with the exception of a change in 2020 granting refugees the right to vote in Scotland) are excluded from the democratic process in the U.K., despite their participation and potentially lengthy time living in communities. They may also face barriers in exercising their right to protest or assemble due to concerns over their immigration status or police action (SHRC, 2021).

2.4 Chapter Summary

Candidacy and intersectionality were chosen as complementary theories for this thesis. As described in this chapter they both offer insights into journeys. Not only the journeys of individuals in accessing healthcare but also the journeys of changing identities, social positioning and feelings of deservingness depending on the context they are in. They are both dynamic and flexible to take account of the facilitators and barriers that may face individuals at different points of healthcare access.

They also consider relationships, structures, and power dynamics at both personal, community and wider societal levels. This can provide a rich understanding of influences on the access journey.

Candidacy was chosen for this thesis as it allowed the integration of a variety of perspectives in the study of asylum seeking and refugee women's access to and use of preventive services. Thus, candidacy helped to inform a fuller picture of health beliefs around individual's views of risk factors for cervical cancer, feelings of eligibility for screening services and health care access, whilst giving a framework which breaks this down into manageable sections. It incorporated both the patient and the healthcare worker view, giving as full a picture of health care access as possible from both sides of the relationship. It also allowed the inclusion of others that are encountered through the journey, such as community workers, who may have a role in bridging the gap between individuals and healthcare workers and therefore enhancing the candidacy journey.

In addition to the variety of perspectives external to the individual being followed, in this case asylum seeking and refugee women, candidacy also allowed exploration of women's multiple roles and identities and how they affect the candidacy process and may change over time. As endorsed by MacKenzie *et al.* (2014) an intersectional lens can enrich the candidacy theory and in this thesis allowed a deeper exploration of the intersecting roles that women face, both individually and within the structure of organisations. It also widened the scope of the research to incorporate the views of other

stakeholders, such as community and healthcare workers, to examine relationships, dynamics, multi-dimensional markers of difference and the reality of working within the inequalities caused by the intersections of poverty, gender, ethnicity and migration status (Collins, 2015; Piacentini *et al.*, 2019).

The concept of deservingness weaves its way through both theoretical concepts. From the hostile environment created in the macro-level of candidacy created in the intersections of discrimination, through to the internalised feelings of deservingness in the patient and health care provider candidacy negotiations in the micro-level of candidacy.

Both theories have methodological challenges, which is to be expected as they encourage the researcher to explore complexity and find a deep understanding of issues. Therefore, there was an awareness that whilst flexibility was needed in the approaches used to be open to emerging themes, identities, and complexity, it was also important for boundaries to be set. There is a danger, particularly with intersectionality for a study to become ever expanding (Anthias, 2012). The boundaries set in this thesis were a focus on newspapers as the public discourse being studied and using cervical screening as a case study within the group of asylum seeker and refugee women. MacKenzie *et al.* (2014) tested the use of an intersectional lens with the candidacy framework, through a literature synthesis of help seeking behaviours of women who have faced domestic abuse and found it an effective means to enrich the candidacy framework, particularly with regards to understanding how structural factors influence access to healthcare at an individual level. Therefore, using both theoretical lenses appeared appropriate for this thesis as it incorporated them into the methodological structure. Having considered the theoretical underpinning for this thesis, the next chapter will present the literature regarding healthcare access for asylum seekers and refugees.

Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Access

3.1 Introduction

Chapter 2 outlined the theory of candidacy and the framework developed by Mackenzie *et al.* (2012), which has been used in the design of this thesis. It also described intersectionality and how that was used as a lens to interpret the findings presented in this thesis. In this chapter, a narrative literature review will present the literature regarding asylum seeker and refugee healthcare access in general, to give context to the wider themes of access, health literacy and entitlement discussed in this thesis. It will also introduce the notion of deservingness and how this can be affected by public discourses, which sit in the macro-level of the candidacy framework but can then affect individual healthcare interactions.

Asylum seeker and refugee health and healthcare is a vast literature and therefore this chapter will focus on the following key questions, which consider health needs and access generally then focus down on three key facilitators for healthcare access: health literacy, entitlement, and deservingness.

1. What is known about asylum seekers and refugees' health needs, behaviours and access to primary healthcare in the U.K.?

2. How do asylum seekers and refugees develop health literacy in the U.K.?

3. How are entitlements to healthcare protected for asylum seekers and refugees?

4. What is known, in the literature, about how newspapers portray asylum seekers and refugees?

5. What is known, in the literature, about how public discourses of deservingness, are internalized?

In order to explore questions 1,2, 3 and 5 literature searches were performed using the search engines MEDLINE, EBSCO Host, Science Direct, Google Scholar and SocIndex, with a date range of 1st January 2000- 19th March 2022, covering the period when the numbers seeking asylum in the U.K. began to increase and then covering the time period this PhD was conducted over.

Due to the 10-years this thesis was conducted over these searches were repeated multiple times in order to keep the literature up to date. Older literature, where appropriate, was still included as it was relevant at the early stages of this thesis and importantly often demonstrated the context the media analysis was conducted in and the participants in the qualitative work were interviewed in.

Table 1 lists the search terms which were used as the base for each search (excluding row 8: the media search terms).

Table 1 Literature Review Search Terms

	Theme	Keywords
1	Refugee and asylum seeker	refugee*OR refugees* OR refugee* OR refugee's* OR asylum seeker* OR asylum seekers* OR seeker, asylum* OR seekers, asylum* OR political asylum seekers* OR asylum seeker, political* OR political asylum seeker* OR seekers, political asylum* OR political refugees* OR refugee, political* OR refugees, political* OR displaced persons* OR displaced person* OR person, displaced* OR internally displaced persons* OR displaced person, internally* OR displaced persons, internally* OR internally displaced person*
2	Migrant, immigrant	Migrant* OR migrants* OR immigrant* OR immigrants* OR foreigner* OR foreigners* OR immigrant, undocumented* OR immigrants, undocumented* OR undocumented immigrant
3	Health access	Health* OR health literacy* OR health social determinant* OR health social determinants* OR structural determinants of health* OR health structural determinant* OR health care* OR care, health* OR healthcare* OR health access* OR access to healthservices* OR access to care* OR health behaviours* OR behaviour, health* OR behaviours, health* OR health-related behaviour* OR behaviour, health-related* OR behaviours, health-related* OR health related behaviour* OR health-related behaviours* OR health needs* OR health services needs* OR need, health services*
4	Health inequalities	Health care inequalities* OR health care inequality* OR inequalities, health care* OR inequality, health care* OR healthcare disparity* OR health inequity* OR inequities healthcare* OR inequity, health*
5	Deservingness	Deservingness* OR deserving* OR deserve*
6	Barriers	Barriers* OR barriers to healthcare* OR barriers to access*
7	Facilitators	Facilitators* OR facilitators to healthcare* or facilitators to access*
8	Media	Media* OR media analysis* OR newspapers* OR news* OR newspaper article* OR mass media* OR communications media*

Inclusion and exclusion criteria were applied to the results in order to focus on asylum seekers and refugees' health and access to healthcare, health literacy and deservingness. Articles which were from the Scottish and U.K. settings were prioritized. However, where bodies of literature were smaller such as around deservingness for healthcare, literature from wider settings were included. Several areas of asylum seeker and refugee literature, whilst recognised as important issues, were out with the scope of this thesis, and therefore have not been included in any detail. These included secondary healthcare access, particularly emergency services, maternity care, and mental health service access and issues surrounding destitution.

For the section of the literature review which explored question 4, what is known, in the literature, about how newspapers portray asylum seekers and refugees, all the search terms were included from the table above with the addition of row 8's search terms relating to media. The parameters for this search were the time-period of January 2001- April 2013. This search was not repeated, unlike the rest of the literature searches. This was deliberate as any update in this particular part of the literature review would refer to political and global events that had not happened at the time of the data collection for the newspaper analysis performed in this thesis (Chapter 6) and would therefore disrupt the chronology of the findings. However, a check of the literature was made when completing the writing-up to ensure that more recent references were included in the discussion of media reporting.

Once key papers were identified from the database searches above, a snowball technique was then used by hand searching the bibliographies of papers to find further key papers. Snowballing is a recognised technique, across many academic disciplines, as a way of extending the sources found in a literature review (Greenhalgh and Peacock, 2005; Sayers, 2008; Wohlin, 2014). Greenhalgh and Peacock (2005) endorse snowballing techniques, as they argue that review of complex evidence cannot rely solely on protocol driven search strategies and that strategies such as pursuing references, asking colleagues and being alert to incidental discovery may identify sources that would otherwise be missed. This literature review used both backward and forward snowballing as a technique (Wohlin, 2014). The backwards snowballing technique involved identifying key articles from the database searches above, searching their bibliography to find

relevant articles that they cite and then retrieving them. This process was then repeated for the articles that were retrieved and so on until no more relevant articles were found (Sayers, 2008). The forward (or reverse) snowballing technique was then used to find more contemporary articles (Sayers, 2008). The Google scholar's citation tracking tool was also used to identify papers that had cited key papers and used for citation alerts. Through this process I could then identify further papers of interest to apply the forwards and backwards snowballing technique to, until I found no more relevant articles.

An example of an important source document used in the snowballing technique is the 2018 UCL-Lancet Commission on migration and health (Abubaker *et al.*, 2018). This was a key, comprehensive piece of work and due to its breadth and depth it has been cited frequently during this chapter as an important source document.

Papers were also identified through discussions with others working in this area, supervisors, academics in the department and other PhD students which also increased the yield of sources and pointed to sources of grey literature. Grey literature is defined as research published outside of commercial or academic publishing, often in the form of reports, fact sheets and policy papers (https://uow.libguides.com/literaturereview/grey-literature). As discussed, some sources of grey literature were found through contacts, a proportion was also found through the snowball technique used with academic articles and others were found through specific searches of relevant refugee, medical and policy websites, such as:

- The Scottish Refugee Council: www.scottishrefugeecouncil.org.uk
- The Refugee Council: www.refugeecouncil.org.uk
- The Migration Observatory: www.migrationobservatory.ox.ac.uk
- Asylum Aid: www.asylumaid.org.uk
- British Medical Association: www.bma.org.uk

- Doctors of the World: www.doctorsoftheworld.org.uk
- Amnesty International: https://www.amnesty.org.uk
- Equality Network: www.equality-network.org
- The Scottish Government: https://www.gov.scot
- Glasgow City Council: www.glasgow.gov.uk
- Home Office: www.gov.uk
- Convention of Scottish Local Authorities (COSLA): www.cosla.gov.uk
- Word Health Organisation: www.who.int
- The UN Refugee Agency: www.unhcr.org

The search of grey literature focused on the U.K., Scotland, asylum seekers, refugees (particularly women), and healthcare access. The grey literature was interrogated alongside the academic papers found through the database searching. Information was cross-checked, when needed, to confirm validity.

Data was extracted from all sources into an annotated bibliography (https://library.leeds.ac.uk/info/1401/academic_skills/80/annotated_bibliographies), which was a table listing all of the sources used with annotations for each describing the sources content and a summary of its main argument. This then allowed for synthesis and analysis of the literature, to provide the basis for this chapter which will provide a context within which to consider how asylum seeking and refugee women identify and navigate primary care services.

3.2 Health Behaviours, Access and Needs of Asylum Seekers and Refugees in Primary Care

Migrant populations are heterogenous and health outcomes vary, but evidence consistently shows the disproportionate health, social and economic burdens of forced migration, such as in the case of asylum seekers and refugees (Abubaker *et al.*, 2018). It is known that, although asylum seekers and refugees may have been healthy enough to make the journey, many arrive in distress, with long standing illness, physical disabilities, increased rates of mental illness and complex health needs (Roshan, 2005; Medecins du Monde, 2016; Abubaker *et al.*, 2018; World Health Organization, 2018; British Medical Association, 2019). Ochieng (2013) estimated that one in six newly arrived refugees has a physical problem severe enough to affect their life and two-thirds have experienced anxiety and depression These can often be attributed to the experiences they were fleeing such as war, torture, rape and from inadequate access to health services both in country of origin and on the journey (Roshan, 2005; British Medical Association, 2019). However, even once the journey is complete, discrimination, gender inequalities and exclusion from health and social services repeatedly emerge as negative health influences for asylum seekers and refugees in their country of settlement (Roshan, 2005; Abubaker *et al.*, 2018; British Medical Association, 2019). In addition health problems can rapidly develop once individuals are in the U.K. if they have difficulty in accessing health promotion services (Ochieng, 2013). This can cause particular concerns for elderly, female, pregnant and disabled asylum seekers and refugees (Roshan, 2005; Zimmerman, Kiss and Hossain, 2011; Abubaker *et al.*, 2018; Davidson *et al.*, 2022).

The effects of loss of familiar culture, family and friends, isolation, threat of abuse and deprivation can all impact on asylum seekers and refugees experiences of health care (Blackwell, Holden and Tregoning, 2002; O'Donnell *et al.*, 2008). Policies are often blamed as being discriminatory, and not adequately addressing barriers to health services and inequalities faced by individuals, especially for women and girls (WHO and IOM, 2010; Abubaker *et al.*, 2018). However, asylum seekers and refugees also travel with their existing health profiles, values and beliefs, cultural background, socioeconomic status and the

disease prevalence's of their countries of origin (WHO and IOM, 2010). Many asylum seekers will come from countries without an established primary care system, may be used to direct access to hospital specialities or have experienced a complete lack of or breakdown of healthcare systems secondary to war or internal conflict (O'Donnell *et al.*, 2008). These factors can all impact on the way that asylum seekers and refugees recognise and access health care. The U.K. has a universal health service, which removes some financial barriers to healthcare access. However, barriers still exist at multiple levels.

Asylum seekers are in constantly changing situations. They have often spent varying amounts of time in different countries on their journey to the U.K. and dispersal between and within cities in the U.K. is common (WHO and IOM, 2010). The Audit Commission (2000) identified concerns that the high mobility of asylum seekers, due to the asylum process, leads to difficulty in providing continuity of care, particularly surrounding the follow up of vaccination, screening, and preventive health programmes. A further report, 20 years later, by the National Audit Office (2020) showed that prolonged stays in initial, temporary accommodation before being moved on to longer term dispersed accommodation could lead to a delay in asylum seekers being able to register with a GP or enrol children in school. The aim is to make this move within 35 days of the persons arrival, but for some this can take much longer delaying initiation and continuity of care (National Audit Office, 2020).

Asylum seekers and refugees also have multiple, competing priorities which can lead to low prioritisation of engaging with and accessing healthcare, particularly non-acute, preventive healthcare (Abdi, Menzies and Seale, 2019). Asylum seeking women are balancing caring for their children, integrating into a new community, learning a new language, financial pressures, stigma and isolation; all of which is amplified by the stress, uncertainty and hostility of the asylum system (WHO and IOM, 2010; Onyigbuo, Alexis-Garsee and van den Akker, 2018; Babatunde-Sowole *et al.*, 2020; Farrington, 2020). For most asylum seekers and refugees their concerns operate further down Maslow's hierarchy of needs compared to where screening or preventive medicine focuses (Keygnaert and Temmerman, 2007; Farrington, 2020),

> ‘if you don’t know where next meal is coming from, then well-meant dietary advice for CVS risk is pointless’ (Farrington, 2020, pg 3).

Intersecting factors such as poverty, destitution, stigma, hate crime, social exclusion, mental distress, loss of social and occupational roles directly influence the health and wellbeing of asylum seekers and refugees (Farrington, 2020). Health conditions can also be influenced from previous experience, which may have predated or been part of the asylum journey, such as trauma, religious or political conflicts, persecutions from cultural practices and previous experiences of poverty (Onyigbuo, Alexis-Garsee and van den Akker, 2018; Isaacs *et al.*, 2020). Higher levels of depression are reported amongst asylum seekers compared to the population as a whole and even when refugee status is achieved there is ongoing adjustment and effects from past trauma and experiences (Mulvey, 2009). When asylum seekers and refugees are able to register with a GP, barriers to accessing and providing effective primary care have been identified: including language barriers; increased time required for consultations; lack of knowledge surrounding the role of the GP; lack of awareness by the GP of the needs of asylum seekers; and competing priorities at the clinician and structural level of healthcare (Audit Commission, 2000; Roshan, 2005; O’Donnell *et al.*, 2007; Zwi *et al.*, 2017; Kang, Farrington and Tomkow, 2019; Farrington, 2020).

Negotiating and navigating the NHS can be difficult. Barriers identified as impeding access to primary care include uncertainty about how the NHS works, being unfamiliar with gatekeeper systems, waiting times, and lack of awareness of appointment systems (O’Donnell *et al.*, 2008; Kang, Farrington and Tomkow, 2019). Studies have found that if appointments with the GP were difficult to achieve then asylum seekers often went straight to hospital (O’Donnell *et al.*, 2007; Kang, Farrington and Tomkow, 2019). Previous healthcare experience also influences expectations of the NHS. In O’Donnell et al (2008) the concept of free access to healthcare was welcomed by all. However, those used to a private system expressed frustration with wait times for hospital appointments or investigations and not being able to access a specialist directly (O’Donnell *et al.*, 2008; Lindenmeyer *et al.*, 2016). Confusion by both asylum seekers and healthcare workers with regards to their entitlement for healthcare was also identified as a barrier to access (Piacentini *et al.*, 2019; Tomkow *et al.*, 2020).

Many asylum seekers and refugees lack confidence in their GP's, as they are an unfamiliar service. They worry that they may not have the expertise or knowledge to deal with the breadth of illnesses that will be presented to them (O'Donnell *et al.*, 2008). Some literature also reports that attitudes of staff and different practices, such as less physical examination or stricter antibiotic prescribing than they are used to, are internalised as being due to their asylum status which can lead to feeling dismissed or devalued (O'Donnell *et al.*, 2008; Mulvey, 2009; Kang, Farrington and Tomkow, 2019; Bradby *et al.*, 2020). Diminished trust was compounded if reasons for clinical decisions were not explained and further distress was caused if there was inadequate interpreter support to do this (Kang, Farrington and Tomkow, 2019; Farrington, 2020). The importance of adequate language provision was identified as a key facilitator of primary healthcare access (O'Donnell *et al.*, 2016; Kang, Farrington and Tomkow, 2019; Bradby *et al.*, 2020)

As with language (which will be considered further in Section 3.3), many of the factors which act as barriers to asylum seekers and refugees accessing healthcare can also act inversely as facilitators, if considered sensitively. For example, education, particularly if provided with the necessary interpretation, has been shown to effectively promote awareness of issues such as health screening and encourage individuals to discuss these with their healthcare worker (Abdi, Menzies and Seale, 2019; Babatunde-Sowole *et al.*, 2020).

Often asylum seekers and refugees educate themselves about healthcare through informal routes, such as through community groups or conversations with each other, rather than through healthcare services themselves (Piacentini *et al.*, 2019). Women, in particular, are less likely to speak adequate English to access statutory agencies directly and often rely on informal networks for information, advice and help with paperwork (Williams, 2006; Kang, Farrington and Tomkow, 2019). The intersection of gender and culture is important to consider with regards to health access. Pre-migration and cultural experiences may also mean that women are more vulnerable than men. They are often afforded lower social status, placing them in a position of dependency on men and may have experienced a lack of educational opportunities, which weakens their ability to

access information needed to make decisions (Davidson *et al.*, 2022). Therefore, involving community and third sector organisations in signposting, educating and disseminating information about healthcare and services can improve access and trust, especially if delivered through trusted sources such as community organisations (Williams, 2006; Abdi, Menzies and Seale, 2019). 'Cultural mediators' or 'brokers', often from migrant groups or communities, have been shown to be successful in bridging the gap between communities and healthcare systems (WHO, 2010; WHO and IOM, 2010).

3.3 Developing Health Literacy

Health literacy has been identified as a key barrier and facilitator in individuals' access to health services. It can be defined as the cognitive and social skills which determine the ability to acquire, understand and use information that promotes good health (Muscat *et al.*, 2016; Gilder *et al.*, 2019). The importance of health literacy is gaining traction, including the production of a World Health Organisation (2014) Health Literacy Toolkit for strengthening health literacy in low and middle income countries, and providing evidence to policymakers and health service providers about the importance of this within the preventive and chronic disease management agenda (Babatunde-Sowole *et al.*, 2020; Farrington, 2020).

However, despite health literacy being deemed an important determinant of health outcomes there is a lack of consensus around definition, measurement tools and intervention (Gilder *et al.*, 2019). It is also argued that many definitions, including the WHO definition above, focus too much on the individual and do not take into account the pivotal role that the health, education and social care systems play in facilitating or impeding an individual's development of health literacy (Gilder *et al.*, 2019; Babatunde-Sowole *et al.*, 2020). For example, Gilder et al. (2019) found that educational attainment at school was a positive predictor of health literacy and a low education level was more likely to be associated with greater reliance on traditional health beliefs.

Improving health literacy can be difficult for refugee women who most often originate from non-English speaking backgrounds and have a number of competing priorities, including multiple caring responsibilities (Babatunde-

Sowole *et al.*, 2020). Language is an essential component of improving health literacy and is a key component of health care (Lehane and Campion, 2018; Piacentini *et al.*, 2019; Rimmer, 2020). Therefore, high quality, culturally appropriate interpreter services are an important need for women who don't speak English (Parajuli, Horey and Avgoulas, 2019; MacFarlane *et al.*, 2020). Communicating with populations who have low levels of health literacy and language barriers is complex, with regards to both language spoken and general literacy levels in both first language and English (Gilder *et al.*, 2019). Many asylum seeking and refugee women may have had a disrupted education and may struggle with literacy in both their own language and English (Abdullahi *et al.*, 2009; Floyd and Sakellariou, 2017).Therefore, it is vital that adequate verbal communication is provided in appointments, with also access to written material using a variety of words and culturally acceptable, non-taboo imagery, in the necessary language (Mengesha *et al.*, 2018; Gilder *et al.*, 2019).

Patients should also feel assured about confidentiality when using an interpreter and interpreters should be supported in their role as they are often torn between their roles as dispassionate interpreter versus patient advocate and educator (Hsieh, 2006, 2008; O'Donnell *et al.*, 2007a; Piacentini *et al.*, 2019; Leanza *et al.*, 2021). It is also important that adequate interpretation is not the only communication support offered as there are multiple components of adequate culturally sensitive communication and dialogue across health care (Piacentini *et al.*, 2019). For example, health education is unlikely to be taken seriously by communities unless it reflects their views, appears relevant, is appropriately targeted and empowers individuals to make the best use of the health system for them (Netto *et al.*, 2010; WHO and IOM, 2010).

With regards to preventive healthcare an initial barrier to health literacy is that an individual may not realise that they need healthcare input or what healthcare is available. This is in keeping with the WHO and IOM (2010) recognition that, in the last 50 years, in western countries in particular, the concept of health has become much broader leading to a potential divergence in what is considered to be a health need or priority, such as screening, between host communities and those migrating from particularly low- and middle-income countries. Therefore, supporting individuals and communities to increase control of their health through improving health literacy and education is vital to improving access and

uptake of preventative healthcare, which may not have been given much focus in asylum seeker and refugees previous experiences (Babatunde-Sowole *et al.*, 2020).

3.4 U.K and Scottish Policy Protection for Entitlement to Health

Section 1.5 presented asylum seekers and refugees' entitlement to healthcare in the U.K. as a whole and specifically Scotland. This section of the literature review illustrates that there is a wealth of policies which protect this entitlement to healthcare. This is both through the primary CEL09 entitlement policy (The Scottish Government, 2010) and through wider policies which protect the other intersecting characteristics that asylum seeking and refugee women possess. It also considers policies which may undermine this entitlement.

Asylum seekers and refugees are entitled by international law to universal human rights without discrimination, including the right to the 'highest attainable standard of health' (Abubaker *et al.*, 2018, pg 2607). Health is considered to be a key dimension of the integration process, alongside other indicators such as employment, education and housing (Jayaweera and Quigley, 2010). However, health behaviour and access do not happen in a vacuum. They can be greatly influenced by the policies which are present within a country.

Key policies and Parliamentary Acts offer protection to many characteristics which will affect asylum seeking and refugee women and intersect with their migration status. The Equality Act (2010) is an example of this as it offers legal protection from direct and indirect discrimination to those who fall under nine specific characteristics, in both the workplace and wider society. It also places a higher standard on public authorities to protect those with these characteristics from discrimination. The nine protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Women who are seeking asylum often fall into several of these characteristics.

Policies which protect asylum seekers and refugees are often framed within wider equality policies in Scotland. The demographic and political context for migration is different in Scotland compared to elsewhere in the U.K. (Wren, 2007; Curtice and Montagu, 2018; Macfarlane, 2021). Concerns about diminishing population size, ageing population and lower fertility led Scotland to be more encouraging of migration through policies and schemes, such as the New Scots Refugee Integration Strategy 2014-2017 and 2018-2022, and was recognised as having a more positive public discourse on migration (The Scottish Government, 2017, 2018;Strang, Baillot and Mignard, 2018).

Policies are also often revised or refined in response to changing global situations. For example, the U.K. Syrian Vulnerable Persons Resettlement Scheme (SVPRS) was launched in January 2014 and then expanded in September 2015 with the aim to resettle 20,000 Syrians in need of protection to the U.K. (Home Office, 2017). As part of this programme the Scottish Government committed to receiving 10% of however many Syrian refugees were brought to the U.K. (COSLA, 2017). Refugees who came to Scotland through this programme were settled in councils throughout Scotland, not just Glasgow (COSLA, 2017). A commitment has also been shown by the Scottish Parliament to incorporate a human rights based approach to policy making, evidenced through the development of the National Taskforce for Human Rights Leadership in 2019 and acceptance of the recommendations from this taskforce, including the incorporation of four United Nations Human Rights Treaties into Scots law through a new Human Rights Bill (The Scottish Government, 2021a, 2021b)

Whilst there is a wealth of wider policies protecting entitlement to health care and equity of access, it is important to consider that punitive policies and the creation of a hostile environment for asylum seekers and refugees can equally erode it.

Punitive policies include those which restrict economic and social support, criminalise asylum seekers, create a hostile environment, focus on detention and deportation and are exclusionary in their language (Wren, 2007; Crawley, 2010; Mulvey, 2010; Abubaker *et al.*, 2018; Kang, Farrington and Tomkow, 2019). An example of a punitive policy affecting confidence in accessing health services

was when in 2017 it became apparent that the Home Office had been using requests for data from healthcare data systems in England, in order to track down migrants for the purposes of immigration enforcement(Abubaker *et al.*, 2018; Hiam, Steele and McKee, 2018). This was reversed in 2018, after being met with condemnation from the General Medical Council (GMC), Public Health England and the National Data Guardian (Abubaker *et al.*, 2018). However, it can be argued to have left a legacy of distrust which will limit access to healthcare for asylum seekers and refugees, particularly those who are vulnerable.

Another example of punitive policy making is the U.K. Governments plan to overhaul the asylum system in the U.K., through the introduction of the Nationality and Borders Bill (2021). If passed and adopted into law this bill will have far reaching negative consequences for people seeking asylum in the U.K. (UNHCR: The UN Refugee Agency, 2022). These include restricting access to the 1951 Refugee Convention depending on how you arrived in the U.K., criminalising arriving in the U.K. without prior entry clearance, consideration of offshore detention facilities, restricting access to the National Referral Mechanism for victims of trafficking (United Nations High Commissioner for Refugees (UNHCR), 2022). During the consultation process for this bill, a wide variety of stakeholders and civil society organisations have expressed deep concerns that the bill would penalise most refugees coming into the country and would undermine international refugee protection rights and practices (British Association of Social Workers, 2021; Doctors Without Borders, 2021; Refugee Council, 2021b; Women for Refugee Women, 2021; UNHCR: The UN Refugee Agency, 2022). The changes proposed by this bill would undermine many of the protective policies which are in place in Scotland for asylum seekers and refugees, tipping the balance from protecting asylum seekers to an increasingly hostile and punitive environment.

This section has demonstrated that despite the presence of wider punitive policies there is a clear entitlement for healthcare for asylum seekers and refugees in Scotland and there are other policies which protect this right. However, the relationship between formal entitlement to healthcare and asylum seekers and refugees feeling or being perceived as deserving of healthcare is often not aligned (Willen, 2012a). The important role of portrayals,

internalisation, and feelings of deservingness for healthcare will be explored in the following section.

3.5 Deservingness of Healthcare

Section 3.4 described the policies which protect the legal entitlement to healthcare. This section explores the more subtle discourse of deservingness which often sits alongside and can undermine or enhance the solid positioning of entitlement. Individual and societal discourses of deservingness are different from entitlement (Willen, 2012a; Abubaker *et al.*, 2018). They bring a moral judgement about whether different subgroups of the population are deemed worthy or unworthy of receiving help from the welfare state, which can be dependent on context and situations (Willen, 2012a; Nielsen, Frederiksen and Larsen, 2020). Deservingness of healthcare is a relatively under-researched theme. However, it is an area of increasing interest, especially in times of recession and welfare state restructuring (Willen, 2012b).

This study focuses on the deservingness debate surrounding asylum seekers and refugees, but distinctions between the deserving and undeserving have also been seen in those living in poverty, women, children, those with mental illness, prisoners and migrant workers (Tyler, 2013). As Sargent (2012) described it is a concept that has been present for a long time and affects many within society, particularly marginalised communities.

> '(Deservingness) draws on centuries-old representations of the "deserving" poor worthy of public support, in contrast to those less meritorious, who are marginalised from the body politic and denigrated for presumed moral laxity' (Sargent, 2012 pg 854)

Deservingness is usually implicit and intersects with other moral viewpoints (Willen, 2012a). Discourses and debates around deservingness are often informed by stereotypes and assumptions of target groups, which create normative yardsticks with which to measure deservingness, rather than actual knowledge of a person's background and lived reality (Huschke, 2014; Nielsen, Frederiksen and Larsen, 2020).

The ‘othering’ practices which create these distinctions between ‘us’ and ‘them’ are often inadvertent and invisible to those who perpetrate them and can originate in policies, institutional structures and through economic and cultural influences (Koehn, 2009; Vanthuyne *et al.*, 2013). As discussed in Section 3.4, legislation and policy can be purposefully hostile and harmful to target populations, such as asylum seekers and refugees, and can interact to undermine social stability and shape welfare systems, leading to normative assumptions of who should get what and why (Calvo, Jablonska-Bayro and Waters, 2017; Kline, 2019). Asylum seekers and refugees can be embodied as a threat, as their culture and ways of life can be presented as incompatible with western society and a fear of unrest and social breakdown can often be associated with this (Anthias 2012).

Within a healthcare setting, this can exacerbate ‘health-related vulnerability’ in particular populations, especially when there are intersections with wider inequalities such as poverty, race, gender inequality, legal obligations, moral judgements and accepted, everyday practice (Willen, 2012a page 815; Willen *et al.*, 2017).

The first step in negotiating healthcare, in any setting, is knowing that you require and deserve it (Koehn, 2009). It has been shown that universal healthcare systems tend to encourage wider feelings of healthcare as a human right and therefore increase the numbers of those who are considered deserving (Marrow, 2012). However, even in universal healthcare systems there is a financial contribution to the health system through tax. It has been well documented, in many countries, that immigrants are often judged to be undeserving of healthcare as they are perceived as being a beneficiary of the healthcare system but not net contributors and this has been exacerbated during times of austerity, recession and limited resources (Vanthuyne *et al.*, 2013; Calvo, Jablonska-Bayro and Waters, 2017). Healthcare is often framed as a ‘privilege’ not a human right, that should be limited to the deserving, law-abiding, taxpaying citizens of a country (Vanthuyne *et al.*, 2013).

Van Oorschot (2006) found a consistent public perception across Europe that elderly people were the most deserving of welfare spending, closely followed by

the sick and disabled; unemployed people less so and migrants were viewed as the least deserving of all. However, refugees were often seen as having traits such as lack of control and a high level of need which would make them a more deserving migrant than an undocumented immigrant, who was perceived as having more personal control and not contributing to the welfare state (Nielsen, Frederiksen and Larsen, 2020), creating a hierarchy of deservingness.

These discourses of deservingness for asylum seekers, refugees and migrants are often played out in the media. This will be explored in the next section.

The next section shall consider how discourses of deservingness can become internalised by asylum seekers and refugees, eroding the solid position of entitlement that the policies should give.

3.6 Newspaper Portrayals of Deservingness

This section will explore what is known in the published literature about the role of newspapers in framing the deservingness discourse. Several themes were presented in the literature surrounding the discourse about asylum seekers and refugees in U.K. newspapers. These included the scale of migration in the U.K.; asylum seekers and refugees as a threat; hostile reporting with techniques used to create panic; and little empathy or context given to the lives of asylum seekers and refugees in the U.K.

Myths around the number of asylum seekers in Britain were perpetuated by unclear, misleading statistics which repeatedly had no source quoted for them and gave the impression that the numbers of asylum seekers entering the country were much higher than they were (Mollard, 2001; Philo, Briant and Donald, 2013). The repeated use of natural disaster and war metaphors, such as “flood” and “invasion”, in connection to immigration created an air of panic about the scale of immigration in addition to dehumanizing migrants, asylum seekers and refugees (Leudar *et al.*, 2008).

Out with the threat of being overwhelmed by the scale of forced migration, asylum seekers and refugees were constructed as a threat in several other ways,

such as a threat to security, identity, economic provision and to British cultural identity and values (Khosravinik, 2009; Innes, 2010; Pearce and Charman, 2011). Asylum seekers and refugees were consistently represented as a group rather than individuals and accompanying photographs constructed a threatening image, usually groups of men, with women and children rarely being seen (Buchanan, Grillo and Threadgold, 2003; Innes, 2010). However, there is a noticeable gap in the literature about the portrayal of asylum seeker and refugee women in the media. This may be because the portrayal of asylum-seeking women and refugees in U.K. newspapers does not exist and therefore cannot be analysed in the media. Asylum seekers and refugees were also depicted as being a burden to the British economy through reliance on the welfare system and taking jobs and housing from British citizens (Mollard, 2001; Lynn and Lea, 2003; Philo, Briant and Donald, 2013).

It was consistently found that there was little coverage of the background of asylum seekers and refugees or the international context as to why they were seeking asylum, including Western countries responsibilities in global events which can lead to mass population movement due to conflict or economic reasons (Coole, 2002; Smart *et al.*, 2005; Philo, Briant and Donald, 2013). Integration was mainly considered only by local newspapers and there was a lack of focus on the benefits of migration particularly with regards to asylum seekers and refugees (Philo, Briant and Donald, 2013). There was a strong perception that few asylum seekers were genuine and frequent use of terms such as "bogus" and "illegal" asylum seeker, particularly in the tabloid right wing press (Buchanan, Grillo and Threadgold, 2003; Lynn and Lea, 2003; Gabrielatos and Baker, 2008; Philo, Briant and Donald, 2013).

These themes were consistent over the period of literature explored (2001-2013). Kushner (2010 pg 258), observed that the repeating themes found across the media were 'accusations that go back at least as far as the late nineteenth century and have been repeated with boring regularity to greet every new arrival'. A key change, however, was the intensity with which the media pursued these themes since the end of the 1990's (Kushner, 2010). The constant repetition of themes, was recognised as a tactic to reinforce them to the reader creating social constructions, in addition to justifying panic and

perceptions of threat (Lynn and Lea, 2003; Khosravinik, 2009; Pearce and Stockdale, 2009; Pearce and Charman, 2011; Banks, 2012). This thesis argues that through consistent repetition of themes, narratives are constructed through the media discourse, irrespective of fact, which are presented, repeated, and reinforced to the public.

In response to a rising number of complaints, the Press Complaints Commission issued guidance in 2003 to editors to avoid misleading or distorted terminology when reporting about asylum seekers and refugees (Press Complaints Commission, 2003). A decrease in terms such as 'illegal' or 'bogus' asylum seeker was noted following the guidance, although less so in the right-wing media (Smart *et al.*, 2005). A wooliness with regards to the sources and exact numbers behind statistics, e.g. 'hundreds' or 'thousands', continued but there was less use of metaphors such as 'flood' (Smart *et al.*, 2005).

Several other actions were also taken about hostile reporting through awareness raising campaigns. These included a Refugee Council awareness raising event 'Don't Believe the Hype' launched at Glastonbury Festival in 2005 (Refugee Council, 2012a), monitoring of the use of the guidance through the Information Centre about Asylum and Refugees (Smart *et al.*, 2005), and comments from Government bodies such as the Joint Committee on Human Rights expressing concern that media coverage of asylum seekers and refugees continued to be inaccurate and hostile (Joint Committee on Human Rights, 2007). Despite this it was felt by the Refugee Council (2012a), in their submission of evidence to The Leveson Inquiry (2012) into the culture, practices and ethics of the press, that asylum issues continued to be covered in an unbalanced and hostile manner, particularly in the right-wing newspapers.

Four media analyses were identified which considered primarily Scottish media reporting around asylum seekers, refugees and migrant groups (Mollard, 2001; Coole, 2002; Barclay *et al.*, 2003; Catto, Gorman and Higgins, 2010). The coverage of asylum seekers was found to be generally better within Scotland but still contained many of the hostile themes and discourses seen in the wider U.K. media (Mollard, 2001; Coole, 2002; Barclay *et al.*, 2003). Local newspapers provided the most positive, local coverage with a focus on integration, whereas

national tabloid newspapers such as the Daily Record were considered the most hostile (Barclay *et al.*, 2003).

The close relationship between politics and the media was identified throughout the media analyses. Migration is a highly political issue with increased written and photographic coverage during the time of general elections, including refugees, asylum seekers and migrants being automatically backgrounded in most of the debates even if not directly concerning migration (Khosravinik, 2009). Pearce and Stockdale (2009) argued that the combination of anti-immigration policies and a media which encourages the assumption that most asylum seekers are not genuine leads to support for anti-immigration discourses. As was observed in Innes (2010) 'securitizing migration and asylum constructs political trust'. Even prior to the Brexit referendum (which was not within the scope of this reviews timescale) there was a noted disproportionate representation of small right-wing parties, such as U.K.IP, who are anti-migration in their political views (Smart *et al.*, 2005).

Philo, Briant and Donald (2013) and the World Migration Report (International Organisation for Migration, 2018) both present that through certain methods the media can and does establish specific ways of understanding.

> 'The press, we are reminded, is stunningly successful in telling its readers what to think about' (International Organisation for Migration, 2018, page 739)

It has been recognised across various media analyses that the negative reporting surrounding migrants, asylum seekers and refugees is very close to racism (Finney 2008, Kushner 2003, Lynn 2003). Finney (2008) describes the negative reporting around migration as having moved from blatant racism to a softer, more subtle racism. Whereas Kushner (2003, p. 257) states: '… Britain has perhaps the strongest anti-racist, anti-discrimination legislation in the world. Paradoxically at the same time, a sustained and unrestrained campaign against asylum-seekers has achieved respectability throughout British society, culture and politics.' Lynn (2003 p.425) describes it as a 'new apartheid'.

The Lancet Commission tackled this question also by considering that anti-migrant language divides populations on ethnic grounds (Abubaker *et al.*, 2018).

A stance which advances the majority view, mobilises fear and hatred and is a combination of prejudice of the other with fear over losing something to the migrant, for example jobs, housing, security (Abubaker *et al.*, 2018). Arguably, the only distinction between anti-migration discourse and racism is that in political and media discourse racism is prohibited and often illegal, however, discrimination against migrant groups is considered acceptable for many (Abubaker *et al.*, 2018).

Therefore, the relationship between politics, the mass media and market forces, can be destructive to the policies surrounding asylum seekers and refugees, especially if newspapers continue to construct hostile narratives.

> 'Immigration policy is fertile ground for political mischief, and both the main parties appear at least as interested in courting public opinion as in leading it. If we cannot rely on our politicians to give a lead, we desperately need newspapers and broadcasters who put their duty to inform ahead of their duty to corner marker share.' (Buchanan, Grillo and Threadgold, 2003 pg 7).

The juxtaposition of deservingness and entitlement is vital when examining patient and healthcare worker relationships. Within healthcare settings it is argued that wider negative portrayals of migrant groups, such as the newspaper portrayal of asylum seekers and refugees, can influence practitioners' attitudes towards them (Holmes, 2012). Section 3.7 will explore this.

3.7 Internalisation of Deservingness and the Effect on the Patient and Healthcare Worker Relationship

The internalisation of public deservingness discourses may affect an individuals' self-esteem and psychological health, while the attitudes or beliefs of healthcare workers can physically hinder access to healthcare (Larchanché, 2012; Ravn *et al.*, 2020). Lipsky, (1980) described how migrants often generalise their experiences with representatives of the Government, such as healthcare workers, to society as a whole. An individual's understanding of their place in society comes from not only legislation but also whether they are treated with respect or fairness in public spaces (Calvo, Jablonska-Bayro and Waters, 2017).

Existing marginalisation and insecurity associated with the migration process could mean that even minor negative interactions when accessing healthcare services may have a profound effect on feelings of deservingness for healthcare and future attempts to seek help (Chase *et al.*, 2017). For example, Chase et al (2017) described that for asylum seekers in Canada, negative interactions with healthcare providers were often perceived as confirmation of a wider hostility towards asylum seekers; a sense of being 'less than' the host society in terms of deservingness, despite relatively strong entitlement policies being in place.

Vanthuyne *et al.* (2013) found that the factors which seemed to bear most influence in shaping healthcare workers judgements about deservingness for healthcare were their own individual personal experiences of accessing healthcare, demographics of the healthcare worker and wider perceptions of the healthcare system's capacity. Even well-intentioned attempts at cultural competency training can often create stereotypical attributes, open to deservingness judgements, that are assigned to whole populations or communities, with little space for inter-group diversity or consideration of the impact of other issues such as social inequalities, gender and language, or in fact whether the culture of the system itself is the bigger issue (Holmes, 2012; Smith, 2016). This emphasises that perceptions about patient deservingness do not originate in the vacuum of healthcare settings but need to be contextualised within the wider public discourse, political and socioeconomic setting, and that deservingness assessments are always relational and conditional (Smith, 2016; Kline, 2019).

Therefore, even in systems which provide health care as a fundamental right, indirect, systematic barriers can exclude vulnerable people from their healthcare rights (Perna, 2018). Confusion and misinformation about the entitlement of asylum seekers and refugees to healthcare, cumbersome administrative procedures and the wider immigration system can further influence both those seeking healthcare and those providing it (Medecins du Monde, 2016; Chase *et al.*, 2017).

Judgements about the traits of asylum seekers and refugees, such as responsibility, self-discipline and compliance, all serve to influence assessments of moral character and deservingness (Kline, 2019; Holmes *et al.*, 2021). The importance of these traits can be internalised by both the individual and by officials, including healthcare workers, who often make subtle judgements distinguishing the deserving from the undeserving (Huschke, 2014; Bowen, Mickus and Rosales, 2018; Viladrich, 2019). Individuals may, therefore, alter their self-presentations in order to 'perform deservingness'(Huschke, 2014). This would, often subconsciously, aim to show that they are vulnerable, accommodating or industrious, in order to receive public services or they may avoid seeking healthcare for fear of being labelled a burden, too demanding or too empowered (Huschke, 2014; Viladrich, 2019). Literature describing welfare distribution research, for example, has shown that docile, passive and shameful clients receive preferential treatment to demanding or empowered clients (Huschke, 2014; Nielsen, Frederiksen and Larsen, 2020).

These alterations in self-presentations reveal how discourses of deservingness can be internalised and embodied by individuals, leading to asylum seekers, refugees and migrants internalising that they are undeserving of care (Larchanché, 2012). More than this, there is literature to support that internalised racism, an intersecting issue for many asylum seekers and refugees, can affect individuals relationship with ill health by negatively affecting an individual's evaluation of themselves, leading to increased perceived stressors, avoidance and negative health relationships (Jones, 2000; Kammeyer-Mueller, 2009; James, 2020; Holmes *et al.*, 2021).

Therefore, for asylum seekers the crucial point is that the intersection of restrictive policies, negative discourses in the media, racializing stereotypes and social stigmatization may stop individuals realising what healthcare they are entitled to by eroding their deservingness (Larchanché, 2012; Sargent, 2012; Willen, 2012a, 2012b; Holmes *et al.*, 2021). Combined with other structural barriers this can exacerbate stress and impede their ability to attend to their health needs (Larchanché, 2012; Holmes *et al.*, 2021).

The narratives created in the media surrounding migrants as a threat to resources and identity have been shown to affect community feelings towards

migrant populations (Kyriakidou, 2020). This is in keeping with Philo's (2013) focus group findings, 10 years later, where it was found that headlines, particularly negative ones, imprint on people's memory. The One Scotland Campaign found that 25% of people surveyed felt it was justified to attack asylum seekers who got housing and benefits in Scotland, although this reduced to 21% after a media campaign to address racism in Scotland but remains a considerable figure (Scottish Executive, 2005). Therefore, the media has a responsibility to reduce the legitimisation of hostility towards newly arrived groups, which can destabilise communities and affect the mental health of asylum seekers and refugees (Philo, 2013 pg 166)

The media not only impacts the opinions of the wider public it impacts migrants themselves. Leuder (2008) found that refugees and asylum seekers often constructed their identities within British society around hostilities expressed towards them in the media and the local community. The World Migration Report (2018) details the ways in which migrants can react to media portrayals, including trying to other themselves from portrayals of migrants by trying to show that they have the traits of productive citizens, and using the media to learn about their host country (International Organisation for Migration, 2018). Thus, together, it is clear that the media can have an important influence on asylum seekers and refugees, on those providing their healthcare and, on the patient-professional interaction. It is worth also noting that social media will have an increasingly profound effect on constructions of deservingness or undeservingness but exploring this was out with the scope of this thesis.

3.8 Chapter Summary

This chapter approached access to healthcare for asylum seekers and refugees from four angles: health care needs and behaviours, the development of health literacy, rights and entitlement to health, and the moral debates around deservingness. The key findings from this chapter are summarised here.

Asylum seekers and refugees have different backgrounds and have experienced different journeys to the Scotland. Therefore, their health needs will vary. However, many will have pre-existing medical issues, have developed health

issues during their journey to Scotland or on arrival. Asylum seekers and refugees will also arrive with expectations of the NHS based on previous experiences. Despite having universal access to healthcare in Scotland, there were several barriers to healthcare identified, including the asylum system itself. The asylum system can affect health care access directly by impeding registering with a GP through long wait times for permanent accommodation and lack of continuity with healthcare services by being dispersed across or between cities. It can also indirectly affect healthcare access by creating instability and fear, which leads to health being deprioritised.

Health access does not happen in a vacuum and despite entitlement being clearly established the policies which surround this have both a protective and undermining influence. Migration is highly politicised, and this has an overlap into health care, as punitive policies, and negative discourses around asylum seekers and refugees, have a detrimental effect on health access and equality through the creation of a hostile environment.

This hostile environment created by punitive policies and negative newspaper discourses can erode feelings of deservingness in asylum seekers and refugees which in turn undermines entitlements and rights. Feelings of deservingness can be internalised by both the individual seeking healthcare and the healthcare worker providing it. Therefore, nurturing deservingness is key and there is a call for deservingness to be further examined and studied, particularly around the wider narratives and interactions that influence it, and then unpack how these feelings shape clinical encounters (Willen, 2012b; Smith, 2016). A gap in the literature around portrayals of asylum seeking and refugee women was identified in the literature review surrounding newspaper portrayals of asylum seekers and refugees, and therefore the link between deservingness for healthcare and women is not as strongly portrayed in the media. This thesis therefore considered how women were portrayed in the media, and whether there was any consideration to their right to healthcare (Section 6.5) and by weaving deservingness into the theory of candidacy and exploring how this affects preventive healthcare access.

Cervical screening is the case study used in this study to explore clinical interactions, identification, and negotiations of candidacy. The existing literature surrounding this with regards to asylum seekers and refugee women will be explored in the next chapter.

Chapter 4 Literature Review: Cervical Screening for Asylum Seeking and Refugee Women

4.1 Cervical Screening Literature Review Introduction

Chapter 3 set out the literature about the more general health access, needs and behaviours of asylum seekers and refugees; the need to develop health literacy, including knowledge of entitlements for healthcare; the effect of the wider public policy and newspaper discourses about asylum seekers and refugees; and how they can be internalised to effect individual access. This chapter will focus down on the literature around the specific case study of cervical screening and literature relevant to cervical screening uptake in asylum seeking and refugee women. It again will be presented in a narrative way.

The global context will be set and then the current arrangements for cervical screening and the screening uptake in Scotland presented. The factors identified within the literature as affecting the uptake of cervical screening will be a good opportunity to consider the importance of an intersectional lens within this thesis (as discussed in Chapter 2 Theory, as they are all important factors singularly but when they intersect inequalities become magnified.

It aims to answer the following questions:

1. What is known about asylum seeking and refugee women's uptake of cervical screening, both in the U.K. and globally?
2. What factors affect uptake of cervical screening by asylum seeking and refugee women?

A literature search was carried out using MEDLINE, EBSCO Host, Science Direct, Google Scholar and SocIndex, to cover both the medical and medical sociology literatures. The search terms used are laid out in Table 2:

Table 2 Database Search Terms Literature Search Terms

Theme	Keyword
Refugee and asylum seeker	Refugee*OR refugees* OR refugee* OR refugee's* OR asylum seeker* OR asylum seekers* OR seeker, asylum* OR seekers, asylum* OR political asylum seekers* OR asylum seeker, political* OR political asylum seeker* OR seekers, political asylum* OR political refugees* OR refugee, political* OR refugees, political* OR displaced persons* OR displaced person* OR person, displaced* OR internally displaced persons* OR displaced person, internally* OR displaced persons, internally* OR internally displaced person*
Migrant, immigrant	Migrant* OR migrants* OR immigrant* OR immigrants* OR foreigner* OR foreigners* OR immigrant, undocumented* OR immigrants, undocumented* OR undocumented immigrant
Cervical cancer screening	Cervical cancer screening* OR smear test* OR cervical smear* OR cervical smears* OR smear, cervical* OR cancer of the cervix* OR cervical cancer* OR uterine, cervical cancer* OR cervix cancer* OR cancer, cervix* OR cervix neoplasms* OR neoplasm, cervix* OR cervical neoplasm, uterine* OR screening* OR mass screenings* OR screening, mass* OR cancer early detection* OR cancer screening* OR screening, cancer* OR cancer screening tests* OR cancer screening test* OR screening test, cancer* OR screening tests, cancer* OR test, cancer screening* OR tests, cancer screening* OR early diagnosis of cancer* OR cancer early diagnosis* OR pap test* OR test, pap* OR pap smear* OR smear, pap* OR Papanicolaou smear* OR test, papanicolaou*
Access, uptake	Health access* OR access to health services* OR access to care* OR access to services* OR health behaviours* OR behaviour, health* OR behaviours, health* OR health-related behaviour* OR behaviour, health-related* OR behaviours, health-related* OR health related behaviour* OR health-related behaviours* OR health needs* OR health services needs* OR need, health services* OR uptake* OR uptake of service* OR motivation* OR barriers to uptake* OR adherence* OR receive* OR undergo* OR accept*

The bibliographies in the identified articles were hand searched using the snow balling technique, described in Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Access, to provide further citations and key authors were identified. A further literature search was also performed by the Royal College of General Practitioners (RCGP) Librarian, using the search terms as above but including healthcare as a general term.

Grey literature, as described in 0Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Access, was manually identified through relevant third sector organisations, personal knowledge, discussions with health professionals and from the bibliographies of academic articles identified in the database searches. Grey literature searches were focused on what is happening in clinical practice with cervical screening, access issues and advice re facilitation to access. Webpages were either directly accessed or websites were searched, using their search functions, to identify relevant grey literature. Websites included:

- Public Health Scotland: www.publichealthscotland.scot
- World Health Organisation: www.who.int
- NHS Inform: www.nhsinform.scot
- NHS Scotland: https://www.scot.nhs.uk and https://www.publications.scot.nhs.uk
- Information Services Division: https://www.isdscotland.org
- Jo's Cervical Cancer Trust: https://www.jostrust.org.uk

Papers were limited to January 2000- January 2022, unless they were felt to be particularly relevant. Papers looking specifically at treatment methods for cervical cancer, such as colposcopy outcomes, test validity and new HPV testing were excluded from the search as, although important, were not within the scope of this thesis.

The terms migrant and immigrant were also used in the search as often it was not clear which migrant group was being discussed in literature, therefore this widened the findings to encompass themes which would affect migrants broadly. The body of literature specifically focusing on asylum seekers and refugee women was small, therefore including migrant and immigrant as search terms opened the search to include likely intersecting themes.

Data was extracted from all sources into an annotated bibliography (https://library.leeds.ac.uk/info/1401/academic_skills/80/annotated_bibliographies), which was a table listing all of the sources used with annotations for each describing the sources content and a summary of its main argument. This then allowed for synthesis and analysis of the literature, to provide the basis for this

chapter which provides an overview of the global context of cervical cancer, the provision of cervical screening in Scotland and the factors which affect uptake, particularly those which are likely to affect women who are asylum seekers and refugees.

4.2 Global Context: Cervical Cancer

For the purposes of this thesis, it is important to consider cervical cancer and screening in a Global context, as the populations being studied come from many different countries. This section does not focus on global solutions to the cervical cancer burden but recognises the context from which asylum seeking and refugee women may approach cervical screening in Scotland.

Cervical cancer, a preventable disease, is the fourth leading cancer in women worldwide, ranking after breast, colorectal and lung cancer (Ginsburg *et al.*, 2017; Ginsburg and Paskett, 2018; Arbyn *et al.*, 2020; Mahumud *et al.*, 2020; World Health Organisation, 2020). In 2018 it accounted for 6.8% of all female cancers and for 7.5% of all deaths in females globally (Mahumud *et al.*, 2020). However, low and middle income countries have the highest burden of cervical cancer globally: estimates suggest approximately 85% of cervical cancer cases and 87% of deaths occur amongst women living in these countries (Gakidou, Nordhagen and Obermeyer, 2008; Finocchario-Kessler *et al.*, 2016; Jassim, Obeid and Al Nasheet, 2018; Arbyn *et al.*, 2020; Ginsburg and Horton, 2020; Mahumud *et al.*, 2020). Such marked differences in incidence and mortality of cervical cancer globally reflects differences in exposure to risk factors but more importantly serious inequalities in access to adequate screening and effective cancer treatment (Arbyn *et al.*, 2020).

When detected early, through screening, and managed effectively, cervical cancer is one of the most successfully treatable forms of cancer (World Health Organisation, 2020). However, in many countries this is not possible and in 2020 cervical cancer persisted as the leading cause of cancer death among women in 42 countries, mostly in Sub-Saharan Africa where the prevalence of HIV (a known risk factor for cervical cancer) is high (Ginsburg and Horton, 2020). The global

average age of death from cervical cancer was 59 years (Arbyn *et al.*, 2020). It also ranks in the top three cancers affecting women younger than 45 years old in 146 countries worldwide (Arbyn *et al.*, 2020).

The most important risk factor for invasive cervical cancer is Human Papilloma Virus (HPV) (Ginsburg *et al.*, 2017; Arbyn *et al.*, 2020). The WHO estimates that 99% of cervical cancer cases are linked to infection with HPV, through sexual contact (World Health Organisation, 2020). Therefore, any risk that increases an individual's chance of getting HPV, having it for a prolonged time or a reduced chance of clearing it increases the risk of cervical cancer. This may include being sexually active, sexual intercourse before 18 years old, multiple sexual partners, previous history of sexually transmitted infections, smoking and immunosuppression (Ogbonna, 2017; Public Health Scotland, 2021a). Immunosuppression, especially through HIV infection, which both increases the duration of oncogenic HPV infections and decreases the probability of clearing them, exacerbating the progression of HPV infection to invasive cervical cancer (Zeferino and Derchain, 2006; Finocchario-Kessler *et al.*, 2016; Ginsburg *et al.*, 2017).

On average over 60% of women attend cervical screening programmes in high income countries compared to an average of 19% of women in low and middle income nations (Gakidou, Nordhagen and Obermeyer, 2008; Mahumud *et al.*, 2020). Cervical screening in low and middle income countries tends to be more opportunistic compared to high income countries, therefore only targeting women who have symptoms or contact with healthcare providers offering this (Jassim, Obeid and Al Nasheet, 2018; Mahumud *et al.*, 2020).

Incidence rates of cervical cancer in high income countries in the 1960s and 1970s were similar to those in low to middle income countries now (Gakidou, Nordhagen and Obermeyer, 2008). Falling cervical cancer incidence and mortality rates in high income countries, such as the U.K., over the past 30-40 years is the result of effective population-based screening (Zeferino and Derchain, 2006; Aminisani *et al.*, 2012; Ginsburg *et al.*, 2017; Arbyn *et al.*, 2020). However, even in high-income countries, cervical cancer continues to be more common amongst ethnic minorities, women living in poverty, marginalised

groups and women who were born overseas, such as migrants, asylum seekers and refugees (Ginsburg and Horton, 2020).

Within the U.K. the smear test is the mainstay of cervical screening. The next section will give an overview of the national cervical screening programme in Scotland and the uptake of this.

4.3 Scotland's National Cervical Screening Programme

Early detection and prompt treatment of any changes in the cervical cells is the cornerstone of prevention for cervical cancer (Finocchario-Kessler *et al.*, 2016). Cervical cancer screening, the smear test, has been shown to reduce both the incidence, morbidity and mortality of cervical cancer by identifying pre-cancerous lesions (Zeferino and Derchain, 2006; Finocchario-Kessler *et al.*, 2016; Landy *et al.*, 2016; Jassim, Obeid and Al Nasheet, 2018; Jansen *et al.*, 2020). In women aged 35-64 years, regular screening is associated with a 67% reduction in stage 1a cancer and a 95% reduction in stage 3 cancer (Landy *et al.*, 2016). Pre-cancerous lesions can be treated, preventing progression to invasive disease (Jansen *et al.*, 2020).

The national cervical screening programme was introduced in Scotland in 1988 (Public Health Scotland, 2020). Currently, screening is offered every 3 years for women aged 25-49 years and every 5 years for women aged 50 until their 65th birthday (Public Health Scotland, 2020). The process of inviting women to attend screening is run through the national Scottish Cervical Call Recall System (SCCRS) which sends invitations to eligible women (Information Services Division and NHS National Services Scotland, 2020). Women can choose to make an appointment with their GP practice or a local sexual health service.

The HPV vaccination programme was introduced for girls in Scotland during their first year of secondary school in 2008 (NHS Inform, 2020; Public Health Scotland, 2020). Since the start of the academic year 2019 it has also been rolled out to boys in this age group (NHS Inform, 2020). As it does not protect against all cervical cancers, the cervical screening programme still remains vital in detection of cervical cancer and females who have received the vaccine will still

receive future invitations to the NHS Cervical Screening Programme (Henderson *et al.*, 2011; Public Health Scotland, 2020).

In 2018/19 the uptake of cervical screening in Scotland was 73.1% of all eligible women (Information Services Division and NHS National Services Scotland, 2019). Unfortunately, there is not specific data available for the uptake of cervical screening by asylum seeking and refugee women in Scotland, but the next section will present what is known, in the literature, about the uptake among women who are asylum seekers and refugees.

4.4 Cervical Screening Uptake in Migrant, Asylum Seeker and Refugee Populations

This review found a very small body of literature looking specifically at asylum seeking and refugee women's uptake of cervical screening. Much of the literature is international, describing migrant women more generally and many studies do not specify, or in some of the larger registry based quantitative studies do not know, the makeup of the migrant group being discussed. The studies referenced in this section were performed in a range of countries: Switzerland (Bischoff *et al.*, 2009), United States of America (Ivanov, Hu and Leak, 2010), Australia (Aminisani, Armstrong and Canfell, 2012), Canada (Vahabi and Lofters, 2016), Sweden (Åkerman *et al.*, 2017), Norway (Leinonen, Campbell, Ursin, *et al.*, 2017), Scotland (Gorman and Porteous, 2018), Denmark (Hertzum-Larsen *et al.*, 2019), U.K. (Thomas, 1997; Rogstad and Dale, 2004), and a systematic review which covered literature from multiple countries (Davidson *et al.*, 2022).

This section, therefore, gives a brief overview of the main themes from papers around migrants, asylum seekers, refugees, and screening uptake. Section 4.5 then reviews in more detail well established factors, identified from the wider cervical screening literature, affecting the uptake of cervical screening, many of which may affect asylum seeking and refugee women in Scotland.

Across the literature it was found that women who were migrants, particularly from low-income countries, had a lower participation in cervical screening than

women from the host population (Bischoff *et al.*, 2009; Ivanov, Hu and Leak, 2010; Aminisani, Armstrong and Canfell, 2012; Vahabi and Lofters, 2016; Åkerman *et al.*, 2017; Leinonen, Campbell, Ursin, *et al.*, 2017; Gorman and Porteous, 2018; Hertzum-Larsen *et al.*, 2019; Davidson *et al.*, 2022). These differences were not explained by sociodemographic, education or health related characteristics alone(Bischoff *et al.*, 2009; Aminisani, Armstrong and Canfell, 2012; Leinonen, Campbell, Ursin, *et al.*, 2017; Hertzum-Larsen *et al.*, 2019). It was hypothesised, in one Australian study, that other factors such as cultural values, knowledge about cervical cancer and screening, and awareness of the principles of preventive medicine may be more dominant explanations (Aminisani, Armstrong and Canfell, 2012).

A key point across the studies, was that migrants are a heterogeneous group and large variations were seen between migrants from different countries and world regions(Thomas, 1997; Leinonen, Campbell, Ursin, *et al.*, 2017; Hertzum-Larsen *et al.*, 2019). Uptake and information requirements may be different, for example, depending upon screening provision in their country of origin, religious beliefs, social exclusion, ethnicity, cultural backgrounds, socioeconomic circumstances, fear, embarrassment, age, relationship status, experience of sexual violence, language and social networks (Rogstad and Dale, 2004; Abdullahi *et al.*, 2009; Ivanov, Hu and Leak, 2010; Vahabi and Lofters, 2016; Leinonen, Campbell, Klungsøyr, *et al.*, 2017; Gorman and Porteous, 2018).

Two service needs assessments were found about asylum seeker and refugee uptake of healthcare in the U.K. were identified. A health needs assessment of asylum seekers in Sunderland and North Tyneside in 2002 found uptake of cervical cancer screening was low, although there were no clear reasons given about why this might be the case (Blackwell, Holden and Tregoning, 2002). A mapping exercise of Sexual Health Improvement Interventions in Scotland suggested that sexual health needs specific to the refugee community should include widening access to services, sexual health education and support for victims of sexual violence and that this should occur as an integrated health and community approach (NHS Scotland, 2011).

As this literature was small, the following section explores the wider factors affecting cervical screening uptake and cervical cancer outcomes, as identified

in Section 4.2, which are likely to be transferrable to asylum seeking and refugee women in Scotland.

4.5 Factors Affecting Cervical Screening Uptake

Reasons for the disparities in uptake in asylum seekers and refugees are multi-faceted, poorly understood and include socioeconomic factors, education, previous healthcare access, past experiences, fear, embarrassment and awareness of services (Marlow, Waller and Wardle, 2015; Ginsburg *et al.*, 2017). This section examines these, often intersecting, influences on cervical screening uptake.

4.5.1 Ethnicity, Cultural Health Beliefs and Stigma

Asylum seeker and refugee women come from a variety of ethnic groups. Ethnic minority women are well documented across the literature to have a lower participation rate in cervical screening both in the U.K. and in other developed countries (Steven *et al.*, 2004; Abdullahi *et al.*, 2009; Moser, Patnick and Beral, 2009; Ludman *et al.*, 2010; Aminisani, Armstrong and Canfell, 2012; Lu *et al.*, 2012; Ochieng, 2013; Ekechi *et al.*, 2014; Marlow, Waller and Wardle, 2015; Ginsburg *et al.*, 2017; Ginsburg and Paskett, 2018). Ethnicity has been found to be the most important sociodemographic predictor of poor uptake of cervical screening, with ethnic disparities persisting after controlling for age and occupational group (Robb *et al.*, 2010; Ekechi *et al.*, 2014).

Potentially due to lower rates of early detection and treatment of pre-cancerous stages, those from ethnic minorities have a disproportionately higher share of cervical cancer diagnosis and mortality in the U.K. (Steven *et al.*, 2004; Ekechi *et al.*, 2014; Johnson *et al.*, 2018). Johnson et al (2018) modelled that Asian woman were 1.7 times more likely to be diagnosed with cervical cancer than white women, although they did not report if some groups of Asian women were at greater risk than others. White British women were significantly more likely to have had a cervical smear test than women in other ethnic groups (Moser, Patnick and Beral, 2009).

Research shows that lack of knowledge, awareness and understanding about cervical cancer and screening is a significant barrier to screening among ethnic minority women and is an independent predictor of uptake (Sutton and Rutherford, 2005; Abdullahi *et al.*, 2009; Robb *et al.*, 2010). Abdullahi *et al.* (2009) discussed that despite cervical cancer being the most common cause of cancer death in women in Somalia, cervical screening is not undertaken in Somalia and there are no Somali words for 'smear test' or 'cancer'. The same was found for many ethnic minority women in a qualitative study conducted by Marlow, Waller and Wardle (2015) with community groups in London suggesting that the terminology is not always familiar, including among those who spoke English. Ogbonna. (2017) performed a cross-sectional study involving female Sub-Saharan African students in a U.K. university, which found that, even in a highly educational setting, there was poor knowledge of cervical cancer which then influenced their attitude towards screening. From the 186 students participating in the survey, 127 (68.3%) had no knowledge of cervical cancer as a disease, and more than half reported not being confident in identifying cervical cancer signs and risk factors (Ogbonna., 2017). Only 71 (38.2%) had awareness of the NHS cervical screening programme (Ogbonna., 2017). These studies demonstrate that it cannot be presumed that knowledge will improve through incidence of cervical cancer deaths, good spoken English, or education levels in ethnic minority women in the U.K.

To fully embrace preventive healthcare, the notion of picking up disease in pre-cancerous, early asymptomatic stages requires to be understood. Studies have shown that women who are migrants, particularly, tend to believe that the absence of symptoms indicates good health, which perpetuates lower cancer screening rates as in the absence of pain or other symptoms they are unlikely to seek healthcare (Ludman *et al.*, 2010; Marlow, Waller and Wardle, 2015). Women may also rely heavily on culturally based health care, such as traditional medicine, such as herbs and teas, before seeking medical advice for persistent symptoms that are unresponsive to home remedies (Ivanov, Hu and Leak, 2010; Vahabi and Lofters, 2016).

Fatalism with regards to cancer beliefs were commonly cited across studies with African and South Asian populations, which can undermine preventive health

strategies (Abdullahi *et al.*, 2009; Ludman *et al.*, 2010; Vahabi and Lofters, 2016; Ogbonna, 2017). Common beliefs found in ethnic minority communities across the literature is that cancer is equated with death, is always painful, is impossible to treat and there is little that a woman can do to reduce her chances of getting cancer (Thomas, 1997; Kelaher *et al.*, 1999; Ogbonna, 2017. Differences in experiences of prior healthcare systems can exacerbate fatalistic attitudes towards disease as factors such as lack of universal healthcare, cost of medical care in home countries, or lack of treatment opportunities offer little hope for prevention or cure (Vahabi and Lofters, 2016). For some women the belief that illness and healing only occur by the will of God can also be a barrier to screening or preventive medicine, as it can be interpreted to demonstrate a lack of faith (Abdullahi *et al.*, 2009). It can also be linked to signs of transgressions, such as reproductive cancer being believed to be associated with promiscuity and therefore a punishment from God (Thomas, 1997; Ludman *et al.*, 2010).

Culturally, stigma and embarrassment can weigh heavily on decisions around accessing cervical screening. In Ogbonna's (2017) cross-sectional study of students at a U.K. University, 109 (58.6%) students interviewed viewed cervical cancer as a forbidden disease and 97 (52.2%) reported they would not be comfortable in associating with people who have cervical cancer. Embarrassment and fear of exposing body parts or discussing sex organs was found across studies, and was often seen as private, taboo and shameful (Ludman *et al.*, 2010; Marlow, Waller and Wardle, 2015; Marlow, Vrinten and Waller, 2016; Jassim, Obeid and Al Nasheet, 2018; Ogbonna, 2017). Marlow, Vrinten and Waller (2016) found that community level stigma was particularly prevalent across ethnic groups in the U.K., with less than 5% of Bangladeshi and Pakistani women believing that cancer was talked about openly in their community compared to 97% of white women. Religious beliefs and potential cultural pressures around sexuality, modesty and premarital virginity may also limit discussions about female genital health compared to general health due to connections to sexual activity, including preconceived assumptions about the sexual activity of Muslim women by healthcare workers (Abdullahi *et al.*, 2009; Vahabi and Lofters, 2016).

Low awareness of cervical cancer risk factors among ethnic minorities has also been found (Marlow, Waller and Wardle, 2007, 2015; Low *et al.*, 2012; Ryan, Marlow and Waller, 2019; Murfin *et al.*, 2020). Women from non-white ethnic backgrounds were less likely to recognise non-attendance for cervical screening as a risk factor compared to white women in the U.K. (Fernbach, 2002; Ryan, Marlow and Waller, 2019). In studies where awareness of cervical cancer risk factors was found, ethnic and minority migrant women identified a range of risk factors including lifestyle stress, chemicals, moving country, war, contraceptive pill, multiple parity, early marriage, early sexual intercourse and sex with an uncircumcised partner (Fernbach, 2002; Ogbonna, 2017). Multiple sexual partners was cited by women but the mechanism of why this was a risk factor through HPV transmission was under-recognised (Low *et al.*, 2012). White ethnicity, older age, higher education and close experience of cervical cancer were associated with increased symptom and risk recognition (Low *et al.*, 2012). This is worrying as women can perceive themselves as unlikely candidates for cervical cancer if they are unaware of risk factors or don't consider them relevant to themselves (Marlow, Waller and Wardle, 2015).

This section has demonstrated that ethnic minority women are more vulnerable to exclusion from cervical screening, through issues such as embarrassment, gender inequality, being less fluent in the host country language and perceived cultural or religious judgements by healthcare workers and their cultural or religious communities (Abdullahi *et al.*, 2009; Ivanov, Hu and Leak, 2010; Vahabi and Lofters, 2016). The next section shall consider the effect of sexual trauma on cervical screening uptake.

4.5.2 Sexual Trauma

Within asylum and refugee populations the incidence of rape, sexual and gender based violence, including in Europe, cannot be underestimated and the experience of cervical screening could be traumatic due to this (Fernbach, 2002; Rogstad and Dale, 2004; Keygnaert and Temmerman, 2007; Wilding *et al.*, 2020). Female Genital Mutilation (FGM) is also a significant factor which may influence how different groups of women perceive cervical screening, between and within different ethnic groups (Abdullahi *et al.*, 2009). The literature linking cervical screening uptake and FGM is limited. However, parallels can be drawn to

literature around survivors of sexual assault and cervical screening, which shows that women who have experienced sexual violence are less likely to attend regular cervical screening and may find the screening examination retraumatising (Cadman *et al.*, 2012; Edmonds *et al.*, 2021; Madden *et al.*, 2022).

Women who have undergone rape, torture or FGM are more likely to experience both physical and mental health problems, in addition to being more vulnerable to ongoing victimisation (Roshan, 2005). There is a high risk of sexual violence for women seeking asylum (Abubaker *et al.*, 2018). The data around this varies and is likely largely unknown. Ceneda (2003) reports that almost all women who claim asylum on political grounds have suffered three or more forms of harm, including rape, beatings and detention, and one in six have experienced sexual violence. Whereas, Vu *et al.* (2014) found in their meta-analysis that 21% of female refugees had experienced sexual violence, although they felt this was probably an underestimation. A recent study in Switzerland has found that migrant women with FGM also seem to have a high prevalence of cervical dysplasia, therefore the importance of supporting women to feel comfortable with cervical screening is two-fold (Azuaga Martinez and Abdulcadir, 2020). At least 200 million girls and women have been subjected to FGM globally (Abubaker *et al.*, 2018).

As described in Chapter 1, female asylum seekers and refugees face additional challenges within the process of migration and the asylum system. Women's social status undergoes a big change on arriving in the U.K. as an asylum seeker or refugee. They often lose the protection of wider family or social networks and may have to take on new roles and responsibilities which often relates to an increase in domestic violence rates, they often become isolated due to language difficulties, have a poorer self-assessed health, increased levels of depression and unmet health needs, particularly sexual health (Roshan, 2005; Abubaker *et al.*, 2018; Mengesha *et al.*, 2018). On top of this, women who had undergone FGM had additional feelings of embarrassment and worried about the potential reaction of the smear taker (Carroll *et al.*, 2007; Leinonen, Campbell, Klungsøyr, *et al.*, 2017). Self-blame is also a misconception with some women identifying

cervical cancer as being caused by ‘psychosomatic pathways’ following sexual abuse (Marlow, Waller and Wardle, 2015).

4.5.3 Socioeconomic Status

As discussed in Section 1.2 asylum seekers are one of the most deprived groups in the U.K. Substantial variations occur in cervical cancer screening attendance across socioeconomic groups in the U.K., with those in more deprived groups attending less and at the same time bearing a higher burden of cervical disease (Sutton and Rutherford, 2005; Walsh, Silles and O’Neill, 2011; Damiani *et al.*, 2012; Spencer *et al.*, 2014; Douglas *et al.*, 2016; Hanson *et al.*, 2019; Mahumud *et al.*, 2020; Wilding *et al.*, 2020). Women from the most deprived areas in Scotland had a lower uptake of cervical screening (67%) compared to the least deprived areas (78%) (Information Services Division and NHS National Services Scotland, 2019). It is important to consider whether these differences are because of lack of information, poorer access and the wider societal determinants of health rather than due to an informed choice (Douglas *et al.*, 2016; Hanson *et al.*, 2019).

Hanson *et al.* (2019) demonstrated that for women who are living in marginalised and deprived circumstances there is a need to prioritise day-to-day basic needs such as safety, shelter and food for themselves and their family, rather than longer term preventive healthcare, such as screening. This is similar to the pressures applied to women in the asylum system (see Section 1.4) This may also explain why delayed presentation is associated with socioeconomic deprivation (Hanson *et al.*, 2019). Women living in deprived circumstances may also be more likely to adopt a fatalistic view, due to a lack of control and voice when navigating systems of health, social care and benefits, which create a power imbalance (Hanson *et al.*, 2019). Patients from affluent areas were less likely to have concerns about money, co-morbidity and family issues (Woods, Rachet and Coleman, 2006). In developing countries, particularly, socioeconomic inequality is the most dominant predictor driving inequalities in women’s knowledge and utilisation of cervical screening (Mahumud *et al.*, 2020), which may be relevant for asylum seeking and refugee women in Glasgow.

Education, particularly that which continues into adulthood, was shown to have a direct positive impact on uptake of screening programmes, which was not reduced by income, occupation or social class (Sutton and Rutherford, 2005; Sabates and Feinstein, 2006; Moser, Patnick and Beral, 2009; Damiani *et al.*, 2012; Broberg *et al.*, 2018; Murfin *et al.*, 2020). Therefore, this is also an important facilitator for improved access for women living in deprivation.

4.5.4 Healthcare Providers and The Cervical Screening Test

Many women, across the wider literature, reported being screened as a result of advice from their GP, as they saw them as trusted and authoritative figures (Abdullahi *et al.*, 2009; Gil Lacruz, Gil Lacruz and Gorgemans, 2014; Vahabi and Lofters, 2016; Willems and Bracke, 2018). Others reported that if their doctor did not recommend a smear test then they took this to mean that the test was not required (Vahabi and Lofters, 2016). This supports the research that the positive attitude of GPs towards cervical screening can have a powerful effect on women's uptake (Labeit and Peinemann, 2017).

Conversely, a negative experience could be a barrier to repeat attendance, which is often a bigger challenge than the first attendance (Kelaher *et al.*, 1999; Abdullahi *et al.*, 2009; Marlow, Waller and Wardle, 2015; Leinonen, Campbell, Ursin, *et al.*, 2017). Distrust in health services, as a perceived extension of the Government, can be reduced by building relationships between patients and health providers (Young *et al.*, 2018).

It is, therefore, important that health professionals take an active role in offering screening opportunistically during health appointments, communicate about sexual health in a culturally appropriate way and be aware of any potential barriers, particularly in women from ethnic minority and low education groups, who often rely more on guidance and advice from third parties (Vahabi and Lofters, 2016; Willems and Bracke, 2018). This is not always required as face to face encouragement by the GP as participation rates are seen to be increased by invitation letters being personalised with the GP's signature or name in the prompting information rather than letters from health boards or screening hubs, which appeared more anonymous (Armstrong, James and Dixon-Woods, 2012; Willems and Bracke, 2018; Young *et al.*, 2018).

Individuals' relationship with the health service are also influenced by underlying dynamics of trust, power, control and authority (Young *et al.*, 2018). Qualities associated with a positive healthcare experience included culturally sensitive verbal and nonverbal communication; feeling valued and understood; the availability of professional, female interpreters and healthcare workers; and an assurance of privacy (Kelaher *et al.*, 1999; Carroll *et al.*, 2007; Mengesha *et al.*, 2018). Language and the importance of interpreting was covered in Section 3.3. However, despite the importance of interpreting, healthcare workers were found to underuse professional interpreting services, instead using patients family members or friends, which can negatively impact on openness and quality discussion within the consultation (Mengesha *et al.*, 2018).

A female smear taker is important to women undergoing the test and a male GP was a cited reason for non-adherence, particularly in migrant groups (Kelaher *et al.*, 1999; Leinonen, Campbell, Ursin, *et al.*, 2017). The prospect of a male carrying out the test caused particular anxiety in the studies examining Muslim women's uptake (Leinonen, Campbell, Ursin, *et al.*, 2017). Within primary healthcare settings the responsibility for taking smears is largely considered a female role, often conducted by the (usually female) Practice Nurse (McSherry *et al.*, 2012).

Women often preferred to have GP's with similar ethnic and language backgrounds, however this can also be seen as a barrier as sometimes this can prevent discussions around sexual health (Vahabi and Lofters, 2016). Younger and unmarried Muslim women were particularly worried about being asked by their physician about whether or not they were sexually active (Vahabi and Lofters, 2016). Muslim women felt that by being Muslim and wearing the hijab would automatically cause physicians to assume that they were abstaining from any sexual activity before marriage, which could lead to an inequitable provision of sexual health information and services (Vahabi and Lofters, 2016). This belief is reinforced by Gott *et al.* (2004) who found that GP's and Practice Nurses believed that sex was something less openly discussed by people from ethnic minority groups. However, very few of those interviewed had had consultations about sexual health with patients from ethnic minority groups, which indicated

that their belief about this was based upon pre-existing beliefs rather than direct experience (Gott *et al.*, 2004). Mengesha *et al.* (2018) found in a study of refugee and migrant women that as sexual and reproductive health can be considered taboo, even with their husbands, it was often difficult for women to freely discuss their needs or concerns.

Smear tests ask a lot of women and are an emotional experience; allowing intimate examination, exposure of private body parts and penetration of the vagina with a speculum, all of which place women in a vulnerable position (Armstrong, James and Dixon-Woods, 2012; Young *et al.*, 2018). A common barrier among ethnic minority women was fear of pain during the test (Randhawa and Owens, 2004; Thomas, Saleem and Abraham, 2005; Marlow, Waller and Wardle, 2015). It is, therefore, important for the GP or Practice Nurse to ease discomfort and facilitate positive testing experiences, as many women find the test painful, uncomfortable, embarrassing and occasionally threatening (Armstrong, James and Dixon-Woods, 2012; Wilding *et al.*, 2020). If done sensitively it is argued that the cervical screening appointment could be utilised as an opening to further discussions about general and sexual health needs, including sensitive issues such as sexually transmitted infection (STI) checks, HPV risk factors, any previous sexual trauma and contraception needs (Sabates and Feinstein, 2006; McSherry *et al.*, 2012; Mengesha *et al.*, 2018; Åkerman *et al.*, 2019; Wilding *et al.*, 2020).

A critical gap was identified in this literature review, which was also commented on in Davidson et al's (2022) systematic review of the literature relating to access to preventive sexual health care for women from refugee-like backgrounds. This gap is a lack of literature looking at the viewpoints, experiences and needs of healthcare workers with regards to providing cervical screening to this population. Only one U.K. paper was found in this literature review which focused on that (Gott *et al.* (2004) and only one paper was referenced in Davidson et al's (2022) systematic review which focused on the healthcare workers perspective (Zhang *et al.*, 2017), which was based in the US. As has been shown in this section this gap in knowledge is significant as in order for cervical screening to be successfully accessed, health care workers need to

be part of improving health literacy, healthcare access journeys and making cervical screening as comfortable an experience as possible.

The next section considers the practical and personal barriers that women can face in accessing cervical screening.

4.5.5 Practical and Personal Factors

Throughout the literature there were several individual practical and personal factors that could affect migrant, refugee or asylum seekers women's uptake of cervical screening.

Married or cohabiting women were more likely to participate than unmarried, widowed or divorced women (Kelaher *et al.*, 1999; Ludman *et al.*, 2010; Damiani *et al.*, 2012; Leinonen, Campbell, Ursin, *et al.*, 2017; Broberg *et al.*, 2018). Younger women were less likely to participate, which is problematic as cervical cancer peaks in the 30-35 year age group (Thomas, 1997; Low *et al.*, 2012; Broberg *et al.*, 2018). Uptake of cervical screening was lowest in younger women (61.8% in 25-29 years-old) and highest in 50-54 years-old (80.5%) (Information Services Division and NHS National Services Scotland, 2019). Whilst the uptake data are not broken down by ethnicity or population, it can be hypothesised that for ethnic minority, asylum seeking and refugee women marital status and age are important due to cultural, social and personal value placed on some women to preserve their virginity before marriage and it may be felt that a cervical smear either compromises virginity or is a sign of an active sex life (Thomas, 1997; Leinonen, Campbell, Ursin, *et al.*, 2017).

Practical barriers were found to be of importance in the literature, including distance to the GP surgery particularly for older women; adequate, affordable transportation; difficulty in navigating a new system; and ease of making appointments (Kelaher *et al.*, 1999; Carroll *et al.*, 2007; Woolley *et al.*, 2007; Waller *et al.*, 2009). Waller et al (2009) found that practical barriers often outweighed emotional barriers. Inflexible appointment times, which were during the day mostly, and the issue of childcare were a significant barrier for some (Abdullahi *et al.*, 2009; Marlow, Waller and Wardle, 2015; Leinonen, Campbell, Ursin, *et al.*, 2017; Wilding *et al.*, 2020). If the process of making or

rescheduling an appointment was found to be difficult then this often led to a non-adherence to screening (Abdullahi *et al.*, 2009; Waller *et al.*, 2009; Marlow, Waller and Wardle, 2015). Women also suffered from a lack of time for screening appointments, due to competing priorities (Leinonen, Campbell, Ursin, *et al.*, 2017; Wilding *et al.*, 2020).

Practical facilitators identified in the literature included making it easier for women to prioritise the appointment. A number of studies cited women's preference for being given a fixed appointment time within the invitation letter and this has been shown to be a successful initiative to increase screening uptake (Broberg *et al.*, 2018; Aasbø *et al.*, 2019). For example, breast cancer screening rates in the U.K. are higher than cervical screening rates and whilst there are multiple factors linked to this, out with the scope of this research, one difference is that women invited to breast screening are provided with a scheduled appointment (Douglas *et al.*, 2016). Extended hours appointments that could be facilitated around work and childcare were also rated by women as a significant facilitator to their decision making about attending (Wilding *et al.*, 2020).

Out with the healthcare environment, celebrity experiences and the media portrayal of these can also play a facilitating role in screening awareness and uptake (Bowring and Walker, 2010; Casey *et al.*, 2013). The 'Jade Goody effect' in the U.K. was documented after cervical screening rates increased in the wake of reality TV star Jade Goody's diagnosis and subsequent death due to cervical cancer (Bowring and Walker, 2010; Casey *et al.*, 2013). This resulted in an increase in the diagnosis of significant pathology and increased referral to colposcopy in women who might otherwise not have attended screening (Casey *et al.*, 2013). The U.K. cancer registry report showed a 19.8% increase in cervical cancer in situ in the year 2008-2009, corresponding to the 'Jade Goody' effect, particularly in the 15-19 and 25-29 year age groups (Casey *et al.*, 2013). The 'Jade Goody' effect is thought to be the first-time that a celebrity triggered screening has been associated with an increase in detection of significant pathology (Casey *et al.*, 2013).

4.6 Summary

This chapter explored the literature surrounding cervical cancer and cervical screening globally. It then presented the Scottish National Cervical Screening Programme and considered the barriers that asylum seeking, and refugee women are likely to face when accessing cervical screening. Several key findings were identified which shall be summarised in this section.

Cervical cancer is a global issue, with higher levels of morbidity and mortality from cervical cancer seen in low- and middle-income countries. This is likely due to a lack of focus on screening in countries with fragile healthcare systems, conflict or poverty, compared to high income countries where cervical screening is the mainstay of cervical cancer prevention. Most asylum seeking and refugee women in Scotland will have come from low- and middle-income countries. However, from the literature it does not appear that this increased burden of disease in countries of origin translates to an increased awareness or feeling of risk for cervical cancer.

As the literature about asylum seeking and refugee women's uptake of cervical screening in the U.K. was low, the literature search was widened to include factors which were likely to intersect with asylum seeking and refugee women's experiences. The barriers which were identified from this approach were ethnicity, culture, stigma, poverty, religious pressures, interactions with the healthcare provider and practical barriers. Many of these are transferrable to multiple groups of women in the U.K. but the key point for the women in this study is that many of these barriers will intersect with each other and with the asylum system which magnifies their vulnerability as they are in a very unstable position. Asylum seeking and refugee women are not homogenous so these barriers will intersect in different ways and with varying impact.

Several factors which influenced uptake of cervical screening overlapped. A noticeable one was feelings of fatalism towards cancer diagnosis in women who were from ethnic minorities and from those who were living in poverty. The key overlap here is a feeling of a lack of control, which also overlaps with the instability and lack of control that the asylum process brings. Education as a

facilitator linked across the barriers of ethnicity and poverty. It was also identified as being a key component of the healthcare workers role in promoting cervical screening. By providing education about the purpose of cervical screening and the role of it, especially if it is targeted to those who are vulnerable, then women can develop their health literacy and feel empowered in managing their health.

Two main gaps were identified in the literature, which this thesis aims to contribute to. First, there was a lack of specific asylum seeker and refugee studies. Second, there was only one study found which considered the viewpoints of primary care healthcare workers about uptake of cervical screening in marginalised groups and how to improve it. This thesis will contribute to the wider literature by researching asylum seeking and refugee women specifically, in addition to take a full view of the factors affecting those providing the smear test (primary healthcare workers) and of those signposting for it (community workers). The next chapter will present the methods used in this thesis.

Chapter 5 Methods

5.1 Introduction

This chapter describes and defends the multiple qualitative methods used in this thesis to answer the overall thesis aim to:

Identify and explore the factors that influence how asylum seeking and refugee women access preventive healthcare, using cervical screening as a case study.

As described in Section 1.7, this was broken down into three research questions, the methods for which shall be described in this chapter:

1. What discourses are constructed in the UK's print media around asylum seekers, refugees and health?
2. How do these discourses affect asylum seeking and refugee women's and health care workers perceptions of this population's deservingness for preventive healthcare?
3. What are the barriers and facilitators, identified by asylum seeker/refugee women, community workers and primary care healthcare workers, with regards to the identification of candidacy, the assertion of this candidacy and the provision of cervical screening to women who are asylum seekers and refugees?

Question 1 was explored through a newspaper analysis which examined how asylum seekers, refugees and health are discussed in U.K. newspapers. Questions 2 and 3 were examined through qualitative interviews and focus groups with asylum seeking and refugee women, community workers and healthcare workers. The methods for these approaches are presented in this chapter.

The ethical considerations of this thesis shall also be presented (Section 05.6).

5.2 Rationale for Methodology

5.2.1 Ontological and Epistemological Positions

Social research needs to be carried out with an awareness of philosophical debates about the nature of research-based knowledge, mainly the researcher's ontological and epistemological position (Seale, 2017). In brief, ontology refers to the researchers beliefs about the nature of social reality and how they understand it: what exists, what it looks like, what units make it up and how they react with each other (Blaikie, 2000 pg 8). Whereas epistemology refers to beliefs about how we understand that reality and create knowledge (Grix, 2002; Moon and Blackman, 2014; Bryman, 2015)Therefore, epistemology focuses on the knowledge gathering process (Grix, 2002).

Ontological beliefs are often discussed in terms of a dichotomy between an objective reality that exists independent of the subject observer (positivism or objectivism) and a subjective reality where the subject imposes meaning (interpretivism or subjectivism)(Silverman, 2001; Moon and Blackman, 2014). Constructionism understands that meaning is created from interplay between the subject and object, meaning that social phenomena and categories are not only produced through social interaction but they are in a constant state of revision (Grix, 2002; Moon and Blackman, 2014; Bryman, 2015 pg 122). Given the methodological approach that AB was taking to the research questions, working closely with asylum seeking and refugee women over a period of time and recognising her own position and world view of migration (a supportive and welcoming position), the most appropriate approach for this thesis was an interpretivist epistemology and constructivist ontology was taken.

Historically, women's experiences have been overlooked within research (Oakley, 1981; McCall, 2005). Work within feminist studies has sought to address this, with many drawing upon intersectionality theory to explore the lives of women in marginalised groups who experience multiple oppressions (McCall, 2005). Informed by a feminist ontology, this research aimed to foreground the experiences and voices of refugee and women seeking asylum. This required attention to the power relations within the research process, reflexivity around my positionality as a researcher and consideration of the research methods used

to engage with women (Stanley and Wise, 1979, 1990; Oakley and Roberts, 1981; Edwards, 1990; Oakley, 2016, McCall, 2005).

5.2.2 Overall Study Design and Relation to the Theoretical Underpinning of this Thesis

As discussed in Chapter 2 Theorythis study was informed by the theory of candidacy, particularly the developments described by (MacKenzie *et al.*, 2014), which articulated the macro-, meso- and micro-level influences on candidacy. This lent itself to using a range of approaches to enable consideration of the different levels of candidacy, as can be seen in Figure 4.

The media analysis largely covered how the media framed a public discourse on deservingness through the presentation of stories relating to health in asylum seeking and refugee populations. This aimed to explore an area which is in the macro-level of the candidacy figure (shown in red in Figure 4). The methods used for this are presented in Section 5.3 and results are presented in Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?.

The qualitative interviews were with asylum seeking and refugee women, healthcare workers, and community workers. Focus groups were with asylum seeking and refugee women. The methods for this are presented in Section 5.4. They aimed to further explore macro-, meso- and micro-level factors of candidacy such as the impact of public discourse on deservedness, asylum and refugee labels, class, gender, organisational structures, and cultures (shown in blue in Figure 4).

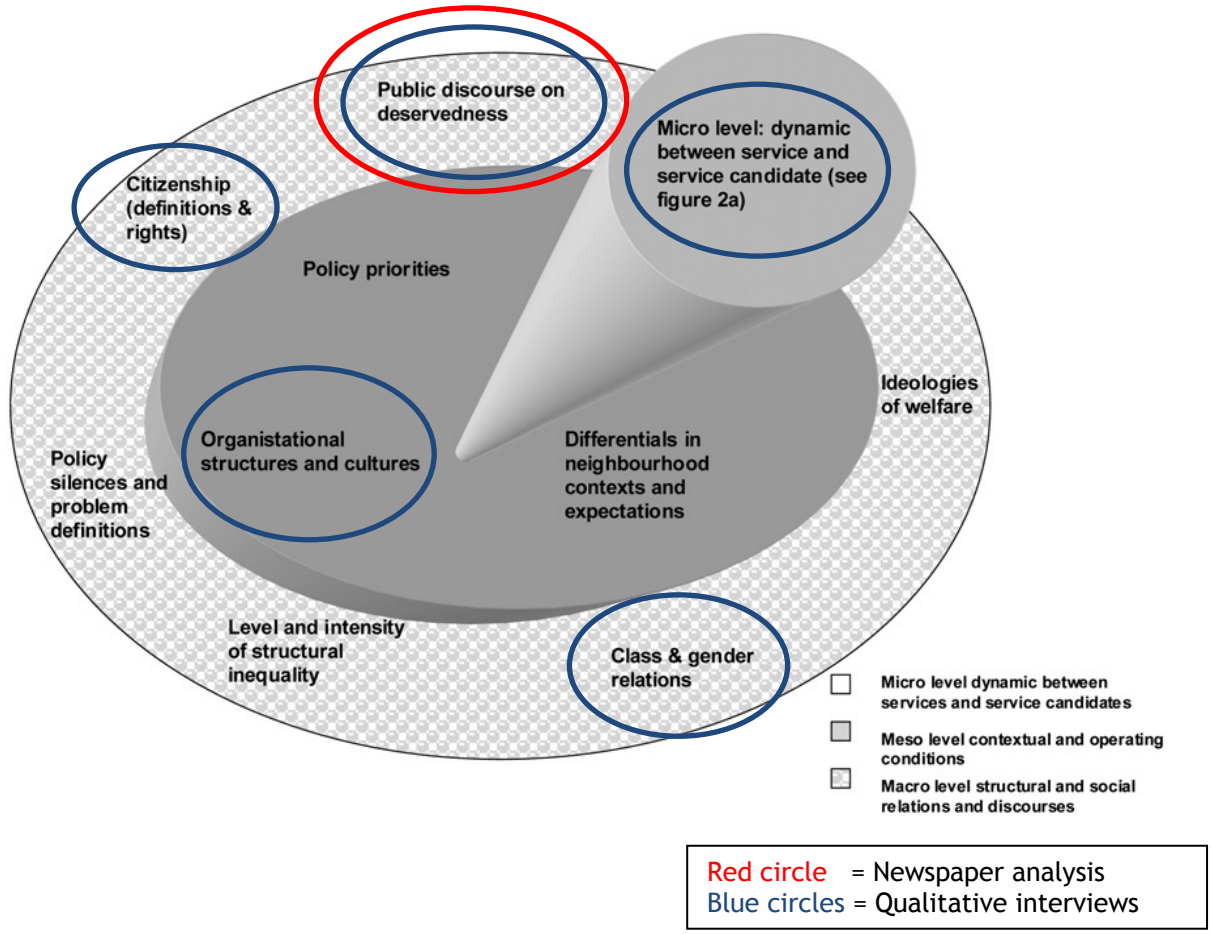


Figure 4: Macro-, Meso- and Micro-levels of candidacy relating to methods used

In addition to candidacy, this study also drew on intersectionality theory especially to aid interpretation of findings. An accepted disadvantage of intersectionality is that the methodology can be difficult to carry out in practice (United Nations Division for the Advancement of Women, Office of the High Commissioner for Human Rights and United Nations Development Fund for Women, 2000; McCall, 2005; Davis, 2008; Hankivsky *et al.*, 2010; Bowleg, 2012; Springer, Hankivsky and Bates, 2012). Collins (2015) describe different ways that intersectionality has been used across different projects: as a methodological approach, as a research paradigm and as a means of identifying measurable variables. They suggest that it is best considered as an overarching knowledge framework, with its inherent complexity embraced by the researcher (Collins, 2015).

To address this, it is suggested that qualitative or mixed methods are most suited to an intersectionality framework, with data included from a number of sources to give as full a picture as possible (Bowleg, 2012).

5.2.3 Multiple Qualitative Approach

This thesis took a multiple qualitative approach, which allowed a full exploration of the factors affecting candidacy formation around accessing and taking up cervical screening by asylum seeking and refugee women. It also allowed in-depth coverage of some of the issues, for example gender roles, the effect of their asylum status and issues such as language barriers, which provided the nuance needed for an intersectional focus.

Mixed methods are described as the third research paradigm, usually seeking to conduct and integrate qualitative and quantitative research to fully respect both but also create a solution for many research questions (Johnson, Onwuegbuzie and Turner, 2007). However, Fetters and Molina-Azorin have recently argued that the term ‘mixed methods research’ needs to develop to encompass any approach that seeks to combine more than one type of data collection method (Fetters and Molina-Azorin, 2017). Thus, a study may combine quantitative and qualitative approaches, but could instead combine different types of qualitative data collection. This, they refer to as multiple methods. Combining multiple qualitative approaches ensures that the research question of interest is explored from different angles, with each method providing a particular set of insights (Hall and Rist, 1999). As with mixed methods, however, the researcher must think about the approaches to data integration and triangulation.

As discussed in Creswell, Fetters and Ivankova (2004) mixed methods and multiple methods research ‘indicates that data will be integrated, related or mixed at some stage of the research process’. This allows a pragmatic approach, where multiple viewpoints, perspectives, positions, and standpoints can be considered (Johnson, Onwuegbuzie and Turner, 2007). Consideration of how approaches are triangulated are important in this process; triangulation models add rigor and ensure comprehensiveness to mixed methods studies (Denzin, 1978; Creswell, Fetters and Ivankova, 2004). In keeping with Denzin's (1978)

definition of the four different types of triangulation that can be used, the following triangulation methods were used in this thesis:

1) Data triangulation: A variety of data sources and literature were used in this study including academic papers, policy documents and grey literature; newspapers; and qualitative interview data from different groups of participants-asylum seeking and refugee women, healthcare, and community workers.

2) Theory triangulation: Although candidacy was the main theoretical perspective used to inform the data collection and analysis, an intersectional lens was applied to it to ensure that the effect of different identities and structural influences on these were acknowledged.

3) Methodological triangulation: As will be outlined in this chapter qualitative methods were the dominant approach. This allowed narrative descriptions of how access, negotiation and uptake of cervical screening was achieved. Quantitative content analysis was used initially in the newspaper analysis, but the main approach was a thematic analysis.

5.2.4 Case Study Design

A case study can be described as

> 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evidenced'(Yin, 2009 pg 18)

Case studies are used when context is thought to be important to the phenomenon under study (O'Donnell *et al.*, 2011). They can be powerful as a study design as the methodology has a level of flexibility which can cope with the complexity of having multiple variables of interest (O'Donnell *et al.*, 2011; Ebneyamini and Sadeghi Moghadam, 2018). It relies on multiple sources of information and is well suited to a mixed methods approach to provide a full picture (O'Donnell *et al.*, 2011). Yin (2003) also views one of the purposes of case studies as theory development, therefore theoretical propositions are a

starting point and integrated into the design of study, as has been done with candidacy in this study.

Although this is a single case study of cervical screening access and uptake, in the context of asylum seeking and refugee women, it could also provide insights into the issues present for this population in other screening programmes, such as breast or bowel screening. In addition to this it provides insights into accessing primary care services in Glasgow. Therefore, a case study is an in-depth study of a single unit which aims to highlight transferable features within similar phenomenon (Gerring, 2004).

Having considered the overarching methodological approaches, the next section describes the methods in more detail.

5.3 Methods: Newspaper Analysis

The aim of the media analysis was to explore what discourses are constructed in the UK's print media around asylum seekers, refugees and health. Discussion of these discourses would then be taken further in the qualitative interviews with asylum seeking and refugee women, healthcare workers and community workers to analyse how the affect perceptions of the asylum seeking and refugee populations deservingness for healthcare.

The methods used in the media analysis in this thesis were informed by previous studies (Hilton, Patterson and Teyhan, 2012; Philo, Briant and Donald, 2013; Patterson *et al.*, 2015), and based on advice from media analysis experts based at Glasgow University, in particular Professor Gregory Philo and Professor Shona Hilton. Searching and inclusion techniques were informed by these experts widely reported methods, as were their media analysis techniques of content and thematic analysis, all of which are described below in sections 7.33.65.3.1, 7.33.65.3.2 and 5.3.3 Coding and Analysis.

5.3.1 Newspaper Inclusion Criteria

Newspapers were purposively selected to represent the breadth of the U.K. and Scottish national newspapers, in terms of format, political alignments and

readership demographics, such as age and social grade range. This included newspapers from quality (broadsheet/ "serious" papers), mid-market (mid-market tabloids), popular (tabloid, also known as 'red tops') and regional publications. This typology was selected on the basis of previous studies of U.K. newspapers (Williams and Dickinson, 1993; Hilton, Patterson and Teyhan, 2012; Rooke and Amos, 2014; Patterson *et al.*, 2015). Eight publications (plus the Sunday counterparts) were included in total:

U.K. Quality Publications: The Daily Telegraph/Sunday Telegraph, The Guardian/The Observer

Scottish Quality Publications: The Herald/The Sunday Herald, The Scotsman/Scotland on Sunday

Mid-Market Tabloids: The Daily Mail/Mail on Sunday

Popular Tabloids (red tops): Daily Record/Sunday Mail

Regional: The Glasgow Evening Times, The Edinburgh Evening News

As discussed below the Sun, which is the U.K.'s best-selling national tabloid was not included due to practical limitations in the media database used. No Scottish-specific middle market tabloids exist, but the Daily Mail issues a Scottish edition, which was included in the searches.

5.3.2 Newspaper Search

Two main databases can be utilised to search for newspaper articles: Lexis Nexus and Newsbank. Lexis Nexus was selected to perform the search for this analysis, as it was available through the University of Glasgow. It also included the Daily Mail (which was considered an important paper in relation to the topic of migrants), whereas Newsbank did not. Neither of these databases included the Sun or its Scottish edition, therefore despite having a high Scottish readership profile it could not be included.

Following several scoping searches to gain an indication of the number of articles returned the parameters for the search were as follows:

- Newspapers: Guardian and Sunday Guardian, Daily Mail and the Mail on Sunday, Telegraph and the Sunday Telegraph, the Daily Record and the Sunday Mail, the Herald and the Sunday Herald, the Scotsman and Scotland on Sunday, the Glasgow Evening Times and the Edinburgh Evening News.

- Date Range: 01/01/08- 09/04/13 (the date of the search)

- Exclusion of non-business news: such as advertisements, community, lifestyle events, birth and wedding announcements.

- Search Terms: Asylum Seeker OR Refugee OR Migrant AND Health OR NHS

A date range from the 01/01/2008 to the 09/04/2013 (the date on which the search were run) was set. This gave 5 years of media coverage, including the 2010 U.K. general election and was within a time scale relevant to the asylum seeking/refugee women who were interviewed as part of this thesis. The search dates were prior to the build-up of the Scottish Independence Referendum in 2014 and pre-dated the announcement of the EU Referendum in the U.K. in 2016 The searches of Lexis Nexus were conducted by Chris Patterson of the MRC Social and Public Health Sciences Unit, imported into word documents, and then passed to AB.

Duplicates were included in the search as there was uncertainty as to how Lexis Nexus removed these. True duplicates, defined as articles which were exact copies published on the same date, were removed manually. Care was taken to ensure that repeats of the same story on a different date were not removed as repeating the same story on different days increases how many times it is read. Letters were included as there is an editorial decision made regarding which letters to print and they also create an impact on readers.

The terms asylum seekers, refugees and migrants were all used in the search terms and analysed as these groups were not reliably distinguished in print media, therefore it was felt to be most accurate to include them all.

5.3.3 Coding and Analysis

The content of articles was coded and analysed in two stages: a quantitative content analysis followed by qualitative content analysis incorporating thematic analysis (Macnamara, 2005; Krippendorff, 2018).

For the quantitative component, a pro-forma was developed by AB, KOD and NB which allowed articles to be initially analysed using a set of pre-defined questions (see Appendix 1). This data included: how often and in which newspapers migrants, asylum seekers and refugees were reported about; which populations were mentioned; what the overall tone of reporting was; which broad themes were contained in the article; and who or which groups were quoted in articles. This provided useful context on the tone and style of reporting before conducting the more detailed health-related analysis. Due to thesis length, not all of this analysis is reported in Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?.

Article tone was analysed by looking at the language used in the article and the headline, surrounding the issue being reported. It was assessed as being broadly positive, negative, or neutral. As this was a subjective part of the coding process, a sample of 60 articles were triple coded by AB, KOD and NB to check for consistency. AB then coded the remaining articles.

Thematic analysis was then used to identify the main discourses in the articles identified (Macnamara, 2005; Bruan and Clarke, 2006; Vaismoradi, Turunen and Bondas, 2013). From the initial coding of the article for tone and context, several themes were identified and included in the coding schedule: these were health care entitlement, health care access and border security. Reading and re-reading of the articles, along with discussions with the supervisory team, identified further themes within the articles, including for example health needs, health seeking behaviour, and healthcare spending. This process was facilitated using the qualitative software package, NVivo10. Software packages such as NVivo10 are useful when coding, compared to doing it in a word document, as they allow easy retrieval and manipulation of data (Ziebland and McPherson, 2006).

The One Sheet of Paper (OSOP) method (Ziebland and McPherson, 2006) was then used as an aid to generate meaning and identify discourses constructed by the media in each of the themes identified. The OSOP method is described in Section 7.33.65.4.4 and an example of an OSOP is shown in

Figure 5, p 119.

5.4 Qualitative Focus Groups and Interviews

This section describes the methods used for engaging, recruiting, and interviewing participants for the qualitative interviews. Three different groups of participants were included in the qualitative interviews: asylum seeking and refugee women, community workers and primary health care providers.

5.4.1 Participant Recruitment

Participants were recruited who were asylum seekers and refugees (n=17), healthcare workers (n=7) and community workers (n=2). Each group of participants required a different recruitment approach, which is described in this section. Recruitment, engagement and interviews took place over 2013-2014.

5.4.1.1 Asylum Seeking/Refugee Women and Community Workers

Asylum seeking and refugee women were the focus of this thesis. However, while this group is often treated as homogenous, the reality is that they are found at the intersection of many identities, through their different migration journeys, ethnicities, countries of origin, different religions, different legal status etc.

In order to answer the research question posed in this thesis it was necessary for some characteristics to be pre-set in participant recruitment, such as age (to be within the age of cervical screening invitations), sex and asylum status. However, space was given within the interviews for new identities to emerge and for the existing identities to be given less emphasis if it was felt that they were less important by the participants. One potential limitation was that by focusing on smaller groups at the intersection, the focus on the larger structural and system-wide processes may be lost (Walby, Armstrong and Strid, 2012). This was mitigated in this thesis by the inclusion of candidacy and the focus on the macro-and meso-levels within it, particularly in relation to the media analysis.

It was also mitigated for by a broad purposive sampling approach being taken for women who are asylum seekers and refugees (Silverman, 2019 p.63). A sampling frame was developed for each group interviewed. A sampling frame defines the members of the population who are eligible to be included in a study (Given, 2008). The sampling frame for the women recruited for this thesis was broad as they are often considered as a 'hard to reach' population but included:

- Women who were asylum seekers or refugees
- Between the ages of 20-60 years (the eligibility criteria for cervical screening)
- Resident in the U.K. for greater than 6 weeks (to enable GP registration).

Women of any spoken language were included in the research and appropriate interpreters were organised to facilitate inclusion of women who did not speak English. One woman recruited was in fact an EU migrant as she had mistakenly been identified as an asylum seeker by the community worker for the women's group. This was only established when an interpreter was present at the interview. Her interview was included though as the information she provided was helpful to the study, especially as she revealed that she was often mistaken for an asylum seeker.

Women who were asylum seekers or refugees were recruited for interviews from several sources, their demographics are presented in Table 3.

The initial source of participants was an asylum seeker and refugee community women's group, which met on a weekly basis in Glasgow. This group was engaged with via a community organisation based in Glasgow, which works with asylum seekers, refugees and the local community. When the women's group was approached, they requested a period of engagement before participating in interviews.

This period of engagement was informed by an ethnographic process (Wolcott, 1990; Barbour, 2010; Bryman, 2012; Fusch and Fusch, 2017). AB attended the group, as a participant of the group, on a weekly basis for six months. It was

agreed with the women that during this period of engagement that a reflective field notes journal could be kept by AB. At the end of the engagement period the women elected to take part in a focus group interview rather than individual interviews. As was the case here, focus groups are recognised as being an effective way of encouraging participation from people reluctant to be interviewed on their own (Kitzinger, 1995). In addition to this and the convenience of being able to collect data from several people simultaneously, they explicitly use group interaction as part of the method by allowing group discussion and exploration of different experiences, beliefs and attitudes, which makes it an approach particularly sensitive to cultural and social variables (Kitzinger, 1995; Nyumba *et al.*, 2018).

The focus groups in this thesis consisted of eight women, who attended this women's group, and was conducted over three consecutive weeks to allow adequate time for the interview questions to be discussed. An interpreter was present throughout. The link worker and project manager for the community women's group were also recruited. This allowed exploration of their views on the facilitators and barriers facing asylum seeking and refugee women accessing preventive health care, in addition to their knowledge and role in signposting for health services.

From the engagement with the women's group a snowball recruitment process took place to recruit participants for individual interviews. Snowball sampling (Bryman, 2012 p. 424; Silverman, 2019 p.75) is an accepted method of recruitment in qualitative research, where the researcher engages with an initial small group of participants and then uses the contacts of this group to contact and recruit others. It is a recommended method when trying to sample hard-to-reach or marginalised populations, who may otherwise lack visibility and defined routes of contact (Bryman, 2012 p.424; Silverman, 2019 p.75). It is recognised, however, that this can lead to all the participants being linked. In this study this might mean that all the women would be part of the same regular community, peer support group or at least have knowledge of it. Therefore, there was also recruitment through the Scottish Refugee Council (SRC) to include participants who were unconnected with this community group, as the SRC had no affiliation with the women's group whatsoever.

A further seven women were recruited for individual interviews through introductions made by members of the women's group. Two of them asked to be interviewed together, which was accommodated, as they felt more confident with this arrangement. One of the individual interviewees recruited in this way was the interpreter used for the focus groups, as she had been through the asylum process and after interpreting the focus groups was keen to take part in an individual interview as she felt she had things to say.

Two participants were also recruited through the recruitment campaign run by the Scottish Refugee Council, which utilised a flyer designed by AB (Appendix 2: Recruitment Flyer).

As with focus groups, individual interviews are also a commonly used data collection method in qualitative health and social research. There are, however, fundamental differences between the two techniques (Smithson, 2010; Nyumba *et al.*, 2018). One to one interviews involve an in-depth discussion between the researcher and participant, with the researcher potentially adopting the investigator role, asking questions and mostly retaining control of the discussion (Nyumba *et al.*, 2018). In contrast, in a focus group researchers adopt the role of facilitator, facilitating a group discussion between the participants rather than between the researcher and participants (Kitzinger, 1995; Nyumba *et al.*, 2018). As will be described in Section 05.4.2.2 Focus Groupsand 5.4.2.3 Individual InterviewsAB took great care to try and put women at ease and in a position of control in each type of method.

5.4.1.2 Primary Healthcare Workers

GP recruitment occurred in several ways. Again sampling was purposive (Silverman, 2019 p.63). It was felt that the richest sources of information regarding the barriers and facilitators to access for asylum seeking/refugee women would come from the practices registered as caring for significant numbers of this population. Therefore, participants were sampled from these surgeries.

AB identified practices with high numbers of asylum seekers and refugees through the Locally Enhanced Service (LES) database[3]. Invitation letters (see 0Appendix 3: Invitation Letter General Practice, Appendix 4: Invitation Letter Community Workers were sent to the identified practices and a follow up phone call was placed to the Practice Manager. Both GPs and Practice Nurses were invited to take part in the research. One participant was recruited in this way.

The remaining six healthcare participants were recruited through a snowballing technique: introductions from other participants, through contacts in the General Practice and Primary Care (GPPC) research group and through other professional, clinical contacts.

There was no link between asylum seeking/refugee participants and their healthcare providers. Recruitment was separate for each group so that there was no risk of a breach of confidentiality.

5.4.1.3 Obtaining Consent

Participants were invited to the research either by flier (see Appendix 2: Recruitment Flyer) invitation letter (see Appendix 3: Invitation Letter General Practice,Appendix 4: Invitation Letter Community Workers), or face-to-face invitation from AB. They were given an information sheet (Appendix 5: Information Sheet Asylum Seeking and Refugee WomenAppendix 6: Information Sheet Healthcare Workers,Appendix 7: Information Sheet Community Workers,Appendix 8: Arabic Version of Information Sheet) and consent form to read prior to the interview (Appendix 9: Consent Form,Appendix 10: Arabic Version of Consent Form). The consent form was signed at the start of the interview. The invitation letter, participant information sheet, and consent form were also provided in Arabic, which was the language spoken by many of the participants. These forms also had to be reformatted as Arabic is written right to left, therefore the consent boxes were moved to the left. For participants who

[3] At the time this PhD commenced, practices caring for asylum seekers and refugees in NHS Greater Glasgow & Clyde (GG&C) were enrolled in a Local Enhanced Service (LES) for asylum seekers and refugees, which paid practices for the additional workload of caring for this population.

did not speak English or Arabic these documents were verbally translated by an interpreter at the start of their interview, with the opportunity to ask questions.

No incentive was given to participants for taking part in this research, due to a lack of funding for this. This was explained to participants in the invitation letter, was well accepted and did not appear to cause any issues with recruitment.

At the end of each interview with asylum seeking and refugee women information was offered about cervical screening in language appropriate copies. These information sheets were from the Health Scotland website (http://www.healthscotland.com/documents/24327.aspx).

5.4.2 Qualitative Data Collection

5.4.2.1 Topic Guide Design

Topic guides were designed for the individual interviews and focus groups, these were a list of open-ended questions, with follow up questions and prompts (Dicicco-Bloom and Crabtree, 2006; Dejonckheere and Vaughn, 2019). Four topic guides were designed for the qualitative data collection work package. An asylum seeker and refugee women's focus group topic guide, an individual asylum seeker and refugee women's interview topic guide, an individual community workers topic guide and individual healthcare workers interview topic guide.

The topic guides (See Appendix Appendix 11: Topic Guide Individual Asylum Seeker and Refugee Women's Interviews-Appendix 14: Topic Guide Community Worker) were all designed around the figure of candidacy described by Mackenzie et al (2012), as well as being informed by the wider literature on deservingness, entitlement and media representation. Topics included were: previous experiences of healthcare, awareness of rights to healthcare, barriers and facilitators to access, and the affect of media discourses on access.

The interview questions were arranged in the topic guides to allow the interview to flow easily, in a conversational way. The topic guides were refined during the interview processes to make them as effective as possible. Flexibility was also

given in all the interviews for emergence of new topics or themes which the interviewee felt was important and for the topic guides to be altered in view of this. This iterative approach of exploration and refinement as the interviews progressed allowed emergent as well as anticipated themes to be included in the interview analysis. This is in keeping with a feminist ontological approach, as it allows women to be central in the process and able to bring up issues that are important to them (Oakley and Roberts, 1981; Stanley and Wise, 1990).

An example of this was FGM, which was discussed in some early healthcare worker interviews. The healthcare workers interview schedule was amended to include two questions about FGM. This amendment was approved by the MVLS Ethics Committee (see Appendix 15: Ethics Amendment: FGM and Recruitment). It was not brought into the asylum seeking and refugee women's topic guide as a direct question as it felt too intrusive, but space was made to discuss it when enquiring about barriers to cervical screening if women wanted to identify it.

The language and style of questioning differed depending on who was being interviewed. For example, the healthcare workers topic guide was more technical in points than the asylum-seeking and refugee women's topic guides.

5.4.2.2 Focus Groups

The three consecutive focus group interviews held with the members of the women's group were 1.5-1.45 hours each in length. As discussed above the interviewer in focus groups has an important facilitation role, to facilitate discussion to occur freely within the group in response to the open-ended questions in the topic guide. Therefore, the focus needs to be on creating a warm supportive and comfortable environment to foster open and honest dialogue, where the researcher takes a peripheral role in the focus group discussion (Morgan, 1996; Litosselit, 2004; Nyumba *et al.*, 2018). Hence, the focus groups were held during the Friday women's group, in the community flat where they normally met, and were designed to be relaxed in nature. Lunch was cooked, as was usual with the women's group, by the women and AB, and shared during the interviews. The community group provided childcare in a room adjacent to the focus group, but children were free to come and go into the room as needed.

The separate topic guide was designed to be used with the group over a three-week period, moving through the topics of interest.

- Focus Group 1- Women's background and context building: Focus group 1 was based around constructing a narrative of the women's life experiences, their backgrounds as they felt comfortable to share and building a context for the next focus groups. Informed by intersectionality it aimed to gently unpack their individual identities, roles and potential changes that have occurred since leaving their country of origin and arriving in Glasgow.

- Focus Group 2-Exploring Deservingness: Focus group 2 aimed to explore where the women felt positioned within Scottish society by the media, healthcare entitlement, and those that they encountered in their daily lives. The influence that this had on their feelings of deservingness for healthcare and the decisions around health were explored further in Focus Group 3.

- Focus Group 3- Healthcare Decision Making: Focus group 3 aimed to collate the discussions from the previous two focus group sessions and centred on decision making with regards to health, in particular cervical screening. Women were also given the option to discuss any issues they felt were more sensitive in a follow up individual interview.

A female Arabic interpreter was used for the focus groups. She was identified by the women's group as an interpreter they knew and trusted, as she had provided interpreting services for the group before.

The focus groups were audio recorded. As AB conducted the focus groups her supervisor NB observed and took notes of who was speaking and when so that this could be matched to the transcription, as this was sometimes difficult as it was the interpreter who was mostly being transcribed. Therefore, it was sometimes difficult to recognise the original speaker. However, this note taking, and identification made this much less of a problem.

The focus groups were transcribed by either a member of GPPC administration staff or an outside professional transcription agency. Transcripts were anonymised by AB.

5.4.2.3 Individual Interviews

Individual interviews with asylum seeking and refugee women (n=9), primary care healthcare workers (n=7) and community workers (n=2) were between 30 minutes to 2 hours long.

As discussed above the relationship between interviewer and participant is more intense in individual interviews (Ryan, Coughlan and Cronin, 2013; Nyumba *et al.*, 2018). Therefore, techniques should be used to build trust and rapport (Ryan, Coughlan and Cronin, 2013; Dejonckheere and Vaughn, 2019). Hence, in addition to adjusting language and style in response to different interviewees to create dialogue and a relational focus, interviewees were also offered other adjustments. Such as, individual interviews were conducted in a place of the interviewee's preference, where they felt most comfortable and in control. These included the premises where the community group met, individuals' homes, workplaces and General Practice and Primary Care (GPPC) at the University of Glasgow.

Telephone interviews were also offered to all individual interviewees, but this was not preferred by participants. Interviews were audio-recorded and transcribed in the same manner as the focus groups.

The same interpreter was used for all three focus groups and for one of the individual interviews with women seeking asylum. This provided consistency, she was trusted by participants, and she became familiar with AB and the nature of the interview questions, which helped interpreted interviews run smoothly and instilled confidence in the participant. The interpreter was paid for her interpreting role with the focus groups, individual interviews and for interpreting the information sheets and consent forms. Another interpreter, also paid, was used for one other individual interview as a different language was needed. The remaining individual interviews were all conducted in English.

5.4.2.4 Reflective Field Diary

Feminist researchers, for example, Hankivsky *et al.* (2010) also discussed the importance of individual researcher reflexivity when conducting research informed by intersectionality. This is to recognise that research itself is

controlled by privileged individuals and to locate the researcher with respect to the communities, the issues being researched and to examine the researcher's own assumptions (Clark *et al.*, 2009; Hankivsky *et al.*, 2010)

> 'Intersectionality demands that researchers understand how, they themselves and people living and working in community, live at multiple, fluid and ever-changing intersections.' (Hankivsky et al., 2010 p12)

To help counter and acknowledge this, a field diary was kept by AB throughout the engagement with the participants and reflected upon. In addition, throughout the engagement, interviews and analysis AB remained reflexive about her positioning. A reflexive account is given in Chapter 9 Discussion.

AB reflected on the interactions of the group, observations or discussions that were relevant to the study. She also reflected on her positioning within the group both as a researcher and participant (Section 9.4), in order to explore any potential interviewer bias which can stem from perceptions of a researchers own identity.

The notes from the field diary were included in the final analysis (as described in Section 5.4.4). Fieldnotes are ideally suited for comparison between categories and the demographics of the interview participants, as an aid to finding explanations (Gale et al, 2013).

5.4.3 Analysis

Analysis took a thematic approach, using the theories of candidacy and intersectionality as a conceptual lens through which to understand the data (Bruan and Clarke, 2006; Thomas and Harden, 2008). This involved coding the transcripts, the development of themes and then the generation of meaning (Bruan and Clarke, 2006; Thomas and Harden, 2008).

The aim of coding in qualitative analysis is to organise the data, allowing all interview sections related to each other to be found with ease (Ziebland and McPherson, 2006). Coding followed several steps:

1. Familiarisation with the Data: AB listened to the interviews and read the transcripts, several times, to become fully familiarised with them.

2. Development of codes: Several transcripts were read and coded by both the student and 2 supervisors (KOD and NB), independently. Coding was, at first, thematic, namely the codes were identified from the data. Coding was then discussed and refined in data coding clinics. Refining including applying meaning to the codes and then grouping any overlapping codes together. This ensured consistency in the approach and reliability in the results (Gale *et al.*, 2013).

3. Coding Framework: A coding framework was then developed from the codes identified in Step 3. Different frameworks were designed for the different groups interviewed: women, community workers and healthcare workers. The frameworks were then applied to the remaining interviews and the focus group.

4. This framework was then applied to all transcripts by AB. The coding frameworks were also applied by KOD and NB to a sample of transcripts to ensure consistency in approach. Initially coding was guided by the research questions and theoretical framework of candidacy, but AB was attentive to identifying codes and themes that hadn't been considered prior to conducting the interviews. These were then fed back into the coding framework and coding was repeated to include these. An example of this was religion and islamophobia.

A coding notebook was kept by AB which is considered good practice in qualitative research as it allows the researcher to record ideas, thoughts regarding analysis and links to literature (Ziebland and McPherson, 2006). For transparency in the coding across AB and her supervisors a coding dictionary was also kept which explained the meaning behind each code (see Appendix 16: Coding Dictionary Newspaper Analysis).

Similar to the media analysis (see Section 5.3.3 Coding and Analysis) the coding process was facilitated using the qualitative software package, NVivo10.

5.4.4 Generating Meaning

Ziebland and McPherson (2006) state that ‘once all the data have been coded the real analysis can begin’ (p. 408).

Coding reports were printed, using NVivo10, for all codes identified in the coding process. A coding report is where all the material referenced under a code is placed in a single MS Word document, allowing the researcher to visualise all the different participant’s perspectives regarding that code.

Meaning was generated for each of the identified codes by using the one sheet of paper (OSOP) technique to aid thematic analysis (see

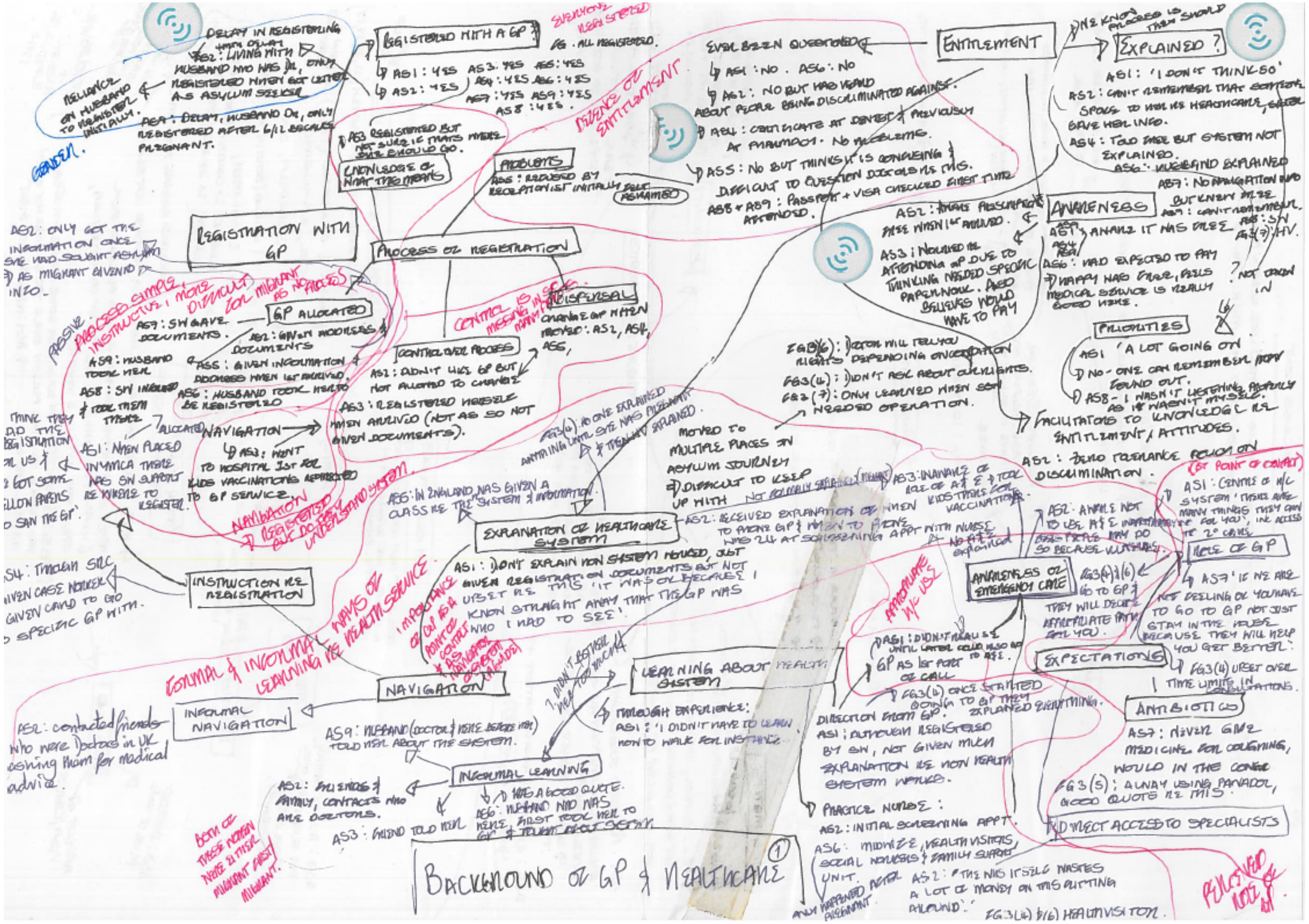
Figure 5). The OSOP technique encourages the researcher to use one, often large, sheet of paper per coding report (Ziebland and McPherson, 2006). On this sheet of paper, a mind map is produced which notes all of the participant responses relating to that code, with their participant ID next to the response so that the response is always connected to the demographics of the person saying it.

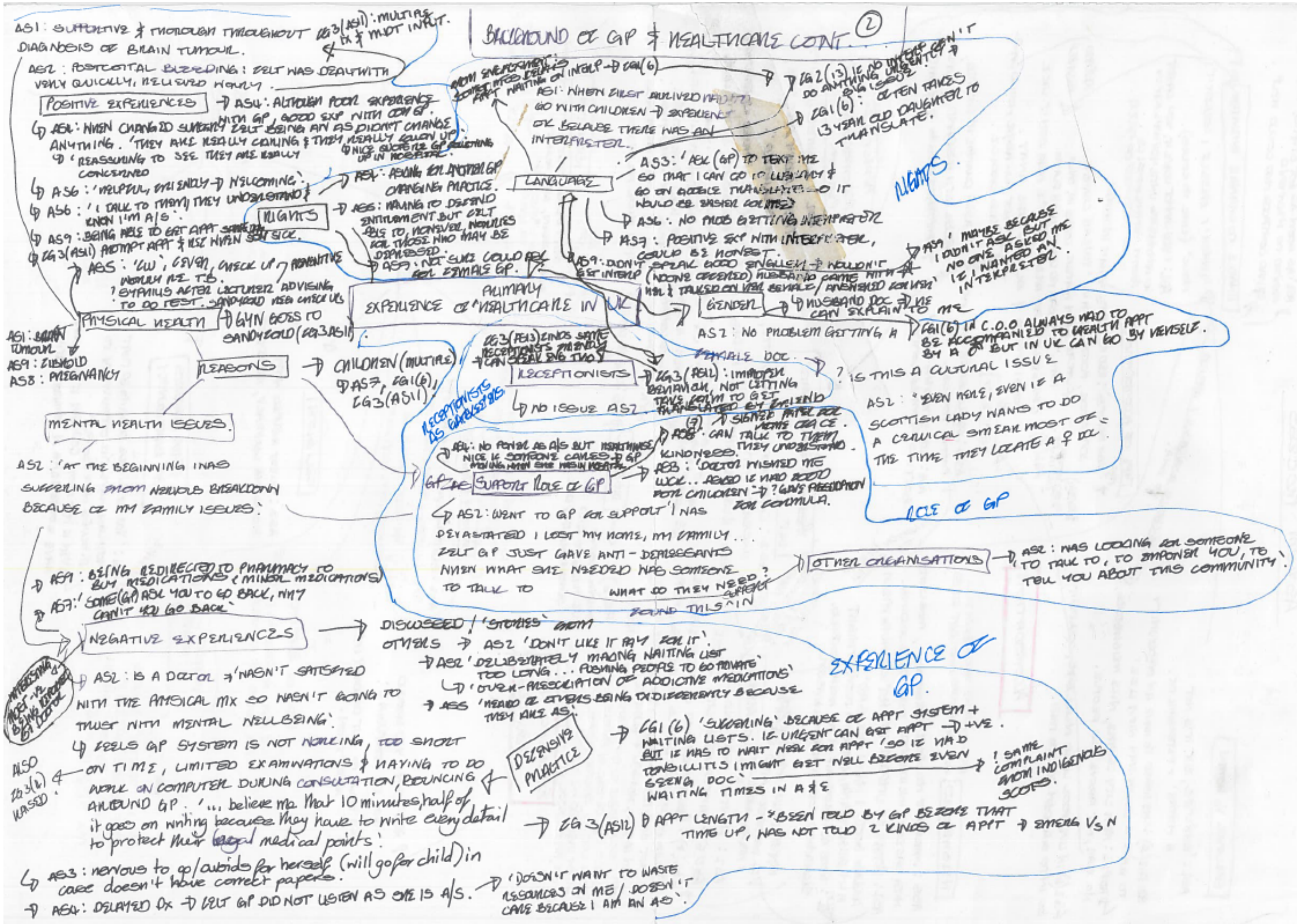
Once the mind map is complete the researcher has a complete summary of all the responses relating to that code (Ziebland and McPherson, 2006). The next step was to see how the codes related to one another, whether they could be grouped together to form themes and whether the participants who gave the responses could be grouped together in terms of demographics or other characteristics (Ziebland and McPherson, 2006). This allowed consideration of commonalities and differences in the codes and who was saying that. The OSOP was repeated when necessary to pin down further data if themes emerged across OSOPs or more detail about a certain theme was needed. Figure 5 shows an example of an OSOP from this analysis.

Field notes, from AB's period of engagement with the women's group and from during the interview process, were also added into the OSOP.

AB discussed the identified themes with her supervisors, with colleagues and comparison was made with current understanding in the literature. From there an analytical narrative was built around the findings.

Figure 5: Example of an OSOP





BACKGROUND OF GP & HEALTHCARE CONT. ②
AS1: SUPPORTIVE & THOROUGH THROUGHOUT DIAGNOSIS OF BRAIN TUMOUR.
EG3(AS11): MULTIPLE IX & MOST INPUT.
AS2: POSTCOITAL BLEEDING: FELT WAS DEALT WITH VERY QUICKLY, RELIEVED HUGELY
POSITIVE EXPERIENCES
AS4: ALTHOUGH POOR EXPERIENCE WITH GP, GOOD EXP WITH CONS GP.
AS1: WHEN CHANGED SURGERY FELT BEING AN AS DIDN'T CHANGE ANYTHING. 'THEY ARE REALLY CARING & THEY REALLY FOLLOW UP'
'REASSURING TO SEE THEY ARE REALLY CONCERNED'
AS6: 'HELPFUL, FRIENDLY → WELCOMING'
AS6: 'I TALK TO THEM, THEY UNDERSTAND & KNOW I'M A/S'.
AS9: BEING ABLE TO GET APPT SAME DAY
EG3(AS11) PROMPT APPT & USE WHEN SICK.
AS5: 'GW', SEVEN, CHECK UP / PREVENTIVE
RIGHTS
AS5: HAVING TO DEFEND ENTITLEMENT BUT FELT ABLE TO, HOWEVER, WORRIES FOR THOSE WHO MAY BE DISPLEASED.
AS4: ASKING FOR ANOTHER GP CHANGING PRACTICE.
AS9: NOT SURE COULD ASK FOR FEMALE GP.
PHYSICAL HEALTH
GYN GOES TO SANDYFORD (EG3AS11)
AS1: BRAIN TUMOUR
AS9: FLU/COLD
AS8: PREGNANCY
REASONS
CHILDREN (MULTIPLE) AS7, EG1(6), EG3(AS11)
MENTAL HEALTH ISSUES
AS2: 'AT THE BEGINNING I WAS SUFFERING FROM NERVOUS BREAKDOWN BECAUSE OF MY FAMILY ISSUES'
PRIMARY EXPERIENCE OF HEALTHCARE IN UK
LANGUAGE
AS1: WHEN FIRST ARRIVED HAD TO GO WITH CHILDREN → EXPERIENCE OK BECAUSE THERE WAS AN INTERPRETER.
EG2(13) IF NO INTERPRETER CAN'T DO ANYTHING URGENTLY → BIG ISSUE
EG1(6): OFTEN TAKES 13 YEAR OLD DAUGHTER TO TRANSLATE.
AS3: 'ASK (GP) TO TEXT ME SO THAT I CAN GO TO LIBRARY & GO ON GOOGLE TRANSLATE → IT WOULD BE EASIER FOR ME'
AS6: NO PROB GETTING INTERPRETER
AS7: POSITIVE EXP WITH INTERPRETER, COULD BE HONEST.
AS9: DIDN'T SPEAK GOOD ENGLISH → WOULDN'T GET INTERP (NOONE OFFERED) HUSBAND CAME WITH
AS9: 'MAYBE BECAUSE I DIDN'T ASK BUT NO ONE ASKED ME IF I WANTED AN INTERPRETER'.
RIGHTS.
GENDER
HUSBAND DOC → HE CAN EXPLAIN TO ME
AS2: NO PROBLEM GETTING A FEMALE DOC.
EG1(6) IN C.O.O ALWAYS HAD TO BE ACCOMPANIED TO HEALTH APPT BY A ♂ BUT IN UK CAN GO BY HERSELF.
? IS THIS A CULTURAL ISSUE
AS2: 'EVEN HERE, EVEN IF A SCOTTISH LADY WANTS TO DO A CERVICAL SMEAR MOST OF THE TIME THEY LOCATE A ♀ DOC'
RECEPTIONISTS
EG3(AS13) FINDS SAME RECEPTIONISTS FRIENDLY → CAN SPEAK ENG TO
RECEPTIONISTS AS GATEKEEPERS
EG3(AS11): IMPROPER BEHAVIOUR, NOT LETTING THEM TO GET TRANSLATED BY FRIEND
NO ISSUE AS2.
SUPPORT ROLE OF GP
AS1: NO POWER AS A/S BUT NICE IF SOMEONE CARES → GP
AS8: CAN TALK TO THEM, THEY UNDERSTAND. KINDNESS.
AS8: 'DOCTOR WISHED ME LUCK... ASKED IF HAD FOOD FOR CHILDREN' → GAVE PRESCRIPTION FOR FORMULA.
AS2: WENT TO GP FOR SUPPORT 'I WAS DEVASTATED I LOST MY HOME, MY FAMILY...'
FELT GP JUST GAVE ANTI-DEPRESSANTS WHEN WHAT SHE NEEDED WAS SOMEONE TO TALK TO
WHAT DO THEY NEED? SUPPORT FOUND THIS IN
ROLE OF GP
OTHER ORGANISATIONS
AS2: WAS LOOKING FOR SOMEONE 'TO TALK TO, TO EMPOWER YOU, TO TELL YOU ABOUT THIS COMMUNITY'.
AS9: BEING REDIRECTED TO PHARMACY TO BUY MEDICATIONS (MINOR MEDICATIONS)
AS7: SOME (GP) ASK YOU TO GO BACK, WHY CAN'T YOU GO BACK'
NEGATIVE EXPERIENCES
DISCUSSED 'STORIES' FROM OTHERS
AS2 'DON'T LIKE IT PAY FOR IT'.
AS2 'DELIBERATELY MAKING WAITING LIST TOO LONG... PUSHING PEOPLE TO GO PRIVATE'
'OVER-PRESCRIPTION OF ADDICTIVE MEDICATIONS'
AS5 'HEARD OF OTHERS BEING TX DIFFERENTLY BECAUSE THEY ARE AS.'
EXPERIENCE OF GP.
INTERESTING MOST VS BEING REFERRED BY DOCTOR
AS2: IS A DOCTOR → WASN'T SATISFIED WITH THE PHYSICAL MX SO WASN'T GOING TO TRUST WITH MENTAL WELLBEING'
FEELS GP SYSTEM IS NOT WORKING, TOO SHORT ON TIME, LIMITED EXAMINATIONS & HAVING TO DO WORK ON COMPUTER DURING CONSULTATION, BOUNCING AROUND GP. '... believe me that 10 minutes, half of it goes on writing because they have to write every detail to protect their legal medical points'.
ALSO EG3(L) RAISED
DEFENSIVE PRACTICE
EG1(6) 'SUFFERING' BECAUSE OF APPT SYSTEM + WAITING LISTS. IF URGENT CAN GET APPT → +VE. BUT IF HAS TO WAIT WEEK FOR APPT 'SO IF HAD TONSILLITIS I MIGHT GET WELL BEFORE EVEN SEEING DOC'
WAITING TIMES IN A&E
! SAME COMPLAINT FROM INDIGENOUS SCOTS.
EG3(AS12) APPT LENGTH - 'BEEN TOLD BY GP BEFORE THAT TIME UP', WAS NOT TOLD 2 KINDS OF APPT → SYMS Vs N
AS3: nervous to go/avoids for herself (will go for child) in case doesn't have correct papers.
AS4: DELAYED DX → FELT GP DID NOT LISTEN AS SHE IS A/S.
'DOESN'T WANT TO WASTE RESOURCES ON ME / DOESN'T CARE BECAUSE I AM AN AS'.

5.5 Strengths and Limitations

Strengths and limitations will be reflected upon further in the discussion chapter. Those presented below present those that were considered at the start of the study and describes the actions that were taken to mitigate them.

5.5.1 Media analysis

A strength of this media analysis was the number of articles and the time period which was examined. It allowed a broad overview of the representation of asylum seekers, refugees and health. Focusing on health reporting was also a strength and this allowed depth within the analysis also.

Due to limitations in the database Lexis Nexus, two highly circulating newspapers, the Sun and the Metro, had to be excluded. However, the range of newspapers which were included did cover a wide range of readership profiles. The combination of the newspapers used for the analyses in this thesis and those covered by the other media analyses that have been performed and discussed as part of the wider literature in this thesis showed a consistency in findings.

Newspapers were chosen as the source of media for this analysis. Due to this being a sole thesis student led project, with support from supervisors, it was felt out with the scope of the resources to include social media or TV.

Judging tone, and in some cases deservingness if it was implicit, was recognised as being the most subjective part of this media analysis and various measures were taken to ensure that tone was judged fairly. As the principal researcher, AB was aware of her own potential biases at the start by recognising that she is a Guardian reader and left wing in her political stances. The supervisors involved in the analysis were of a similar viewpoint. Unfortunately, due to the way that Lexis Nexus presented the articles it was not possible to blind AB of her supervisors to the newspaper publishing each article, therefore several safeguards against bias were put in place. The headline and the body of the article were coded separately for tone, with the headline being coded prior to

the body of the article being read to judge the tone that an individual would glimpse on a newsstand without necessarily reading the rest of the article. Samples were also triple coded between AB, KOD and NB to mitigate bias as much as possible.

Within the inclusion criteria there was a discussion between AB and her supervisors as to whether to include letters written by the general public as these were not written by newspaper staff. It was felt important to include letters, however, as although these were not written by the newspaper the newspaper had chosen to print them and therefore it was felt that the newspaper should be held accountable for the views that they print.

Within this analysis the Daily Mail, Daily Telegraph and the Guardian have been referred to as U.K. national newspapers, despite them having Scottish editions. For the purposes of this analysis, it was decided to refer to them as U.K. national for two reasons. The first is that Lexis Nexus did not reliably distinguish the Scottish editions from the London based editions. The second is that the main editorial offices for these newspapers are based in London with the Scottish offices being likely influenced by this, whereas the Scottish media only has offices in Scotland.

5.5.2 Qualitative Interviews and Focus Groups

Strengths that were identified within the qualitative interviews were the care given to engagement, particularly with the focus groups. This allowed rapport and trust to be built. Due to this trust both with the focus group and the women who were recruited through them sensitive topics were able to be explored. AB also tried to provide as much flexibility and comfort in the interview process as possible. Conducting interviews in a location of the woman's choice, with a known trusted interpreter and having flexibility for children to be present.

The views of healthcare workers and community workers were also sought in this study. Again, AB was flexible within their schedule to make the interview process as easy as possible for them. Whilst the main focus was mostly on the asylum seeking and refugee women's and healthcare workers relationship, community workers gave context and triangulation of data.

Limitations in this study were that there was likely underrepresentation of more isolated women. The focus group was an established women's group and many of the women recruited from snowballing from this group would have had connections with it. By recruiting through the Scottish Refugee Council, it allowed a wider reach of participants, but they would still have had contacts with this organisation so women who were truly isolated were recognised as being difficult to reach and an awareness was maintained of this. The community and healthcare workers who were recruited, were also recruited through their known work with asylum seekers and refugees, therefore there was a risk that they would be more positive than others who were not as involved. However, it was accepted that there would be a lack of significant data with workers who had no direct experience with these groups, therefore no active recruitment of those not working with asylum seekers and refugees took place.

5.6 Ethical Considerations and Approval

Ethics was granted by the College of Medicine, Veterinary and Life Science, University of Glasgow Ethics Board (see Appendix 17: Ethics Approval) for the qualitative part of this thesis.

It involved participants taking part in either an individual or a focus group interview, for which information sheets and consent forms were given in advance (Appendix 5: Information Sheet Asylum Seeking and Refugee Women- Appendix 10: Arabic Version of Consent Form) Participant's language needs were considered, through the provision of interpreters when required and translated written material (see Appendix 8: Arabic Version of Information Sheet and Appendix 10: Arabic Version of Consent Form).

The main risks to participants, particularly asylum seeking and refugee women, in taking part in interviews was that upset may be caused in talking about upsetting or traumatic experiences. Therefore, questions were carefully considered with regards to this and there was no questioning around reason for seeking asylum or country of origin as it was felt that it was a sensitive, personal issue which did not have direct relevance to the research questions posed by this thesis. It was also important that interviews did not seem too close in nature to any official Home Office interviews that women may have previously experienced. However, AB was aware that the subject of this thesis could also raise intimate and personal issues. Therefore, participants were fully informed that they could stop the interview at any time if they were uncomfortable with any of the questions in the topic guide and signposting to appropriate services was planned for. This never occurred and participants gave feedback that they enjoyed taking part in the interview process.

During the engagement process with the community women's group, the women were reminded each week that field notes were being taken in case they would like to ask for anything to be omitted from them. If any sensitive, obviously private topics were discussed at the groups these were not recorded in the field notes.

AB was also very aware of her position in the group. She was there as a researcher, but the group also knew that AB was a doctor (GP trainee at the time of engagement). It was acknowledged that this may make women reluctant to be fully open about their experiences with GPs, but it was hoped that the period of engagement would help mitigate this as they would also get to know AB as a fellow participant at the women's group.

All recordings of interviews were transferred to transcribers and back to AB in a secure way and then stored in password protected files. Files were anonymised during the transcription process. All consent forms were kept in a locked cupboard, in an office which is locked when vacant within the General Practice and Primary Care building.

Two amendments were made to the original ethics application, and both were granted. The first was to include questions about female genital mutilation in the topic guide for healthcare workers as it was emerging as a theme in the women's and community workers interviews. The second was to allow recruitment for women through the Scottish Refugee Council and for them to use a flier for this (see Appendix 15: Ethics Amendment: FGM and Recruitment for approvals and Appendix 2: Recruitment Flyer for the flyer).

5.7 Chapter Summary

In this chapter the multiple methods employed in this thesis were outlined and the rationale for using this approach described. These were considered the most appropriate methods for answering the different research questions posed in this thesis. Through these multiple methods a rich amount of data was collected, which allowed the theories of candidacy to be explored from every level: the macro-, meso- and micro-level, which as described in Chapter 4 Literature Review: Cervical Screening for Asylum Seeking and Refugee Women is not often achieved within one study.

The next chapter, will present the findings from the media analysis performed to explore how asylum seekers, refugees and health are portrayed within newspapers in the U.K.

Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?

6.1 Introduction

This chapter is the first data chapter of this thesis and presents the findings from the newspaper analysis. This was conducted in order to explore the research question:

> What discourses are constructed in the UK's print media around asylum seekers, refugees, and health?

In addition to presenting patterns of health reporting, this chapter considers specifically how the media portray the deservingness of healthcare for these groups. Therefore, the findings from this newspaper analysis, will be used as a context within which to consider the qualitative interview and focus group findings from asylum seeking and refugee women, healthcare and community workers (Chapters Chapter 7 Operating Conditions and Chapter 8: Cervical Screening Negotiations- Micro-Level Candidacy) to explore how these narratives influences feelings of deservingness, access and use of health services by women who are asylum seekers and refugees.

The methods for this newspaper analysis are presented in Section 5.3. As described there, this analysis explored five years of newspaper articles (2008-2013) about asylum seekers, refugees, and migrants where health constituted 50% or greater of the article.

6.1.1 Article Inclusion

The search, described in Section 7.33.65.3.2, returned 2342 articles. Each article was read by AB and KOD and were retained in the final sample if they met all the following inclusion criteria:

1. Asylum seekers/refugees/migrants had to be the focus of 50% or greater of the article

2. The article had to be based in the U.K.

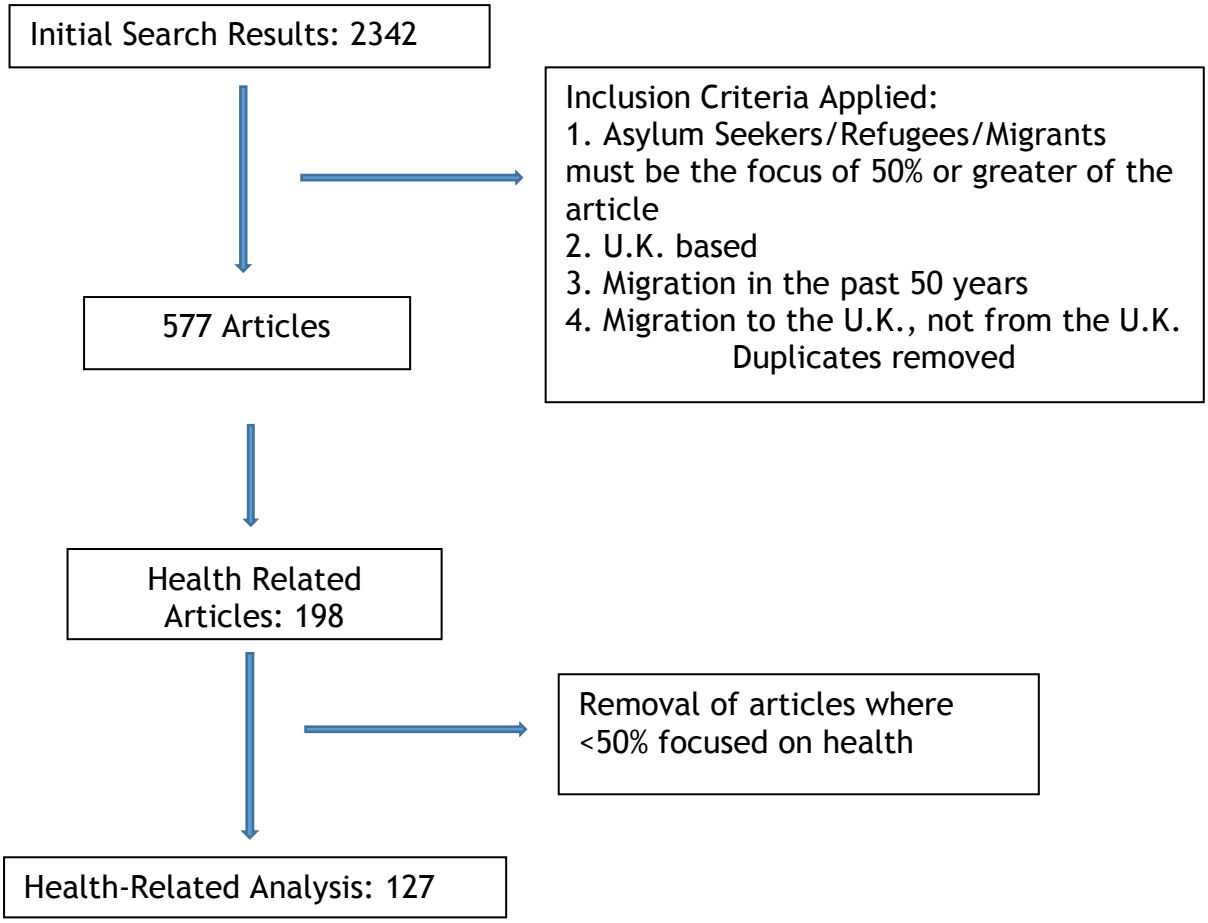
3. The article had to be about migration within the last 50 years

4. The article had to focus on migration to the U.K., not from the U.K.

Any discrepancies between inclusion decisions were discussed and a third opinion from a second supervisor (NB) was sought. After the inclusion criteria were applied, 577 articles were identified. These were initially analysed in order to explore how migration was portrayed in general in the U.K. and Scottish media; this work is not presented in this thesis but did provide an important background to the more detailed analysis on health and health care.

The 577 articles identified for the initial analysis were then examined for health content. 198 health related articles were found. Articles with a content of greater than 50% about a health-related subject were included from this in the final analysis (n=127). Figure 6 provides a flow chart of the inclusion criteria.

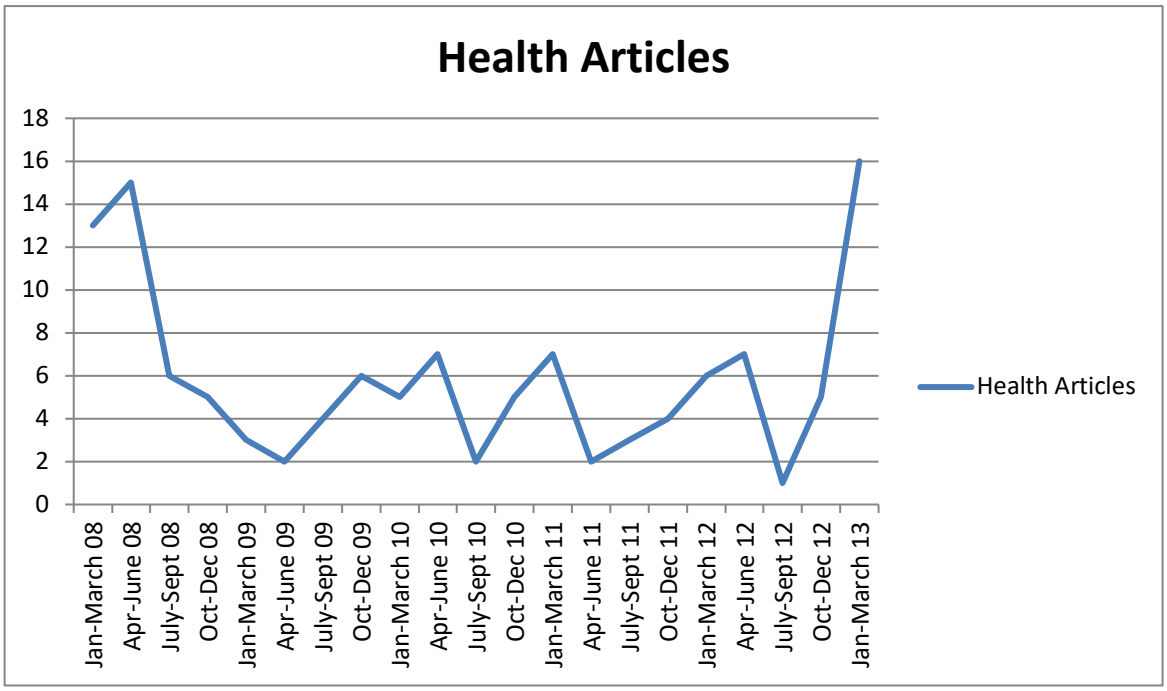
Figure 6: Flow Chart of Inclusion Criteria



6.2 Patterns within Health Reporting

127 articles were identified which reported stories on migrants, asylum seekers, refugees, and health over the five-year period (see Figure 7).

Figure 7: Health Articles Published Over Time Period January 2008 to March 2013.



Two spikes in reporting were identified. The first, in April to June 2008 was due to coverage of two issues. The first surrounded the first case of drug resistant TB in Scotland, in a patient who was from Somalia. This was linked to the individual's asylum status (The Scotsman, 2008a), with migrants blamed for the rise in TB (Daily Mail, 2008a) and a risk to indigenous Scots' health (Daily Mail 2008b). The second most popular story published at this time was about a High Court ruling in England that failed asylum seekers were entitled to free NHS care, a decision which was later reversed by the Appeals Court in April 2009 (The Daily Telegraph, 2009a).

The spike in health themed articles from December 2012-March 2013 was similar to the general media reporting (not presented here) around the lifting of free movement restrictions on the A2 accession states (Romania and Bulgaria) and the perceived effect that this would have on health care resources. Most of this reporting was in the right-wing national newspapers and focused on the strain that migrants from the A2 accession states would put on resources including health, housing, and education.

The range of themes discussed in the health-focused articles was broad Figure 8) with ten themes identified through the coding of the health care articles. These themes fed into wider narratives which will presented in Section 6.4.

Figure 8: Main Themes within Migration and Health Reporting

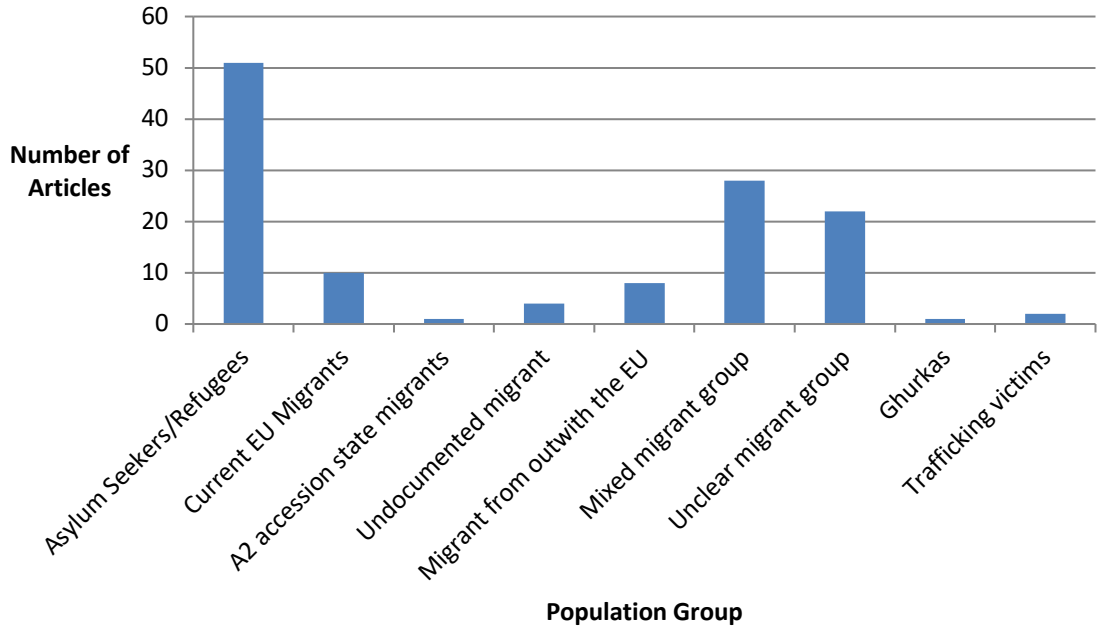
Theme Number	Health Theme	Number of Articles cited in (% of articles)
1	Health Care Access	63 (50%)
2	Health Needs	52 (41%)
3	Health Care Spending	39 (31%)
4	Specific Health Problems	37 (29%)
5	Health Seeking Behaviour	34 (27%)
6	Pressure on the NHS	25 (20%)
7	Patient Safety	25 (20%)
8	Migrant Healthcare Workers	22 (17%)
9	Health Expectations	22 (17%)
10	Maternity Care	5 (4%)

The different newspapers presented these themes in different proportions and in different ways and over 50% of articles had overlapping themes. For example, the Daily Mail and the Daily Telegraph, reported more on health care access than health needs, which is consistent with the Daily Mail being very concerned about healthcare spending compared to any other newspapers. In contrast, the Guardian focused on health needs. Scottish reporting also had this focus with articles exploring the specific health problems of migrant groups and patient safety.

6.2.1 Health Articles by Population Group

Within the 127 health articles included in the health media analysis several migrant groups were discussed. As Figure 9 shows the group mentioned the most in health articles were asylum seekers and refugees, comprising 40% of health care reporting in this media analysis.

Figure 9: Health Articles Divided by Population Group



Mixed (22%) and unclear (17%) migrant groups were the next most reported groups with regards to health. Analysis of the mixed group articles found mention of asylum seekers, refugees, along with EU, non-EU, A2 accession state and undocumented migrants. Within these 28 mixed articles the mention of different population groups ranged from two groups per article to ten different population groups in one article.

6.2.2 Healthcare Settings

Primary healthcare as the sole health setting focus of an article accounted for 18% (n~23) of healthcare reporting about migrant groups; 31% (n~39) focused on the secondary healthcare setting. 27% (n~35) focused on a mix of both primary and secondary healthcare and the remainder did not discuss setting.

Asylum seekers and refugees were the population group most frequently reported with regards to primary and secondary healthcare.

Primary care was consistently portrayed as being overwhelmed by migration, with registration of migrants reported as disadvantaging the care of indigenous

Britons. This created an impression of deserving, indigenous Britons being pushed out of the health service by a group who were less deserving. Other articles reported on longer appointment times required to allow for language difficulties and confusion regarding the entitlement of migrant groups to healthcare, with GP's often being left in difficult ethical and professional positions regarding this.

GPs were quoted frequently. In the right-wing media they were quoted to validate concerns that the NHS was being overwhelmed. In the Scottish and left-wing media, they were quoted in a lobbying role, advocating for the rights of migrants to healthcare.

The Scottish newspapers consistently defined whether they were talking about NHS Scotland, NHS England and Wales or Northern Ireland. The national media was less discerning with regards to this and in most national health articles there was no distinction made with regards to which nations' health system was being discussed. In many it could be discerned that they were discussing NHS England, however, it was confusing when reading these articles from a Scottish viewpoint as differences in health care entitlement in each country were not made clear.

6.2.3 Aspects of Health Reported

Physical health was the most widely covered aspect of health, discussed in 43% (n~55) of health articles. Mental health was very rarely discussed: 5.5% (n~7) discussed mental health and 7% (n~9) discussed both mental and physical health. The remaining articles either did not specify a specific health condition or it was not applicable.

Asylum seekers were the most represented group in all aspects of health reporting. 50% (n~28) of all articles about physical health focused on asylum seekers/refugees. Mental health was almost exclusively discussed in association with the asylum seeking/refugee population (n~6/7 of the mental health articles).

Chronic disease featured very little in the reporting. Screening was only reported regarding screening for TB, as a protective measure for the indigenous

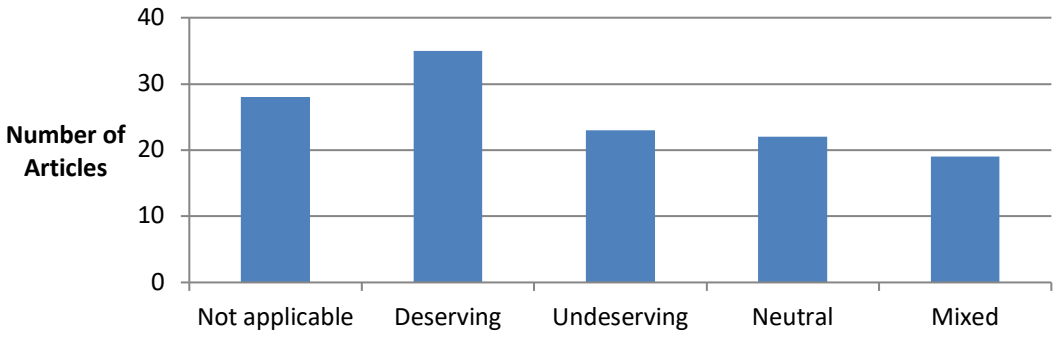
population. There was no reporting about cervical screening or other prevention programmes within the articles analysed. Mental health and sexual health, in particular sexual assault and FGM, were reported with regards to asylum seeking women in the Scottish and left-wing media.

6.3 Deservingness for healthcare

Reporting of entitlement to healthcare for migrant populations was widely discussed. However, the manner of reporting was confused with a lack of distinction between policies in England and Scotland. 49% (n~62) of the articles mentioned entitlement to healthcare but no distinction was made between the different entitlement policies in Scotland and England. Facts surrounding entitlement to healthcare were often mixed with rhetoric about deservingness therefore making it difficult to understand the rules of entitlement. Different migrant groups entitlements were not clearly distinguished, with general terms such as 'health tourist' used.

Deservingness for healthcare was reported more frequently than entitlement, occurring in 78% (n~99) of the articles; 28% (n~35) portrayed migrants to be deserving of healthcare in the U.K., compared to 20% (n~23) which portrayed migrants to be undeserving of healthcare (Figure 10). A similar number were neutral (17%/n~22)) or mixed (15%/n~19) in their portrayal of whether migrants were deserving of healthcare.

Figure 10: Portrayal of Deservingness of Healthcare in Health Articles

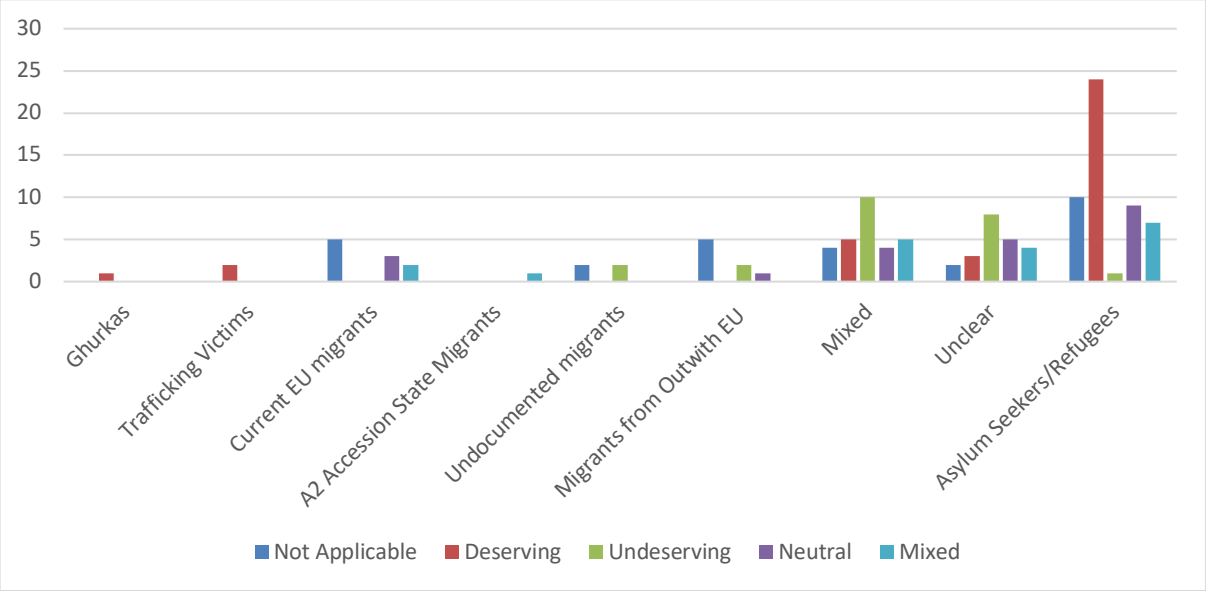


A migrant hierarchy was seen in the portrayal of health deservingness (Figure 11). Asylum seekers and refugees were portrayed as the most deserving group,

with only 1 out of 51 articles about asylum seekers/refugees portraying them as undeserving. Ghurkas and trafficking victims were also portrayed as deserving, although there was a low level of reporting about these groups.

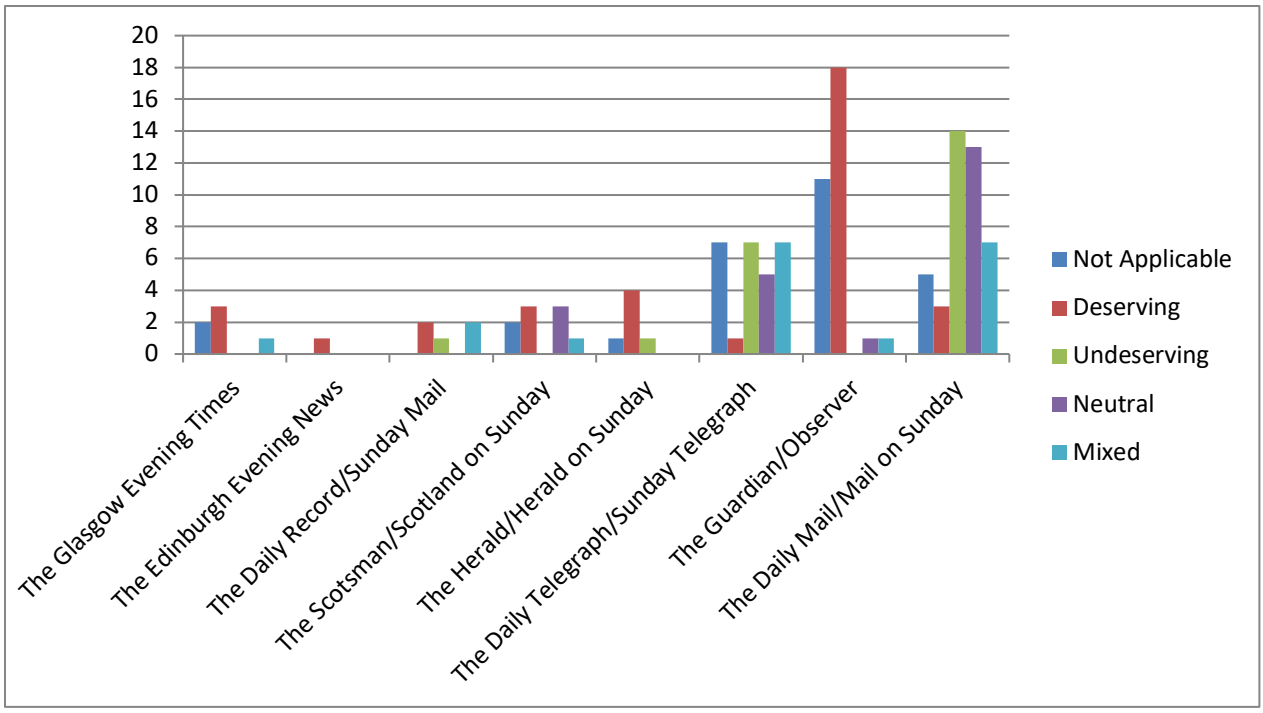
Conversely, current EU migrants and migrants from out-with the EU were consistently reported as undeserving of healthcare. Undocumented migrants were placed at the bottom of the migrant hierarchy in the healthcare articles portrayal of deservingness, being portrayed as completely undeserving with no neutral or mixed articles about them.

Figure 11: Portrayal of Deservingness in Different Population Groups within Healthcare Articles



Patterns emerged when the portrayal of deservingness was divided by newspaper, (Figure 12). The Guardian published no articles which portrayed any migrant group to be undeserving and had the highest number of articles across all newspapers portraying migrant populations to be deserving of healthcare. The Daily Mail, conversely, had the highest number of articles portraying migrant populations as undeserving of healthcare. The Daily Telegraph had an equal proportion of undeserving and mixed articles and rarely published positive articles about deservingness.

Figure 12: Portrayal of Deservingness in Different Newspapers within Healthcare Articles



The Scottish media was more positive towards migrant's deservingness of healthcare, compared to the U.K. media. All but one of the Scottish newspapers examined had articles which supported migrants' rights to healthcare as their highest proportion of health articles (Figure 12).

6.4 Presentation of asylum seekers, refugees, and health in U.K. Newspapers

As discussed in Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Access, the media uses techniques to frame stories about migrants to shape public narratives. The construction of ways of understanding within these narratives relies upon certain newspaper techniques including the repetition of key phrases and themes (Philo, Briant and Donald, 2013).

These strategies were identified within this analysis. There was, for example, repetition of figures and quotes across articles, often over quite long time periods, which reinforced and validated the presented themes and ways of understanding. For example, the phrase 'The NHS is a national health service not

an international one' (Daily Mail 2011b, Daily Mail 2012a, Daily Mail 2013a, Daily Telegraph 2013a) was repeated numerous times and in different newspapers from 2011-2013, which reinforces the narrative that entitlement should be for citizens only.

It was also common practice for articles to use migrant voices, descendants of migrants or individuals with a 'surname that implied foreignness' to validate the view being portrayed, particularly if this view could be considered negative or undeserving in its tone.

> 'Dr Vijayakar Abrol, a GP who practises in Edgbaston, Birmingham said: The [guidance] is not worth the paper it is written on. We do not have endless resources. Why should we give these patients – be they from India, Canada, the US or Eastern Europe – free treatment?' (Daily Mail 2012b)

> 'Shafait Hussain, 34, came to Britain from Pakistan as a baby. Now a father of two, he works at Heathrow. It's realism, rather than racism, that motivates him. "Slough is very, very full; new arrivals in Britain should be sent to the North," he says. "There are so many people here now that I can't even get an appointment with my GP' (The Daily Telegraph 2010a)

Such practices have been reported by others. For example, Rasinger (2010) reported recurring references to local members of the public to establish a close link between the story and the readers. Philo (2013) interviewed journalists and found that newspapers would try to obtain a quote from someone with an overseas background so that the newspaper had 'covered itself' if it was accused of doing a 'stitch up' job on asylum seekers.

The health care reporting analysed in this thesis, presented and reinforced four main narratives:

1) Migrants are a threat:

    a. To British culture and norms around healthcare

    b. To the availability of NHS resources for the host population

    c. To resident Briton's health

2) The NHS is fragile:

    a. It is vulnerable to attack and could be easily overwhelmed

    b. It relies on migrant health care workers

    c. It has the potential to become unsafe in the wrong hands

    d. Entitlement needs to be policed

3) The typical indigenous British citizen

4) The typical migrant healthcare user

These themes and their components are presented in the following sections.

6.4.1 Migrants are a Threat

This narrative was presented and reinforced in three different ways, which are discussed below.

6.4.1.1 Migrants are a Threat: To British culture and norms around healthcare

As discussed in Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Access, the media has often portrayed migrants as a threat to Britain's identity and culture (Khosravinik, 2009; Innes, 2010; Pearce and Charman, 2011). This rhetoric was further heightened with regards to the National Health Service.

Cultural differences were repeatedly highlighted through discussion regarding food choice in hospitals, differences in family size at visiting time and the need for cultural competence training for healthcare providers. These were often reported with an underlying sentiment that by improving cultural awareness for one population the host population automatically suffers.

> 'Walk into Ealing Hospital and you could be forgiven for thinking you were in a foreign land…You could see the strain of coping with such a

> diverse population, the curry menu at the hospital was fantastic, far better than the English food on offer' (Daily Mail, 2011a)

There was a discourse regarding how much the health system should accommodate different cultures and languages. Reporting around this, particularly in the right-wing newspapers was often negative and mocking in its tone.

> 'Healthcare professionals have been given bizarre guidelines to avoid offending asylum seekers and refugees...The pack also suggests that females cover themselves up when they are in Islamic homes. More comically, there is advice on rubbing noses with Afghans. Also, when dealing with Albanians, one should nod to say no and shake one's head to mean yes. Last night, the dossier was dismissed by critics…Richard Cook, of the Campaign against Political Correctness, described the booklet as 'patronising, inaccurate and insulting'.' (Mail on Sunday, 2008a)

Language barriers transected several of the themes presented in this chapter and often appeared an inflammatory issue within the reporting. Accommodating patients who do not speak English as their first language was again often illustrated as disadvantaging the host population.

> 'Dr Richard Fieldhouse, of The National Association of Sessional GPs, said one issue was that many of the newly registered immigrants spoke little or no English adding to appointment times.' (Daily Mail, 2009a)

Scottish reporting featured the launch of Language Line in 2008, a telephone interpreting service. While the initial reporting surrounding this was positive, an intolerance and discrimination to non-English speakers was observed in the letters published in the same newspapers in response to this. This was in addition to reinforcing indigenous culture by calling for a protection of Scottish language rights, such as Gaelic being a language included in Language line.

> 'The setting up of NHS 24's Language Line in response to the growing number of people arriving in Scotland who speak little, or no English is another indication of the unnecessary squandering of precious financial resources.' B.Glasgow (Evening Times letter, 2008)

> 'Learn the lingo, please….I feel it is important to ask why, of the 120 languages that can be accessed to facilitate health care, is Gaelic not included? Weegie' (Evening Times, 2008)

6.4.1.2 Migrants are a threat: To the availability of NHS resources for the host population

Migrants were portrayed as a threat to the availability of NHS resources for the host population. This was the most persistent discourse, seen across the reporting period. It was emotive, with suggestions that by providing services for migrants something was taken away from the indigenous population. This again brought out discourses of deservingness. Comparing both the deservingness of one population against another, and also the deservingness of one service against another. For example, the quote below compared the deservingness of spending money on translators when there is a more deserving issue, for example cancer treatment.

> 'Cash-strapped health boards have had to splash out at least £7 million on translators in recent years…Chairman of the Scotland Patients Association Margaret Watt said … "This is £7 million pounds you could be using to pay for cancer drugs not deemed too expensive to provide on the NHS"' (Daily Record, 2010)

> 'They [Doctors] warned that in some parts locals faced being told that there was no room for them to be admitted to practices because of the foreign surge.' (Daily Mail, 2008c)

Immigration was repeatedly blamed for inadequacies in the NHS such as waiting times and quality of care.

> '…the TaxPayers' Alliance, said: 'It is clearly unacceptable that someone who has paid for the NHS throughout their working life should face delays or queues as a result of recent immigration' (Daily Mail, 2009a)

Maternity care was a frequently discussed issue in the healthcare reporting, either as an example of the lack of resources or more specifically around the increased birth rate associated with migration and the impact on healthcare systems and resources available within the NHS.

> 'Midwives say the quality of NHS care has plummeted because ministers failed to predict a massive rise in the birth rate among immigrant mothers' (Daily Mail, 2008d)

However, whilst being critical of immigration policies there was also a blaming of migrant populations for the stretch on maternity resources.

> ‘The revelations have inevitably sparked criticism of Britain’s immigration policies, and renewed concern that the NHS is being overwhelmed by an influx of foreign mothers keen to take advantage of free healthcare.’ (Daily Mail, 2011)

The Guardian was the only newspaper to produce an article which was sympathetic to migrants with regards to maternity healthcare access. It was particularly concerned with asylum seeking women being put at risk by asylum dispersal policies which could lead to a lack of continuity in maternity care (The Guardian, 2013).

General Practice was the other clinical area frequently discussed within the ‘truth’ that migrants are a threat to NHS resources. A tone of panic was often found within these articles in the right-wing newspapers, as illustrated by the following headlines.

> ‘A Migrant a Minute Registers with GPs’ (Daily Mail, 2009)

> ‘Migrants join a GP practice every minute: Influx of patients leaves surgeries “straining at the seams”’ (The Daily Telegraph, 2009b)

However, in contrast to the negative reporting surrounding NHS resources and migration there was also some ethical debate around the withholding of treatment. For example, the treatment of a refused asylum seeker with a life-threatening liver condition was debated across newspapers, as whilst he was not considered eligible for healthcare, there was an argument that it was unethical to withhold treatment in a patient with no means to leave the country (Daily Mail 2008e, The Daily Telegraph 2009a).

A moral argument, such as this was seen in the reporting every so often, but fear remained the prevailing rhetoric. For example, in an article promoting free healthcare for HIV patients a caveat was made that it must not be open to abuse, therefore bringing back a suspicion of abuse and feelings of mistrust towards migrants accessing healthcare (The Guardian, 2012), and that only once migrants are vetted as being fully trustworthy are they deserving of healthcare.

6.4.1.3 Migrants are a threat: To the Host Communities Health

Migrants were portrayed as a direct threat to the host community's health, particularly through infectious diseases. This was reported with alarm.

> 'Doctors last night warned Scots are at a growing risk of a deadly lung disease caused by Eastern European immigrants' (Daily Mail, 2008f)

TB and HIV were the main infectious diseases portrayed as a threat. They were also the main health problems focused on by the media in relation to migrant health overall; seven articles were published about TB and six articles about HIV.

All the articles about infectious diseases discussed the importance of migrants being treated for these conditions. However, there was a difference in the way TB and HIV were portrayed, and which newspapers they were portrayed by.

HIV reporting discussed the importance of treatment to limit the spread of infection to the indigenous host population of the U.K. but gave more attention to the benefits of treatment for the health of the individual with HIV. The articles about HIV focused on asylum seekers/refugees and discussed injustices in the denial of HIV treatment for refused asylum seekers. There was a feeling of injustice and hypocrisy in these articles around the politics of HIV treatment, with the Guardian reporting as below.

> 'The U.K. has strongly supported the G8 pledge to get treatment to all people who need it in poor countries and yet it is sending back people who have discovered they have HIV and have been put on drugs while in the U.K., to places where they have no hope of continuing their medication' (The Guardian, 2008)

These stories included individual personal stories in which a face was put to the issue of treatment for HIV with a lot of community workers voices being heard in the articles.

TB was not portrayed in the same sympathetic manner. The importance of treatment was not argued for through sympathy for the individual migrant with TB but instead was reported as essential to protect the host population of the

U.K. from infection. TB was portrayed as a disease of poverty and a result of inferior healthcare systems.

These differing portrayals of two infectious diseases is a good example of the pattern of the portrayal of deservingness in different newspapers. Most of the HIV articles were published in the Guardian, with one published in the Herald, which may explain this individual and more sympathetic focus. As can be seen in Figure 12 the portrayal of articles reporting migrant populations to be deserving of healthcare in both of these publications outweighed any other stance. TB articles, however, were published mostly in the Daily Mail/Mail on Sunday (n~5/7), which may explain the portrayal of TB in a less sympathetic way as a disease of poverty and a result of inferior healthcare systems. As seen in Figure 12: Portrayal of Deservingness in Different Newspapers within Healthcare Articles, the Daily Mail had by far the highest number of articles portraying migrants to be undeserving of healthcare compared to any other stance that they published, or any other newspaper included in this analysis.

All six articles about HIV were deserving in their tone with regards to access to healthcare, whereas the TB articles were either neutral or mixed. The populations within the TB articles were poorly defined and although the first man in Scotland with multidrug resistant TB was an asylum seeker, there was little discussion about him as an individual. Therefore, the reporting around TB as a specific health problem remained faceless.

6.4.2 The NHS is Fragile

6.4.2.1 The NHS is Fragile: It is vulnerable to attack and could be easily overwhelmed

Much of the reporting portrayed the NHS as being attacked by migrants and that the NHS could be easily overwhelmed. The primary motivation for migrants moving to the U.K. was constructed as access to free healthcare.

> '…people coming in from abroad with the sole purpose of accessing free healthcare when they have never paid anything towards the NHS.' (The Daily Telegraph, 2013b)

Within the right-wing newspapers there was very little sympathy for any individual and their health. Reporting often focused on individual treatments and suggestions that migrants might be encouraged to take advantage of the NHS. This was illustrated in the reporting surrounding the High Court ruling in 2008 that a refused asylum seeker would receive medical treatment for a serious liver condition: a decision later reversed by the Court of Appeals in 2009. The Daily Mail portrayed access to healthcare, in this case, as a prize rather than a human right, with no sympathy for the individual involved.

> 'Victory would have opened the door for thousands of failed claimants to claim treatment' (Daily Mail, 2009b)

Health as a human right was repeatedly discussed in a negative tone, particularly by the Daily Mail, with the Human Rights Act portrayed as allowing migrant populations to overwhelm the NHS. As illustrated in the quote below, adding terms such as 'illegal immigrant' when discussing asylum seekers also created an illusion of criminality.

> 'NHS treatment will be available for tens of thousands of failed asylum seekers to ensure their human rights are honoured…it could open the floodgates to 'up to a million' illegal immigrants' (Daily Mail, 2009)

There were also clear accusations of criminal behaviour surrounding migrant healthcare, including accusations towards doctors.

> 'A Panorama investigation this month found places on GP's lists were being sold to health tourists for £800. This practice enables foreign nationals who have no legal right to free hospital treatment to be seen without paying.' (The Daily Telegraph, 2012a)

The term 'health tourist' was used repeatedly in constructing this 'truth'. It validated ideas that a migrant's primary motivation for coming to the U.K. was to access healthcare and presumed that they would only be here temporarily, therefore unable to contribute to taxes or the health system. As in the quote below, these claims, figures and validations are often unsubstantiated with no references or citations to support the data.

> '"This is not just about the money, vital though that is - we cannot have the NHS, paid for by taxpayers, being abused by people who pay

> nothing into the system and who are not eligible for free care." …Mr Skidmore has obtained figures showing that health tourists currently owe the NHS £40million in unpaid medical bills.' (Daily Mail, 2012b)

There was also an assumption that the reason migrants were keen to access the NHS was because it is a superior healthcare system to others.

> 'Many of the migrants pouring into Scotland, often from countries with inferior healthcare systems, are suffering from serious illnesses requiring immediate high-level healthcare… "We're much better at dealing with it over here because our service is not so antiquated"'(Daily Mail, 2008f)

A small number of articles in the analysis did recognise the expected norms of healthcare that migrants may have and how these may have been challenged upon accessing healthcare in the U.K., such as having easier access to specialities and earlier involvement by obstetricians in their country of origin; and longer waiting lists in the U.K. However, this was often linked to them having a choice to return to their country of origin for treatment.

> 'Eastern European patients are taking their children back to their home countries to the doctor or dentist because of NHS waiting lists' (Daily Telegraph, 2012b)

6.4.2.2 The NHS is Fragile: It relies on migrant healthcare workers

Throughout the health and migration reporting there was a strong defence, across all the newspapers, of migrant healthcare workers in the U.K. This was the only topic within which a consistent, sustained appreciation of migrant contribution was seen in the media during this analysis, where there was an intersection between migration and job role as a healthcare worker. This was particularly true for nurses and the important role that they play in the NHS. There was a clear recognition that the NHS relies on migrant healthcare workers and very little rhetoric regarding migrant healthcare workers taking jobs from other Britons, as is demonstrated in the quote from the Guardian below.

> 'Amid all the rhetoric on illegal migration [Cameron urges public to report suspected illegal immigrants 11 October] we seem to have lost sight of the fact that the U.K. has for years relied upon the contribution of highly skilled migrants to deliver our public services.' (The Guardian, 2011a)

There was also worry in the media about how immigration caps would affect the NHS's workforce and the overall safety of patients.

> 'The British Medical Association, the doctors' union, also warned the cap on non-EU migrant workers - due to come into effect permanently from this April - will "undoubtedly" create skills shortages which would likely lead to operations being cancelled and waiting times increasing.' (The Daily Telegraph, 2011)

> 'Ministers have been accused of risking patient health in favour of a "crude" immigration policy after government documents revealed that almost half of the nurses from abroad now working in the NHS will be forced to leave Britain under new plans.' (The Observer, 2012)

This was particularly true in the Scottish media, where the tension between border security and health staffing became apparent. Border security is a reserved matter in the U.K. whereas health is devolved to the Scottish Government. Thus, staffing the NHS in Scotland was made more difficult by U.K. immigration policies with little Scottish control over the issue.

> 'The Scottish Government's bid to attract doctors from outside the EU in four key medical disciplines has been rejected by Gordon Brown's Westminster administration…. The rejection forms part of the U.K. government's new immigration strategy, which critics claim is too focused on the needs of southern England' (Scotland on Sunday, 2009)

The Daily Mail and the Herald both reported in February 2008 about a change to immigration rules for doctors from out with the EU. This banned doctors from out with the EU from being given NHS training posts unless they were graduates from a U.K. University or were currently working in the NHS with no suitable British or EU candidate for the post. The two papers reported about this very differently. The Herald explained that the reason for this restriction on non-EU migrants was because of changes in the training system for junior doctors which reduced the number of jobs available and quoted the British Medical Association (BMA) in accusing the U.K. Government of "shifting the blame for its own failures of workforce planning on to international medical graduates." (The Herald, 2008). The Daily Mail article, however, implied that migrants were responsible for this job shortage. "…more than 3,000 U.K. doctors could still miss out over the next few years because of the number of overseas medics already here" (Daily Mail, 2008g). Hence, within the right wing press the intersection of migration and job status, as a health professional, was only

positive at certain times. Once it became a wider discussion about immigration rules overall, the intersection of migrant and healthcare worker became negative and threatening to British doctors.

6.4.2.3 The NHS is Fragile: It has the potential to become unsafe in the wrong hands

While there was recognition of the importance of migrant workers within the NHS staffing infrastructure, an alternative set of reporting focused on the potential for migrant healthcare workers to be unsafe. Here, healthcare was linked to possible illegality and criminality.

> 'Dozens of illegal immigrants have been found working with patients in National Health Service hospitals…this embarrassing revelation comes almost a year after the Prime Minister Gordon Brown pledged stringent vetting of overseas medics when three Muslim Doctors were charged with the attempted car bomb attacks in London and Glasgow.' (Mail on Sunday, 2008)

Some stories focused on whether migrant doctors provided safe care; linking acts of terror to the profession, as in the case of the Glasgow Airport bombers; immigration status of healthcare workers; and cases such as Dr Ubani, a German GP who gave a lethal dose of morphine to a patient while working in an out-of-hours centre. These issues created a link between border security and health.

> 'NHS statistics show doctors who qualified outside the U.K. are more likely to be excluded or suspended from their jobs than those who trained in this country…' (The Guardian, 2011b)

Language was also a major component of the media's worry surrounding migrant healthcare workers. This concern was magnified around reporting of cases such as Dr Ubani's.

> '…concerns grow for patient safety because of language difficulties. Andrew Lansley, the Health Secretary, recently announced plans to make medical staff prove that they can speak English before they treat patients. His action follows the death of David Gray, 70, in Cambridgeshire in 2008. He was given 10 times the correct dosage of painkiller by out-of-hours locum Daniel Ubani, of Germany, who had failed an English test with one health authority.' (The Daily Telegraph, 2012c)

6.4.2.4 The NHS is Fragile: Entitlement needs to be policed

As above, health was closely linked to the politics of migration and border security in the media. Tension was drawn between migration status and health access from both the patient and healthcare workers perspective.

> 'Despite crackdown on health tourists…Doctors have been threatened with legal action if they do not treat illegal immigrants…would be taken to court if they refuse to add a group of failed asylum seekers to the books' (Daily Mail, 2012c)

Access to health services was linked to border security. This occurred in several ways. The first was through reporting that many migrants feared accessing medical services as they believed they would be asked for identification or visas.

> '…all new patients registering with a GP will be asked to sign a declaration allowing their details such as address, date and place of birth, previous address and mother s maiden name to be shared with other government agencies. These include HM Revenue and Customs, the Department for Work and Pensions, the U.K. Border Agency, the Identity and Passport Service and councils…However, it also risks deterring people who fear official bureaucracy, particularly those awaiting a decision on their right to remain in this country, from accessing medical treatment, including vaccinations for their children.' (The Herald, 2010)

Secondly, there was consistent rhetoric, particularly in the right-wing press, that overseas visitors who did not pay their healthcare bills would be deported from the U.K. This reporting was often unclear with regards to which migrant group it was being discussed and often used the term 'health tourist'.

> 'A crackdown on so-called health tourists was announced by ministers yesterday. Foreigners who have failed to pay NHS bills of £61,000 or more will be kicked out of the country and banned from returning until the debt is paid. Visitors are supposed either to have health insurance or pay themselves for hospital care in Britain.' (Daily Mail, 2011b)

The role of the GP in policing the health service and the encroachment of border security into clinical work was frequently discussed. Discomfort was expressed that doctor would be expected to decide eligibility for healthcare.

> 'the first role of a doctor is to treat patients not to act as policemen for the state' (The Daily Telegraph, 2013b)

Guidelines, around entitlement to treatment for irregular migrants and refused asylum seekers, were acknowledged to be very confusing for medical staff. The reporting of these guidelines was also confused at times, because of High Court rulings being made regarding entitlement and then appealed so there was a change or ambiguity over guidance. It was acknowledged that this could often lead to difficult ethical decisions for healthcare professionals and often left refused asylum seekers in limbo.

> 'Ministers had threatened to withdraw the right to free GP treatment from asylum seekers whose claims are rejected, forcing them to pay for care privately or go without in all cases except emergencies. However, doctors have argued the move would be unethical and potentially illegal, with some saying they would treat patients regardless of any new rules.' (The Observer, 2008)

6.4.3 The Typical British Citizen: The hard working, British taxpayer disadvantaged by migration

A strong image was constructed by the British media, particularly the right-wing, of the typical British citizen. He/she was portrayed as a hardworking, taxpayer disadvantaged by and concerned about migration.

> 'I am sure you too feel that those of us who pay out taxes do not expect to see precious NHS resources abused by people coming in from abroad with the sole purpose of accessing free health care when they have never paid anything towards the NHS' (The Daily Telegraph, 2013b)

As reported above, there was a pervasive discourse that allowing migrant populations to be treated on the NHS had a direct negative effect on the care available for the host population: a balancing of deservingness, rights and resources. This was particularly repeated within the right-wing media.

> 'more rights than those living in the U.K.', 'taxpayers will regard this as an insult' (Daily Mail, 2012d)

Letters from readers and quotes from healthcare professionals helped to construct the concerned citizen, as is illustrated by the following quotes from GPs.

> ‘If we are using that money for treating visitors then the taxpayer loses out.’ (The Daily Telegraph, 2013c)

> ‘We do not have endless resources, why should they get free treatment when we wouldn’t get it in their country’ (The Daily Telegraph, 2012a)

However, there was a distinction between concern regarding migration as a political issue and migrants as individuals.

> ‘Three-quarters of British people, according to recent surveys, want to reduce immigration…Despite this much-mentioned 75% opposition, people don’t connect their opposition to the migrants they know personally.’ (The Guardian, 2011c)

There was also an implication that the public were being deceived by policy makers, as illustrated using the word “slipped” in this quotation.

> ‘Illegal immigrant must be given free treatment by GPs…The guidance, which was slipped out in July, states that an oversea visitor can register with a doctor provided they are in the area for more than 24 hours’ (Daily Mail, 2012a)

6.4.4 The ‘Typical’ Migrant Healthcare User

The ‘typical’ migrant healthcare user was constructed in several different and often contradictory ways. Migrant healthcare users were often portrayed as being young, fit, and healthy. However, in contrast to this healthcare was persistently portrayed as the motivating factor for migration to the U.K. There was a high utilization of the term ‘health tourist’, with clear links to the perceived cost of migration to the NHS as a theme and with the tone of criminality.

> ‘Recent figures suggested that as much as £40million is owed to hospitals by so-called health tourists who have been treated but never paid their bills… She added: We know that people won't always tell the truth and we won't be able to capture everyone.’ (Daily Mail, 2012c)

This construction of a health tourist was, in the right-wing media, often portrayed as someone who had pre-existing health conditions or were pregnant: but overall, the portrayal tended to be faceless and unrecognisable as to which migrant group they fell into. This created a barrier for the reader in considering

these issues in the context of someone they may know or recognise, therefore dehumanising the narrative. This was in stark contrast to the more identifiable Ghurka population, who received sympathetic reporting in comparison.

> ‘A Gurkha with an 'exemplary' Army record faces deportation from the U.K. and could be forced to pay thousands of pounds in hospital fees after his wife collapsed in a coma… The plight of Mr and Mrs Gurung contrasts with the many illegal 'health tourists' who arrive on holiday visas to give birth in NHS hospitals, while thousands of desperate HIV sufferers target U.K. hospitals for treatment.’ (Daily Mail, 2008h)

Throughout the entire period of the media analysis, the Scottish media focused on concerns that the typical migrant healthcare user had difficulty in accessing services. This was portrayed through articles which discussed women being scared to access maternity services due to a fear of being charged for these services, lack of awareness of entitlements and the effect of the detention of asylum seekers, especially children on health access and outcomes. The migrant group which was identified the most with regards to healthcare access was asylum seekers.

6.5 Portrayal of Asylum Seeking/Refugee Women and Children with Regards to Health

Asylum seeking and refugee women were the most referred to population group with regards to health throughout the 5 years of healthcare reporting examined. They were high in the migrant hierarchy: receiving the most positive tone towards any migrant group and were portrayed as the most deserving of healthcare, after Ghurkhas and trafficking victims.

Asylum seeking women were portrayed more sympathetically than asylum seeking men. Asylum seeking men tended to be linked to court cases regarding entitlement, interchangeability of terms and infectious diseases, such as TB and HIV. Asylum seeking women were portrayed more sympathetically with regards to their health needs and backgrounds. They were commonly linked to trauma, sexual and physical violence, poor mental health, and female genital mutilation. Therefore, the intersection of female gender and asylum status in this way constructed them as victims, which was often linked to sexual health. All of

these sympathetic articles were either in the Scottish media or the Guardian/Observer newspaper. Mental health was discussed almost solely in relation to asylum seekers (6/7 mental health articles), with the majority published in Scottish newspapers. They were very sympathetic towards asylum seekers and recognised that the asylum process contributed to mental health problems. These articles included reporting on the suicides of Russian asylum seekers in Glasgow in 2010, post-traumatic stress in asylum seekers and refugees leading to increased levels of depression and suicide, and the effect of detention on mental health.

> 'Nearly a quarter of women seeking asylum in Scotland have attempted to take their own lives… some women described themselves as "walking dead", and said the asylum process had served only to worsen their health… The findings have led to calls for improved access to services and support for those women who are often suffering from post-traumatic stress disorder.' (The Scotsman, 2009)

In addition to mental health, asylum seekers were also connected to female genital mutilation (FGM) and child health as specific health problems. FGM was the only sexual health condition that was reported about in the media analysed, with two articles in the Guardian and one in the Herald newspaper. This reporting involved several individuals and personal accounts. This built a relationship between the reader and the story, making it easier to empathise with the population being discussed.

6.6 Summary

This chapter provided a broad overview the narratives that portrayed asylum seekers, refugees, migrants, and health in both the U.K. national and Scottish newspapers.

Healthcare and migration were shown throughout the health media analysis to be consistently used as a political football. Health was repeatedly linked to border security, with little concern for the well-being of individual migrants. The significance of links such as this was described in Innes (2010b) below,

> ‘when individual security is seen as threatening a sovereign state, concern for state security tends to take precedence over individualistic concern for human rights’

As discussed in Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Accessit can be strongly argued that sustained, largely negative media coverage of migrant groups in relation to health could affect beliefs surrounding deservingness for healthcare, awareness of their entitlement for healthcare and difficulty in recognising and negotiating their candidacy. This is likely to be true for asylum seeking and refugee women, and primary healthcare staff. A belief in entitlement is required for candidacy identification and negotiation but the presentation of entitlement to healthcare, particularly with regards to the differences in Scottish entitlement, was confusing in the media.

The hostile reporting around asylum seekers and refugees was mainly constructed through the narrative of threat, specifically a threat around the diseases that migrant populations may bring to the U.K.; a threat that there were not enough health resources to provide for the indigenous U.K. population if they had to be shared with the migrant population; and a threat that the motivation for migration was purely to access and take advantage of the health service in the U.K.. These threats were constructed through repeated themes, emotive topics, using tones of panic and through faceless descriptions of migrants.

Pearce (2011) described the panic that the media can build, and Mollard (2001) found that fear was created around four repeated topics: 1) The scale of migration, particularly asylum seekers and refugees, 2) Questions of eligibility for asylum seekers, refugees and migrants accessing healthcare services, 3) the economic cost and 4) the social cost of supporting migrants. This is entirely in keeping with the narratives identified in this analysis. It also demonstrates that very little had changed in the 13 years of newspaper reporting between Mollard (2001) and the end date of this analysis. Health reporting was often very emotive. Emotive issues and conditions, such as maternity care and cancer care were often chosen as examples to report about in relation to migration and to build narratives of deservingness around. The construction of threat around these emotive topics can be argued to cause panic, fear and anxiety in the host community reader and an awareness of being judged as undeserving in the

migrant reader, as detailed in Chapter 3 Literature Review: Asylum Seeker and Refugee Healthcare and Access

Whilst attracting the most sympathy in the media, asylum seeking and refugee women were often portrayed as victims, an intersection of labels which may disempower them. This thesis only examined the formation of candidacy for asylum seekers and refugees; therefore, it cannot hypothesise as to whether they find candidacy recognition and negotiation easier than those migrants who are portrayed further down the media's hierarchy, although it is an interesting and worthwhile consideration.

The following interview findings chapters, however, shall explore whether this more positive reporting of deservingness for asylum seeking and refugee women is internalised by them, or whether the wider hostile environment dominates. The link between media and candidacy formation and negotiation shall also be further explored in the following chapters.

Chapter 7 Operating Conditions

The previous chapter presented the findings from the newspaper analysis conducted for this thesis. This gave an overview of how asylum seekers, refugees and healthcare are portrayed in the media, with a particular focus on the portrayal of deservingness for healthcare. As a newspaper analysis it was able to give a flavour of this but was not able to inform about how those discourses of deservingness are internalised by asylum seekers, refugees and those who provide them with healthcare. Feelings of deservingness, as discussed previously, are essential when it comes to individuals identifying their candidacy for screening, as they must identify that they are at risk of the disease being screened for and that they are eligible and deserve the service being offered.

Therefore, this chapter will present the first of the qualitative interview chapters and will move on from the newspaper analysis to consider where the discourses of deservingness from newspapers sit in the wider candidacy framework, how they affect asylum seeking and refugee women and their interactions with services, and what other operating conditions affect the assertion of candidacy for cervical screening.

These operating conditions form the macro-and meso-level of Mackenzie *et al.'s* (2012) candidacy figure (see the outer and middle circles of Figure 13) and provide a context within which consultations around cervical screening occur in primary care in Glasgow. Chapter 8: Cervical Screening Negotiations- Micro-Level Candidacywill present the findings related to the micro-level, which is where the interaction with primary care occurs.

As described in the methods the interview topic guides were designed around this figure of candidacy and the analysis of the qualitative interviews used the Mackenzie development of the Dixon-Woods candidacy model to guide the analysis. In the discussion chapter (Chapter 9 Discussionit will be considered

how this was applied, where it works and if there were any gaps in its applicability in this study.

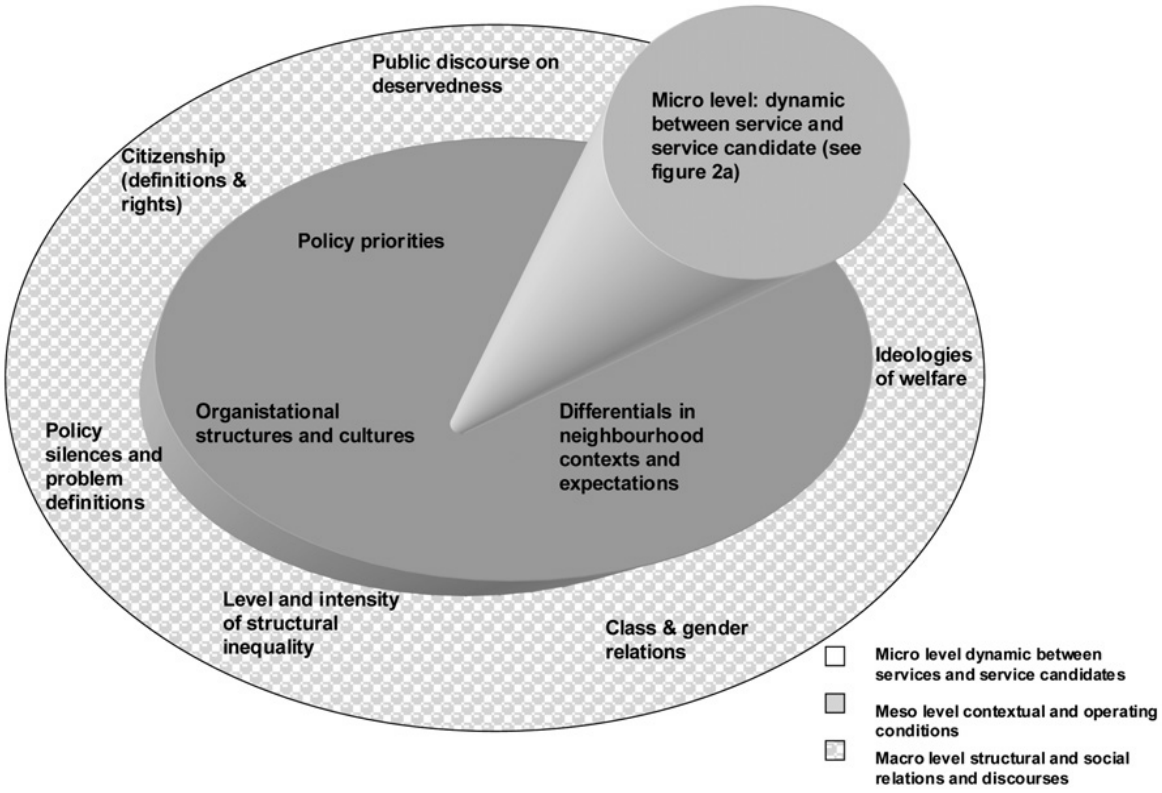


Figure 13 : Macro- Meso- and Micro-Influences on Candidacy (MacKenzie et al 2012)

Figure 13 provided a good structure for the interview topic guides (Section 5.4.2.1 Topic Guide Design) but for presentation of findings the headings used by Mackenzie *et al.*(2012) led to overlap and repetition. Therefore, they have been reorganised and renamed at points in this chapter to better suit the analysis. It will be signposted where this has occurred.

7.1 Background of Interviewees

Please note all names of interviewees have been changed to maintain anonymity.

Table 3 Demographics of Female Interviewees

	Name (Changed for anonymity)	**Age**	**Education Level (CoO)**	**Education (U.K.)**	**Asylum Status**	**Religion**
1	Souhila	42	Secondary School	Higher Education	Refugee	Christian
2	Selma	42	Higher Education	Nil	Refugee	Muslim
3	Reham	35	Secondary School	ESOL Classes[4]	Migrant	Christian
4	Grace	31	Higher Education		Asylum Seeker	Christian
5	Aisha	46	Unknown	ESOL College (HNC)	Refugee	Christian
6	Safaa	28	Primary School	Nil	Refugee	Muslim
7	Noura	40	Secondary school		Refugee	Christian
8	Mouna	35	Higher Education	Nil	ILR[5] (embassy programme)	Muslim
9	Nawal	37	Higher Education	nil	British Citizenship	Muslim
10	Wafa	31	Higher Education	ESOL Driving Licence	Refugee	Muslim
11	Shabana	30	Higher Education	ESOL	Refugee	Muslim
12	Azra	38	Primary School	ESOL	ILR (embassy programme-through spouse)	Muslim
13	Serine	36	Higher Education	Higher Education	Refugee	Muslim
14	Sumera	35	No education		Refugee	Muslim
15	Kishwar	34	Unknown		Refugee	Muslim
16	Nadira	32	No education	ESOL	ILR (embassy programme-through spouse)	Muslim
17	Mobeen	40	Unknown	ESOL	Refugee	Muslim

Seventeen asylum seeking and refugee women were interviewed in total. Women 1-9 in Table 3 were individual interview participants and women 10-17 were focus group interview participants. As can be observed from the table the ages

[4] English for Speakers of Other Languages (ESOL)

[5] Indefinite Leave to Remain

of the women ranged from 28 years to 46 years old. Women came from the Congo, Iraq, Guinea Bissau, Zimbabwe, Sudan, Libya, Algeria, and Pakistan.

Their education levels ranged from no formal education whatsoever to postgraduate degree level. Many had also undertaken further education in the U.K., particularly English for Speakers of Other Languages (ESOL) classes at college. For those who were employed in their countries of origin occupations included medical doctor, nurse, office manager, retail, hairdresser, and interpreter.

Seven health care workers were interviewed individually and consisted of two nurses (one practice nurse and one nurse working in the Asylum Health Bridging Team) and five GPs. The GPs were at various stages in their careers: two GP Partners, two Salaried GPs and one Clinical Fellow. Apart from one of the GPs, who was from Pakistan, all healthcare interviewees were female, white and Scottish. They all worked within Greater Glasgow and Clyde Health board: five of the seven worked in Glasgow City, one worked in Renfrewshire and one in Inverclyde. The demographics of the healthcare workers interviews are summarised in Table 4.

Table 4 Demographics of Health Care Workers (HCWs) Interviewed

	Name **(changed for anonymity)**	**Role**	**Gender**	**Ethnicity**	**Area**
1	Dr Smith	Salaried GP	Female	White, Scottish	Glasgow City
2	Nurse Campbell	Practice Nurse	Female	White, Scottish	Glasgow City
3	Nurse Brown	Nurse	Female	White, Scottish	Glasgow City

4	Dr Grayson	GP Partner	Female	White, Scottish	Renfrewshire
5	Dr Saeed	GP Partner	Female	Pakistan	Glasgow City
6	Dr MacDonald	GP Clinical Fellow	Female	White, Scottish	Glasgow City and Inverclyde
7	Dr Wright	Salaried GP	Female	White, Scottish	Glasgow City

All the healthcare workers interviewed had been involved in asylum seeker and refugee healthcare in some way for varying levels of time. Four of them had been involved in caring for asylum seekers and refugees since the very start of dispersal to Scotland, whereas one had only been involved since the initiation of the Syrian Resettlement Programme in 2015. Every healthcare worker was based in a practice which would be considered to cover an area of deprivation.

Two community workers were also interviewed: Mathilde and Sofia (not their real names). They were both from the same organisation but had different roles within it. Mathilde worked very closely with women who were asylum seekers and refugees, whereas Sofia had more of a managerial role within the organisation. Both community workers were female and lived in Glasgow.

For the purposes of anonymity in this thesis all of the participants names have been changed and identifying factors about them have not been included. For example, some of the demographic information about interviewees such as asylum seeking and refugee women's previous or current occupations. The practices or areas that the healthcare workers work in and the name of the community organisation that the community workers were from have also not been included.

7.2 Macro-Level Operating Conditions

The areas focused on, in this findings chapter, from the macro-level of the MacKenzie *et al*. (2014) candidacy figure (Figure 13) are: Citizenship (renamed The Fluidity of Migrant Status) (7.33.67.2.1); Gender (7.33.67.2.2); Ideologies of Welfare: Healthcare (7.33.67.2.3); and Public discourses of deservingness (7.2.4).

Within Figure 13, policy is covered in both the macro- and meso- level of candidacy. In this chapter policy is discussed as part of the meso-level (7.33.67.3.2). Structural inequalities are presented throughout the sections below and within the Organisational Structures and Cultures (7.33.67.3.3), rather than as a separate section.

7.2.1 The Fluidity of Migrant Status

Migrant status provides an important context within which individuals operate. For asylum seeking and refugee women this can include not only their current migrant status but the journey, and sometimes multiple different migrant statuses, that they have been through to get to their current position.

The women interviewed were at different stages of the migration or asylum process (Table 3). Their experiences of the asylum process were all unique and feelings of difference were voiced within the focus group. For example, some women felt those who had come through out-of-country fast track programmes had experienced a much easier journey than those who had to present in the U.K. and seek asylum at the border.

> ‘I am explaining to Azra that our pain is different. Although we are both Iraqi and we came from the same country, but I sought asylum here and then I got refugee status after a battle with the home office but for them it’s not a situation, they got their status from Baghdad…Even [name] because their husbands they were employee at the British embassy in Baghdad…so when they come here, they already got their refugee status’ (Selma, Refugee, interview)

During their asylum journeys many women’s status or labels of status changed, which links to the concept of translocational positionality (Section 2.3.3), where

changing identity or in this case migrant status in different situations leads to differing levels of control and individual power, as the shift of migrant status causes different intersections of identity to occur. Selma's (refugee) experience exemplified this. When she first left her country of origin, she was an irregular migrant in Turkey. During this time, she worked but her employer refused to pay her and she was unable to challenge him in any formal way as this would have alerted authorities to her presence. She then moved to the U.K. on a spousal economic-migrant visa with her children to join her husband and during this time was in a comfortable position. However, when her husband filed for divorce, this nullified her spousal visa. She claimed asylum to avoid returning to Iraq as a divorced woman, which would have placed both her and her daughters in a very vulnerable situation. When going through the asylum process, she was again financially vulnerable, lost control of where she lived and was in an uncertain position regarding her and her daughters' future.

> 'The Home Office are always trying to convince you that you are a liar, it wasn't easy at all, for a year I wasn't myself, and because of that I told you that I used to go to the GP every time because I was devastated. I lost my home, I lost my family, I took the girls to live in a situation they have never been through.' (Selma, Refugee, interview)

It was felt by the interviewees that labels were imposed on them by others. The label often felt irrelevant to the woman but could affect how they were treated, the rights that they had or increased feelings of insecurity and instability.

> 'Yeah they make you like so shy you know, you kind of know you are not level, you are an asylum seeker and feel like you get a different treatment from other people. Like for example now I remember I used to go to the midwife, everything was fine and then until I ask for a MatB1. I said I want to take it to the home office and then the midwife suddenly changed and said 'oh you are an asylum seeker' and I had that written all over my notes and I asked myself why. Maybe I'm being treated differently from everybody else.' (Grace, Asylum Seeker, interview)

> 'I was like ooh you feel ashamed you know, and you don't have a passport, oh my god, something like you feel ashamed bad you know, it's, it's not my fault if I'm an asylum seeker but it's ok now [as has refugee status].' (Aisha, Refugee, interview)

Labels could also be applied based on how one looked. Reham (EU migrant, interview) for example, felt that she was often mistaken for an 'illegal' immigrant or an asylum seeker rather than an EU migrant because she was black. This was the case in this thesis as she was recruited through a community worker who thought she was an asylum seeker but on interview with an interpreter she in fact held dual European citizenship with her country of origin. This mislabelling by others caused her problems as she was often not treated with the same status and rights as an EU migrant but simultaneously not supported in the way that she perceived asylum seekers to be. Therefore, she was disadvantaged due to the intersection of labels and the presumptions of those placing them on her.

In contrast to Reham's experience, it was recognised by the community workers interviewed that as white, European, economic migrants' their experiences were very different from both those of asylum seeking and refugee women and from Reham's as a black, European migrant. This demonstrated how the intersections of race, class and migrant status combine to either privilege or disadvantage different groups.

> 'I'm very aware of that, acutely aware of that, that as white European going to live somewhere else is…yes, it's not plain sailing and it's not easy but it's nothing like I think what it is for people of different ethnicities and backgrounds and origins…especially when they're seeking safety.' (Sofia, community worker, interview)

These findings point to the wider context that the constantly changing and unstable nature of the immigration system forces women to operate within. It also demonstrates that whilst the asylum system is an overall negative force within the women's lives the extent of the impact from this often differed depending on the intersection of other identities, such as race or class. Whilst asylum seeking and refugee women may have entitlement to healthcare in Scotland, their shifting statuses and the hostile environment produces fear, feelings of difference, vulnerability, and uncertainty. It also alters their feelings of deservingness; the perceptions of others' beliefs of deservingness; and consequently the willingness of others to offer services to them.

7.2.2 Gender

A prominent finding was the multiple gendered roles that the women interviewed were expected to fulfil and the differences in experience they had in their countries of origin compared to the U.K.

All the women interviewed were mothers and all, except one, were or had been married. Their primary role as caregivers within these relationships was discussed frequently and for many women caring roles began at a young age, often superseding other roles or opportunities, such as education.

> 'In my country before I had no education. I was the only sister of five brothers, so I had to look after them and not go to school' (Sumera, refugee, focus group)

> 'Unfortunately, I didn't get a chance to complete my higher education because at that time my mum she was diagnosed with diabetes…my family they ask me if I would like to choose going to school or be at home and look after my Mum, so I took the decision to look after my mother' (Azra, refugee, focus group)

This lack of education was observed to have an impact when women came to the U.K. Mathilde (Community Worker) found it more difficult to broach deeper issues, engage fully and provide basic signposting with women who had little education. For example, some women had no literacy skills in either their language of origin or English, so written materials could not be used.

Women who had succeeded in progressing their education could still have this overridden by a more gendered role. This was the case for Wafa (refugee, focus group) who was halfway through University when she got married and it was decided for her, by her family, that University was not a priority, now she was a married woman, and she had to leave. A key point in these stories is that it was not the women's choice or within their control to choose a caring role over education or work, it was made by their family.

Even when education was prioritised by families and there were no financial limitations to them receiving an education, women's independence was often still curtailed. Selma (refugee, interview), for example, was encouraged to gain an education by her family. She attended medical school, graduated, and

worked as a doctor. However, she still did not have the same freedom as her male counterparts.

> 'In my country you are a woman, and he is a man. So, there are some rules in regards to the community. I mean there are traditions you can't overcome. If you try to be independent or try to have freedom it means that you are a bad woman and none of the family would accept that for their daughter. According to your background maybe you are allowed to go in any station of education to whatever you want but still you will be super observed.' (Selma, refugee, interview)

This feeling of being observed or supervised was particularly apparent in the women who were from a Muslim faith. Women who were Muslim all described not being allowed to leave house on their own or without a man, in their country of origin, no matter their education or socioeconomic level. This was not identified as an issue by the women who were Christian.

In the focus group there was a strong feeling that the roles that the women perform within the family are of higher value than the individual woman themselves. For example, they all laughed in agreement when one woman stated,

> 'she could be dying but all he cares about is the next baby'
>
> (Wafa, refugee, focus group)

Sofia (community worker, interview) also observed that the women she worked with had full responsibility for the care and health of the whole family, more so than she had experienced within women in her family or social group. Mathilde (community worker, interview) became quite agitated when discussing having to manage her own feelings of equality with the experiences of the asylum seeking and refugee women she worked with.

> '…the values are you know around empowerment, about diversity, about confidence and it's very much sometimes some of the things maybe that come through they can seem so at odds with what I'm trying to do like for example with the Muslim thing it's so very male dominated and that does come through in discussions.... You know it's very clear role division between them, like the women they do all the work with the children bringing them up, taking them to school, going to parents' night, doing anything, clothes shopping. You know looking

> after them in the house, homework, very few of the men partake in that…' (Mathilde, community worker, interview)

On moving to Scotland, the roles of the women were often required to change. For many this was due to no longer living with extended family, so they required more independence to leave the house alone to take the children to school, do food shopping and meet other women. In the focus group when asked about the transition of their roles on moving to Scotland several women shouted 'Freedom' (in the style of Braveheart).

This had also required a change in attitude on the part of their husbands, which was described as more difficult for some than others. Some husbands were very supportive of their wives attending groups such as the women's group, whereas others worried about this increased independence and often put limitations on it.

> 'Well, I feel that my husband, he doesn't feel comfortable and relaxed about me going by myself because I'm going out a lot and doing a lot of stuff by myself and I'd learned a lot so sometimes I feel that he feels not upset but doesn't feel very well…' (Wafa, refugee, focus group)

The women who described this transition were very clear that their extra freedoms were only allowed if their primary roles as caregivers and home makers were not affected. Hence, the number of roles they were assuming increased.

> 'Now my husband he is asking me to go out because of the responsibilities, all the responsibilities of getting bigger and bigger' (Nadira, ILR, focus group)

The feelings of comfort with increased levels of freedom varied. Some women learnt to drive, attended ESOL classes and College to gain further qualifications. They discussed how pleased they were to know that their daughters would have access to education and opportunity in the U.K. Others, particularly those women who did not have previous access to education, described finding things like ESOL classes stressful and overwhelming as they had never had experience of learning.

For these women, at least initially, when they moved to Scotland, there remained a reliance on their husband for information, particularly if their level of education was poor. This could lead to feelings of isolation. Mouna (ILR, interview) for example, discussed that as her husband was able to speak English, he tended to take on the roles which involved contact out with the home hampering her integration with the community.

> 'I don't have any connection' (Mouna, ILR, interview)

Women who had worked in their country of origin, particularly those who were in the professions such as medicine, found their opportunities were impeded in the U.K. and described feeling 'trapped', both professionally and financially, rather than freed due to not being allowed to work whilst an asylum seeker and not having their qualifications recognised in the U.K. once they were refugees.

> 'I didn't work here. I tried before I had my second child. I tried for different jobs, but no one gave me. I didn't have any interview, they said that I don't have the U.K. experience…I'm pretty good in my job but nothing to do.'(Mouna, ILR, interview)

> 'I don't want to be on benefits you know I just want to work but they are forcing people on benefits to be honest.' (Nawal, British citizenship, interview)

This section demonstrates how due to their gender the asylum seeking and refugee women interviewed as part of this thesis were controlled, had limitations placed on them from a young age, monitored and supervised. Being a woman, a primary caregiver and a wife were the dominant identities, even when they intersected with other identities such as education, occupation and social status. It also made them less deserving than their male partners or brothers with regards to education and freedoms. This happened in their early family lives, their marriages and within the asylum system.

7.2.3 Ideologies of Welfare: Healthcare

Ideologies of welfare in this section refers to experiences of the welfare state within the U.K., which is represented in the macro-level of candidacy. To avoid repetition, as the themes overlap, access to education, housing and benefits will

be considered within other sections (7.33.67.2.2, 7.33.66.4.35.2.16.4.17.3.1 and 7.33.67.3.3).

Opinions of the healthcare system in the U.K., differed depending on previous experiences of healthcare provision. Healthcare experience out with the U.K. varied depending on country of origin. None of the women came from a country where there was universal healthcare.

Examples were given of low-income countries having poorly resourced healthcare systems. For example, Souhila (refugee, interview) described that in the Congo there was only one or two health centres for an area the size of Glasgow. There was no appointment system or triage, people were just expected to queue. She described that it was not uncommon for people to die whilst in the queue. Aisha (refugee, interview) described that the system in her country of origin had previously been very good but due to 'changes within the country' secondary to poverty, conflict and political upheaval it had deteriorated.

> 'People die because they don't have £20 to pay for healthcare' (Aisha, refugee, interview)

Women often described a two-tier healthcare system, dependent on class and financial status, even in very resource poor settings. For example, Souhila (refugee, interview), described that those with connections and money in the Congo were able to skip the queue outside health centres. Grace (refugee, interview) also described that in Zimbabwe the treatment you would receive depended upon your social status: if you were poorer, you would just queue outside a public clinic for hours whereas if you had money, you could make an appointment with a private doctor. In some countries resources were so low, however, that the system couldn't provide even to those who could pay more. Therefore, for many, discourses of deservingness had been present in their country of origin related to financial status and health.

> 'In my country even if I pay a huge sum of money, I won't get the exact treatment and I won't get the proper medical I deserve.' (Wafa, refugee, focus group)

There were also distinctions within some countries between rural and urban experiences of healthcare. For example, Sumera (refugee, focus group) reported

that in rural Pakistan there were no doctors and no access to healthcare. When she was pregnant there was no access to ultrasound scans out with the city, no provision to travel, and you delivered at home with just your family in attendance.

These experiences contrasted with those from Iraq who felt that they had a good healthcare system: a mix of public and private provision. All the women from Iraq described this system as effective and relatively inexpensive, with equally good care in all parts if the system, no matter their socioeconomic backgrounds.

When comparing previous healthcare systems to the U.K.'s there was both positive and negative feedback to now being part of a universal healthcare system. Many of the women were very appreciative of the U.K.'s healthcare, particularly those coming from areas where healthcare had been scarce. They were pleased with the appointment system, that there was no queuing, and that access was not limited by cost or geography. However, those who were used to a private system found the appointment times restrictive in the U.K. and they had been used to being able to see a specialist the same day, so were frustrated by referral systems.

> 'NHS wastes money on this flitting around and referral' (Selma, refugee, interview)

Therefore, they found waiting times and the gatekeeping role of the GP in the U.K. hard to adjust to, in addition to feeling that they had more trust and confidence in a private doctor as they 'will always give you some medicine' (Aisha, refugee, interview).

> 'Here we are suffering because of the appointment system and because of the waiting lists…sometimes she has to wait for a week to get an appointment so she said if I had tonsillitis I might get well before even seeing the doctor.. it is not like that in Iraq, for example if you are not feeling well or you are really in pain, they immediately all of them around you, the doctors, the nurse, looking after you, give you the medication so you feel more protected and more secure' (Azra, ILR, focus group)

Overall, the key feeling from this section was that women were appreciative of universal healthcare in the U.K. However, for those used to a private system the NHS could seem prohibitive.

7.2.4 Public Discourses of Deservingness

Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?provided an analysis of the role of the media in forming public discourse around deservingness. This section analyses the impact that the public discourse on deservingness has on healthcare access through exploration of asylum seeking and refugee women's, healthcare workers and community workers views on the media's portrayal of asylum seekers and refugees, how this is internalised and how it then affects access to primary care.

7.2.4.1 Newspapers Read

The most read newspaper, by the asylum seeking and refugee women interviewed, was the free newspaper, the Metro as it's 'the one that you get on the bus' (Grace, asylum seeker, interview). A few read the Guardian, Migrant Voice (a local paper produced by migrants) and the Herald. No one read the Daily Mail or the Sun. Those women who did not speak English or had poor literacy skills in their own language tended to watch news channels such as Al-Jazeera rather than read English language newspapers. Women also became aware of a lot of news through social media, particularly through their children and from comments on Facebook by friends or acquaintances which made them aware of wider, often negative, public feelings towards asylum seekers and refugees.

Healthcare workers also read a variety of newspapers, mainly broadsheets. The Herald, Times and The Guardian/Observer were the most common newspaper choices. Only Dr Grayson (GP Partner) discussed reading the Daily Mail but stated that she only read this for celebrity gossip, not for information about immigration as she felt it was not a good source for this. Both community workers interviewed did not read much printed press but if they did it was the Guardian.

7.2.4.2 Perceptions of media coverage of asylum seekers and refugees

The media was identified by the asylum seeking and refugee women interviewed as having a great deal of power in forming public opinion. Unfortunately, however, it was felt that the media portrayed asylum seekers as trying to manipulate the system, steal houses, steal jobs, coming from poorer backgrounds and often being involved in crime. The women interviewed observed that there was little coverage as to why people seek asylum, how they contribute to the U.K. or about any crimes committed against asylum seekers/refugees.

> 'The media have a very good power to give a very good impression about us to the community by showing programmes or by writing about our culture, our vision…unfortunately it shows the world that we are terrorists, and it gives a very bad impression' (Wafa, refugee, focus group)

> 'most of the time it's just something wrong they have done [asylum seekers and refugees]. You don't read much good about it, they're here to take the houses, jobs you know most of the time, somethings wrong they have done yeah' (Souhila, refugee, interview)

There was consensus across all groups that the media's portrayal of asylum seekers and refugees was mostly negative. They were aware of reporting differences across different publications and that *'you have to take it all with a pinch of salt'* (Dr MacDonald, GP clinical fellow, interview).

> 'On the whole, I think it's quite negative, but there are exceptions, thankfully. But on the whole …it's still this kind of sensationalise kind of reductionist, quite absurd kind of commentary, or articles or statements…' (Sofia, community worker, interview)

Scottish publications, such as the Glasgow Evening Times, the Daily Record and the Herald were also identified by Nurse Brown (Nurse), Dr Wright (Salaried GP) and Sofia (community worker) as running good, fair stories about issues such as the asylum system, personal stories of refugees and coverage of homelessness. Aisha (refugee, interview) described that she chose to read the Herald after she was interviewed by them about her experiences as an asylum seeker and found their portrayal to be fair.

> ‘National media at the moment is all…you know Calais under siege that sort of thing…whereas the Scottish Government seem to have a slightly more relaxed approach to welcoming people.’ (Dr Grayson, GP Partner, interview)

The Guardian was also seen as being fairer in its representation towards asylum seekers and refugees.

> ‘A lot more balanced, a lot more inclusive, more, I suppose, kind of, agreeing with my opinion that these are often very, very well-educated people who have experienced things that thankfully we will never know.’ (Dr Smith, Salaried GP, interview)

Tabloids in general (mid-market and red tops), particularly the Daily Mail, were identified as being misleading in their coverage of asylum seekers and refugees. One interviewee commented on repeating themes spanning decades.

> ‘The tabloids will pretend to be more kind of you know hordes of people are coming to our country sort of thing you know and our jobs are at risk, our homes are at risk and this kind of hysteria type of thing which is really unhelpful but you look, I mean I once heard someone speak about this and they pointed out, they showed a newspaper sort of front page and just cut out the date and it was actually exactly the same from like 1942 or something you know about continental Europe you know so you realise it's just exactly the same attitudes as back then.’ (Dr Wright, Salaried GP, interview)

> ‘The Daily Mail is just, you know, it’s ridiculous, it’s like you know immigrants cause cancer and kill Princess Diana sort of thing’(Dr Grayson, GP Partner, interview)

Healthcare workers also discussed representations that asylum seekers and refugees were taking something from the host community and therefore making them subsequently worse off.

> ‘There’s a group of society that believes that if we had no asylum seekers, no immigrants and no benefit scroungers then we’d all be on a mint, with a private healthcare system’ (Dr Smith, salaried GP, interview)

> ‘I think, you know, the media can whip up those sort of myths and misconceptions about, you know, all asylum seekers get given a phone, and you know all asylum seekers get whatever….but they can do that with all sorts of other marginalised groups as well…like all drug addicts get a house.’(Nurse Brown, nurse, interview)

Two of the women, Mouna (ILR, interview) and Nawal (British Citizen, interview), agreed with the media's portrayal that asylum seekers, refugees, and migrants are putting a strain on services and there should be a strong cap on migration. They did not seem to relate to the populations being discussed in the media and did not feel it related to their situation. This could be postulated to being due to their class and professional status, their journeys through the asylum system or that the media representations were so faceless that they didn't recognise any similarities.

> '…all that immigrant who are coming to the country and they are putting a lot of pressure on that country as well, sometimes I think they are to be honest, sometimes I think they are right… that puts a lot of pressure on NHS and of course it's going to restrict you know or make the service they are giving to the patient let down.' (Nawal, British citizen, interview)

This view was reiterated by a healthcare worker, who talked about 'health tourists' as a problem but questioned the portrayal of 'benefit scroungers'.

> 'I mean you do hear about things that people come over to use the health service for care and things like that, but you question what they say about them when they talk about benefits…they're taking our jobs, they're taking our benefits, they're taking our homes and it's just a bit, I mean it's hard' (Dr MacDonald, GP clinical fellow, interview)

In addition to the portrayal of asylum seekers and refugees, some women interviewed also felt that other identities they held were portrayed unfairly in the media, such as their religion. It was felt strongly by several interviewees that Muslims were portrayed as terrorists and any crime committed by a Muslim was linked to their religion and branded terrorism, whereas the same was not true for crimes committed by white people. Those who were both asylum seekers or refugees and Muslim expressed that they felt doubly attacked due to the intersections of these identities.

> 'They are always putting the spot on us. For example, 3 years ago in Norway one guy he killed a lot of people and shoot them a lot of times. But do they say that it's terrorists? No-one said that. But if someone did the same from one of the Muslim or Arabic countries they would say yeah it's terrorists.' (Serine, refugee, focus group)

Selma (refugee, interview) and Grace (asylum seeker, interview) also discussed that Muslim countries in general are portrayed in a negative way and nothing positive about the culture of these countries is discussed. Selma noticed that her neighbour stereotyped Muslims and she felt that a lot of these opinions were founded in what she read in newspapers. These stereotypes included thinking that Muslims were terrorists, not trustworthy and that they treat their women badly.

> '…generally speaking, it shows that the Arabic world, the Muslim world is always in conflict, and they had a very bad attitude…I agree each community has its politics and they're just as bad so why are they always showing the negative parts, why they don't show the other part. We have culture and traditions… for example the family unit is very strongly built in our culture, we have respect to the older, we care about the kids…why they always showing the negative part' (Selma, refugee, interview)

7.2.4.3 Internalisation of Media Discourses and Effects on Deservingness

There was a strong feeling of injustice and unfairness across the interviews with asylum seeking and refugee women, about how they were portrayed in the media. It was described as hurtful, stressful, and frustrating.

> 'Yeah definitely it's hurtful when you read and when you hear they are writing such things about you' (Azra, ILR, focus group)

> 'Immigrants are clever; it is very hard to start from scratch again. Therefore, it is very difficult to hear these stories' (Selma, refugee, interview)

There was also an internal pressure to try and enlighten people who they met about the truth regarding asylum seekers, refugees, and their personal journeys.

> 'Sometimes it makes you feel sad and frustrated sometimes because you want to enlighten these people what it is really like to be an asylum seeker and what it means. Because you feel people are not informed yet.' (Grace, asylum seeker, interview)

Media discourses impacted on women's confidence in accessing services but also their perception of how they would be received by service providers.

> 'I feel like not comfortable or not welcome so that can be awful you know it can be an issue having access to services because the person I

> am going to see, he or she may be thinking like you know, she agrees with what they [newspapers] say' (Souhila, refugee, interview)

Selma (refugee, interview) had noticed through her work as an interpreter that women who wore headscarves or as she described were 'covered', were often treated differently than those who were not. Demonstrating again the intersection between migration status and religion creating further inequality and prejudice.

> 'Sometimes you can tell that there is something in them, they are not treating you in a proper way…. especially if you are a covered lady' (Selma, refugee, interview)

On the flip side of the coin, women also expressed concern about the media's portrayal of GP services, which made them worry about the quality of service that they would receive when they attended, as they had read about waiting times and that there was a shortage of doctors. The media also affected interactions with the host community both in and out of health settings, as will be discussed in Section 7.33.66.4.35.2.16.4.17.3.1.

Healthcare workers recognised the difficulties that asylum seeking, and refugee patients must have when reading newspaper discourses about them. However, they did not feel that it affected their access to primary healthcare services. This is an important finding as healthcare workers lack awareness of the impact of deservingness discourses on their patients, and that the impact itself may be barrier to them accessing healthcare.

> 'Health I think is fairly secure because they tend to, well I'm not saying that everyone has a good experience…but we hope that it's better' (Dr Wright, salaried GP, interview)

> 'No I can't think of how it would affect them in terms of seeking services for screening and things like that'(Dr Saeed, GP partner, interview)

Despite not feeling that the media would affect asylum seeking and refugee women's access to services, five of the healthcare workers interviewed gave examples of negative influences that they believed the media to have had on their staff, in particular shaping prejudicial, undeserving, and sometimes racist attitudes.

> ‘That, kind of, in going back to the attitude of, we are born and bred here. Therefore, we are entitled to this and one member of staff feeling that people should be appreciative of anything she does for them when she’s just doing her job’ (Dr Smith, salaried GP, interview)

> ‘I think if you spoke to some asylum seekers…they will tell you about people who have been less than welcoming and less than helpful…and you’ll speak to some staff who’ll, who if you just dig a bit beneath the surface, and it...you won’t have to dig very hard to find, you know, it’s [racism] there’ (Nurse Brown, Nurse, interview)

This section has demonstrated that although none of the interviewees said that they regularly read right-wing newspapers or tabloids, the themes of deservingness for healthcare that these newspapers present were still known by all the interviewees and internalised by them, suggesting that hostile environment created by the media is pervasive and powerful.

Internalisation of negative messages affected women’s feelings of deservingness and confidence in accessing services and speaking up for their rights. It was also seen in the attitudes of some healthcare staff, however there was a lack of recognition by the GPs about the effect this may have on access inequality. This disconnect, in health care workers interviews, between being aware of racist or discriminatory attitudes and how this may affect patients’ feelings of deservingness to healthcare may be a barrier in actively challenging these attitudes and the causes of them within practices.

The second half of this chapter shall now move on to consider the meso level of Mackenzie *et al*. (2012) candidacy figure.

7.3 Meso-Level Operating Conditions

The meso-level of the Mackenzie *et al*. (2012) figure can be visualised as a layer of operating conditions that are closer to individual’s daily experience. The areas of the meso-level that are presented in this section are community (re-named from neighbourhood in the Mackenzie figure) contexts and expectations; policy, particularly around awareness of rights and entitlements; and the organisational structures and cultures that asylum seeking, and refugee women interact with.

7.3.1 Community Contexts and Expectations: Experiences of Living in Glasgow

As outlined in Section 1.3 asylum seekers do not have control over the neighbourhoods and accommodation where they are housed. Women described that on arrival to Glasgow they had hoped to be housed in areas which they perceived to be safe and where they could set up a home.

> 'We hoped to have an opportunity to have a calm way with life' (Shabana, refugee, focus group)

However, the reality was that they were housed in hard-to-let housing in areas of deprivation, often with existing social problems. Selma (refugee, interview) and Aisha (refugee, interview) described that there were community wide issues with vandalism, aggression and drug taking in the areas they were dispersed to, and they would often see a police presence in the area.

> 'Yes it's a shelter but it's not a home' (Selma, refugee, interview)

It was believed by many of the women that if they lived in communities which had a higher number of 'foreigners' then they were more likely to be accepted by the host community, as they would be used to diversity. However, in reality, it was felt that many in the local host community had pre-determined assumptions, mostly caused by negative media coverage, about asylum seekers, refugees, and migrants, which could affect their attitudes towards them. This was particularly acute for those who were Muslim and *'covered'* (Sumera, refugee, focus group), as the intersection of their religion, race and migration status made them particularly visible and, therefore, vulnerable.

> 'Because their religion is so different, and you know you can just physical see it it's not just that they are maybe some other because they are wearing headscarf's you know immediately there is a difference there.' (Mathilde, community worker, interview)

Housing was seen as a key area where feelings of discontent towards asylum seekers and refugees arose within the wider community. Feelings were exacerbated by the existing deprivation in the community

> ‘You would get quite a lot of folk kind of bitching if they were on a housing application list or something. Ah these bloody Asylum Seekers they are getting a front and back door and I am waiting…you know you’d get a lot of kind of whinges like that’ (Dr Grayson, GP Partner, interview)

Discontent within the community about issues such as housing could lead to hostility. Women shared stories about negative interactions they had experienced in the community which included racist remarks and verbal abuse. Two healthcare interviewees described serious attacks on asylum seeker and refugee patients with several patients being attacked in the community, racist vandalism on their front doors and bits of paper which were on fire being put through doors. This again was often felt to be the consequence of the media’s misrepresentation of asylum seekers and refugees.

> ‘There’s…you know, I think there is a high Sun and Daily Mail readership around this area at the moment, and of course, it’s going to increase the problem’ (Sofia, community worker, interview)

Several women reported that barriers were often broken down once conversation was made, and commonalities found.

> ‘Once they know you are a good person they start to be very friendly’ (Nadira, ILR, focus group)

> ‘People didn’t talk, judged and have ignorance but when they start talking to you they change. Some will never talk to you and some will’ (Serine, refugee, focus group)

This was also observed by the community workers interviewed.

> ‘…you have activities or projects that involve everyone, even if people are only involved for a day, and they suddenly, actually, maybe strike up a conversation with someone who’s an asylum seeker or they hear a bit about someone’s story or they...it humanises things. It starts to make people, I guess, realise or see somehow, or feel probably subconsciously that we’re just dealing with people.’ (Sofia, community worker, interview)

The women found that integration with the community could be difficult and often required a lot of work on their part. Practically, Mouna (ILR, interview), described not having the same level of family support around to provide babysitting which would allow her to go out and socialise. As asylum seekers it

could also be difficult to integrate as they received money in a voucher system which restricts where they can shop and travel. Once they were refugees this became much simpler. Nawal (British citizenship, interview) met people at college, whereas Selma (refugee, interview) invited neighbours into her home to share food. Grace (asylum seeker, interview) volunteered with the SRC to create a community dialogue about asylum seekers/refugees and found that she was accepted more once myths were dispelled through this.

Many of the women found a common language with their neighbours through their children. For example, Nawal (British citizenship, interview) described that she got to know a lot of her neighbours when she had a baby as they visited the house with gifts. Generally, though, women who could not speak English found it more difficult to involve themselves in community events or volunteering compared to those who could. Therefore, the intersection of language, socioeconomic status, religion, and migration status was vital in how easy or difficult women found it to integrate with the community.

Some women described feeling trapped between different cultures when they started to integrate with the host community. Selma (refugee, interview) felt the community accepted her more when she let them believe she was from Turkey, like her husband, rather than Iraq, and when she dressed in a more westernised fashion. Serine (refugee, focus group) found that she was often questioned at her mosque due to her lighter skin colour and was often treated as a convert to her religion, yet she was not accepted easily at the school gates due to wearing a headscarf. When she moved from Scotland to England, for a short while due to dispersal, her children were made fun of for having Scottish accents but then when they moved back to Scotland, they were teased for seeming posh. These are also examples of intersectionality, as these women and their children were judged in many ways from different parts of the community and often discriminated towards at every intersection of their identity.

Health care workers were able to observe host community reactions to asylum seekers and refugees. There were some positive comments about how the community has reacted to the change in demographics that has resulted from the dispersal of asylum seekers and refugees.

> ‘I think if somebody had tried to anticipate or predict how Glasgow would have reacted to the complete change in the, sort of, ethnic mix, I think it’s been positive on the whole’ (Nurse Brown, Nurse AHBT, interview)

> ‘The people in my surgery are sort of quite well tuned in to diversity’ (Dr Saeed, GP partner, interview)

Others were more neutral about community reactions.

> ‘I think they got a pretty mixed reception’ (Dr Grayson, GP Partner, interview)

Unfortunately, every healthcare worker interviewee also had an example of racism or intolerance towards asylum seekers and refugees from the host community, within the surgery. This ranged in its frequency and severity.

> ‘Often you would get a lot of just sort of casual racism from the locals…you would get the odd sort of old guy in his 70’s from [area in Glasgow] wondering if he’s in the right country sort of thing’ (Dr Grayson, GP Partner, interview)

> ‘Patients say ‘it’s like the United Nations out there…or why are all these foreigners coming and they’re taking all the time’ (Dr Wright, Salaried GP, interview)

Overall, women felt safer when they became refugees and were able to exert control over where they chose to live in the city, as they were able to gain private lets and build up support networks. The women were keen to live in neighbourhoods where there were similar people to them, either in religion, citizenship, or class status. Although these similarities were often prioritised differently, discussions around these were good examples of how asylum seeking and refugee women are a heterogenous group, with often the only thing connecting them being the asylum system. Selma (refugee, interview), Mouna (ILR, interview), and Nawal (British Citizenship, interview), for example, prioritised living in the west end of Glasgow. an area where they felt the class status was similar over cultural or religious similarities.

> ‘I never thought for a moment that I was going to interact with the community in Springburn’ (Selma, refugee, interview)

Whereas Shabana (refugee, focus group) was keen to live in the city centre and Serine (refugee, focus group) felt that the west end was where everyone talked about, but she found it boring, with unsociable people. She felt the community where she lived, was more friendly and down to earth, with lots of hustle and bustle. Others chose to live in areas far away from bars or drinking as this is something that was at odds with their religious practices.

7.3.2 Policy: Awareness of Rights and Entitlement

Many of the women interviewed had been in the U.K. for several years and could not remember clearly how they had found out about their entitlement to healthcare. They described having competing priorities when they first arrived and healthcare was not high on their list.

> 'A lot going on' (Souhila, refugee, interview)

> 'I wasn't listening properly as I wasn't myself' (Mouna, ILR, interview)

Due to these competing priorities many had not retained the information given to them about the healthcare system or how to access are when needed. Two women remembered social work and the health visitor explaining to them how the system worked. Others did not remember the system being explained to them by professionals and often learnt through conversations with other asylum seekers or refugees. Many only remember learning about the system and that they were entitled to free healthcare when they needed to use the health system.

Some women felt that the media made them nervous about accessing services because the portrayal of entitlement for asylum seekers and refugees was confusing in the media and therefore, they were unsure what the law was regarding access. This confusion about rights was then compounded by the discourses in the media and the hostile environment, which made women feel undeserving of healthcare.

> '… they're being made to feel like they don't deserve it.' (Sofia, community worker, interview)

The community workers demonstrated knowledge of the Scottish entitlement policies to healthcare but one of them felt that this information had been difficult to find.

> ‘Oh it was ridiculous. It was a whole sort of hours of trawling through things…’ (Sofia, community worker, interview)

> ‘I don’t think it would ever hurt to have more signposting or more help because you should never assume we should really never assume that they know it all…(Mathilde, community worker, interview)

Women felt nervous and unsure about defending their entitlement when accessing health services. One woman was not allowed to register with a practice by the receptionist which made her feel ashamed and two women had their passport and visa checked the first time they registered. Aisha (refugee, interview) described that she found the issue of entitlement confusing and that it was difficult to question doctors about this. This made her worry for other women who may be less empowered or have language barriers.

With regards to other rights when accessing healthcare, some women were unsure if they could request to see a specific GP, including gender, and if they had the right to change practice.

Only one healthcare worker reported that they had received training around entitlement. Four were able to demonstrate good knowledge of the entitlement for asylum seekers and refugees to healthcare in Scotland. Two healthcare workers were unsure of the guidance around whether asylum seekers or refugees were entitled to healthcare or whether they would have to pay for it. One of whom intimated that although she didn’t know the policy regarding entitlement ‘I just provide them with care like anyone else’. Dr Grayson (GP partner, interview) partly knew the guidance but believed that refused asylum seekers/refugees would not be entitled to free primary healthcare, which is the guidance in England not Scotland.

Each practice that the healthcare workers interviewed worked in, had developed their own internal policies regarding entitlement, leading to differences in practice. Two practices decided that they would just treat everyone the same

and not consider entitlement issues. If there was a problem with referral to secondary care, then they would leave this to hospital management to decide.

> 'When you work in the NHS…we didn't go into it to charge people and it doesn't feel right to be charging people. It's not something as a Doctor that we should really be involved in' (Dr MacDonald, GP clinical fellow, interview)

Not all practices were as open in their internal entitlement policies. Dr Grayson (GP partner) described that the partners in her practice formed their own policy about entitlement, including not registering refused asylum seekers, and had no awareness that there was a government policy available. This meant that they created their own internal adjudications of deservingness. Others felt worried that they may be treating people who were not entitled to access. Nurse Campbell (Practice Nurse) for example stated that she was glad she had found out a number to phone to check if people were genuine and stated that this 'should have happened a long time ago'.

Therefore, although GPs were stating that they would treat everyone equally, they were often setting up informal entitlement and deservingness procedures at the reception desk which could turn potentially entitled patients away.

> 'Not just anybody can come and register. Have a flag on the system if visa expired and they will be refused an appointment. The GP would treat everyone but reception will stop them getting there.' (Dr Smith, salaried GP, interview)

Several healthcare workers described issues with the community questioning or challenging asylum seekers and refugee's entitlement to healthcare. This was often based around ideas of taxation.

> 'There was one occasion when somebody was getting quite upset. The reception said something about him paying taxes and the others not and all having to wait in the same queue.' (Dr Saeed, GP partner, interview)

Comments such as these particularly upset the healthcare worker's discussing this when they were said by people who were on benefits themselves. This demonstrated a potential hierarchy of deservingness in the healthcare workers mindset around other populations.

> ‘It has to be said I had patients, I think that were the most unwelcoming, were the ones that were on benefits and didn’t work themselves a lot of the time. And you’re kind of like well you’ve got a cheek, like they are not actually taking a job away from you because you can’t be bothered to work yourself.’(Dr Grayson, GP partner, interview)

> ‘From the wider community there is very much the attitude of we’re British, or we’re Scottish, we’re entitled to this. They aren’t and if you want to come here then you come and play by our rules…oh, yes and this I should probably clarify, it’s from people who have, perhaps, contributed very little to the tax and national insurance of this country.’ (Dr Smith, salaried GP, interview)

Findings presented here demonstrate how confusion around entitlement can arise, even if it is supported by existing policy such as the CEL09 healthcare entitlement policy (The Scottish Government, 2018). Policy can be ineffective if it is not disseminated well and in the case of asylum seekers and refugees if it does not drown out the discourses of un-deservingness stoked by hostile media reporting. Through dissemination of this policy not being visible enough it also created a policy silence or space which practices filled with their own, sometimes inaccurate, policies.

7.3.3 Organisational Structures and Cultures

Organisational structures and cultures overlap with other areas, such as structural inequalities at the macro-level and local operating conditions at the micro-level within Mackenzie’s candidacy figure. In this section the organisational structure and culture of the asylum system shall be considered and how it impacted the wellbeing of- and inequalities faced by asylum seekers and refugees. It shall then focus on other organisations that build a supportive culture for women navigating the asylum system. Section 8.8 will discuss the more local operating conditions of the NHS.

The asylum system was not specifically asked about in the interview schedules as it was felt to be too intrusive. However, several issues came up naturally throughout the interviews and period of engagement, many of which were noted in the field notes journal. The most prominent was that the asylum system took away control from almost every aspect of women’s lives: It was described as,

‘a prison but without walls’

(Serine, refugee, focus group - field notes)

Section 7.33.67.2.2 outlined elements of gender inequality that the women interviewed faced in their country of origin or within their cultural groups. Within the U.K.’s asylum process, structural inequalities and policies were identified which can trap women in particularly vulnerable situations. An example of this was the common practice for a women’s application for asylum or leave to remain to be linked to their spouse. If a woman later separated from her husband, this would leave her in a very vulnerable situation with regards to her asylum status as the primary application has been made for her husband. This led to a reliance on husbands and the potential for women to be trapped in marriages which were controlling or abusive.

Domestic violence was openly discussed within the women’s group, during the engagement process, with regards their own experiences and those of others. For many of the women they found that they had to stay within these relationships rather than risk their asylum claim by trying to separate from their spouses. The community workers spoke about trying to encourage couples to place separate claims for asylum but often they were too far into the process by the time they contacted them. Language and cultural differences also acted as a barrier to community workers fully engaging around domestic violence, perpetuating a cycle of entrapment for women. Again, the intersection of gender, language and asylum status left women in a particularly vulnerable and isolated situation.

The lack of control over housing location, due to the asylum system housing policies, also hindered women’s ability to settle in a community and build up support networks (Section 7.33.66.4.35.2.16.4.17.3.1), such as GP’s, children’s schools, and community groups. Another condition of being an Asylum Seeker is the expectation to report to the Home Office on a regular basis. This caused a constant underlying fear as individuals could be removed when reporting and meant that children had to be taken out of school regularly to meet these requirements, which was again disruptive to both their education and integration.

The asylum system in the U.K. also prohibits asylum seekers from working which further reduces control, socioeconomic status, personal freedom, and space to integrate, especially as benefits are provided on a card called the azure card which can only be spent in specific shops. In addition, this affected individual identities and feelings of self-worth.

> 'I wasn't myself, I couldn't work' (Selma, refugee, interview)

Sofia (community worker) recognised that for most women they felt unable to speak up or request for things to be different. They were in constant fear of their asylum case being negatively impacted and were drained by the level of structural inequality faced.

> 'Yes, there's a lot of fear that causing a fuss of any kind is going to negatively affect the case, but also the people, I think, are just quite downtrodden by the whole system anyway. It's one that would demoralise most optimistic and bubbly of people. You know, it's…you know, it's draining. It's designed to be extremely harrowing, and so I think people just feel quite defeated, generally, so, you know, what difference…I think they don't have any hope that that's going to make any difference.' (Sofia, community worker, interview)

During the information session with the focus group the women did express concerns about anonymity, in case the Home Office found what they were saying. There was very little trust in the Home Office or asylum system. One woman disclosed that her husband did not want her to take part in the interviews, even though they had leave to remain. They had applied for their passports and he was worried that their passports would not be sent if his wife was recorded saying anything negative about the asylum system. Therefore, the power the Home Office held over them remained even after they had received indefinite leave to remain and were in a more stable, secure situation. Again demonstrating, as discussed in Section 7.33.67.2.1that the identity of being an asylum seeker dominated.

The asylum system and structure was all encompassing, affecting everyday life. Everything was monitored and controlled: your domestic situation, your socioeconomic status, where you stay, where you shop, your freedom to speak out and all with the stress of regular reporting and fear of removal. This was often over a significant period of time. For example, at the time of interview

Grace (asylum seeker) had been waiting eight years for a decision about her asylum application, leaving her in a very vulnerable situation.

The role of the Home Office in directing people's lives was echoed in health worker perspectives. The intensity of appointments and procedures surrounding the Home Office were identified as prohibitive, with GP appointments often having to be re-arranged to accommodate Home Office appointments.

> 'it's priority…comes above everything else, even their own health'
>
> (Dr Smith, Salaried GP, interview)

Primary Care was identified as having little influence over the Home Office. Some interviewees identified issues around managing expectations, as often patients believed that if the practice wrote a letter in support, it would make a difference. The power of the Home Office to remove recourse to public funds for refused asylum seekers was also felt to be difficult and GPs often dealt with the social issues around this

The lack of control, vulnerability and isolation of women are aspects of the organisational structure and culture within the asylum process. Therefore, other organisational structures were needed to support women, especially as many of them have had to leave the family support that they would have had in their country of origin.

> 'I'm lonely in Glasgow, left behind big family, isolated now.' (Azra, ILR, focus group)
>
> 'All of my family, my mum, they are in the Congo.' (Noura, refugee, individual interviewee)

Churches, the Mosque, schools, and colleges were identified by all interviewees as key places where integration happened. Community organisations, including the SRC, the British Red Cross and Women's Aid, were important sources of support, providing safety plans for domestic violence, return to work schemes, English classes, and an increased self-confidence by providing purpose and opportunity.

> ‘Some people working in organisations to help they were so supportive, and they give us another perspective of good people…someone that is treating you in another way it sometimes helps you to heal your wounds’ (Selma, refugee, interview)

> ‘Very good people in the community, I have friends, go to college to do ESOL, my son goes to school. I’m happy’ (Kishwar, refugee, interview)

The women’s group which was used to recruit the focus group was seen as a where women could make friends, share food and receive support from each other. Sofia (community worker, interview) observed that it created a safe physical space for the women to meet in, as many of them may not have such a space readily available either in the community or in their homes.

> ‘Women’s group is the oxygen in my week’ (Serine, refugee, focus group -from field notes)

Much of the support received at the women’s group spilled over into life outside the group with women able to build up strong networks, spend time with each other socially, help with babysitting, and household tasks etc. They also protected each other through difficulties at home, including domestic abuse. Women found sharing their experiences to be helpful. Even though they came from different countries, and experienced different journeys, they all had a common experience of having moved away from their family and home.

> ‘You feel like joining so that you can have the opportunity to discuss with people’ (Souhila, refugee, interview)

During the period of engagement with the women’s group it was apparent how important the group was to the women, through good times and bad. One woman baked a pineapple upside down cake for the group on the day she found out she was being dispersed to another city, to show her appreciation for the group. On another occasion, Wafa (refugee, interview) ran into women’s group, throwing chocolates around the room as her first port of call when she passed her driving test.

The women interviewed as part of the focus group and healthcare workers expressed worry for women in the community who did not have access to

support networks, such as the women's group, as they could be much more isolated.

> 'If you are a simple person, not searching for groups, then you will be stuck alone' (Selma, refugee, interview)

Grace (asylum seeker, interview) and Safaa (refugee, interview) were examples of women who were more isolated and reported having no solid support networks. Safaa (refugee, interview) was very isolated, mostly due to the limited freedom afforded to her by her husband. Whereas Grace (asylum seeker, interview) was the only asylum seeker interviewed and the difference in her confidence to socialise or attend groups, due to still being stuck in the system, was apparent.

Despite the importance of community support structures, healthcare workers had very little awareness of community services available for the asylum seeking and refugee patients within their practice areas. Often this was put down to not having enough time to learn about services for specific communities when they had other patients to consider as well.

> 'There's probably a lot of things in place that Doctor's don't know about…I would imagine that, just by the nature of it, there would be tons of agencies out there, specifically for asylum seekers that I have no idea about but we're not only an asylum-seeking practice… you get 50,000 emails a week about things anyway…It's impossible to stay on top of all that' (Dr Smith, Salaried GP, interview).

Solutions suggested by healthcare workers, to better inform practices about services available was targeted, easy to access information, such as a directory of community services and the provision of training sessions.

> 'Other things that would make it easier probably would have been if somebody had bothered to tell me half the stuff that I just had to learn myself like what services there are in terms of red cross, the medical foundation, that kind of thing. I didn't know any.' (Dr Grayson, GP Partner, interview)

It was suggested by Dr Wright (Salaried GP, interview) that a useful service would be an informal advocacy service, where patients would be linked with one another to create support networks, in addition to formal community services. She had trialled this within her surgery to good effect.

This section has presented findings on the way that asylum system exerts control in every aspect of women's lives, often leaving women isolated and in very vulnerable situations. Community organisations could support women through the asylum system and provided a much-needed place of support and friendship. However, not all women attended these and there was not a reliable link between health and community organisations. Both did express a hope to improve this and find a way for partnership working, which would offer more support to asylum seeking and refugee women.

7.4 Summary

This chapter explored the macro-and meso-level of Mackenzie *et al.*'s (2012) candidacy figure, adapting the headings within it as needed to better represent the findings from interviews with asylum seeking and refugee women. As can be seen from Figure 13 these levels wrap around an individual's interactions with healthcare providers and are the environment within which these interactions occur. In some circumstances factors within the macro- and meso-levels do not only provide context, they directly affect an individual's interaction with healthcare providers.

As was discussed in Chapter 2 Theory, the macro- level of candidacy which includes migrant status, gender, ideologies of women and public discourses of welfare extend far out with the healthcare service but are often linked closely to the social construction of deservingness.

A key finding with regards to the macro-level of candidacy was the heterogeneity of the women interviewed. Under the umbrella label of asylum seeking and refugee women, were significant intragroup differences, both prior to arriving and after arrival in the U.K. This included: class status, education levels, religion, journeys to the U.K., empowerment, and occupations. It can be argued that the only concrete similarities were that they were all women and that they were all living out with their country of origin. This heterogeneity links to intersectionality and the differences in experiences that women had depending on their differing intersecting identities.

For example, gender inequality transcended all the operating conditions, within both the macro- and meso-level of Mackenzie *et al.'s* (2012) figure, both culturally and structurally. In addition to this the impacts of the intersection of asylum status, race, socioeconomic status, and gender were described as creating experiences of inequality and prejudice in almost every part of asylum seeking and refugee women's lives in the U.K. All of which was compounded even further by the hostile environment created by the U.K. media, with women also feeling the need to take on the extra work of defending themselves as asylum seekers, refugees and for some women as Muslims. This chimes with the work of Shakespeare (2006), around labelling and disability, who discussed that when someone is given a label it may trigger other negative associations and there can be 'identity spread', which is where this label often then dominates and other aspects of their identity are ignored. Therefore, as was found in the newspaper analysis (Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?) and in this chapter, the asylum system or label of being an asylum seeker dominates in public discourses and in interactions with community members and the healthcare system. This was seen in Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?, where in the media the label of migrant, asylum seeker or refugee was linked with discourses of threat to the host population.

The Healthcare workers interviewed were aware of the hostile environment created by the media and in some cases reported it affecting staff attitudes, particularly those in reception. However, they did not connect this to potentially affecting patient access or care, seeing it as a wider context issue. However, this was at odds with the experiences women had encountered when they often felt judged and not as comfortable asserting their candidacy for healthcare when attending services.

A disconnect at the macro-level of candidacy was found between the healthcare workers' good intentions of treating every patient equally and not discriminating based on asylum status and the consequences of their internal policies around entitlement. These policies often left receptionists in a gatekeeping role. These internal entitlement policies, including asking for identification documents, the

lack of knowledge of the Scottish Government entitlement policy and lack of responsibility in challenging racist attitudes from staff can be argued to potentially create an unnecessary access barrier, at the reception desk. It created assumptions of deservingness and a barrier that when women had identified their candidacy, navigated a service to appear and attempt to assert this, they were then turned away and not able to progress in their candidacy journey and ultimately to get the service they required.

The asylum system and its policies overshadowed everything in the macro-and meso-level of Mackenzie *et al.'s* (2012) candidacy figure. It led to feelings of a lack of control for the asylum seeking and refugee women interviewed and a perceived helplessness from the healthcare workers. Many women did not have control within their culture, their religion, and their role as a woman. Structural controls, such as those imposed by the asylum system then further entrapped them in other areas, such as abusive marriages, leading to further vulnerability. These structural controls could hinder candidacy assertion by not being culturally aligned with their individual or community beliefs or by not being accessible enough for women to access on their own, for example having to rely on others to translate information or not having literacy. Even when identifying themselves as a candidate these factors can cause a barrier in the candidacy journey.

Therefore, community organisations were a key support for asylum seeking and refugee women. They mitigated some of the negative effects of the hostile environment created by the media and the asylum system by advocating, signposting, creating a community of support and empowering women. However, negotiation and navigation of candidacy for healthcare is a two-way process and again, there was some disconnect between healthcare workers appreciation of the importance of community organisations but lacking knowledge of organisations which are local to their practice. Healthcare workers were however keen to address the disconnects identified in this summary section and would embrace any training if offered, this will be further discussed in Chapter 9 Discussion

Many of the themes identified in this chapter demonstrate the context that asylum seeking, and refugee women operate within, as part of their daily lives

but also when they access healthcare. The summary has also started to pull together some of the links between the macro-, meso- and micro- levels of candidacy. The next chapter shall present the findings from the qualitative interviews which explored in further how these macro- and meso- level operating conditions affect the micro-level identification and negotiation of candidacy for cervical screening, with a focus on how the micro-level is negotiated by asylum seeking and refugee women, signposted by community workers and on how the relationship between healthcare workers and asylum seeking and refugee women affects this journey.

Chapter 8: Cervical Screening Negotiations- Micro-Level Candidacy

The previous chapter focused on the macro and meso levels of candidacy, creating an understanding of the contexts within which asylum seeking and refugee women need to operate.

This chapter moves on to explore the process by which asylum seeking and refugee women identify that they are a candidate for cervical screening and navigate the candidacy journey with healthcare staff, to receive this service. It presents analysis of the interviews and focus groups conducted with asylum seeking and refugee women, community, and health workers to explore the micro-level of candidacy (see Figure 14), in relation to cervical screening, and links the wider macro- and meso- levels to where they influence the micro-level of candidacy.

The micro-level of candidacy considers, in detail, the identification of candidacy and the steps taken to assert and negotiate this candidacy within the health system, at an individual level. In this chapter candidacy is considered from both the patient and healthcare worker's viewpoints as it is a dynamic two-way process between these individuals. Candidacy negotiations operate within the health system and these operating conditions of this system will be explored in Section 8.8.

The chapter is structured around the seven steps of candidacy shown in the Dixon-Woods *et al*. (2006) figure, which forms the micro-level of the Mackenzie *et al*. (2012) (Figure 14), with each section of this chapter dedicated to one of these steps.

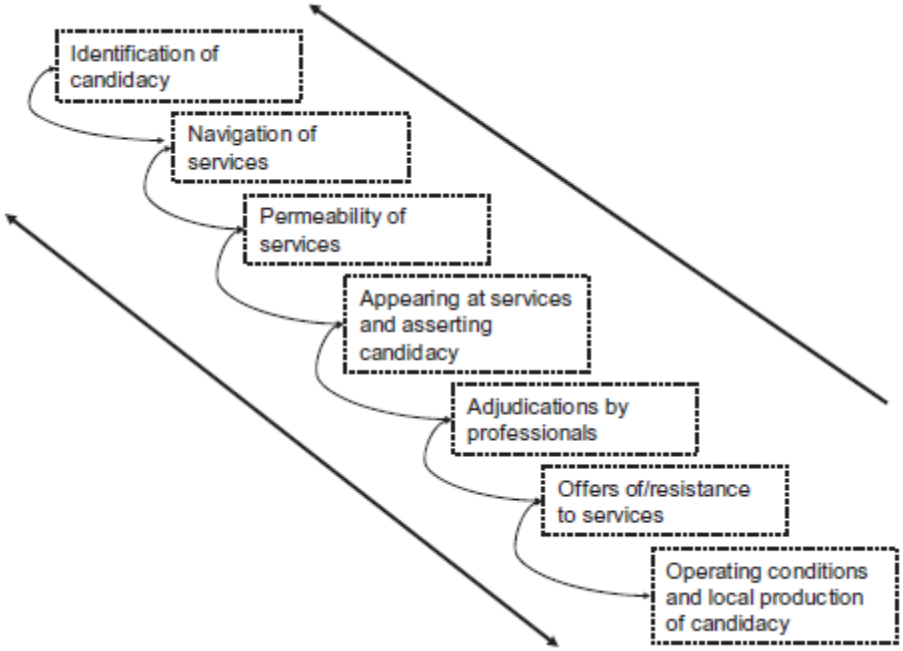


Figure 14: Dixon- Woods et al (2006) Candidacy Framework. From Mackenzie et al (2012)-'Negotiating the Candidacy Journey for Health Services- an extrapolation from Dixon-Woods et al 2006'

8.1 Identification of Candidacy

For an individual to view themselves as a candidate for a particular service they must first see themselves at risk of having the health condition for which the service is being offered, in this case cervical cancer.

Participants suggested many different risk factors for cervical cancer. The top three identified risk factors amongst the women in order of frequency were: sex with more than one partner, childbirth, and canned food. HPV, hygiene of the female and family history were other identified risk factors. Several women were unable to identify any risk factors.

There were mixed views as to whether women felt personally at risk. Many did not, as they felt protected by their culture around sex and their perception that

there was a low incidence of cervical cancer in their country of origin. Several women felt that it was not a big problem in their country of origin, as they did not think it affected Muslim or Arabic women. Those who were identified as being potential candidates were those who did not adhere to their cultural-religious beliefs.

> '…the main factor for getting cervical cancer is having an early sexual life and having more than one partner but it is very rare to have this in Iraq, we maybe have a group of people who need to be examined like prostitutes…' (Selma, refugee, interview)

> 'Just one partner and that's it, you got married and that's it only one partner. So we've all like had that in our mind. We don't need it; we are not you know sexual life wise. It's not like, we are not like sexually active and have more than one partner so maybe that was the main reason why it's putting me off not to do it that much to be honest' (Nawal, British citizen, interview)

Several had heard of women who had had some sort of gynaecological cancer but did not know the details as it was not widely discussed. Souhila (refugee, interview) described that it was taboo in her village to discuss things to do with the reproductive system. When a woman in her village had a gynaecological cancer, she only heard rumours. It can therefore be argued that it can be difficult to identify as a candidate if there is silence around the issue.

> 'Yes there was a lady I know who died, she had cancer. Ehhh...you know…I don't know because when, because of how you know culture is that sick stuff is taboo so even if somebody has it it's just (whispers) we not know, no you cannot know anything in detail you just heard' (Souhila, refugee, interview)

Only four of the 16 women interviewed were aware of cervical screening prior coming to the U.K. Of those who were aware of it in their country of origin they didn't attend for various reasons: the doctors were male, it had to be paid for or it was only offered postnatally, not at other times. Selma (refugee) was the only woman to have attended for cervical screening prior to the U.K., at her request for postcoital bleeding.

Aisha (refugee, interview) observed that as there were no treatments available for cancer in her country of origin, screening would have been pointless as if you had cancer, you would 'most certainly die'. This led to a development of lay

epidemiology, where many women made sense of this inevitability of poor outcomes in their country of origin, through religious beliefs or the idea of luck.

> ‘I said you should have faith in God, and I believe that always God do the best for you…I told him that I won’t be afraid or be worried if God gives me any disease because this is coming from God, so I don’t worry about anything’ (Azra, ILR, interview)

> ‘In my mind is every human being got a cancer sleeping in their body so sometimes they wake up anywhere in the body and sometimes they stay asleep.’ (Shabana, refugee, interview)

Although many of the women viewed their cultures and country as low risk their perception of risk increased when they came to the U.K., due to hearing more about cervical cancer and the screening test. Receiving an invitation for the test, it being free and having friends who encouraged them to go also led to the women welcoming the idea of screening.

> ‘Yeah I feel now it is important yeah because the way it is advertised here and you see people you know being diagnosed with cervical cancer every day, so I feel the need to do it’ (Grace, asylum seeker, interview)

> ‘I ask a friend about it and had a couple of chats you know with a friend here [women’s group], they had done it and encouraged me to do it’ (Mouna, ILR, interview)

Serine (refugee, focus group) was the only woman interviewed to say that she found it a hard concept to accept that you may need to take treatment for something picked up on screening, when you did not feel unwell.

> ‘I don’t know how I would react; you know in our mind if you are not sick why are you going to treat yourself sometimes in a certain situation.’ (Serine, refugee, focus group)

This idea was also raised by some healthcare workers. Where assumptions about cultural homogeneity led some to suggest there would be a lack of focus placed on preventive healthcare.

> ‘I think in a lot of cultures and a lot of societies, you know, health is about ill health. You know, it’s not about preventative stuff necessarily’ (Nurse Brown, Nurse AHBT, interview)

All the women interviewed felt that women in the U.K. were more open to talking about health issues, including those of an intimate nature.

> 'here people are more open to talking about everything' (Aisha, refugee, interview)

This section has presented the journey that women have been on to recognise their candidacy for cervical cancer and therefore for the importance of cervical screening. Healthcare workers were shown to have made some assumptions about women's cultural beliefs and assumed that they would not prioritise cervical screening. However, with increased education about cervical cancer, a free test and potential treatments if there were any abnormalities found, most of the women would welcome the opportunity to take individual control over their health through screening.

8.2 Navigation of Services

Once candidacy is identified for cervical screening there needs to be enough knowledge of the health system and ability to navigate services, in this case primary care, to start the negotiation process for the service. Knowledge and ability to navigate the system often pre-dated the invitation for cervical screening. Therefore, this section will present how asylum seeking and refugee women recollected building their knowledge of primary care when they arrived in the U.K. which would then be useful when it came to navigating primary care specifically for cervical screening, when they received the invitation letter.

Most women interviewed felt that the process of registration with a GP was a simple and passive process, which is likely a reflection of the agencies involved for this group. They recollected that on arrival in Glasgow a GP practice was allocated to them by the Asylum Health Bridging Team[6], the Scottish Refugee Council or Social Work. They were given the relevant documents and sometimes were taken to the practice. All interviewees were registered with a GP, and it

[6] Asylum Health Bridging Team: The AHBT is a Glasgow based health team who offer an initial health assessment for newly arrived Asylum Seekers and facilitate access to GP services once Asylum Seekers have been dispersed from initial accommodation to more permanent housing. (https://www.nhsggc.org.uk/your-health/health-services/homeless-health-and-resource-services/homelessness-health-services/asylum-health-bridging-team-ahbt/#)

was felt that the information given by the AHBT encouraged appropriate use of health services.

The only women who had a delay in this process were Reham (economic migrant, interview) and Selma (refugee, interview), perhaps due to their different entry routes, as an economic migrant and on a spousal visa respectively. There was no specific team dedicated to helping them navigate the healthcare system, in contrast to those in the asylum system. Selma found the registration process more streamlined once she became an asylum seeker. This demonstrated a vulnerability between the intersection of migration status and being a woman in need of sexual healthcare. If you are not an asylum seeker or refugee, you did not have access to services which help you navigate the system.

> 'I don't know why he (ex-husband) didn't register us and I didn't know anything about the medical system. I had my family problems at that time so I didn't know exactly how to go to hospital if you are sick but I was counting on him, because he's a Doctor and he's working…I don't know why he didn't register us with a GP but once I sought asylum I received a letter immediately after 2 weeks telling me that I had to go to the given address to get registered and so on.' (Selma, refugee, interview)

The women interviewed were all under the age of 50 and described that the most common reason for attending the GP was either for their children or for pregnancy related issues, which can be postulated to be true of most women in this age group.

> 'I mean, I don't think it's necessarily biological, I think it's through social construction, but it tends to be that women seem to take on much more that role of not just caring for or concerning themselves about their own health but the family's health or their communities health etc.' (Sofia, community worker, interview)

In Section 7.33.67.2.3 there were a range of feelings about appointment systems and the role of the GP from women who were used to direct specialist access. Positive experiences related to navigating the NHS were identified around feeling that they were being listened to and investigated thoroughly. Follow up and continuity of care was also seen as being important. Women from countries where the healthcare system was underdeveloped or lacking in primary care

were impressed by the breadth of services they were offered and by the quality of the doctors in both primary and secondary care.

> ‘completely different from my country where pay a lot and poor treatment. Service of high standard in the U.K., respect and free’ (Wafa, refugee, focus group)

However, certain practices were noticed to be different. For example, reduced antibiotic prescribing. Four women expressed worry about what they felt was a lack of prescribing compared to their country of origin, with the view that it was comforting to leave with a prescription.

> ‘…in my country you go to the Doctor and get lots of antibiotics, a hundred tablets here and there’ (Serine, refugee, focus group)

It was noted by Serine (refugee) that doctors in the U.K. explained much more to the patient compared to her country or origin where often no explanation was given to the patient about their illness or treatment.

The GP was identified as having a very important support role for asylum seekers and refugees. Noura (refugee, interview) felt that she could talk to her GP, that they understood and provided paperwork for the U.K. Home Office when needed. Kindness and caring about their situation were seen as vital attributes for GPs.

> ‘Doctor wished me luck and asked if I had food for the children’ (Reham, migrant, interview)

However, not all GPs met the role the women expected from them. Selma (refugee, interview) found that the GP was unable to provide the support that she needed which was ‘someone to talk to, someone to empower you, to tell you about the community’. She found this instead in community groups. Grace (asylum seeker, interview) believed that she had a delayed diagnosis because she was an asylum seeker.

> ‘…doesn’t want to waste resources on me or doesn’t care because I am an asylum seeker’ (Grace, asylum seeker, interview)

Support with GP registration procedures, kindness, respect, and open communication were all identified as important facilitators to navigating health services. These were particularly important when clinical practices didn't match what women were used to before and when women were struggling as a consequence of their asylum journey.

8.3 Permeability of Services

Permeability of services will be explored in this section through the issues of gatekeeping and cultural alignment, which were both recognised themes that affected how easy or permeable services were to access.

Most of the women were aware of where to attend for different medical problems but they found the explicit gatekeeper role of the GP within the structure of the NHS limiting. For example, one woman discussed that she had been attending the GP with her daughter who was having stomach pains for several months. However, on discussion with other asylum seekers and refugees she decided to take her to A&E as this would bypass having to wait for a referral from the GP. However, a couple of women had less awareness of where to attend and were even less able to navigate the health system. For example, Reham (economic migrant, interview) attended A&E with her children to get their vaccinations as she was not sure where to attend. This may be linked to her not coming through the AHBT and having the healthcare system explained to her. However, Souhila (refugee, interview), despite having gone through the AHBT, was not initially aware that you could attend A&E in an emergency.

> 'I thought at the beginning I thought that if there is an emergency I can go to the GP then later I've learned that if you can't see the GP in time you have to go to the hospital' (Souhila, refugee, interview)

The asylum system (Section 7.33.67.3.3) was also recognised as decreasing the permeability of services. Dr MacDonald (GP Clinical Fellow, interview) reported that if women were made destitute through the asylum process it was very difficult for them to keep in touch with their GP and they tended to be even more sporadic in their presentations. Other structural barriers such as dispersal, being moved within the city frequently, having to change GP and difficulties in

registering were recognised as system-level barriers to the permeability of the primary healthcare system.

Language and access to interpreters were viewed across interviews as the main barrier to primary care, decreasing its permeability at times. Interpreters were needed by most women when they first arrived. Some described positive experiences in getting an interpreter, they felt the arrangement of this was easy and they did not feel uncomfortable in being honest in front of the interpreter. Some healthcare workers also made an extra effort to help women receive information in an accessible way. For example, Reham's (economic migrant, interview) GP texted information to her that she needed to take to the library. Whereas others found that the time it took for an interpreter to be booked was a hindrance in accessing the GP as it meant they had to wait for an appointment and could not be seen urgently.

Female asylum seekers and refugees were observed by health care workers as requiring interpreters more than their male counterparts. One woman often took her 13-year-old daughter to translate to avoid any delays and Nawal's (British citizen, interview) husband, who was a doctor, always came with her. She described that he would 'talk and answer for me'. An interpreter was never offered to her. This has potential implications for how freely a woman talks if it is her husband or child acting as the interpreter. It also links back to the control and monitoring of women described in Chapter 7 Operating Conditionsand highlights the importance of healthcare workers in offering an independent interpreter, as again this is an example of where the intersection of gender and language can isolate women and make them vulnerable.

> 'Maybe because I didn't ask but no one ever asked me if I wanted an interpreter' (Nawal, British citizen, interview)

Correspondence from the health board or GP could also be difficult as it would often come only in English. Cervical screening invitations were an example of these.

> 'I just keep them [letters] until I go and see my friend and then she can translate for me' (Reham, economic migrant, interview)

Although there are translated cervical screening leaflets available it was recognised that you would need to be able to read this on the initial invitation, which is in English, and then know how to access them.

> 'I suspect, like everything else, it's got a nice big thing at the bottom in English that says, this leaflet is available in other languages, that's brilliant.' (Dr Smith, salaried GP, interview)

Healthcare workers identified interpreted consultations as challenging. Dr Smith (salaried GP, interview) and Dr MacDonald (GP Clinical Fellow, interview) both worried that they did not get the full picture from interpreted consultations. This discomfort on the part of the healthcare worker, when working with interpreters, was noticed by the women interviewed. For example, in the engagement period with the focus group Serine (refugee, focus group) expressed how much she liked her GP. However, he was the GP for several the other women who did not find him to be supportive. Serine, who speaks fluent English, challenged him on this when she was attending a consultation one day and he disclosed to her that he found it very difficult to consult with anyone who didn't speak English and was nervous in interpreted consultations, which could explain the difference in his manner.

Wafa (refugee, focus group), Azra (ILR, focus group) and Serine (refugee, focus group) noted that the gender of the interpreter was as important as that of the doctor in allowing them to discuss health matters. They would always ask for a female interpreter and doctor.

Face to face interpreting was also felt to be harder to obtain at times. Reducing the waiting times for interpreters was seen as a priority by many of the interviewees. Healthcare workers felt this was especially pertinent for cervical screening as it was felt that telephone interpreting would be inappropriate for this procedure. This was potentially problematic as telephone interpreting was being promoted as the preferred choice by the local health board which could add an extra barrier to cervical screening consultations. However, telephone interpreting was also identified as having the ability to increase the permeability of services by reducing wait times by giving an immediate interpreting service. Therefore, there were pros and cons to both which would lead to the argument that both should be available and used as appropriate.

The importance of recognising how different cultures may present for healthcare was identified by healthcare professionals. Sexual health was discussed as being a taboo issue by many of the women interviewed and recognised by healthcare workers as being difficult to broach. Often this was due to a fear around more serious illness. For example, Noura (refugee, interview) described that in the Congo reproductive health was not discussed as there was a fear that any symptom of that nature could be HIV. Talking about sex or intimate areas was particularly unacceptable for women who were not married, and it was recognised that this, combined with some cultural health practices, would often lead to diagnostic delay in their countries of origin.

> 'Maybe it was not cancer but if you have something like there [points to reproductive organs] you know nobody want to see, nobody want to even try you know.' (Souhila, refugee, interview)

There were assumptions made about asylum seeking and refugee women's health. Nurse Brown (nurse) felt that the asylum seeking, and refugee population as a whole were actually 'a very remarkably, healthy population, to be honest' and were difficult to engage with.

> 'difficult population to treat, very, they don't seek healthcare a lot'
>
> (Dr Smith, salaried GP, interview)

Therefore, the assumption by healthcare workers that asylum seeking, and refugee women are healthy, combined with that they and the healthcare worker may feel uncomfortable in discussing sexual health and the gatekeeping challenges felt in getting timely, impartial, appropriate gender interpreters may combine to create barriers and reduce the permeability of primary healthcare. This may in turn affect the uptake of cervical screening.

8.4 Appearing at Services and Asserting Candidacy

This step in the micro-level of candidacy considers what prompted women to attend and then interact with the GP practice to assert their candidacy for cervical screening.

The main prompt for women to attend for a cervical screening test was receiving a cervical screening invitation letter. However, prior to attending the surgery with the invitation letter, the lay community often had a role in helping women to assert their candidacy. Ten of the women interviewed had discussed attending the test before making an appointment, often with their husbands or friends, both in the U.K. and in their country of origin. All reported that the response they received was positive and that they were encouraged to attend by the person they discussed it with.

Other wider influences and sources of knowledge included a TV advert about cervical cancer screening, TV programmes and media coverage of Jade Goody's experience, where the importance of early diagnoses and regular screening was emphasised (Section 4.5.5).

> 'Yes, just because I was talking with my friend, she knows one lady who die in Big Brother had the cancer. So, she was explaining that it's important to go to that test because you know the lady, she had the cancer, but she didn't know. Yeah so, it's very important yeah.' (Noura, refugee, interview)

> 'I was a little but oh how could it be if she [Jade Goody] did the smear so many times but it was negative and all of a sudden she found that. So could it be wrongly done or so I was a little bit worried, so yeah, I went to do the smear and I was just oh that's good I have to do it again.' (Selma, refugee, interview)

Dr Saeed (GP Partner) felt that it was important for women to have access to information independently of their husbands so that they could make autonomous decisions about their healthcare. Community services were identified as being a potential effective partner to primary healthcare in providing evidenced, impartial information and teaching women about their bodies. An example of this was seen during the engagement process with the focus group. The women's group were taken to the Glasgow Science Centre for an interactive teaching session entitled 'How the Body Works'. All the women, were engaged, encouraging each other, and discussing changes to their lifestyle that they had made as a result of health promotion. However, as discussed in Section 7.33.67.3.3 links and knowledge sharing between community organisations and health were often felt to be tenuous.

Another reason for dedicated education was to assure women about the importance of informed consent. Women relayed feelings of being compelled to attend, as they would potentially be questioned if they didn't, which suggests that they felt the felt they had little choice in attending. This links back to feelings of being constantly controlled and monitored as part of the asylum system.

> '…just in case someone [Home Office] ask why I didn't go so it made me go.'(Souhila, refugee, interview)

> 'those people they will follow rules if you will send them a letter telling them so and so, they will go.' (Selma, refugee, interview)

Women who did appear and assert their candidacy had the test performed by either the practice nurse or a nurse at the local sexual health clinic. Feeling prepared and having the test adequately explained to them, in a culturally sensitive way, with an interpreter or interpreted materials available, was seen as an important facilitator for the test. However, Souhila (refugee, interview) felt that rather than this being done at the time of the test she would have preferred a separate consultation for this. Once she was there for the test, she felt pressured to proceed, again raising issues of informed consent.

> 'Told me I had choice but being there, having opportunity and explaining benefit. Feel I have to do it' (Souhila, refugee, interview)

Effective clinical relationships with women who are asylum seekers and refugees were deemed to be important in facilitating access by the healthcare workers interviewed. Dr Wright (Salaried GP, interview) identified that in order to do this the attitude of the GP and Nurses needed to be welcoming, gentle, respectful and prepared to spend time with women, to explain the procedure and identify any cultural barriers.

The women were also appreciative of opportunistic discussions about cervical screening. Serine (refugee, focus group) noted that during her Keepwell Check[7], she was asked about her cervical screening status. She found this re-assuring and

[7] The Keep Well Programmed invites individuals between the age of 40 and 64 years living in areas of high deprivation for a health check (http://www.healthscotland.com/keep-well.aspx).

a good opportunity to ask questions. However, healthcare workers commented that it was difficult to prioritise cervical screening reminders and explanations, within the time constraints of consultations, when there were often other health issues to deal with. Therefore, healthcare workers did not routinely initiate or promote discussions about cervical screening. They relied on the SCCRS call/recall system to prompt women to attend.

It was argued by Dr Grayson (GP Partner, interview) that extra time should be allowed for most cervical smear appointments with asylum seeking/refugee women as many may have experienced trauma, rape or FGM. However, all the GP's interviewed seemed unsure if this happened in practice, demonstrating again a gap between intentions and actual practice. Whilst a cervical screening consultation was recognised as a good time to discuss issues such as sexual violence and FGM, there was a lack of confidence in healthcare workers in how to bring up these difficult conversations. This will be discussed further in Section 8.6.

Four of the health care workers interviewed observed that a noticeable barrier to attending for cervical screening in this population was that it was not a priority, particularly with the other issues that they are dealing with, most notably in the first few years of being in the country when their main aim was to settle in and get status to remain before everything else.

> 'It's a new concept and comes back to what I was saying earlier on, that the priorities for these ladies are putting food on the table, the finances, the housing. It comes much higher up the list than their own health, and definitely much higher up the list than their own preventative health' (Dr Smith, salaried GP, interview).

However, once status and housing were stable, they were often then able to look at the issues of their own health. Nurse Brown (Nurse, interview) felt that once they were able to focus on their own health they were interested and willing to take up health screening and were also keen to bring their children for immunisations. This lends to the argument that although candidacy may have been identified for cervical screening, asserting it is contingent on wider structural factors, and the intersections of the asylum system (Section 7.33.67.3.3) and their role as primary care givers prioritising the needs of

others, such as family (Section 7.33.67.2.2). Drop-in clinics helped to overcome this, somewhat, however, it was noted in the interviews that these were becoming harder for patients to find. GP practices did not tend to offer drop-in services and the sexual health clinic in Glasgow had converted from a drop-in to an appointment system.

Like the findings around navigation of healthcare (Section 8.2) women were more likely to attend services for cervical screening if healthcare workers attitudes were welcoming and respectful. This would promote feelings of deservingness for the service. Time taken to discuss the test was also key. This was especially as women often felt compelled to take the test rather than feeling they were giving informed consent, which was a worrying finding. Again, though a disconnect between GPs intentions and the realities of practice and system pressures were found. For instance, recognising the importance of time in making women feel comfortable but not initiating conversations about cervical screening.

8.5 Adjudications by Professionals

As described in Dixon-Woods et al (2006) once an individual is within the health system, has asserted their candidacy for the service and facilitators and barriers have been assessed as per the section above, an adjudication must be made by the healthcare professional as to whether the service will be provided. Adjudications by professionals at this point can allow or halt the continued progression of candidacy (Dixon-Woods et al 2006). In the case study of cervical screening, used in this thesis, the offer of the service had already been made through the invitation letter. Despite this, adjudications or attitudes of healthcare workers could affect whether a woman felt comfortable to proceed. This links back to the concept of healthcare workers reinforcing that women are deserving of the service. Therefore, this section will mostly focus on healthcare workers views in caring for asylum seekers and refugees.

As discussed in Section 7.33.67.3.2, some women had felt judged and less deserving at health services due to their migration status, particularly during registration procedures at the reception desk. Grace (asylum seeker, interview)

also perceived that she was being judged when the midwife wrote on her hand-held pregnancy notes that she was an asylum seeker. Although she did not clarify the reason for this, and it could have potentially been noted to flag up the need for extra support, it created a great deal of worry for her regarding accessing services and she worried that her GP saw her as less deserving and would not want to waste resources on her when he was made aware of her status.

> 'Like with my previous GP. I thought because sometimes I felt maybe he was treating me like this because I'm an asylum seeker. Like he doesn't want to waste resources on me or something. That's how I felt because I felt as if he didn't want to give me care because I am an asylum seeker' (Grace, asylum seeker, interview)

Adjudications were influenced by the healthcare professionals own personal views, the way services were configured, structural constraints, the impact of the media and the wider community. For example, perceptions of deservingness like that of the migrant hierarchy found in the newspaper analysis (Section 6.3) presented in one of the healthcare worker interviews.

> 'I think there are two things; there are genuine asylum seekers, people that have had horrific situations; they've been raped, they've been tortured, awful things. But there's the other side that are people that are just coming into the country looking for free health care. And that spoils it for the genuine asylum seeker.' (Nurse Campbell, practice nurse, interview)

She did not discuss how she distinguished a 'genuine' asylum seeker from a 'non-genuine' asylum seeker, apart from mentioning how much time they took, but she did identify populations that she viewed as being more genuine than others. This resonates with the literature presented Section 3.7 where it was recognised that subtle judgements around being demanding, requiring attention or not being vulnerable enough, could lead to deservingness judgements and could lead to migrants having to alter their self-presentations to 'perform deservingness'

> 'The Chinese can be quite time consuming, you know. People from the African nations I would say are much more genuine, because they've seen war and horrific things.' (Nurse Campbell, practice nurse, interview)

Most healthcare workers recognised that working with asylum seeking and refugee patients was challenging. Examples of challenges were those mentioned

earlier in this chapter: consulting with an interpreter, managing expectations of healthcare and trying to manage health problems which had been undertreated for years whilst patients have been going through the asylum system.

However, despite the recognised challenges, all the healthcare workers interviewed felt committed to provide good and equal healthcare to the asylum seeking and refugee patients in their practice. For example, Nurse Campbell (practice nurse, interview), despite previous judgements about whether people were 'genuine' or not, defended the care of asylum seekers at a meeting she was at when dispersal first happened. At this meeting practices were choosing to opt out of caring for them, but she felt a strong ethical responsibility to provide care.

> 'I spoke up and said that's ridiculous; we've got to provide them with healthcare, you can't opt out.' (Nurse Campbell, practice nurse, interview)

In addition to attitudes about the deservingness of asylum seekers and refugees, healthcare workers also adjudicated by changing their consultation techniques to make the process of health access and service uptake easier for asylum seekers and refugees. The use of communication skills and time were the most frequently cited techniques.

Managing health expectations and aiding navigation was an important part of communication, for example explaining the healthcare system, discussing the limitations of a free, universal system such as waiting times, triage of referrals and the GP gatekeeper system. Dr Wright (salaried GP, interview) often felt that she struggled trying to convince asylum seeking and refugee women to make their health a priority over the needs of their husband or family, for example not getting pregnant until a health problem was sorted out. Dr Saeed (GP partner, interview), interestingly, felt that as she shared the same religious background with many of the asylum seeking and refugee women that she cared for it made it a lot easier to understand and discuss their concerns freely.

Dr Smith (salaried GP, interview) described that she would often use time as a tool, for example consulting over several appointments so she could spend a lot of time discussing things in detail. This could be risky as patients often 'seem to

disappear into the mist' and was hampered by the time constraints imposed on consultations by wider system pressures. Dr Grayson (GP partner, interview) acknowledged that the time constraints often make it easy to shy away from difficult issues due to worrying that you may 'open a bag of worms'. However, that if she took the time to listen to the experiences of asylum seekers and refugees, it could make the process of caring for them very fulfilling.

> 'These people were really interesting if you actually spent time to speak to them, like the stuff that happened to them was just bonkers and they just wanted to tell somebody about it. They just wanted someone to listen to them and say look you know I'm not surprised you are pretty messed up. What's happened to you is bad, that's not OK what these people have done to you. It's understandable that you've got a headache because you don't know if your family are alive or dead. That kind of thing and they just wanted time and to be treated like human beings' (Dr Grayson, GP partner, interview)

The findings in this section have shown that adjudication by professionals can take many forms. These range from explicit and implicit judgements of deservingness, which can hamper the candidacy journey, to more subtle changes in communication and consultation skills which can progress the journey.

Softer communication skills could also allow room for disclosure of more traumatic barriers to cervical screening, such as FGM, which will be presented next as a subsection of adjudication by professionals.

8.6 Identification and Discussion of FGM as a Follow Up Service to Cervical Screening

Throughout interviews with healthcare workers, it was identified that cervical screening could be an ideal time for opportunistic discussion and identification of FGM. It was decided to present this as a subsection of adjudications by professionals, as it is a presentation that mostly requires to be enquired about and acted on by health professionals.

FGM was only identified by one of the women interviewed as a likely barrier to cervical screening uptake.

> '…because of how the test is done, you have to go there and lie down and things like that and also you feel like some of our culture there are some cultural, there are some practice people do women on the body part. I don't know if you know what I'm talking about? Yeah I don't know maybe do the circumcision or other different things so some people will not feel comfortable to see a GP really…I think that can be very uncomfortable.' (Souhila, refugee, interview)

Despite FGM only being mentioned by one woman, it was identified as a barrier to cervical screening by several healthcare interviewees. A potential reason for this could be that healthcare workers were asked about FGM directly in their interviews, whereas the women were not for fear of being too intrusive.

Some healthcare workers were not sure whether a smear would be physically possible in a woman who had undergone FGM.

> 'I think it must do because for the folk, for the folk that have had it depending on what degree of it they've had it might be impossible just because their … just doesn't exist or whatever you know the actual procedure might be just not technically not a goer kind of thing because of the way their anatomy is and also I'd imagine if you have been kind of pinned down and had that done to you and been and pain and so on I don't think the idea of someone else ferreting around there would be well received if it was, you know if they could get out of it I'm sure they would.' (Dr Grayson, GP partner, interview)

It was recognised that cervical smear consultations may be an ideal time to screen for FGM and gently discuss this. However, the majority of healthcare workers were not confident in how to recognise or discuss FGM.

> 'Zero percent confident. I think it would have to be fairly obvious for me to notice' (Dr Smith, salaried GP, interview)

There was also uncertainty about what to do once FGM had been recognised. No healthcare interviewee was sure about referral guidelines. Dr MacDonald (GP clinical fellow, interview) mentioned that you could refer to gynaecology for assessment, whereas Dr Grayson (GP partner, interview) questioned what was to be gained by referral, but that it would be important to be aware of it with regards to risk to their children. There was also no mention of the specialist FGM midwife who practiced in the local health board and no mention of the option of de-infibulation for women affected by FGM. Overall, there was a feeling of what

is done is done and that there was nothing available for people once it has happened.

> ‘It depends on the patient; how much they are willing to speak about it…what would you do about it? The damage has been done; you know?’ (Nurse Campbell, practice nurse, interview)

Dr Smith (salaried GP, interview) observed that FGM was often not discussed in consultations, despite her feeling that it was a problem within the asylum seeking and refugee community. She felt that women did not discuss it due to shame or embarrassment.

> ‘They’re still very much victims and feeling to blame for it…I don’t know what their opinion is because they’re not talking about it’. (Dr Smith, salaried GP, interview)

Mathilde (community worker, interview) recalled a workshop that she ran with the women’s group about eliminating violence against women and that afterwards, whilst making food, an informal discussion started about FGM, and some women shared their experiences of it.

> ‘...they have no shame in talking about that if they are just women amongst themselves’ (Mathilde, community worker, interview)

Therefore, it was considered by Sofia (community worker, interview) that whilst the women’s group was the safest perceived space for these discussions to happen, with the correct communication it could also be a medical setting.

> ‘I think women’s group are probably… you know, those kinds of settings, once the group is very consolidated, it’s probably a good example of somewhere you can bring it up and discuss it, and certainly really addressing the potential medical problems around the women having experienced FGM, the best setting for that probably is a medical setting, but it has to be very carefully done.’ (Sofia, community worker, interview)

FGM was considered by healthcare workers as a relatively new topic to be introduced in Scotland with little training offered, awareness raising or information about referral pathways. Dr Grayson (GP partner, interview) had attended some training about it when in Kenya but none in the U.K. She felt the only awareness raising she was aware of in Scotland was the Scottish

Government campaign regarding children returning to countries where it is prevalent in school holidays and therefore more specific Scottish training would be useful.

> 'I feel nobody talks about it because nobody really knows what to do with it. I read more about it in Grazia than I do in medical things' (Dr Smith, salaried GP, interview)

FGM was a theme that emerged throughout the healthcare interviews. It was felt to be an issue but, this was more assumed than known, as it was not often talked about due to uncertainty about the issue. Cervical screening was identified as a good opportunity to open discussions around FGM but in order for this to be effective healthcare workers would need to have training around this, to improve their confidence, improve their awareness of referral pathways, and for possible management options of FGM.

8.7 Offers of/Resistance to Services

This part of the candidacy journey refers to the process of an offer of a service being made, once it has been decided that the patient is a candidate for that service, which may be accepted or refused by the patient. In the case of this research, the service that is being offered is a cervical smear test.

While the literature suggests that uptake of cervical screening is likely to be lower in asylum seeking and refugee women than the indigenous population, 13 of the 16 women interviewed had accepted cervical screening at some point. All but one out of the 13 were up to date with cervical screening. Two of those who had not taken up the test stated that they had not received an invitation and the other did not feel comfortable attending for the test.

The women who had had cervical smears were quite vigilant about making sure they kept up to date with them. Grace (asylum seeker, interview) for example, did not receive an invitation letter for her second smear so she went to the surgery to request it. The two women who had not been invited also discussed that they were planning to ask for a smear the next time they were in the practice now that they had heard about it from friends and during this study.

Fear, embarrassment, and shame were all emotions which were identified as reasons why offers of cervical screening may not be acted upon by Dr Saeed (GP partner) and Dr Wright (salaried GP), in both the host and asylum seeking and refugee population. Souhila (refugee, interview) described discomfort the first time she attended but when she went for the second time it was much easier as she knew what to expect. Three women shared that they were nervous to go for a smear test because they were worried about the result but felt it was best to find out and once, they had attended they believed it had 'boosted confidence' (Aisha, refugee, interview). This demonstrated a realignment in beliefs about cervical screening, compared to the more fatalistic beliefs about it in their country of origin, where there was no adequate treatment to be offered (Section 8.1). Azra (ILR, interview) was happy to take up the offer of the service as it was free.

Four of the healthcare workers commented on their perception of cervical screening uptake by asylum seeking and refugee women in their practice. None of them knew the exact figures. Dr Smith (salaried GP, interview) felt that the uptake of preventive health measures such as immunisations and smears was lower in asylum seekers and refugees compared to the general population, due to lack of knowledge and not considering preventive healthcare as a priority. The other three healthcare workers, however, whilst not knowing the uptake figures in their practice, felt that the uptake of cervical screening by asylum seeking and refugee patients would be high.

> 'They seem keen to get it done… they're even willing to come for it even though it must be traumatic for them.' (Nurse Campbell, practice nurse, interview)

Therefore, the key point from this section is that cervical screening is uncomfortable on many levels. It is painful, embarrassing, culturally taboo and can be traumatic depending on women's past experiences. However, if women are supported, given information and opportunity to attend then many of these barriers to cervical screening can be overcome.

8.8 Operating Conditions and Local Production of Candidacy

This area of the micro-level of the candidacy journey is placed at the end of the seven steps. However, realistically it feeds back into the six steps preceding it. It considers the more local operating conditions that affect the prior steps. The local operating conditions that will be focused on in this section are the resources needed by primary care to facilitate the candidacy journey for cervical screening, particularly education and practice adaptations. Links with community services was also an important recognised resource, which was covered in Section 7.33.67.3.3.

Education for healthcare workers was recognised as a vital resource for facilitating candidacy in relation to cervical screening. Dr Wright (salaried GP, interview) and Nurse Campbell (practice nurse, interview) remembered having some training at the time of initial dispersal to Glasgow, around 1999. Others had not been given any training at all.

> 'No, not at Uni, none as MRCGP, none as a registrar, none at work. I think it could have been done. I think it could have been handled a lot better than it was. Well, it wasn't handled at all basically. I just had to work out, myself, the best way of doing things.' (Dr Grayson, GP partner, interview)

Barriers to training were identified as a lack of motivation and a lack of perceived benefit from training. Interest was also felt to have petered out after the initial panic of dispersal and then it was felt that there was a lack of training being offered in later years.

> 'Just folk couldn't be arsed you know' (Dr Grayson, GP partner, interview)

All healthcare workers felt that they would benefit from more training about working with asylum seeking and refugee patients, except for Nurse Campbell (practice nurse, interview) who felt that she had no training needs. She commented that she would learn through the job and asylum seeking and refugee patients should be treated exactly the same as everyone else. This could

perhaps indicate a lack of understanding around the need for differences in approach to tackle health inequities.

The other healthcare worker interviewees focused their training needs on the background of asylum seekers and refugees, such as where they are likely to come from and what their experiences may be. They wanted further information on how the asylum system works, the role of the Home Office and the role of the GP within this. FGM was expressed as a training need by multiple interviewees, as was the role of third-sector services and working with interpreters. Training of receptionists as a first point of contact was also identified as a need.

Dr Grayson (GP partner, interview) worried that her practice would not be interested in participating in further training and therefore wondered if it would be better to embed it into compulsory training for medical students and in the GP training curriculum.

For the asylum seeking and refugee women, it was felt that further education was essential to increase recognition of candidacy for the cervical screening programme and other preventive health programmes. It was recognised that this is universally important, not just for asylum seeking and refugee women.

> 'Just inform people. Educate people about health because health is the centre of the life of the person. Inform people about what is good for them, what is not good for them, their life, not just the refugee or asylum seeker, even white people. I think many people do not know.' (Aisha, refugee, interview)

Dr MacDonald's (GP clinical fellow, interview) practice piloted educational sessions for newly arrived asylum seekers and refugees to inform them about how the NHS worked and give them written and pictorial interpreted information supplied by the AHBT. They found this helpful in reducing the workload on GP's and managing expectations of the patients.

When the interview process for this project were over, women were very keen to receive more information on cervical screening. Therefore, they were provided with leaflets, in the appropriate language from the NHS Inform website. They were also offered an interpreted information session, but they were happy with the written material. The focus group participants stated they

would discuss it amongst themselves and read it to the women who had low literacy skills. This again demonstrated the power of community and peer support.

The second area that was identified which would help improve the candidacy journey was around specific practice adaptations. The main adaptation was time, which was a thematic thread through most of the candidacy steps.

Four of the interviewees commented that the workload was increased by having asylum seeking and refugee patients as part of the practice population. Increased time for consultations with asylum seekers and refugees, particularly interpreted consultations was felt to be important. This was managed by the practices making in-house adaptations, such as arranging appointments at times of the day where it would cause least stress if running late, such as at the end of a surgery.

> 'Well, I think the thing is if somebody needs time, they need the time and then if you invest a bit of time initially usually you don't need to spend quite so much time with them as time goes on because you have kind of got stuff sorted out' (Dr Grayson, GP partner, interview)

Not every practice prioritised making specific adaptations for asylum seekers and refugees. Dr Grayson (GP partner, interview) described frustration towards her practice as she felt that they were motivated by money when they opted in to caring for asylum seekers and refugees. She commented that the practice took payments from the health board but did not fully invest work or time in caring for asylum seeker and refugee patients.

> 'It could have been a really good job if the practice had been supportive. It could have been really interesting yeah if I hadn't been banging my head off the wall the whole time, worrying about time pressures and stuff but hey ho' (Dr Grayson, GP partner, interview)

This was recognised for other vulnerable groups, where GPs commented that they would like more time to develop services and support for all their patients. An example of this was the introduction of flexible drop-in clinics at one practice, such as a baby clinic, which linked patients to one another so they could support each other and reduce GP attendances. This could nurture positive attitude about what is brought to the practice by caring for these patients and

allow room to feel that they are making a difference, with room to widen out to other vulnerable groups.

As the last step of the Dixon-Woods *et al*. (2006) candidacy figure the operating conditions that were identified in this section of education and practice adaptations could link back into the previous steps to break down barriers to access for cervical screening if they were improved and adequately resourced. However, wider systems pressures could lead to healthcare workers feeling that they were working alone to try and improve care for patients when it should be a practice, health board or even wider societal effort.

8.9 Chapter Summary

The micro-level of candidacy allowed detailed exploration of how asylum seeking, and refugee women identify their candidacy, navigate services and assert their candidacy. It also allowed detailed consideration of how HCWs adjudicate, offer services and the operating conditions within which these therapeutic relationships develop. Flexibility was also allowed, within the candidacy figure, for emerging themes such as utilising cervical screening as a time to identify and discuss FGM. As mentioned in Chapter 7 Operating Conditionsthe Mackenzie *et al*. (2012) figure worked particularly well as a structure for the topic guides but when it came to presenting the results there was some overlap between the different steps, so judgements were made as to where best present findings to avoid repetition. This shall be discussed more in Section 9.3.

Within this chapter, what happened at the intersection of gender, culture, asylum status and language was very important when analysing the journey through the micro-level of candidacy and identifying key points where women were more vulnerable, isolated or felt that their deservingness was being called into question.

Culture was a prominent thematic thread throughout the micro-level candidacy journey for cervical screening. Cultural beliefs affected women's identification of candidacy for cervical screening, particularly as they often aligned with the identification of risk factors which were taboo, such as multiple sexual partners.

However, on moving to the U.K. despite continuing to have the same religious beliefs and many of the same cultural practices they realigned their feeling of risk and were keen to take up the offer of cervical screening.

Cultural competency was important in the provision of cervical screening. Primary healthcare workers were shown to have a pivotal role in making women feel comfortable, informing them of the importance of cervical screening and also being an anchor for women to rely on when they were in the unstable environment of the asylum system. The culture of the practice was also important. The healthcare workers interviewed were a self-selected group, who were invited and then volunteered for interview due to their experience and interest in working with asylum seekers and refugees. However, not all their colleagues may feel the same and may be constrained by wider system pressures. There were also repeated disconnects between the intentions of GPs and the actual practice that was happening. For example, believing that they are open to treating everyone equally but not recognising that their practice policies around registration or discriminatory attitudes in reception staff would create a significant barrier for access.

Discomfort was another theme in the findings. Women had to overcome the fear and embarrassment of, and then deal with the physical discomfort of the smear examination. They also had to build trust with the health professional to overcome the discomfort of discussing previously culturally taboo issues, such as sexual health. Healthcare workers also expressed discomfort and a lack of confidence in broaching conversations around potential past sexual trauma or FGM, which was compounded by language barriers and uncertainty in how best to use interpreters. Again, it was felt that there was not enough time to properly build relationships and navigate this discomfort.

A disconnect between healthcare worker and women's interviews was noticed around gender-based violence and FGM. Gender based violence was identified by the women interviews but not by healthcare workers. Gender based violence should be an area which healthcare workers are able to broach in all women but may be impeded by language barriers, especially if husbands or children are used as informal interpreters, which adds another layer of inequity and further limits women's ability to get help. FGM was the opposite and was assumed to be

a barrier to screening by healthcare workers but was not identified by the women in the interviews and had not been specifically asked about by any of the healthcare workers. Therefore, this was an example of a cultural assumption by healthcare workers.

It was not known if this was not mentioned by women in the interviews because they assumed knowledge of the interviewer, didn't feel comfortable disclosing it, didn't feel it was relevant or because they were not asked about it specifically.

The next chapter, Chapter 9 Discussionis the final chapter of this thesis and it will pull together the findings from this thesis to compare to what was already known in the literature, analyse the use of the theories used, consider the impacts this thesis has made and make recommendations for future work and improvement of care for asylum seeking and refugee women.

Chapter 9 Discussion

The three data chapters (Chapter 6 Newspaper Analysis: What discourses are constructed in the U.K.'s print media around asylum seekers, refugees and health?Chapter 7 Operating ConditionsChapter 8: Cervical Screening Negotiations- Micro-Level Candidacy) presented the findings of the newspaper analysis and qualitative individual and focus group interviews. These gave insight into the discourses of deservingness constructed in newspapers around asylum seekers, refugees, and health. They also explored the internalisation of these discourses by asylum seeking and refugee women, community workers and healthcare workers caring for them. The operating conditions or contexts that women access healthcare within were explored, using the macro- and meso-levels of candidacy as a framework. Finally, the micro-level journey of candidacy was explored to consider in more depth the interactions of asylum seekers, refugees and healthcare workers to move through this journey in order to identify and assert candidacy in order to receive cervical screening.

This discussion chapter brings these findings together and considers the contribution to knowledge that this thesis provides through exploring the aim of:

> Identifying and exploring the factors that influence how asylum seeking and refugee women access preventive healthcare, using cervical screening as a case study.

It then considers the use of intersectionality and candidacy as complimentary theories and how the concept of deservingness intertwined with them, to allow a deeper understanding of the complexity of health care access facing asylum seeking and refugee women. An important part of qualitative research is acknowledging the positioning of the researcher within the research. Therefore, Section 2.19.4 provides a personal reflection on my role within this research.

The limitations and strengths of the research will be considered and the impacts that it has generated thus far shall be presented. Finally, recommendations for health care, health policy and future research, including the use of candidacy, intersectionality and deservingness as a combined framework shall be made.

9.1 Key Findings

This section summarises the key findings from this thesis and then the next sections place these within the wider literature and theoretical frameworks to consider what they contribute to the current knowledge around this subject and the theoretical frameworks used.

A key finding in the newspaper analysis was the hostile environment that is created through punitive immigration policies and recurring media discourses which portray asylum seekers, refugees, and migrants as faceless but threatening groups. The repeating themes in the media were internalised by the women, healthcare workers and community workers interviewed even when reported in publications that they did not read.

Newspaper discourses also pervaded into access to healthcare, by undermining entitlement policies and replacing them with judgements regarding deservingness. Entitlement was undermined by staff attitudes, particularly those in reception; internal practice policies around registration; worry about judgments of deservingness being made if healthcare workers found out they were asylum seekers or refugees; and women feeling that they had to defend their identities as asylum seekers and refugees or perform in a way that would be found deserving.

The asylum system was found to be all consuming (Isaacs *et al.*, 2020). It controlled and monitored women's lives, often to the point of exacerbating their vulnerability, created instability, and took priority over health needs. Women were also controlled and monitored in other parts of their lives due to their gender and expected roles. However, community organisations, churches and mosques were recognised as providing women with a safe space to create support networks, advocate, and signpost for other services, such as health. Therefore, women identified, asserted, and navigated their candidacy for cervical screening within a hostile, controlled and often unstable environment.

Low- and middle-income countries, where most of the women came from, have a much higher burden of cervical cancer cases and deaths compared to high-income countries, such as the U.K. (Gakidou, Nordhagen and Obermeyer, 2008;

Finocchario-Kessler *et al.*, 2016; Jassim, Obeid and Al Nasheet, 2018; Arbyn *et al.*, 2020; Ginsburg and Horton, 2020; Mahumud *et al.*, 2020). However, despite this, prior to coming to the U.K. women did not identify themselves as candidates for cervical screening. This was mostly due to not feeling that the risk factors for cervical cancer aligned with their individual cultural beliefs, behaviours, or religion. On moving to the U.K., however, they realigned their feeling of risk and felt that the risk was higher. This was not due to any changes in their individual cultural or religious beliefs but due to the culture in the U.K. being more open about sexual health, more advertising of cervical screening and the awareness that an effective treatment was available. It had been assumed from the findings presented in the cervical screening literature review that cervical screening uptake amongst asylum seeking and refugee women would be low, as it is amongst migrants compared to the host population (Bischoff *et al.*, 2009; Ivanov, Hu and Leak, 2010; Aminisani, Armstrong and Canfell, 2012; Vahabi and Lofters, 2016; Åkerman *et al.*, 2017; Leinonen, Campbell, Ursin, *et al.*, 2017; Gorman and Porteous, 2018; Hertzum-Larsen *et al.*, 2019). However, in this study uptake was high, with 13 out of 16 of the women having undergone cervical screening. This may have been due to the support of the AHBT when the women arrived, or to other reasons but is certainly worth further exploration. The changes to the wider culture around sexual health led the women who were interviewed to welcome the notion of screening and preventive medicine in general.

Despite this change in attitude and willingness to get a smear test in the women interviewed, wider access and support issues were identified which could hamper this. These shall be explored in the next section.

9.2 Contribution to Current Knowledge

This thesis is the first study that the author is aware of that explored health access for asylum seeking and refugee women in the U.K. with regards to cervical screening. It adds to the wider cervical screening literature, as asylum seeking, and refugee women have previously been underrepresented and provides insights into the issues that may present for this population in other screening programmes. It also contributes to the gap identified in the wider

literature by incorporating the viewpoints of primary care healthcare workers and community workers. This study explored the complexity of health care access and provision. Using a case study, a combination of theoretical frameworks and triangulation of data, it explored structures and individual experiences, from multiple viewpoints: triangulating data from asylum seeking and refugee women, community workers, healthcare workers and the mass media. It contributes to the current knowledge in the fields of migration health, health care access, health inequalities and theoretical studies, through the combination of the theories of intersectionality, candidacy, and the concept of deservingness.

Several of the findings with regards to inequality in access, in this thesis, were related to or intersected with gender inequality. For example, prioritising the health of others, inequalities in access such as having to find childcare and finding the test uncomfortable, are universal barriers for all women attending smear tests as they limit women's overall flexibility to present at services for cervical screening (Abdullahi *et al.*, 2009; Marlow, Waller and Wardle, 2015; Leinonen, Campbell, Klungsøyr, *et al.*, 2017; Wilding *et al.*, 2020). However, in addition to these wider universal issues that women face in accessing cervical screening, this thesis in agreement with the wider literature argues that asylum seeking, and refugee women have an extra layer of work due to the intersection of their asylum status with issues such as poverty, gender, race, cultural and religious beliefs. The asylum system was found to be unwelcoming, controlling, and overwhelming: creating constant stress, fear and instability for asylum seeking and refugee women (WHO and IOM, 2010; Onyigbuo, Alexis-Garsee and van den Akker, 2018; Babatunde-Sowole *et al.*, 2020; Farrington, 2020; Isaacs *et al.*, 2020).

Healthcare workers expressed frustration that they had little influence on the asylum process. In addition to this they were also operating within their own pressurised system-the health system. GPs were keen to be advocates for their patients, but they had limited space and time within the health system to do this. Primary healthcare workers who care for asylum seekers and refugees are likely to work in practices which are in socioeconomically deprived areas, where there are competing clinical priorities and populations with complex health and social care needs (Sim and Bowes, 2007; Mulvey, 2009).

However, it can be argued that if healthcare workers provided interpreted consultations, with a professional interpreter; nurtured cultural understanding; and were aware of the vulnerabilities that the asylum system causes, then asylum seeking and refugee women could be empowered to make autonomous healthcare decisions in a supportive environment (Kelaher et al 1999, Carroll et al 2007, Mengesha 2018). This was seen with the women interviewed, who welcomed the decision to take individual control of their health when offered cervical screening in an informed and supportive way. Cervical screening can also be viewed as a 'female-focused' health intervention, which tends to be performed by a female health worker. Hence, if given adequate time and training it can create a safe space to ask about sexual health, gender-based violence, FGM and any other potential intersecting factor which may be affecting women's overall health and wellbeing (Sabates and Feinstein, 2006; McSherry *et al.*, 2012; Mengesha *et al.*, 2018; Åkerman *et al.*, 2019; Wilding *et al.*, 2020). In addition, there would be an opportunity to reinforce their deservingness and entitlement for healthcare and support their candidacy for cervical screening.

Feelings of deservingness were repeatedly identified in all of the data chapters as being vital in the assertion of candidacy and in accessing healthcare. Unfortunately, deservingness can be eroded, and candidacy halted if asylum seekers and refugees perceive hostility in wider asylum policies and public discourses, as is found in the hostile environment. This may erode trust in institutions such as the NHS and affect the relationship that is needed with healthcare workers to work through the steps of the micro-level of candidacy (International Organisation for Migration, 2018). For example, the anxiety that was found within the interview findings about having asylum status recorded in medical notes was a result of wider structural impacts affecting trust in a clinical encounter and that it was a judgement of their deservingness. The label of asylum seeker had been used in a destructive, non-supportive way within wider structures and discourses of deservingness, including the asylum system itself, so it is then perceived as a negative judgement within an individual, potentially supportive, clinical interaction.

Another example of the wider hostile environment affecting candidacy is that media discourses also created confusion about entitlement for healthcare. In

addition to discourses of deservingness, little distinction was made between entitlement for different migrant groups or in Scotland compared to the rest of the U.K. This combined with poor knowledge of the entitlement policy by healthcare workers led to judgements of deservingness forming the basis of decisions about entitlement being made within practices, rather than following legal policy entitlement, which is in keeping with previous findings (Holmes, 2012; Medecins du Monde, 2016; Smith, 2016; Chase *et al.*, 2017; Kline, 2019). These judgements were often enacted by reception staff, with little challenge seen by the GPs in this study. Negative interactions with receptionists have been identified in other studies, which creates an extra layer of often unnecessary gatekeeping to healthcare access (O'Donnell *et al.*, 2007; Lindenmeyer *et al.*, 2016; Kang, Farrington and Tomkow, 2019). Issues with registration across the U.K. and registration refusals, which contravene NHS guidelines, are also unfortunately commonplace and have led to campaigns such as the Doctors of the World Safe Surgeries[8] and Docs not Cops[9] (Mulvey, 2009; Doctors of the World, 2018; Kang, Farrington and Tomkow, 2019). Barriers to GP registration, because of practice cultures such as these, stop candidacy assertion in its tracks and means that there is lost opportunity for illness prevention. It is argued that this could be particularly harmful for women who have identified their candidacy for cervical screening through an invitation letter and then are denied assertion of this candidacy at the first contact with primary care.

The perceived hostility that asylum seekers and refugees internalise from media discourses is justified. The media could respond to the arrival of new populations into communities, where resources are already stretched and inequalities present, in a supportive way by campaigning for fairer policies, integration and exposing inequalities (Philo, Briant and Donald, 2013 p165). Rather, as reported in this thesis and in the wider media literature, it does not do this. Instead, it often chose to scapegoat asylum seekers and refugees, perpetuate myths and repeat hostile themes, and has done this repeatedly for

[8] https://www.doctorsoftheworld.org.uk./what-we-stand-for/supporting-medics/safe-surgeries-initiative/

[9] http://www.docsnotcops.co.uk

decades (Mollard, 2001; Khosravinik, 2009; Innes, 2010; Philo, Briant and Donald, 2013; Parker, 2015; Cooper, Blumell and Bunce, 2020).

Media reporting around asylum seekers and refugees is reductive as it does not reflect the wider context or the complexity of their lives (Coole, 2002; Smart *et al.*, 2005; Philo, Briant and Donald, 2013). Individual asylum seekers and refugees were rarely presented in the media as full and complex human beings with jobs, education, personal histories, and families, and again this has not changed in more recent times (Bennett *et al.*, 2015; Martin and Weerasinghe, 2017; Eberl *et al.*, 2018; Armbruster, 2019; Heidenreich *et al.*, 2019; Pruitt, 2019; Cooper, Blumell and Bunce, 2020). As was also found in the health media analysis, on the rare occasions where migrant, refugee or asylum seeker voices are heard they are there to discuss individual experience and are not given the opportunity to develop their arguments or challenge political authorities, which further reduces the agency of these groups (Cooper, Blumell and Bunce, 2020). This leads to a lack of balanced reporting and understanding of the issues by the British public: but it also leads to poor coverage of the issues faced by migrants in the U.K., and a dampening of their political voice.

This is in keeping with some women who were interviewed explaining that they felt more comfortable with media sources that they knew engaged positively with migrant groups, such as Migrant Voice or the Herald, a Scottish broadsheet newspaper. Al-Jazeera, was a preferred news source, as it retained some aspects of their national or ethnic identity (Martin and Weerasinghe, 2017). However, feeling uncomfortable with mainstream media sources in the U.K. this could further isolate women from being aware of issues and important messaging that may affect them, such as the Jade Goody effect, and their integration with the wider community.

Women internalised media messages and felt that they had to defend their positions as asylum seekers, refugees and in some cases Muslims. Women were particularly vulnerable in this situation as they wore identifiable religious dress such as the hijab. They would do this by trying to start conversations with the host community, dispel myths, share food, and as mentioned above, attend for health appointments if they felt it was expected of them. This is in-keeping with findings from the literature that individuals often try to counteract the negative

effect of the media by working to portray themselves as productive citizens or 'good', deserving refugees (Huschke, 2014; Martin and Weerasinghe, 2017).

Community support organisations or groups however gave women a space where they did not need to enact deservingness. Similar to engaging with media from their country of origin, they were able to feel like themselves, let their voices be heard, regain their identities out with their asylum status and for some enjoy the elements of activism involved. Such organisations are also facilitators to integration with the wider community (Sim and Bowes, 2007; Wren, 2007; Ager and Strang, 2008).

These examples of the macro- and meso-level operating conditions of the asylum system impacting on micro-level interactions emphasise the importance of healthcare workers having an awareness of the context and pressures within the asylum process, as well as the support structures available. Cultural competency was identified as important in the provision of cervical screening. It was recognised by all groups of interviewees that spending time getting to know asylum seeking and refugee women, using culturally appropriate verbal and non-verbal communication, independent interpretation services and understanding their background could aid the therapeutic relationship, improve health literacy, and the candidacy journey (Kelaher *et al.*, 1999; Carroll *et al.*, 2007; Mengesha *et al.*, 2018; Piacentini *et al.*, 2019). Healthcare professionals need to actively work at addressing worries, such as communicating the purpose of recording potentially stigmatizing labels in patients' medical records. This is particularly pertinent as these concerns are not baseless, as the Home Office has previously requested data from healthcare systems in England for immigration enforcement (Abubaker *et al.*, 2018; Hiam, Steele and McKee, 2018). It is also an important issue to reassure as there is a current push for ethnicity monitoring in order to monitor inequalities in Covid-19 mortality and vaccine uptake (Public Health Scotland, 2021b). As Young *et al.*(2018) found distrust in health services, as a perceived extension of the Government, can be reduced by building relationships between patients and health providers. Within cervical screening discussions it is important to make time for explanation of the test, the risks, benefits and to make clear that it is not compulsory or reported back to any external officials.

Healthcare workers positive attitudes towards cervical screening have been shown to have a powerful effect on women's uptake (Labeit and Peinemann, 2017). Within this thesis, however, there was a reliance on the part of the healthcare workers on the national call, recall system for cervical screening, with little work put in to promoting cervical screening directly to asylum seeking and refugee women. In this work and in the wider literature healthcare staff also made assumptions of what women would be comfortable talking about which is a barrier to care as they are not being given the opportunity to discuss issues such as sexual health due to cultural assumptions (Gott *et al.*, 2004; Vahabi and Lofters, 2016). Active opportunistic discussion and education about sexual health and cervical screening can be argued to be even more important in this group as it is often a new concept for them (Vahabi and Lofters, 2016; Willems and Bracke, 2018). Therefore, there is potential benefit in making the healthcare worker a more active participant and facilitator in the micro-level candidacy journey with the patient.

Improving cultural competency and decreasing barriers to access is essential, especially as the hostile environment does not look like it will abate anytime soon in the U.K. Brexit, the proposed Nationality and Borders bill (2021), and the Covid-19 pandemic are all examples of this.

Covid-19 is a further example of how precarious the situation of asylum seekers is in the U.K. The Covid-19 pandemic has made the intersection of inequalities that asylum seekers and refugees experience (poverty, ethnicity, asylum status) even more dangerous as these are all factors which increase the social burden and mortality from Covid-19 (Greenaway *et al.*, 2020; McKee, Pearce and Leahy, 2020; Scottish Refugee Council, 2020; Knights *et al.*, 2021). Asylum seekers had a further stripping of rights during the pandemic. Many were moved to hotel accommodation, with little provision for social distancing and concerns about provision of hygiene and sanitation products (Scottish Refugee Council, 2020, 2021; The Guardian, 2020; Refugee Council, 2021a). Asylum claims were put on hold creating further uncertainty and anxiety (Doctors of the World, 2020). There was no uplift in asylum support payments comparable to that of universal credit, therefore asylum seekers had no assistance with the additional financial pressure of the covid pandemic (Refugee Council, 2021a). Through being moved out with catchments of the GPs they were registered with and health and

community services being suspended or changed, asylum seekers have become increasingly vulnerable to isolation and health care access barriers (Knights *et al.*, 2021).This in turn causes problems with vaccine access and hesitancy in these groups, further increasing their risk from Covid-19 (Knights *et al.*, 2021). This emphasises again the effect of the asylum system on health inequalities and the extra layer of work that this causes at an individual level due to the intersection of asylum status with ethnicity and poverty as inequalities.

As will be discussed in the next section, combining candidacy, intersectionality and deservingness worked well to explore health access for this group. Suggestions will be made about ways in which they could be combined into one framework to allow deeper exploration of health care access in vulnerable groups, something which will be needed in the post-covid recovery period.

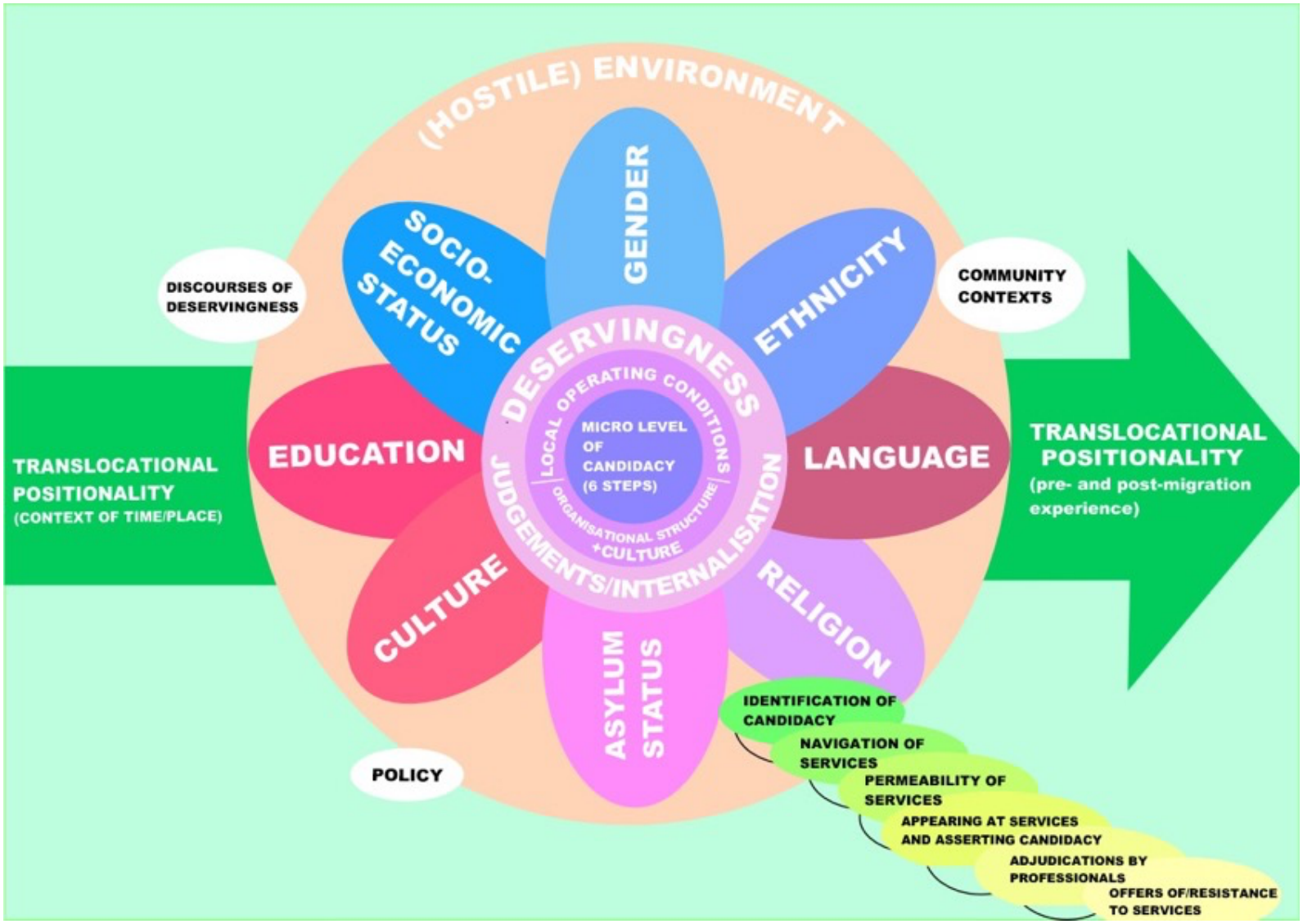
9.3 Using Candidacy, Intersectionality and Deservingness Together to Further Understanding of Health Care Access

Cervical screening worked well as a case study for asylum seeking and refugee women's access to preventive healthcare and to explore the use of candidacy with an intersectional lens. It covered a wide age range of women, and a specific invitation was sent therefore prompting the consideration of whether they identified as a candidate. This system approach to issuing invitations should create equality in access to cervical screening as all women of eligible age were invited, no matter asylum status, socioeconomic position, religion etc. However, despite the equality of invitations there remains inequalities in access to healthcare to receive the test. A recognised benefit of case studies as a methodological approach, is the level of flexibility within it, to allow for further exploration of inequalities and barriers to access such as gender, asylum status and culture, in addition to the emerging themes of FGM and religion (O'Donnell *et al.*, 2011; Ebneyamini and Sadeghi Moghadam, 2018). It also allowed for theory development and consideration of how the theoretical frameworks could be best used (Yin, 2003).

MacKenzie *et al*. (2014) considered how intersectionality and candidacy can be used together and found that, together, they could potentially develop a deeper, 'more nuanced structural understanding(s) of women's experiences and constraints' (p1). This thesis put this into practice, demonstrating that they complement each other well as theoretical frameworks and will go onto argue that deservingness as a concept is also integral to using these theories in a combined way.

This study also found that, like the work of Mackenzie *et al*. (2012), the Dixon-Woods *et al*. (2006) model of candidacy was enhanced when it was visualised that the micro-level, patient and healthcare worker journey, was surrounded by macro- and meso-level factors to show the influence that these had on individual consultations. Cervical screening identification, assertion, navigation, and acceptance do not happen in a vacuum. Migrant status, gender inequalities, public discourses of deservingness and macro- and meso-level organisational structures all influence assertions of candidacy. By designing the individual interviews and focus group topic guides around the Mackenzie *et al*. (2012) figure a framework was provided within which to explore both the wider influences and the individual candidacy journey. However, the figure was always intended as a guide not a rule book to this approach and as was shown, the findings often straddled two or more areas of the figure. It was also found that the influences of each level on the other was not as straightforward as the Mackenzie *et al*. (2012) suggested: they often intersected or influenced each other more directly rather than surrounding each level. Therefore, this study has developed the Mackenzie 2012 figure to show these direct and intersecting relationships between levels, as well as combining intersectionality and deservingness into the figure (Figure 15).

Figure 15: Combined Intersectionality, Deservingness and Candidacy Figure



When describing this figure, it will be described in the context of this study but as will be discussed it could be transferrable to other studies or populations. The figure moves away from the macro-and meso-levels surrounding the micro-level of candidacy. Instead, it has a wide circle to demonstrate the environment within which asylum seeking and refugee women operate. In this case this is referred to as the hostile environment which consists of discourses of deservingness, policy, and community contexts.

The eight petals, incorporate intersectionality, as they represent identities and their intersections which are likely to affect asylum seeking women. These identities also incorporate several of the factors which were in the original Mackenzie *et al.*(2012) macro- and meso-levels. Figure 15 showed an example of identities and their intersections which were likely to be found in this study, however, these were expanded after the qualitative interviews to include culture, religion, education, and language as additional intersecting identities. These identities cross over from the wider environment into the micro-level of candidacy in Figure 15, as they operate at all levels and within this thesis it was shown several times how factors previously thought to operate at the macro-level, such as asylum status, affect micro-level interactions. This is important in gaining a wide understanding of health care access and could be considered when designing services to improve health access for this, or other marginalised, populations.

Translocational positionality (see arrow in Figure 15) was an important concept, within intersectionality, for this study (Anthias, 2008, 2012). It takes account of the effect of pre- and post-migration experiences, seeking asylum and the context of time and place on women's identities. Identities change due to these experiences and change in place. For example, the loss of professional status could contribute to vulnerability and inequality both in and outside the home by increasing isolation through lack of opportunities to learn English or integrate further. For other women, however, their positionality changed to give them more freedoms and over time helped them tackle inequalities through accessing education.

In addition to the complementary theories of candidacy and intersectionality the concept of deservingness weaved throughout this thesis and was explored in a

deeper way within the media analysis and the impact of the hostile environment that the media creates on the candidacy journey for asylum seeking and refugee women, healthcare workers and the community workers who often had a signposting role. However, this thesis argues that deservingness requires to be highlighted and embedded more explicitly as part of the candidacy journey.

As Koehn (2009) observed, the first step in negotiating healthcare is knowing that you require and deserve it. Therefore, judgements and internalisation of deservingness have been placed in Figure 15 surrounding the micro-level of candidacy, as they are a key factor in deciding whether the micro-level journey of candidacy continues. Another reason for it being placed as a circle surrounding the micro-level of candidacy, within the wider environment circle and with all the identities of intersectionality crossing it is because deservingness can be influenced from all these directions not only the wider environment and discourses of deservingness. For example, as Calvo, Jablonska-Bayro and Waters (2017) described, an individuals' understanding of their place in society comes from not only legislation but also whether they are treated with respect or fairness in public spaces.

The Dixon-Woods *et al.* (2006) micro-level of candidacy was not necessarily meant to be seen as a linear process and there was recognition that each step can influence the others in a non-linear way. However, it is suggested by this work that the seventh step (operating conditions and local production of candidacy) works better if it surrounds the micro-steps of candidacy rather than being visualised as the last step. This is for two reasons. Firstly, it had a lot of potential overlap with the wider operating conditions in the Mackenzie *et al.(*2012) figure, so by having it surrounding the micro-level it demonstrates that these are more local operating conditions but also allows room for the consideration of the effect of wider operating conditions on the local ones. Second, the local operating conditions that were identified in this thesis were primary care resources and community services, both of which affect every step of the micro-level steps of candidacy. Therefore, it was felt to work better as a surrounding factor rather than a last step. Having developed the conceptual thinking of the model, it will be important to think about how it can be further tested.

When performing qualitative research, particularly that informed by intersectionality, it is important to maintain researcher reflexivity (Clark *et al.*, 2009; Hankivsky *et al.*, 2010). Therefore, the next section will describe how AB considered her influence and positioning with the interviewees, particularly the focus group.

9.4 Researcher Influence, Positioning and Personal Reflections

As described in Section 5.4.1.1 Asylum Seeking/Refugee Women and Community Workers, I spent six months engaging with the women who were taking part in the focus group. During the period of engagement, I was open with the women about my life, sharing stories and experiences. As part of this I shared that I was a GP trainee in addition to being a PhD student. This led to the women referring to me as 'Dr Anna' despite my request that they call me Anna. The women were also sometimes nervous about saying negative comments about their GP's as they knew **I** was training to be one. However, it was felt that by having such a long, regular weekly engagement process, **I** was able to build up their trust and I also actively tried to separate my identities as a PhD student, GP, and woman during the engagement process. I attended the women's group on a weekly basis, took part in the activities, cooked, and ate lunch with them. This allowed me to be seen as a woman and active participant in the group. I refrained from being drawn into giving medical advice during engagement, focus groups or individual interviews, although I did signpost after the interviews if asked and offered the provision of cervical screening leaflets in different languages.

By gaining trust with the group, they were happy to help recruit women for individual interviews who were out with the group. There was not as much engagement with individual interviewees but several also asked me to perform interviews in their home and provided snacks and hospitality for these, which was accepted as being an important cultural part of meeting and very much enjoyed by me as part of the process. In addition to the women in the group making these introductions easier with some of the interviewees recruited, the interpreter also helped with this. The Arabic interpreter who was used for most of the interviews that required interpretation was picked by the women's group.

She was well known to them, worked for an approved interpreting agency and had also been through the asylum process so they felt very comfortable with her. She also volunteered to be one of the individual interviewees and recruited several participants for the study.

My identity as a woman changed considerably over the nine years taken to complete this thesis. When it started, I was single and a GP trainee. Over the time of the research, I got married, developed a chronic illness which has led to me identifying as having a disability, became a mother, qualified as a GP and took on leadership positions within Public Health and Human Rights. As these identities changed it changed my positioning with the women who were engaged with and interviewed in focus groups and individual interviews, both directly at the time and on reflection. An example of this is when the women's group hosted a hen party for me after the focus groups were completed and shared marriage advice and cultural traditions. They had the curtains drawn, took off their head scarves and swung their hair as a celebration of womanhood in a safe, trusting space.

Figure 16: AB at hen party arranged by women's group

I reflected upon my experiences with the women's group in a blog for the University of Glasgow's GRAMNet[10] personal reflections series, where contributors offered reflection on their day-to-day interactions with migrant issues (Appendix 18: Gramnet Blog: The Divides That Bond Us). My contribution considered my position as a woman within this group compared to another female only group.

[10] GRAMNet is a network funded by the University of Glasgow which brings together researchers, practitioners, NGOs and policy makers working with migrants, refugees and asylum seekers in Scotland https://www.gla.ac.uk/research/az/gramnet/

As mentioned above, when engagement with the women's group was first initiated, I was called 'Dr Anna'. I was served first at the weekly shared lunch. As time went on, I worked hard to try and decrease the amount of power I was perceived to have in the group, by getting involved in the cooking and helping with the serving for example. I was also aware of the openness within the group about issues at home which were often due to gender inequality and how this differed from my experiences at home. As one of the community workers interviewed observed, it could be quite difficult not to become involved in the conversation around what we would expect fairer gender roles to be. It was important for me to remember that, whilst being aware of any safeguarding issues, that I was in a very different position when it came to demanding equality in the home as a white, independently socioeconomically stable, professional woman with British Citizenship. An example of this being particularly challenging was when an interpreter and I went to a woman's house to conduct an interview and her husband wanted to sit in on the interview. When we discussed that it may be easier to be just women, he insisted on bringing a chair to outside the door and leaving the door open. This felt very uncomfortable but the woman being interviewed told the interpreter that she knew that was as much privacy he would afford her, so we had to continue with him listening.

As will be seen in Section 2.19.6, I continued to be part of the women's group, at their invitation, after the data collection for this thesis was finished. At this point my relationship with the group changed again and several of the women worked in partnership with me to produce impact work. This included becoming involved as members of the board that governed the charity which provided the women's group, co-producing videos for BBC the Social and more recently being directly involved in designing and giving training to healthcare workers about caring for asylum seekers and refugees.

Moving from the researcher, participant relationship to partnership working has, for me, been the best outcome from this thesis. Even better, many of the women are now leading in areas of activism within their community and workplaces, as a number have received leave to remain and are employed, often in community development.

9.5 Strengths and Limitations of this Research

A strength of this thesis, as discussed above, is the relationship and trust that was built up between the women who participated, particularly the focus group. This led to a depth and breadth of information being collected which gave a richness to the data. It also led to easier recruitment of other women. The focus groups took place over three separate sessions (with the topic guide divided into three) to allow a deep dive into the issues and ensure details were not missed due to time constraints. A further strength was the flexibility allowed in the interviewing process for children, either by them being present or, as was the case in the focus group, childcare being provided by community workers in an adjacent room. Accommodation was also given to timing, holding the focus groups over the lunch of the women's group to not interfere with their normal timings and routines. Women were also free to arrive late and leave early as needed, to be as inclusive and accommodating in the process as possible.

Another strength was the multiple perspectives and triangulation of data through a multiple methods approach. In addition to the asylum seeking and refugee women interviewed, community workers, GPs and Primary Care Nursing staff were also included. This allowed different perspectives with regards to the candidacy journey, structural inequalities, and health access issues. Cervical screening as a case study also worked well as a jumping off point for exploring health care access and inequality issues pertinent to women within the individual interactions, health care system and wider societal structures.

Limitations in the recruitment of participants included not recruiting socially isolated asylum seekers and refugees. Most interviewees were either recruited through the women's group or contacts of theirs or through the Scottish Refugee Council. This is a common problem in qualitative research with marginalised populations and efforts were made through the flexibility in the process and different recruitment methods. These included snowballing from the women's group and the Scottish Refugee Council advertising for participants. Through recruiting community workers and healthcare workers into the study they were able to share some of the issues that their more isolated patients or service

users faced, although it is recognised this is not equivalent to hearing directly from those who are experts by lived experience.

As described in Section 5.4.1.2 Primary Healthcare Workers, primary healthcare workers were recruited by targeting practices which were known through the LES data (see below) to have asylum seeking and refugee patients registered with them. Therefore, the healthcare workers had experience in caring for these patients which contributed to the richness of the data; however, by not recruiting from practices who did not routinely care for asylum seekers and refugees this may have limited knowledge about what training or information is required more generally. This is important now, as asylum seekers are being housed more widely throughout the city and as was the case with the Syrian Vulnerable Persons Resettlement Programme, dispersed out with Glasgow. However, basic information such as entitlement policies were not well known even in experienced practices taking part in this study. Therefore, as will be seen in Section 2.19.7, a recommendation is made for better dissemination and training regarding entitlement and caring for this population generally. The numbers of healthcare workers (7) and community workers (2) interviewed was smaller than the number of asylum seeking and refugee women (17). Whilst more healthcare workers and the inclusion of reception staff would have been desirable, this was out with the capacity of this study. There was, however, enough data collected to enable triangulation of findings.

Something that would have strengthened this thesis would have been quantitative data about the uptake of cervical screening by asylum seeking and refugee women in Glasgow compared to that of the host population. This was attempted but as described next was not possible. At the time of this study there was no routine collection of cervical screening uptake by specific populations, such as asylum seekers and refugees in Scotland. Therefore, for the purposes of identifying uptake of cervical screening in this population a method of data linkage between asylum seekers and refugees CHI (individual health identification numbers) and the SCCRS database was devised.

As described in Section 5.4.1.2 Primary Healthcare Workersthere was a LES for asylum seekers and refugees in Glasgow, which paid practices for the additional workload of caring for this population and required collection and reporting of a

minimum dataset relating to this patient population which included: name, address, date of birth and gender. The CHI number, however, was not recorded as part of this LES.

To facilitate a data linkage the health board screening team agreed to match names and date of birth information with CHI numbers. The CHI number was then to be used to perform a data linkage with SCCRS which stores the details of every woman invited for a smear in Scotland and whether this invitation was taken up or not.

The data was to be anonymised and aggregated into 5-year age bands before being passed to AB who would not have access to any patient identifiable data. This work was to be carried out by NHS Greater Glasgow and Clyde Department of Public Health and the Scottish Cervical Screening Programme.
The percentage of asylum seeking and refugee women attending for a cervical smear in the past five years were to be compared with nationally available data published on the ISD website[11].

This data uptake was discussed with the relevant clinicians in Public Health whose staff would conduct the data linkage on our behalf. Both agreed to this work. In addition, a formal application was made to the Data Group for permission to access and link data from the asylum seeking/refugee LES and this was approved in May 2013. Caldicott Guardian approval was also granted. It also formed part of the original ethics application for this study (Appendix 17: Ethics Approval).

This data linkage and analysis, however, was not possible. First technical difficulties due to data storage in the LES database meant data could not be extracted in any meaningful way to send it to the Health Board Screening Team for data linkage. Therefore, another source of asylum seeker and refugee CHI numbers was sought. It was discovered that the practices who were part of the LES collected cervical screening data and sent the information to the LES team

[11] http://www.isdscotland.org/Health-Topics/Cancer/Cervical-Screening/).

in an annual report. Unfortunately, however, the data was not collected in a way that could be used for research purposes.

While consideration was given to attending individual practices and performing searches for any patients coded as asylum seekers and refugees, due to resource limitations this was felt to be impractical and would not have provided sufficient data to be useful.

Therefore, it was decided that central linkage of Scottish data of asylum seeker and refugee was not possible, hence information about uptake of cervical screening in asylum seeker and refugee women relied upon that available in the literature reviewed in Chapter 4 Literature Review: Cervical Screening for Asylum Seeking and Refugee Women This does however highlight a difficulty in monitoring inequalities and trends within them, in this area if the data is not available to do so.

9.6 Generating Impact

This study has generated meaningful impact over the nine years that it has been conducted, with some pieces of impact work conducted in partnership with asylum seeking and refugee women.

An example of this is work done with BBC the Social. BBC the Social is BBC Scotland's social media enterprise, broadcasting across 5 different social media platforms, aimed at 18–30-year-olds, and reaching an average of 29 million people at the time that AB worked with them. AB in partnership with asylum seeker and refugee women produced two VLOGS (video blogs) for BBC the Social in 2016. The first was for International Women's Day and asked asylum seeking and refugee women 'what is it like being a woman in Scotland compared to the country you came from?'(https://www.youtube.com/watch?v=2onP_DO6LDY). This reached 89,000 people and was featured in the BBC Scotland News. The second VLOG interviewed women about Headscarves, the reasons for wearing them or not, and the controversies that can surround them (https://www.youtube.com/watch?v=KPD0hLcyI80) and reached 16,915 people. These VLOGS were an important impact from this study and for the women involved in making them. They contributed positively to the media industry, had

a large reach, and allowed asylum seeking and refugee women to represent themselves and issues that were important to them in an honest and positive way. A large target audience was reached, and interactive discussion achieved through the comment and chat functions in the different social media platforms. From this it was clear that there was an appetite for positive stories about asylum seekers and refugees. The women who took part reported feeling empowered and more confident from the process. It also demonstrates to other researchers that social media can be an innovative and highly impactful way to engage with wider public audiences. These videos have since been shown on the national news and BBC the Social again on subsequent International Women's Day and charitable organisations to showcase powerful, thought-provoking stories about women living in Glasgow.

Training was identified as a key need in the interviews with healthcare workers in this thesis. As mentioned in Section 2.4 as part of the Syrian Resettlement Programme, Syrian refugees were dispersed to areas with no or little experience in caring for refugees. Therefore, in January 2016, AB secured Scottish Government funding for a training event for healthcare workers in Glasgow. Eighty healthcare workers attended the event and there were eight speakers from different spheres of asylum seeker and refugee care: clinical, policy makers, third sector agencies and researchers. The event received excellent feedback (see Appendix 19: GP Training Feedback Report) and has created several important networks and impacts.

In the feedback, healthcare workers reported that their confidence in caring for asylum seekers and refugees had increased because of this event and that they would make some practice changes as a result. A positive impact of this teaching event was that it led to AB and another speaker being invited to teach on the compulsory Health Inequalities training day for GP trainees, which is held twice per year. This teaching has become a permanent part of the agenda of that teaching day, which means that since 2016 every GP trainee in the West of Scotland will have undergone teaching around caring for this population. From 2020 a member of the women's group has joined the teaching session so she can speak from lived experience and has co-designed the presentation to better reflect this. This presentation has also been incorporated into the annual Train the Trainers Conference for GP Trainers in the West of Scotland. A major benefit

of this has been knowledge exchange between practices about how they deal with issues such as time management, interpreting and complex health care issues.

Several follow-on training events were also organised for GP's, Practice Nurses and Practice Managers, focusing on clinical scenarios and FGM, as part of the Department of General Practice and Primary Care's ongoing continuing professional development (CPD) programme for primary care. An email network was set up following this which allowed sharing of information between practitioners, it also introduced health professionals and third sector organisations. At all the training events AB has provided a contact sheet of community organisation links, which is regularly updated. AB has also received feedback that the third sector organisation which presented at the teaching evening now regularly hosts medical students as part of their placement at a nearby practice because of connections made at the teaching event.

The feedback report (Appendix 19: GP Training Feedback Report) was disseminated by the Scottish Government to all health boards, councils, and relevant government departments. AB presented the outcomes of the teaching event to the Syrian Resettlement Programme Joint Session with Local Authority Lead Groups and Scottish Government, therefore also benefiting the policy sector. The New Scots Report (2017) included this teaching event as a case study of how to improve service providers awareness of meeting the needs of asylum seekers and refugees (Scottish Government, 2017).

FGM as a training need has been addressed as an ongoing issue by there being a dedicated FGM CPD session for primary healthcare workers in Glasgow. AB underwent an FGM Awareness Training course and with the specialist FGM midwife for Glasgow provides annual training to the Deepend GP Pioneers Fellowship Group[12]. These training sessions have again strengthened communications between key practitioners with many primary care healthcare workers making direct contact with the specialist midwife because of the training. She has feedback that the GPs who contact her through this route seem

[12] The GP Deepend Pioneers Scheme was an early career GP fellowship scheme which placed fellows in Deepend (deprived) practices to release time for experienced GPs to focus on service development and provided a tailored learning programme for fellows.

more confident about referring women as they have better awareness of what will be offered.

AB has also accepted invitations by community groups and by researchers working with asylum seeking, refugee, ethnic minority, or Muslim women to give direct talks about the benefits of cervical, breast and bowel cancer screening. These sessions have allowed a lot of time for questions, teaching of self-examination for breast lumps, interpreted materials and awareness raising of rights.

The impacts discussed above have empowered women to have their own experiences heard in the media, reached a large young demographic, and made them aware of some of the experiences of asylum seeking and refugee women. The Scottish Government teaching event, then subsequent teaching, networking, and dissemination of information as an output of this has provided information and support to primary care healthcare workers, researchers, and policy makers.

In addition to being a GP, AB is also now a non-executive board member for Public Health Scotland and a Scottish Human Rights Commissioner. In these spaces she has shared her knowledge of the lived experience of asylum seeking and refugee women, created networks and discussed her thesis findings.

The next section shall outline the recommendations from this study, for clinical practice, policy makers and future research.

9.7 Recommendations

In an ideal world the principal recommendation from this thesis would be for the hostile environment created by the media discourse and the increasingly negative U.K. migration policy making to be reduced and for a nurturing, welcoming and supportive environment for asylum seekers and refugees to be widely promoted in the U.K. However, as this is unlikely in the current U.K. political environment, recommendations for ways in which clinical practice in primary care, policy makers and future research can mitigate the effects of this with regards to health access for asylum seeking and refugee women are made in this section.

9.7.1 Health Care Recommendations:

Practice level recommendations that could increase access to cervical screening are to develop drop-in clinics and targeted education sessions, which is in keeping with recommendations from Jo's Cervical Trust (https://www.jostrust.org.uk/professionals/cervical-screening/improving-access). Drop-ins would be particularly effective at times where women may have easier access to childcare, such as evenings or Saturday mornings. Targeted education or invitations for cervical screening for women who are not attending would also be helpful. Education or information sessions would allow entitlements to healthcare to be presented, explanation of the health system so that health literacy could be improved and could explain the purpose and benefits of preventive healthcare measures, including cervical screening.

Practices could do this work either in partnership with or by supporting community organisations who could provide signposting and basic information sessions. Spending time providing education to women, both in targeted sessions and opportunistically in consultations, would be worthwhile. It would also be beneficial to repeat these messages as women may be distracted when they first arrive at the surgery. It was clear from the interviews with women that most of their health knowledge comes from friends and acquaintances in the community. Therefore, by improving the knowledge of women this would increase the spread of accurate information through peer learning. Another approach would be to work with community link workers who are in place in many practices across Scotland and it is recommended that education and increasing health literacy could be incorporated as part of their expanding role. All these recommendations would require cultural sensitivity and adequate interpreting.

Training was also identified as a need for primary healthcare workers around caring for asylum seekers and refugees. It is recommended that there is continued focus on developing training materials and sessions for primary care. As modelled by the inclusion of training into the West of Scotland GP Trainees Health Inequalities Day, incorporating training into already established teaching sessions particularly those around health inequalities can work well. It allows a wide audience to be reached, including those who may not have as much

experience working with asylum seekers and refugees. Opportunities, such as the trainers conference, GP cluster training or Practice Based Small Learning Groups (PBSGL) groups also allow opportunities for knowledge exchange and shared learning across practices. The inclusion of speakers who are experts by lived experience is also highly recommended.

9.7.2 Health Policy Recommendations:

A broad recommendation to policy makers from this thesis is that a rights-based and intersectional approach to policy making is taken. The focus on this has increased, for example through the National Human Rights Leadership Taskforce (The Scottish Government, 2021a). The importance of the consideration of intersectionality has been seen during the Covid pandemic, as the magnification of existing health inequalities during covid has increased discussion of health inequalities, along with a greater awareness of public health (Suleman *et al.*, 2021). In the recovery from covid, with an aim and momentum to 'build back better', health policies need to focus on reducing health inequalities, in an intersectional way with true partnership working between the NHS and the third sector. This could allow the voices of those with lived experience of the asylum system to be involved in policy making and involve third sector organisations in signposting services.

The development of the role of a national clinical lead in asylum and refugee care is recommended as a conduit between policy and clinical practice, to lead education, ensure equality issues are considered within an intersectional and rights-based approach in primary care, avoid duplication of effort across the NHS by working with other inclusion teams such as mental health and homelessness to promote best practice.

Changes are also needed to the health system issues of time and resources. Therefore, it is recommended that there needs to be increased spending in primary care to free time for clinicians to do work which will reduce health inequalities. Ways in which the pressures on primary care can be decompressed to do this work include greater use of community link workers, creating time for GPs to spend time in the local community groups making connections, time for primary care staff to be involved in patient education, research, and advocacy

roles. This could also enhance GPs' experiences in a time of burnout and recruitment issues within the system. There are already good examples of similar work to address health inequalities in the work of the GPs at the Deep End (https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/). A Clinical GP Lead in asylum and refugee care would be able to keep any increase in resources in primary care relevant to asylum seekers and refugees.

A final policy recommendation is that the entitlement policy for healthcare for asylum seekers and refugees in Scotland (The Scottish Government, 2010) is disseminated more widely to avoid confusion. It is recommended that GP surgeries should be made aware of this policy through clear messaging from their Local Medical Council (LMC) and Health Board and be encouraged to display the policy in their waiting room, which would also educate the wider community about entitlement. The Doctors of the World Safe Surgeries initiative, which has been based in England, is a good example of an initiative like that suggested. It supports GP practices to commit to tackling the barriers migrants face in accessing healthcare (https://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative/). These commitments include removing barriers to registration and facilitating training for clinical and non-clinical staff.

9.7.3 Research Recommendations

The first recommendation that would improve both research and the monitoring of inequalities about asylum seekers and refugees would be to improve recording of ethnicity and migration data, particularly within primary care, with adequate consent and explanation given to patients. This has been highlighted in the literature previously (Fulton, 2010) and then again more recently as an issue within the covid pandemic as there has been a lack of recorded ethnicity data, making comparisons of cases, outcomes, and vaccine uptake data difficult (Razai *et al.*, 2021).

An important outcome of this thesis is the richness of data that comes from qualitative interviews with individuals and focus groups who are experts by

lived experience. Continued qualitative research to understand the experiences felt by asylum seekers and refugees is recommended and co-production even more so, where asylum seekers and refugees could be involved in setting the direction of research themes towards issues that most impact them. This allows research to be led by those it is likely to impact, hears their voices clearly and prioritises their research needs. Co-production of research could also allow asylum seekers and refugees to partner in performing the research, which may help recruit more isolated participants. Candidacy, intersectionality and deservingness worked well as a combined theoretical framework for qualitative research, and it is recommended that the uses of this continue to be developed and tested in further research. The suggested model (Figure 15) in this thesis would provide a basis for this and could be tested with regards to health access for any vulnerable group.

In the last year the covid-19 pandemic has completely transformed the way that general practice works in the U.K. Face to face appointments have in the main been replaced by telephone appointments, including using telephone interpreters to phone out to patients. Therefore, research is needed to consider how this has affected asylum seeking and refugee women as it may have increased health access issues and limited the opportunity for private consultations which allow safe discussions around gender-based violence for example. Many asylum seeking and refugee women may also be more vulnerable and isolated due to the pandemic restrictions.

9.8 Conclusions

This thesis has demonstrated that even within a relatively small sample size asylum seeking and refugee women are a heterogeneous group, and it is important to recognise this within research and practice. Intersectionality aided the unpacking of this heterogeneity by allowing consideration of different intersecting identities within individuals, the group and in different locations. Candidacy then allowed the structural influences on identities and health access behaviours to be explored further. Despite the differences within the group of

women interviewed, several of the barriers identified to accessing cervical screening were universal to women, such as having to prioritise caring roles, gendered issues in accessing healthcare such as having to find childcare and wider inequalities such as gender-based violence.

The uptake of cervical screening was high in the women interviewed. Therefore, a strong conclusion from this study is that if women are given the correct information, opportunity, access, and support there is a willingness to engage in cervical screening. It is hypothesised that this is likely a transferable finding to other forms of preventive health care. However, structural issues such as time affected GP and Practice Nurse availability for providing explanation and support, even when they were willing to do so.

Scotland was shown to be more positive in its entitlement policies and media reporting around asylum seekers and refugees. However, it cannot afford to be complacent as there are still noticeable inequalities faced by asylum seeking and refugee women in Glasgow, all of which must be navigated under the cloud of the hostile environment, which inflames deservingness discourses that are internalised by women and creates judgements by staff.

However, support was also found out with the healthcare environment in community groups and through social connections. Through nurturing this supportive framework in the community with health, community and social care working together in a coordinated way it is postulated that health literacy would increase, as would health access and health inequalities would lessen.

Combining candidacy, intersectionality and deservingness aided the exploration of the issues raised in this research. A combined framework was proposed which could be used for further health access research to provide further nuanced understanding of the complex and intersecting issues which affect health access in vulnerable groups.

Appendix 1: Media Analysis Pro-Forma

Codesheet no: _____ **Article no:** _____ **Date:** _____

Headline: _____

_____

_____

Tone of Headline: Positive ☐ Negative ☐ Neutral ☐

Newspaper: 1. Scotsman ☐ 2. Herald ☐ 3. Daily Record ☐

4. Sunday Mail ☐ 5. Gla Eve Times ☐ 6. Edin Eve Times ☐

7. Daily Mail ☐ 8. Guardian ☐ 9. Telegraph ☐

Edition: _____ **Page:** _____ **Word Count:** _____

Region: _____

What type of article is this?

Feature ☐ Letter ☐ Opinion ☐ Column ☐ Editorial ☐ News ☐ Society ☐

Is the headline in keeping with the rest of the article?

Yes ☐ No ☐ Some ☐

What prompted this article to be written?

Individual's story ☐

Government action ☐

Community Action ☐

Other _____

What major themes are within the article?

Migration Impact ☐

Health ☐

Resources/Welfare ☐

Political Popularity/Votes ☐

Border security ☐

Devolution ☐

Integration ☐

Public Feeling ☐

Migrant Hierarchy ☐

Human Rights ☐

Racism ☐

Which migrant population group is mentioned in the article?

Asylum seekers ☐ Refugees ☐ Economic Migrants ☐

EU Migrants ☐ Undocumented Migrants ☐ Mixed ☐

Other_____ ☐ Unclear/Unspecified ☐

Is the definition of the group portrayed accurate in comparison to the legal definition?

Yes ☐ No ☐ Partly ☐

Are any other population groups mentioned?

Yes ☐ No ☐

If so were they:

Prisoners ☐ Terrorists ☐ Homeless ☐ Unemployed ☐

Other _____

Whose views are cited in the article?

Politicians ☐

Migrants[2] ☐

Community Group ☐

Health Worker ☐

Charity Organisation ☐

Religious/Faith Leader ☐

Are any figures quoted in the article about?

Asylum Seekers Yes ☐ No ☐

Refugees Yes ☐ No ☐

Migrants[1] Yes ☐ No ☐

Where are they sourced from?

_____

Is the overall tone of the article?

Migrants[2] Positive ☐ Negative ☐ Neutral ☐ Unclear ☐

Migration Positive ☐ Negative ☐ Neutral ☐ Unclear ☐

Comments: _____

_____

_____

[1.] Any migrant group except refugees and asylum seekers

[2.] Migrants in the broadest definition; inclusive of economic migrants, undocumented migrants, asylum seekers, refugees and overseas students

Health Related Articles

What is the focus on health within the article about?

1. Health Access ☐
2. Health Needs ☐
3. Specific Health Problem ☐
4. Health Seeking Behaviour ☐
5. Health Care Spending ☐
6. Migrant Health Care Workers ☐
7. Mental Health ☐

Is the article discussing primary or secondary health care?

Primary Healthcare ☐

Secondary healthcare ☐

Is there any discussion around healthcare entitlement for asylum seekers, refugees or migrants?

Yes ☐ No ☐

Are any health care policies mentioned in the article?

Yes ☐ No ☐ If so what policy is mentioned? _____

Whose views pertaining to healthcare are cited in the article?

UK Government ☐

Scottish Government ☐

UKBA ☐

Healthcare professional ☐

Migrant ☐

Does the article suggest asylum seekers/refugees/migrants as being deserving or undeserving of health care?

Deserving ☐ Undeserving ☐ No mention ☐ Mixed ☐

Views Cited:

Deserving _____

_____

_____

_____

Undeserving _____

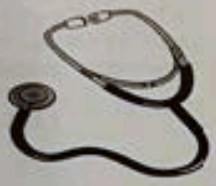
_____

_____

_____

Appendix 2: Recruitment Flyer

Invitation to take part in research about Asylum Seeking and Refugee Women's Experiences of Cervical Screening Services in Glasgow



Are you an asylum seeking or refugee woman living in Glasgow?

This research aims to improve and develop the healthcare asylum seeker and refugee women receive in GP Practices to ensure that your needs are met.

Would you like to share your views about GP services in Glasgow, for example the cervical screening service?

EVERY WOMAN HAS SOMETHING VALUABLE TO SAY.

All interviews will be confidential and will be conducted with Anna, a female researcher at the University of Glasgow.

If you are interested in taking part please give your name and contact details to the worker/volunteer who gave you this flier and they will arrange for Anna to contact you with more information

OR You can contact Anna directly by email anna.matthews@glasgow.ac.uk or between 9-5pm on Tuesdays to Thursdays.

Community Workers- please pass on contact details to Anna via the email (preferred) or telephone number provided above. Thank you.

University of Glasgow | College of Medical, Veterinary & Life Sciences

Appendix 3: Invitation Letter General Practice

University of Glasgow | College of Medical, Veterinary & Life Sciences

19.05.14
Dr Anna Matthews
Department of General Practice and Primary Care
University of Glasgow
1 Horselethill Road
G12 9LX

Dear

R.E: Exploring the decision to take part or not take part in cervical screening by asylum seeking and refugee women.

My name is Anna Matthews, and I am a Clinical Research Fellow within the Department of General Practice and Primary care. I am writing to request your help with the above study being undertaken by the Department of General Practice and Primary Care at the University of Glasgow, which is the MD project being undertaken by myself. Ethical approval for this project has been granted by the University of Glasgow Medical, Veterinary and Life Sciences College Ethics Committee.

This study aims to determine the uptake of cervical screening by asylum seeking women; exploring their decision to take part or not take part in cervical screening. It will also discuss potential barriers and facilitators in providing this service to asylum seeking and refugee women. Health care professionals play an important role and we are interested in hearing the views of GPs initially and then also Practice Nurses about their experiences of providing health care for this population, particularly cervical screening.

We are contacting surgeries that have been identified from the LES database for Asylum Seekers as having a large number of asylum-seeking patients registered and therefore are well placed to share experiences of providing primary health care for this population.

What we would ask you to do:

Ideally, we would like to recruit a GP and a Practice Nurse from your practice to take part in this study. However, if not all of these health care professionals are willing to take part, we would be very happy to recruit whoever from within these groups would be interested. If you were interested in taking part, I would interview you about your experiences of caring for the asylum-seeking population, cervical screening provision for this population and your opinions about barriers/facilitators in providing this service. I will be flexible around the time commitments of your practice and will be happy to travel to your practice. The interview can be face to face, over the telephone or in a group, whichever would be your preference.

With permission all interviews will be audio-recorded. Any information collected will be anonymised.

An information sheet with further details about the study has been enclosed and I would be happy to discuss the study details further either by phone or by visiting the practice.

If you are interested in taking part in this study or would like further information please contact Anna Matthews on (between the hours of 9am-5pm Tuesday-Friday), email anna.matthews@glasgow.ac.U.K. or return the attached reply slip in the envelope provided.
I look forward to hearing from you.
Thank you
Yours sincerely

Dr Anna Matthews
Clinical Research Fellow

EXPRESSION OF INTEREST REPLY SLIP:

Study Title: Exploring the decision to take part or not take part in cervical screening by asylum seeking/refugee women.

If you are willing to consider taking part in the study please complete this form and return in the prepaid addressed envelope or if you would prefer please contact the study lead, Dr Anna Matthews directly on or by email anna.matthews@glasgow.ac.U.K. to arrange a visit.

Tel number ……

Best times to call……..…….……

Signature ……..…….……

Name (print) ……..……

Date ……..……..……

Appendix 4: Invitation Letter Community Workers

University of Glasgow | College of Medical, Veterinary & Life Sciences

Date:

Dr Anna Matthews
Department of General Practice and Primary Care
University of Glasgow
1 Horselethill Road
G12 9LX

Dear

R.E: Exploring the decision to take part or not take part in cervical screening by asylum seeking and refugee women.

My name is Anna Matthews, and I am a Clinical Research Fellow within the Department of General Practice and Primary care. I am writing to request your help with the above study being undertaken by the Department of General Practice and Primary Care at the University of Glasgow, which is the MD project being undertaken by myself. *(line about ethical approval if granted)*

This study aims to determine the uptake of cervical screening by asylum seeking women; exploring their decision to take part or not take part in cervical screening. It will also discuss potential barriers and facilitators in providing this service to asylum seeking and refugee women. Community workers play an important role and we are interested in hearing the views of Community Workers about the role you playing signposting health services for asylum seeking and refugee women. We are also interested in your experiences of women from this population accessing GP services.

You have been contacted as you have been identified as working closely with asylum seeking and refugee women in the community and therefore are well placed to share your experiences of providing primary health care for this population.

What we would ask you to do:

If you were interested in taking part, I would interview you about your experiences of working with the asylum-seeking population, your knowledge cervical screening provision for this population and your opinions about barriers/facilitators for asylum seeking and refugee women in accessing this service and other GP services. I will be flexible around your time commitments. The interview can be face to face or over the telephone, whichever would be your preference.

With permission all interviews will be audio-recorded. Any information collected would be anonymised. Once the research is complete you will be invited to attend a Knowledge Exchange Event where the results of this study would be presented with time for discussion afterwards.

An information sheet with further details about the study has been enclosed and I would be happy to discuss the study details further either by phone or in person.

If you are interested in taking part in this study or would like further information please contact me, Anna Matthews, (between the hours of 9am-5pm Tuesday-Friday), email anna.matthews@glasgow.ac.U.K. or return the attached reply slip in the envelope provided.

I look forward to hearing from you.

Thank you
Yours sincerely

Dr Anna Matthews
Clinical Research Fellow

EXPRESSION OF INTEREST REPLY SLIP:

Study Title: Exploring the decision to take part or not take part in cervical screening by asylum seeking/refugee women.

If you are willing to consider taking part in the study please complete this form and return in the prepaid addressed envelope or if you would prefer please contact the study lead, Dr Anna Matthews directly on or by email anna.matthews@glasgow.ac.U.K. to arrange a visit.

Tel number ……

Best times to call……..…….……

Signature ……..…….……

Name (print) ……..……

Date ……..……..

Appendix 5: Information Sheet Asylum Seeking and Refugee Women

University of Glasgow | College of Medical, Veterinary & Life Sciences

PARTICIPANT INFORMATION SHEET

Study title:

Exploring the decision to take part or not take part in cervical screening by asylum seeking/refugee women.

Invitation:

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Why is the study being done?

All women, between the ages of 20-60 years of age, living in Glasgow should be invited for cervical screening every 3 years. This is to screen for the early stages of cervical cancer. Little is known about the uptake of cervical screening by asylum seeking and refugee women in Glasgow. This study aims to find out what the uptake of cervical screening is in the asylum and refugee population, what asylum seeking and refugee women in Glasgow know about cervical screening and why they choose to either take part or not take part.

Why have I been chosen?

You have been approached for this study as you have been identified through the Women's Group you attend as being a woman between the ages of 20-60 years and are eligible for cervical screening. We are interested in talking to you whether you have chosen to take part in cervical screening or not.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

This study will not affect your asylum claim in any way. Your involvement with any services, including the women's group you attend, shall not be affected by this study. This is the case whether you decide to take part or not.

What do I do if I want to take part?

If you are interested in taking part in this study, or have any questions about the study please either speak directly to Anna Matthews when she returns to your Women's Group, ask the community worker that discussed this study with you to pass on your contact details to Anna Matthews or contact her directly on (between the hours of 9am-5pmTuesday-Friday) or anna.matthews@glasgow.ac.U.K.

If you decide to take part, you will be asked to sign a consent form. You will be given a copy of the consent form and this information sheet for your own records.

What will this study involve?

If you decide to take part in this study you will be interviewed either one to one, or as part of a group interview. If it is a one-to-one interview this will be with yourself and the researcher Anna Matthews. If you are part of a group interview this will be with other women who are asylum seekers/refugees, and you will be interviewed by the researcher Anna Matthews who will be helped by another female researcher. It is your choice whether you would prefer to be interviewed one to one or in a group. You can also choose to be involved in both a one-to-one interview and a group interview; if there are some things you would like to discuss on your own with the researcher but other topics you would be comfortable talking about in a group.

During the interviews you will be asked about your experience of healthcare both in Glasgow and in your country of origin, as well as about your personal wider background and experiences. The researcher will also ask you questions about the cervical screening programme and why you decided to take part or not take part. They will be interested to know if the previous experiences you will have discussed earlier affected your decision to take part or not take part.

All interviews will last up to 1 hour and, with your permission, they will be tape-recorded so that the interviewer does not need to take notes. Group interviews may be run over more than one session as it will take longer to discuss the topics due to a bigger number of people taking part. There will be a maximum of three group sessions approximately 2 hours each, which will be over approximately 3 weeks.

After the interviews you will not be required to do anything further, but you will be invited to a presentation of the results of the study when they are available.

What are the possible disadvantages and risks of taking part?

If you decide to take part you will be talking in some detail to the researcher about your experiences of health care, cervical screening and of living in Glasgow. Some people may

find some of the issues discussed upsetting or the interview process tiring. The interview can be stopped at any time, or the researcher can be asked to move on to another topic.

What are the possible benefits of taking part?

This project will give you the opportunity to discuss your experiences of living in Glasgow, your experiences of accessing your GP and of cervical screening. Although there may be no direct benefit to you from doing this, people often enjoy the opportunity to discuss experiences that are important to them, and the findings of this study will help us to understand better how we may develop the very best GP care for the asylum seeking/refugee population in Glasgow.

Will my taking part in this study be kept confidential?

Everything you tell us will be **strictly confidential**. You will be identified by an ID number, and any information about you will have your name and address removed so that you cannot be recognised from it.

All transcripts from audio recordings shall be anonymised, as shall the audio tapes. Any information held on computer will be password protected and all audio tapes and written notes will be stored securely in locked filing cabinets in the Department of General Practice and Primary Care, University of Glasgow. This information will only be available to the research team. All paper copies of information shall be destroyed once the research project is fully complete, and all reports/presentations have been written. Anonymised electronic data shall be stored securely within the University of Glasgow and may be used in future research. The electronic files shall be destroyed 10 years after the study is complete.

We may use quotes from your interview in the study, but we will ensure that any identifying information will be removed.

What will happen to the results of the research study?

It is intended that the results of this research study will be published in reports and papers for medical and academic journals. The results will also be presented at medical and academic conferences. We would like to assure you that you will not be identified in any report, publication or presentation.

If you would like to read published reports of the study, they can be provided to you by the research team. You will also be invited to attend a Knowledge Exchange Event where the research will be presented to both people who have taken part in the study and people who are interested in the study results. It is planned that discussion will occur at this event about how to act upon the results of the study. It is up to you whether you would wish to attend this event.

Who is organising and funding the research?

This research has been organised by the Department of General Practice and Primary Care, University of Glasgow. Funding is being sought from the Royal College of General Practitioners. There is no commercial funding involved in this research.

Who has reviewed the study?

The study has been reviewed by the College of Medical, Veterinary and Life Sciences Ethics Committee, University of Glasgow.

Contact for Further Information

If you are interested in taking part in this study or have any further questions, please speak to Anna Matthews directly when she next attends your Women's Group. Alternatively contact Anna Matthews by calling between the hours of 9-5pm Tuesday to Friday, email anna.matthews@glasgow.ac.U.K. or write to:

Anna Matthews
Department of General Practice and Primary Care
University of Glasgow
1 Horselethill Road
Glasgow
G12 9LX

Alternatively, please feel free to contact one of the other members of the research team:

Kate O'Donnell, Professor of Primary Care, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Kate.O'Donnell@glasgow.ac.U.K.

Nicola Burns, Research Associate, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Nicola.Burns@glasgow.ac.U.K.

Frances Mair, Professor of General Practice, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Frances.Mair@glasgow.ac.U.K.

Thank you very much for taking the time to read this information sheet and for giving consideration to taking part in this study. Please discuss this information with your friends and family if you wish.

Appendix 6: Information Sheet Healthcare Workers

University of Glasgow | College of Medical, Veterinary & Life Sciences

PARTICIPANT INFORMATION SHEET: Health Care Workers

Study title

Exploring the decision to take part or not take part in cervical screening by asylum seeking/refugee women.

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Why is the study being done?

Women, between the ages of 20-60 years of age, living in Glasgow should be invited for cervical screening every 3 years. This is to screen for the early stages of cervical cancer. Little is known about the uptake of cervical screening by asylum seeking and refugee women in Glasgow. This study aims to find out what the uptake of cervical screening is in the asylum and refugee population, what asylum seeking and refugee women in Glasgow know about cervical screening and why they choose to either take part or not take part.

Why have I been chosen?

You have been approached to take part in this study as you have been identified, through the Locally Enhanced Service for Asylum Seekers, as having registered patients within your GP practice from the asylum seeking and refugee population. We are interested in talking to you as you have experience of caring for asylum seeking and refugee women and will be involved in the provision of cervical screening. This project is keen to hear the views of GPs, Practice Nurses and Receptionists and would encourage individuals from each of these roles to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What do I do if I want to take part?

If you are interested in taking part in this study or have any questions about the study, please contact Anna Matthews on or anna.matthews@glasgow.ac.U.K.. Alternatively, please return the reply slip attached in the envelope provided.

If you decide to take part, you will be asked to sign a consent form. You will be given a copy of the consent form and this information sheet for your own records.

What will happen to me if I take part?

If you decide to take part in this study, you will be interviewed by the researcher Anna Matthews. This interview can either be face to face, over the telephone or as part of a group interview with other members of your practice team, depending upon your availability and own preference. During the interview you will be asked about your experiences in caring for asylum seeking and refugee women and your opinions regarding the barriers and facilitators in providing healthcare to this population. You will also specifically be asked about your experience providing cervical screening services for asylum seeking and refugee women.

The interview will last approximately 1 hour and will be tape recorded so that the interviewer does not need to take notes, therefore concentrating fully on what is being said.

After the interviews you will not be required to do anything further, but you will be invited to a presentation of the results of the study, when they are available.

What are the possible disadvantages and risks of taking part?

If you decide to take part, you will be talking in some detail about your experiences of working with the female asylum seeking and refugee population. Some people may find some of the issues discussed upsetting or the interview process tiring. The interview can be stopped at any time, without explanation needed, or the researcher can be asked to move on to another topic.

What are the possible benefits of taking part?

You will receive no direct benefit from taking part in this study. However, the information that is collected during this study will give us a better understanding of how GP services in Glasgow may be developed to provide the best possible care for the asylum seeking and refugee population.

No payments are available for taking part in this study.

Will my taking part in this study be kept confidential?

Everything you tell us will be **strictly confidential**. You will be identified by an ID number, and any information about you will have your name and address removed so that you cannot be recognised from it.

All transcripts from audio recordings shall be anonymised, as shall the audio tapes. Any information held on computer will be password protected and all audio tapes and written

notes will be stored securely in locked filing cabinets in the Department of General Practice and Primary Care, University of Glasgow. This information will only be available to the research team. All paper copies of information shall be destroyed once the research project is fully complete, and all reports/presentations have been written. Anonymised electronic data shall be stored securely within the University of Glasgow and may be used in future research. The electronic files shall be destroyed 10 years after the study is complete.

We may use quotes from your interview in the study, but we will ensure that any identifying information will be removed.

What will happen to the results of the research study?

It is intended that the results of this research study will be published in reports and papers for medical and academic journals. The results will also be presented at medical and academic conferences. We would like to assure you that you will not be identified in any report, publication or presentation. No information shall be traceable back to you and your information will be combined with that of other peoples' so you will not be identified in any way.

If you would like to read published reports of the study, they can be provided to you by the research team. You will also be invited to attend a Knowledge Exchange Event where the research will be presented to both people who have taken part in the study and people who are interested in the study results. It is planned that discussion will occur at this event about how to act upon the results of the study. It is up to you whether you would wish to attend this event.

Who is organising and funding the research?

This research has been organised by the Department of General Practice and Primary Care, University of Glasgow. Funding is being sought from the Royal College of General Practitioners. There is no commercial funding involved in this research.

Who has reviewed the study?

The study has been reviewed by the College of Medical, Veterinary and Life Sciences Ethics Committee, University of Glasgow.

Contact for Further Information

If you are interested in taking part in this study or have any further questions, please contact Anna Matthews by calling (Tuesday to Friday 9am-5pm), emailing anna.matthews@glasgow.ac.U.K. or writing to:

Anna Matthews
Department of General Practice and Primary Care
University of Glasgow
1 Horselethill Road
Glasgow
G12 9LX

Alternatively, please feel free to contact one of the other members of the research team:

Kate O'Donnell, Professor of Primary Care, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Kate.O'Donnell@glasgow.ac.U.K.

Nicola Burns, Research Associate, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Nicola.Burns@glasgow.ac.U.K.

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Thank you very much for taking the time to read this information sheet and for giving consideration to taking part in this study. Please discuss this information with your friends and family if you wish.

Appendix 7: Information Sheet Community Workers

PARTICIPANT INFORMATION SHEET: Community Workers

Study title

Exploring the decision to take part or not take part in cervical screening by asylum seeking/refugee women.

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Why is the study being done?

Asylum seeking and refugee women, between the ages of 20-60 years of age, living in Glasgow should be invited for cervical screening every 3 years. This is to screen for the early stages of cervical cancer. Little is known about the uptake of cervical screening by asylum seeking and refugee women in Glasgow. This study aims to find out what the uptake of cervical screening is in the asylum and refugee population, what asylum seeking and refugee women in Glasgow know about cervical screening and why they choose to either take part or not take part.

Why have I been chosen?

You have been approached to take part in this study as you have been identified as working with asylum seeking and refugee women in the community. We are interested in talking to you as you have direct contact with asylum seeking and refugee women and are aware of many of the experiences they face and may be involved with sign posting for health care services.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What do I do if I want to take part?

If you are interested in taking part in this study or have any questions about the study, please speak to Anna Matthews during her next contact with you or alternatively contact Anna Matthews on or anna.matthews@glasgow.ac.U.K.

If you decide to take part, you will be asked to sign a consent form. You will be given a copy of the consent form and this information sheet for your own records.

What will happen to me if I take part?

If you decide to take part in this study, you will be interviewed face to face by the researcher Anna Matthews. During the interview you will be asked about your experiences in working with asylum seeking and refugee women. You will also be asked about your experience of asylum-seeking women accessing health care and cervical screening services at their GP surgery.

The interview will last approximately 1 hour and will be tape recorded so that the interviewer does not need to take notes, therefore concentrating fully on what is being said.

After the interviews you will not be required to do anything further, but you will be invited to a presentation of the results of the study, when they are available.

What are the possible disadvantages and risks of taking part?

If you decide to take part, you will be talking in some detail about your experiences of working with the female asylum seeking and refugee population. Some people may find some of the issues discussed upsetting or the interview process tiring. The interview can be stopped at any time, without explanation needed, or the researcher can be asked to move on to another topic.

What are the possible benefits of taking part?

You will receive no direct benefit from taking part in this study. However, the information that is collected during this study will give us a better understanding of how GP services in Glasgow may be developed to provide the best possible care for the asylum seeking and refugee population.

No payments are available for taking part in this study.

Will my taking part in this study be kept confidential?

Everything you tell us will be **strictly confidential**. You will be identified by an ID number, and any information about you will have your name and address removed so that you cannot be recognised from it.

All transcripts from audio recordings shall be anonymised, as shall the audio tapes. Any information held on computer will be password protected and all audio tapes and written notes will be stored securely in locked filing cabinets in the Department of General

Practice and Primary Care, University of Glasgow. This information will only be available to the research team. All paper copies of information shall be destroyed once the research project is fully complete, and all reports/presentations have been written. Anonymised electronic data shall be stored securely within the University of Glasgow and may be used in future research. The electronic files shall be destroyed 10 years after the study is complete.

We may use quotes from your interview in the study, but we will ensure that any identifying information will be removed.

What will happen to the results of the research study?

It is intended that the results of this research study will be published in reports and papers for medical and academic journals. The results will also be presented at medical and academic conferences. We would like to assure you that you will not be identified in any report, publication or presentation. No information shall be traceable back to you and your information will be combined with that of other peoples' so you will not be identified in any way.

If you would like to read published reports of the study, they can be provided to you by the research team. You will also be invited to attend a Knowledge Exchange Event where the research will be presented to both people who have taken part in the study and people who are interested in the study results. It is planned that discussion will occur at this event about how to act upon the results of the study. It is up to you whether you would wish to attend this event.

Who is organising and funding the research?

This research has been organised by the Department of General Practice and Primary Care, University of Glasgow. Funding is being sought from the Royal College of General Practitioners. There is no commercial funding involved in this research.

Who has reviewed the study?

The study has been reviewed by the College of Medical, Veterinary and Life Sciences Ethics Committee, University of Glasgow.

Contact for Further Information

If you are interested in taking part in this study or have any further questions, please contact Anna Matthews by calling (Tuesday to Friday 9am-5pm), emailing anna.matthews@glasgow.ac.U.K. or writing to:

Anna Matthews
Department of General Practice and Primary Care
University of Glasgow
1 Horselethill Road
Glasgow
G12 9LX

Alternatively, please feel free to contact one of the other members of the research team:

Kate O'Donnell, Professor of Primary Care, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Kate.O'Donnell@glasgow.ac.U.K.

Nicola Burns, Research Associate, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Nicola.Burns@glasgow.ac.U.K.

Frances Mair, Professor of General Practice, Department of General Practice and Primary Care, University of Glasgow. Tel: Email: Frances.Mair@glasgow.ac.U.K.

Thank you very much for taking the time to read this information sheet and for giving consideration to taking part in this study. Please discuss this information with your friends and family if you wish.

Appendix 8: Arabic Version of Information Sheet

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ورقة معلومات المشارك

عنوان الدراسة :

استكشاف قرار المشاركة أو عدم المشاركة في فحص عنق الرحم بواسطة طالبي اللجوء / اللاجئات

الدعوات
:

لقد تم دعوتكم للمشاركة بهذه ة الدراسة . لكن قبل قبولكم بلمشاركه يجب ان تلموا بلاسباب التي ادت الى اجراء هذه الدراسة و ما تشمل بصورة عامة . رجاء قراءة المعلومات المرفقة بصورة جيدة مع مناقشة بعض المواضيع مع اخرين , حسب الرغبة . لكم مطلق الحرية بلسؤال والاستفسار حول اي مضوع عير واضح . ليديكم مطلق الحرية للمشاركه او عدم المشاركه في الدراسة المقدمة
.

لماذا يجري القيام بهذه الدراسة
؟

كل النساء من عمر 20-60 سنة , ومقمين في كلاسكو يجب عليهم اجراء فحص عنق الرحم كل ثلاثة سنوات . الغرض منه الكشف عن المراحل المبكرة لسرطان عنق الرحم . لا يعرف سوى القليل من النساء عن الإقبال على فحص التحري عن عنق الرحم بين فيئات اللاجئات او طالبي اللجوء في غلاسكو . الغرض من هذه الدراسة هو الكشف عن نسبة االسيدات الذين لديهم الالمام بفحص عنق الرحم بين النساء اللاجئات او طالبات اللجوء في كلاسكو .كذلك لمعرفة السبب الذي دعاهم للمشاركة او عدم المشاركة في هذه الدراسة.

لماذا أنا تم اختياره للقيام بهذه الدراسة
؟

لقد تم اختيارك لهذه الدراسه وذلك من خلال تصنيفك في فريق النساء اللواتي تنضم اليهن على كونك سيدة بين 20-60 من العمروالمؤهلة لعمل فحص الدوري لعنق الرحم . ونحن مهتمون في الحديث معك ما إذا كنت قد اخترت للمشاركة في فحص عنق الرحم أو لا .

هل يجب أن أشارك ؟

القرار عائد لك في حال المشاركة او عدم المشركة . في حالة رغبتك في المشاركة , سوف تم اعطاءك ورقة المعلومات للحفاظ عليها وسيطلب منك التوقيع على نموذج موافقة . في الوقت ذاته حتى اذا كنت مشارك ,لايزال لديك مطلق الحرية في الانسحاب في أي وقت ودون إبداء أسباب . هذه الدراسة سوف لن تؤثر على طلبك للجوء بأي شكل من الأشكال . في نفس الوقت لن تتأثر مشاركتكم مع أية خدمات متوفرة لكم ، بما في ذلك مجموعة النساء المنضمين اليها من خلال هذه الدراسة . هذا هو الحال إذا كان عليك أن تقرر بان تشارك أو لا
.

ماذا أفعل إذا كنت تريد أن تأخذ جزء ؟

اذا كنت مهتما بلمشاركة في الدراسة أو هنالك أي استفسار تود ان تطرحه , رجاء أتصل مباشرة بل السيدة انا ماثيوز عندما تعود الى الانضمام الى فريق النساء ,او اطلب من عامل المجتمع الذي ناقش هذه الدراسة معك لكي ينقل تفاصيل الاتصال الخاصة بك إلى السيدة آنا ماثيوز أوممكن ان تتصل بها مباشرة على الرقم 0141330838(بين الساعة 9صباحا حتى 5 عصرا ,من الثلاثاء الى الجمعة), او الاتصال بها على البريد الالكتروني anna.matthews@glasgow.ac.U.K. .

إذا قررت المشاركة , سوف يطلب منك التوقيع على استمارة الموافقة . وسوف تحصل على نسخة من استمارة الموافقة و ورقة المعلومات ا لخاصة بسجلك .

ماذا تشمل هذه الدراسة ؟

إذا قررت المشاركة في هذه الدراسة ,سيتم مقابلتهم لك ام شخصيا اي واحد إلى واحد ، أو كجزء من مقابلة أجريت جماعيا . في حالة المقابلة شخص الى شخص , سوف تكون بينك وبين الباحثة انا ماثيوز .لكن إذا كنت جزءا من مجموعة النساءاخرى من الذين هم طالبي اللجوء / اللاجئين, سوف يتم مقابلتك من قبل الباحث آنا ماثيوز والتي سوف تساعدها باحثة اخرى في الوقت ذاته . هو اختيارك ما إذا كنت تفضل أن يتم استجوابك 1-1 أو من ضمن مجموعة . يمكنك أيضا اختيار أن تشارك في كل من المقابلة 1-1 وفي المقابلة جماعية ايضا في حين اذا كان هناك بعض الأشياء ترغب لمناقشتها مع الباحث بصورة انفرادية ولكن المواضيع الأخرى ممن ان تشارك المجموعة في مناقشتها جماعيا .

خلال المقابلات سوف تسال عن تجربتك الشخصية من الرعاية الصحية سواء كانت في غلاسكو وفي بلدك الأصلي، فضلا عن السؤال عن خلفيتك و خبراتك الشخصية على نطاق أوسع . فإن الباحث سوف يطلب منكم أجوبة حول الاسئلة المتعلقة حول برنامج فحص الدوري لعنق الرحم , ولماذا قررت المشاركة أو عدم المشاركة في هذه الدراسة .

وسوف يكون الباحثون مهتمون لمعرفة ما إذا كانت التجارب السابقة التي نوقشت في وقت سابق لها التاثيرفي قرارك بلمشاركة او عدم المشاركة .

جميع المقابلات تستمر لمدة تصل إلى 1 ساعة ، وبعد إذنكم ، سوف يتم تسجيل المقابلات صوتيا بحيث ان المقابلة لا تحتاج لتدوين الملاحظات خطيا . يمكن اجراء المقابلات الجماعية على أكثر من دورة واحدة وذلك لأنها سوف تستغرق وقتا أطول لمناقشة الموضوعات وذلك يرجع إلى مشاركة عدد أكبر من الناس . سيكون هناك حد أقصى قدره ثلاث جلسات جماعية كل منها تستغرق مايقارب الساعتين ، والتي سوف تجرى على مدى 3 أسابيع .

بعد المقابلات لن تكون هناك حاجة لك لفعل المزيد, بعد ذلك سوف تتم دعوتك الى عرض تقديمي تعرض فيه نتائج الدراسة عندما تصبح متاحة .

ما هي عيوب المحتملة والمخاطر من المشاركة ؟

إذا قررت أن تشارك في هذا البحث ممكن ان تتحدث بشيء من التفصيل إلى الباحث عن تجاربك من الرعاية الصحية ، وفحص عنق الرحم والمعيشة في غلاسكو . بعض الناس قد يجد بعض القضايا التي ممكن أن تناقش مزعجة أو عملية المقابلة متعبة بصوزة عامة . في تلك الحالات ممكن ايقاف المقابلة في أي وقت , أو يمكن أن يطلب من الباحث للانتقال إلى موضوع آخر.

ما هي الفوائد المحتملة من المشاركة ؟

هذا المشروع سوف يعطيك الفرصة لمناقشة تجاربكم و خبراتكم حول المعيشة في غلاسكو ،كذلك ماهي خبراتكم من الوصول إلى طبيبك العام وفرص الحصول على فحص عنق الرحم . رغم أنه قد لا تكون هناك فائدة مباشرة لك من القيام بذلك ،لكن الناس غالبا ما تتمتع من خلال اعطائهم الفرصة لمناقشة الخبراتهم المكتسبة و التي تعتبر مهمة . نتائج هذه الدراسة سوف تساعدنا على فهم كيفية توصيل أفضل رعاية صحية للاجئين أو طالبي اللجوء
في غلاسكو .

وهل ستبقى مشاركتي في هذه الدراسة سرية ؟

سيكون كل شيء تخبرنا به يكون في غاية السرية . سيتم التعرف عليك من قبل رقم الهوية ، و بعد ذلك سيتم حذف أي معلوما ت فيها أ سمك او محل السكن لكي لايتم التعرف عليك شخصيا .

جميع النسخ من التسجيلات الصوتية و الاشرطة السمعية سوف تعنون مجهولة المصدر ، وسوف تكون أي المعلومات على جهاز الكمبيوترمحمية بكلمة السر . وسيتم تخزين جميع الأشرطة السمعية ومذكرات مكتوبة بشكل آمن في خزائن لحفظ الملفات مؤمنة في قسم الممارسة العامة والرعاية الأولية ، جامعة غلاسكو.

هذه المعلومات سوف تكون متاحة لفريق البحث فقط. وسوف يتم إتلاف جميع النسخ الورقية من المعلومات مرة واحدة عند اكتمال المشروع البحثي و اكتمال كتابة جميع التقارير / العروض التقديمية . أما البيانات الإلكترونية سوف يتم تخزينها بشكل آمن و مجهول المصدر داخل جامعة غلاسكو،و ذلك لامكانية استخدامها في البحوث المستقبلية .البيانات الالكترونية يتم اتلافها بعد 10 سنوات من اكتمال الدراسة .

ممكن ان نستخدم مقتطفات من المقابلة في الدراسة، ولكن سوف نضمن أنه يتم إزالة أي معلومات شخصية .

ماذا سيحدث لنتائج دراسة بحثية؟

الغرض من هذا البحث هو نشر نتائج هذه الدراسة البحثية في تقارير و المجلات الطبية والأكاديمية . كما سيتم عرض النتائج في المؤتمرات يتم الافصاح عن اي معلومات شخصية ممكن ان تحدد هويتكم في أي تقرير للنشر أوفي اي .الطبية والأكاديمية . ونود أن نؤكد لكم ان لن عرض تقديمي .
إذا كنت ترغب في قراءة التقارير التي نشرت الدراسة يمكن توفيرها لك من قبل فريق البحث . كما سيتم دعوتك لحضور حدث تبادل المعرفة حيث سيتم تقديم البحث لكل الناس الذين شاركوا في الدراسة و الذين يهتمون في نتائجها ومن المقرر أن المناقشة البحث سوف تتناول المواضيع حول كيفية التصرف بناءا على نتائج الدراسة . والأمر متروك لك ما اذا كنت ترغب في حضور هذا الحدث .

من الذي ينضم ويمول البحث ؟

وقد تم تنظيم هذا البحث من قبل وزارة الممارسة العامة والرعاية الأولية لجامعة غلاسكو. ويجري تمويل البحث من قبل الكلية الملكية للاطباء الممارسين . لا يوجد أي تمويل التجاري يشارك في هذا البحث .

من الذي استعرض الدراسة ؟

وقد استعرضت الدراسة من قبل كلية الطب والطب البيطري وعلوم الحياتية , لجنة الأخلاقيات , جامعة غلاسكو.

الاتصال للحصول على مزيد من المعلومات :

ذإا كنت مهتما في المشاركة في هذه الدراسة أو لديك أي أسئلة أخرى يرجى التحدث إلى آنا ماثيوز مباشرة عندما تحضرجاتماع جموعة لانساء لامقبل .وبدلا ميكن لااتصالبـ نآا ماثيوزبماشر ةنع طريـ ق لااتصال بلرقم عة لاتاسعة صباحا حتى لاخامسة عصرا من لاثلاثاء لاى لاجمعة او الاتصال عن طريق لابريد الالكتروني
. anna.matthews@glasgow.ac.U.K.
او الكتابة على العنوان الاتي :

Anna Matthews
Department of General Practice and Primary Care
University of Glasgow
1 Horselethill Road
Glasgow
G12 9LX

بدلا من ذلك، لا تتردد في الاتصال بأحد أعضاء آخرين من فريق البحث :

Kate O'Donnell

سأتاذ الرعاية الأولية، قسم الممارسة العامة والرعاية الأولية، جامعة غلاسكو. اه
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Frances Mair,

سأتا ذ لاممارسة لاعامة، قسم لاممارسة لاعامة ولارعاية الأولية، جامعة غلاسكو .هاتف
Email : Frances.Mair@glasgow.ac.U.K.

شكرا جزيلا لأخذ الوقت الكافي لقراءة ورقة المعلومات هذه والاخذ بنظر الاعتبار إلى المشاركة في هذه الدراسة. أذا كنت ترغب, يرجى مناقشة هذه المعلومات مع أصدقائك وعائلتك .

Appendix 9: Consent Form

University of Glasgow | Institute of Health & Wellbeing

CONSENT FORM: Participants

Title of Research Project: Exploring the decision to take part or not take part in cervical screening by asylum seeking and refugee women.
Name of Researcher: Anna Matthews

Please initial box

I confirm that I have read and understand the information sheet for the above study. ☐

I have asked all the questions I want ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

I know it is OK to say no. It won't affect my rights, services, supports or participation in the women's group if I say no. ☐

I agree to the interview being tape-recorded. ☐

I agree to photographs being taken of any written or drawn work produced during the interview. ☐

I give my consent to the use of the data collected during interview on the understanding that:

- All data will be anonymised.
- The data will be treated as confidential and kept in secure storage at all times.
- All paper copies of the data will be destroyed once the project is complete.
- Electronic copies of the data collected will be retained in secure storage for future academic research. ☐

- The material may be used in future publications both in print and online.

Sign here if you agree to take part.……

Date……..

Name……..

Signature of researcher……

Date……..

Name of researcher…….

Appendix 10: Arabic Version of Consent Form

University of Glasgow | Institute of Health & Wellbeing

استمارة موافقة المشاركون

موضوع البحث :

استكشاف قرار المشاركة أو عدم المشاركة في فحص عنق الرحم بين مجموع السيدات الطالبات اللجوء واللاجئات .

اسم الباحثة : انا ماثيوز

يرجى وضع علامة امام الاستفسارات الاتية :

أنا أقر بأنني قرأت وفهمت ورقة المعلومات الخاصة بالدراسة أعلاه

لقد وضعت جميع الأسئلة التي اود السؤال عنها

وأنا أفهم أن مشاركتي هي طوعية وأنني حرة في الانسحاب في اي وقت دون ابداء أي سبب .

وأنا أعلم أنه ممكن لي ان امتنع عن المشاركة وذلك لن يؤثر على حقوقي أو على الخدمات والدعم المقدم ضمن مجموعة النساء التي انضم اليها في حالة عدم المشاركة .

أنا أوافق على تسجيل المقابلة صوتيا .

انا اوافق على اخذ الصور لاي مستندات كتابية او صورية ناتجة من جراء المقابلة .

أعطي موافقتي على استخدام البيانات التي تم جمعها خلال مقابلة على

فهم ما يلي:

_ سيتم تكون كل البيانات مجهولة المصدر.

_وسيتم التعامل مع البيانات على أنها سرية ويتم الاحتفاظ بها في خزائن آمنة في جميع الأوقات.

سيتم تدمير جميع نسخ ورقية من البيانات مرة واحدة عند اكتمال المشروع .

_ سيتم الاحتفاظ بلنسخ إلكترونية من البيانات التي تم جمعها في مخازن آمينة لكي تستعمل في الدراسات الاكادمية اللاحقة .

_ البيانات ممكن استخدامها في المنشورات المستقبلية سواء كانت على شكل مطبوعات أوعلى الإنترنت.

رجاء التوقيع في حالة الموافقة على المشاركة ..

Signature ……

التاريخ Date ……..

الاسم Name ……..

توقيع الباحث Signature of researcher ……..

التاريخ Date……..

اسم الباحث Name of the researcher……

Appendix 11: Topic Guide Individual Asylum Seeker and Refugee Women's Interviews

Aim of interview. To find out about:

- Uptake of cervical screening
- Barriers and facilitators in accessing cervical screening services within primary care
- The effect of policies and newspaper stories on the decision to access preventive medical services

Please note sections in *italics* will act as prompts for the interviewer.

Introductions

- AM will introduce herself to the interviewee.
- Interviewee will be asked to introduce themself and provide the following information: age, country of birth, ethnicity, education, number of children and if they are registered with a GP.

Questions

1. In your country if you needed to see a Doctor what would you do? *(Did you have a GP in your country of origin? what role do they play?)*
2. How did you register with a GP when you arrived in Glasgow?
3. Did anyone explain to you how healthcare works in Scotland, when you arrived in Glasgow? *(Who? did they explain what services you can use? did they explain what your rights are?)*
4. Have you ever had your rights to healthcare questioned? *(Have you ever been denied services?)*
5. Have you had much contact with your GP since arriving in Glasgow? *(talk through experiences of this)*
6. Are you aware of what a cervical smear test is?
7. Before coming to the U.K. did you attend for cervical screening?
8. Were you aware of cervical cancer as a disease? *(Do you see yourself as being at risk of cervical cancer?)*
9. Have you ever had a letter from the health board inviting you for a cervical smear test? *(What did you do when you received the letter? Were you able to understand it? Did you discuss the letter with anyone?)*
10. If you attended for the cervical smear, why did you decide to attend? OR If you didn't attend for the cervical smear, why did you not attend? *(Talk through experience of attending)*
11. What influenced your decision to attend? (*Were there any other influences such as newspaper stories or friends/family experiences that influenced your decision to attend?*)
12. Can you tell me about any stories you have read about asylum seekers or refugees in the newspaper?

13. How did these stories make you feel when you read them? *(Do you feel that these stories were a fair representation of asylum seekers and refugees? Was the story negative or positive? Did the story make you worry about what people think of you and your family?)*
14. Does anyone in your community talk about newspaper stories about asylum seekers and refugees?
15. Have any stories in the newspaper ever made you feel differently about going to your Doctor for anything?
16. Do you feel that newspaper stories have ever affected your experiences of healthcare?
17. Is there anything else you wish to talk about that we haven't covered?

Appendix 12: Topic Guide Focus Group Interviews

It is anticipated that there will be repeated focus groups (maximum of 3) with the same group of women to allow in depth coverage of the topics.
Please note the sections in *italics* are prompts for the interviewer.

Focus Group 1: Women's Background and Context Building

Focus Group 1 shall be based around constructing a narrative around the women's life experiences so far, their backgrounds and build a context for the rest of the project. Influenced by an intersectional approach it also aims to gently unpack the individual women's identities, roles, and potential changes in these throughout their life course so far.

Introductions: Names, age, country of origin, children, how long have lived in Glasgow.

- Where did you grow up?
- Where were you educated?
- Life events, such as marriage, children etc.
- Why did you come to Glasgow? *(open to discussion about time to get to Glasgow, journey through the asylum process, any other countries passed through, any experiences of healthcare during these times)*
- What was life like at different points in your timeline? *(Discuss roles at different points in life-i.e., mother, wife, care giver, occupation?)*
- Do you feel that your roles now are different from before you came to Glasgow?
- What experiences of healthcare did you have at different points in your journey? *(what did you attend the Doctor for before? what influenced your decision to attend the Doctor before?)*

Focus Group 2: Exploring Deservingness

Focus Group 2 will aim to explore where asylum seeking and refugee women feel positioned within Scottish Society by the media, healthcare entitlement and those that they come into contact with. The influence that this has on their feelings of deservedness for health care and sub sequentially the decisions that they make around this shall be explored.

- How do you find life in Glasgow? *(Do you feel welcomed by the community? Positive and negative experiences?)*
- Do you read any newspapers which are written in the U.K.?
- Can you tell me about any stories you have read about asylum seekers or refugees in the newspaper? *(What did you think of these stories? Were these stories a fair representation of asylum seekers/refugees? Was the story negative or positive? Do people in the community talk about these stories? Do you think it influences their attitude towards you?)*
- Did anyone explain to you how healthcare works in Scotland, when you arrived in Glasgow? *(Who? did they explain what services you can use? did they explain what your rights are?)*

- Have you ever had your rights to healthcare questioned? *(Have you ever been denied services?)*
- Have any stories in newspapers ever made you feel differently about going to your Doctor for anything?
- Do you ever find what you read in a newspaper about asylum seekers or refugees confusing in comparison to what you were told about your rights?

Focus Group 3: Healthcare Decision Making

Focus Group 3 aims to bring together the discussions from the previous 2 focus group sessions to become more focused on decision making with regards to health, in particular cervical screening. Women will be given the option to discuss these issues in an individual interview if they prefer.

- Do you have a GP in Glasgow? *(How did you register/find out about your GP?)*
- In your country of origin how is healthcare organised? Was having a GP a new experience for you?
- What are the main problems that you would go to the GP for? *(Is the GP easily accessible? How do you decide what problem to go to the GP about-influence of friends, family, media campaigns?)*
- Are you aware of what a cervical smear test is? *(Knowledge about cervical cancer? Do you perceive yourself to be at risk of cervical cancer?)*
- Prior to coming to the U.K. were you aware of cervical screening (aka smear test)? *(Had you had a smear test before coming to the U.K.?)*
- Since you have come to the U.K. have you been invited for a smear test?
- If so, what did you do when you received a letter from the health board inviting you for a smear test? *(Did you understand the letter? Were you expecting it? Had anyone from the practice discussed this invite/cervical screening with you prior to the invitation?)*
- What sort of things do you consider when making your decision about whether to go for a smear test or not?
- Do you discuss your invitation for a smear test with anyone else?
- If you decided not to go for a smear test, did you take any other action?
- Has your GP or practice nurse ever discussed your decision about attending or not attending for a smear test with you?
- Can you think of any other times when you would attend the GP practice for a check-up when you feel well?
- How do you find this experience?
- On reflection of all the things we have discussed during the 3 focus groups, do you feel that any of the things that we have discussed *(such as your different roles, your experiences, newspaper stories and your rights)* influence your decision to attend for a cervical smear or any other form of health check?
- Is there anything else you wish to talk about that we haven't covered?

Appendix 13: Topic Guide Healthcare Worker

Aim of interview:

To gather information about:

- The health care professional's experiences of working with asylum seekers and refugees
- Any barriers that they have experienced in providing care to this population
- Any facilitators that they have experienced in providing care to this population
- Experience of cervical screening in this population
- Emphasis on preventive medicine in this population
- Influence of policy and newspapers

Introduction:

- AM will introduce herself to the interviewee
- The Health Care Worker will be asked to introduce themself and provide the following demographic information: age, gender, professional background, country of birth, ethnicity and role within the practice. Basic information shall also be asked about the practice and the community which it serves.

Questions for all Interviewees

1. How many asylum seekers and refugees are registered with your practice?
2. What is your experience of working with asylum seeking and refugee women? *(Length of time working with this population? Did you receive any training about asylum seekers needs, working with interpreters etc? Do you feel that there are cultural issues that affect the dynamic of your consultations?)*
3. What are the challenges in providing a health service to this population?
4. Can you think of any factors which help in providing a health service to this population?
5. Can you tell me about asylum seekers/refugees rights to health care in Scotland?
6. Are you aware of any specific policies/guidance around asylum seeker rights to healthcare in Scotland? *(Are you aware of policies surrounding equal rights that may apply to asylum seekers/refugees?)*
7. Are there discussions within the practice regarding any policies about asylum seeker/refugee health and healthcare access?
8. How did you or the practice become aware of these policies? *(Did you find them easy to find?)*
9. How do you feel the community that you serve responds to the asylum-seeking population? *(Are you aware of any attitudes or opinions of the wider community about asylum seekers/refugees' rights to health care or use of health care?)*
10. Do you read any U.K. based newspapers?
11. Can you tell me about any stories you have read about asylum seekers and refugees?

12. How do these stories make you feel? *(Do you feel they are an accurate reflection of asylum seekers/refugees in Scottish Society? Do you feel that the stories take a negative or positive stance on asylum seeking/refugee populations?)*
13. Are there discussions within the practice relating to newspaper stories about asylum seekers and refugees?
14. Do newspaper stories lead to any discussion about asylum seeking/refugee patients' entitlement to healthcare?

GP and Practice Nurse Only

15. In your experience what are the main health issues that you deal with in the asylum seeking/ refugee female population?
16. Can you tell me about the provision of preventive healthcare for the asylum seeking/refugee population within your practice?
17. What is the uptake of cervical screening by asylum seeking/refugee women within the practice?
18. In your experience do you feel that this is considered a priority for asylum seeking/refugee women?
19. What do you think the barriers for asylum seeking/refugee women will be in accessing the cervical screening service?
20. Do you feel that Female Genital Mutilation may act as a barrier for cervical screening in some asylum seeking/refugee women? *(What would you do if you suspected this to be the case? Has this ever been an issue in your practice?)*
21. Have you ever identified FGM during a cervical smear? *(How confident would you feel in the identification of FGM? How would you deal with this in the consultation?)*
22. What do you think acts as facilitators for asylum seeking women accessing the cervical screening service?
23. Are there any difficulties for you in providing this service to asylum seeking/refugee women?
24. What enables you to provide this service?
25. What would help you both individually and as a practice to provide the cervical screening service to asylum seeking/refugee women?
26. Would the above factors help to provide other types of preventive health services to this population?

Receptionist Only

1. What is your experience of asylum seeking/refugee women arranging cervical smear tests?
2. Have you had experience of asylum seeking/refugee women enquiring about smear tests or invitations they have received? *(if so what information do you give?)*
3. Do you feel that there are any challenges in organising this appointment for asylum seeking women?

4. Do you feel that there are any challenges for the woman in making the appointment?
5. Is there anything that could improve the organisation of this service for asylum seeking/refugee women?

Appendix 14: Topic Guide Community Worker

Aim of interview:

Gather information regarding:

- Community link workers perceived barriers and facilitators for preventive primary care
- Their experiences of asylum-seeking women's perceived entitlement to healthcare
- The effect of policies and media on asylum seeking/refugee women's access to healthcare

Introductions:

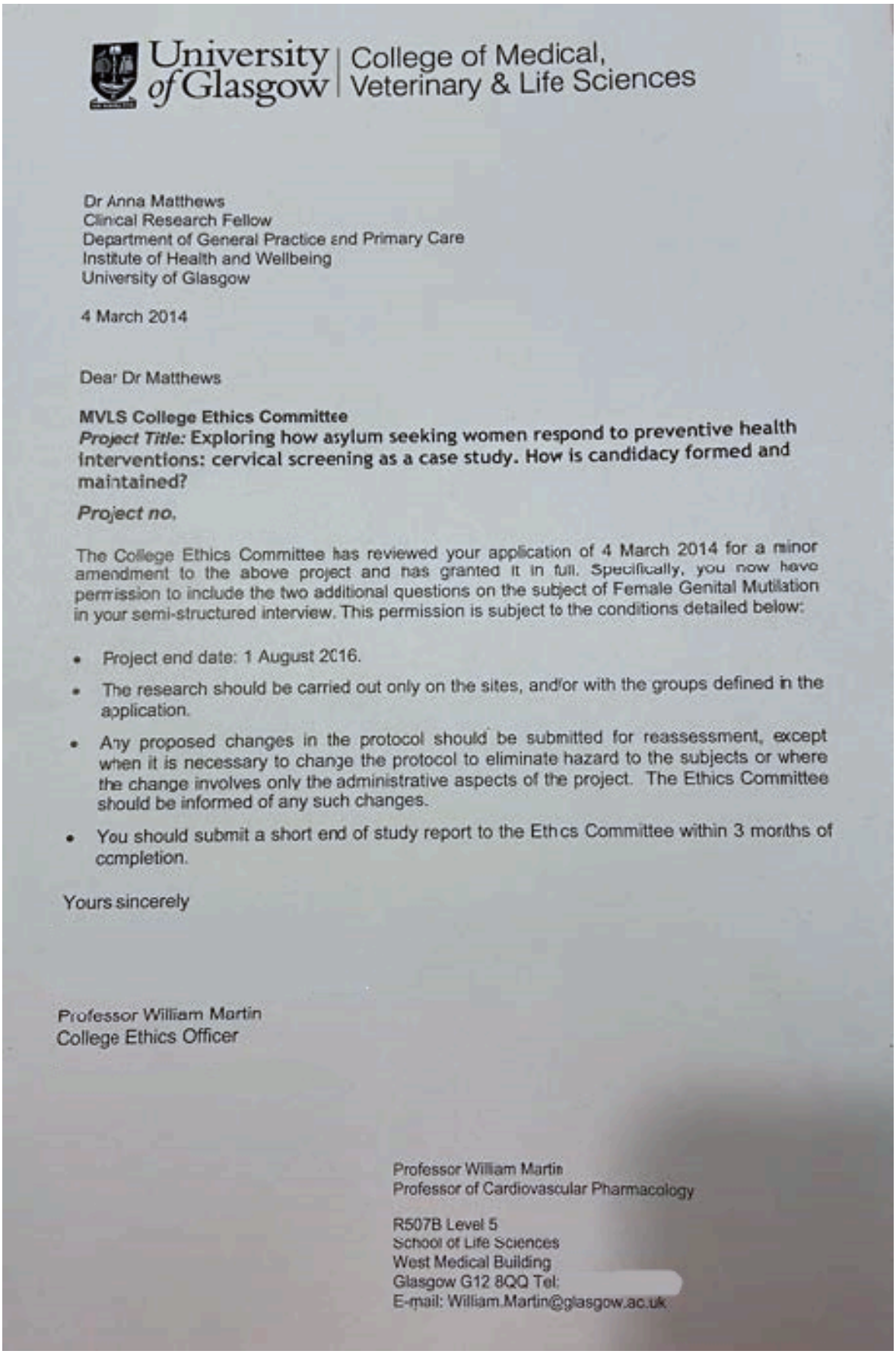
- AM will introduce herself to the interviewee
- Interviewee will be asked to introduce themselves and provide information on their age, gender, country of birth, ethnicity, experience of working with asylum seeker, refugee and migrant groups and their role within the community organisation.

Questions:

1. Within the women's groups that you work is there discussion about health issues?
2. If so, what issues are discussed?
3. Do you provide any signposting for health services?
4. Have you ever supported a woman in accessing a health service?
5. In your experience how do women find out about their rights to healthcare?
6. Are you aware of any policies about asylum seeking/refugee women and health?
7. From your experience as a community worker, are these policies enacted in practice? *(can you give an example of this?)*
8. What experiences have been fed back to you about the women's experiences of accessing GP services?
9. Are there any similarities between your own experience of going to your GP and that of the women in the group?
10. Have you been aware of the experiences of the women in accessing cervical screening service?
11. What do you think the barriers may be for asylum seeking/refugee women in attending cervical screening services?
12. In your experience, what do you feel helps women in attending cervical screening?
13. In your view what factors do you think impact on an asylum seeking/refugee woman's decision making about whether to attend for a cervical smear or not?
14. What factors impact on women accessing health services/ cervical screening? *(Community?, peers?, media?)*
15. Do you read any U.K. based newspapers?

16. How do you feel that asylum seekers and refugees are portrayed in the newspapers?
17. Do you feel that this impacts on women's decision making about accessing healthcare?
18. Do you feel that newspaper stories affect how asylum seekers/refugees are treated when accessing health services?
19. Is there anything else you wish to talk about that we haven't covered?

Appendix 15: Ethics Amendment: FGM and Recruitment



University of Glasgow | College of Medical, Veterinary & Life Sciences

Dr Anna Matthews
Clinical Research Fellow
Department of General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow

4 March 2014

Dear Dr Matthews

MVLS College Ethics Committee
Project Title: **Exploring how asylum seeking women respond to preventive health interventions: cervical screening as a case study. How is candidacy formed and maintained?**

Project no.

The College Ethics Committee has reviewed your application of 4 March 2014 for a minor amendment to the above project and has granted it in full. Specifically, you now have permission to include the two additional questions on the subject of Female Genital Mutilation in your semi-structured interview. This permission is subject to the conditions detailed below:

- Project end date: 1 August 2016.
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Professor William Martin
College Ethics Officer

Professor William Martin
Professor of Cardiovascular Pharmacology

R507B Level 5
School of Life Sciences
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Glasgow G12 8QQ Tel:
E-mail: William.Martin@glasgow.ac.uk

University of Glasgow | College of Medical, Veterinary & Life Sciences

Dr Anna Matthews
Clinical Research Fellow
Department of General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow

18 October 2013

Dear Dr Matthews

MVLS College Ethics Committee
Project Title: **Exploring how asylum seeking women respond to preventive health interventions: cervical screening as a case study. How is candidacy formed and maintained?**

Project no. [redacted]

The College Ethics Committee has reviewed your application of 15 October 2013 for minor amendments to the above project and has granted them in full. Specifically, you now have permission to: (i) use a flier to advertise the research to potential participants; (ii) allow community workers, volunteers and other participants to pass on contact details to AM; and (iii) increase the maximum number of community workers to 6 persons. These permissions are subject to the conditions detailed below:

- Project end date: 1 August 2016.
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Professor William Martin
College Ethics Officer

Professor William Martin
Professor of Cardiovascular Pharmacology

R507B Level 5
School of Life Sciences
West Medical Building
Glasgow G12 8QQ Tel:
E-mail: William.Martin@glasgow.ac.uk

Appendix 16: Coding Dictionary Newspaper Analysis

Themes

Migration Impact on host country: Population growth, cost: benefit ratio of migration, contribution from migrants, talent, overseas students

Health: Health Tourism, Healthcare workers, Health Access, Infectious Diseases, Mental Health

Border Security: Migration Controls, Immigration Controls, ID checks, Migration numbers, Criminalisation- fingerprints, biometrics, illegality, immigration deterrents.

Policy: Policy, Welfare Policies, Entitlement, this includes EU policy and law, healthcare policy and guidance.

Political Popularity: Votes, politics, public opinion, political pledges, different political parties, campaigning.

Welfare and Resources: Benefits, budget, economy, employment, housing, austerity, health spending, poverty.

Racism: Labelling, stereotyping, fascism.

Devolved Needs: Scotland's needs, differences, independence debate.

Impact of Migration on the migrant: social problems, crime, homelessness, alcohol, pull factors, push factors, reasons for migration.

Integration: Individual stories, community groups, education, awards, bravery, cultural awareness, language, theatre, mixture of services/shops etc, cultural awareness, assumptions made towards population groups, overcoming language barriers, religion, personal relationships, comparisons between what migrants get and what other members of the public get.

Migrant Hierarchy: Class divide, low skilled vs high skilled, some groups being more desirable than others.

Public Feeling: Community or local people's feelings, unknown, fear, blame, "them and us", confusion, insecurity and panic.

Human Rights: Abuse, violence, human rights, murder, trafficking, force, FGM, cultural practice, living conditions.

Stereotyping/ Assumptions: assumptions or stereotypes made towards the migrant population.

Crime and Anti-Social Behaviour: any crimes, terrorism

Type of Article

Feature: An article exploring news stories in more depth. May be triggered by an ongoing news story, purpose is to analyse and explore the reasons why something is happening. Have put articles that call themselves Analysis in this as well.

Letter: A letter that is written to the newspaper from an outside source, i.e., not a journalist.

Editorial: Article in a newspaper presenting the opinion of the newspaper (as a collective) about issues in the community, not usually about personal issues. (see http://www.wayneindependent.com/article/20111208/NEWS/312089994)

Column: This is written by one staff member or a celebrity and is usually about their individual opinion on something. It may be designed to either inform or entertain. Can be about a wide variety of issues. (see http://www.wayneindependent.com/article/20111208/NEWS/312089994 and BBC Bitesize definitions)

News: Found at the start of a newspaper, inform readers about what is happening in the world or local area. (see http://www.bbc.co.U.K./schools/gcsebitesize/english/creativewriting/commissionsrev2.shtml)

Comments: Multiple comments being made about news stories, either by journalists or members of the public.

Health Article

To be included as a health article the main focus of the article must be health. There is a query section in the classifications section for articles which I am unsure whether they fulfil this criteria, therefore, to check with Kate's list or double check with both Kate and Nicky.

Migrant Group

Asylum Seeker/Refugee: An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the ECHR. Article 3 of the European Convention on Human Rights (ECHR) states that 'No one shall be subjected to torture or inhuman or degrading treatment or punishment'. A person can make a claim for protection based directly on Article 3 of ECHR as states are prohibited from returning a person to a country where she/he may suffer a violation of his/her rights under Article 3.

A refugee is a person 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 to or, owing to such fear, is unwilling to avail himself of the protection of that country…' (Definition quoted from the 1951 Refugee Convention)

Refugee status is awarded to someone the Home Office recognises as a refugee as described in the Refugee Convention. A person given refugee status is normally granted leave to remain in the U.K. for 5 years, and at the end of that period can apply for Indefinite Leave to Remain. See *ILR*.

Current EU Migrants: Current EU migrants refers to migrants who are currently within the free movement allowed by the EU and already migrate to the U.K., therefore excluding A2 Accession State Migrants but including A8 accession state migrants.

A2 Accession State Migrants: Using the definition of migrant above. This classification refers to those included in that definition but who are from the A2 accession state and therefore whilst included in the EU they still have to ask permission to come to the U.K.- countries are Romania and Bulgaria

Undocumented migrants: Irregular migrants (or undocumented / illegal migrants): people who enter a country, usually in search of employment, without the necessary documents and permits. (from http://www.unesco.org/most/migration/glossary_migrants.htm)

Migrant from outwith the EU: Any migrant fulfilling the definition above but from outwith the European Union and A2 Accession States.

Mixed: Mixed refers to the article using mixed terms. Therefore, talking about lots of different groups of migrants/asylum seekers/refugees

Unclear: Refers to when it is unclear which population group the article is referring to.

Tone Migration

What is the overall articles tone towards migration as an issue, not the individuals? Can choose mixed tone if feels that some positive and some negative stances are taken, for example about different groups of migrants.

Tone Migrant

What is the overall articles tone towards individual migrants (covering all migrant groups above) or migrant groups?

Reason for Article

Statistics or Research Finding: Where a new statistic or research finding is being presented.

Government Action: This broad term covers all actions from Governments- policy change, speech, letter

Individual story: Where an individual's story or experience is being told or discussed.

Community Action: Any meetings, protests, events or action undertaken by community groups or community members.

Event or Incident: An acute piece of news, something new that has happened.
Ongoing news story or discussion: When something has not happened acutely but is a story or discussion that has been ongoing for a while.

Unclear: On reading the article as a stand-alone article it is unclear why it was written or what prompted it.

New Policy or Guideline: Any new policy or guideline which is being introduced not by the Government.

Headline Tone

The tone of the headline- i.e., if you just read the headline would you feel the story was going to be positive, negative or neutral about migration/migrants. There is also the option for non-applicable as many columns for example always have the headline of the columnist no matter what the story, n/a will also apply if the headline does not specifically mention migrants/migration.

Headline Consistency

Is the subject matter of the headline consistent with the subject matter of the rest of the article?

Figures Quoted in the Article

Figures Migrants: covers any figures about migrants- including current EU, A2 Accession State Migrants, Undocumented Migrants and non-EU migrants.

Figures Unclearly Defined Group- this is if the article has quoted a figure, but it is unclear which population group they are referring to.

Figures Asylum Seeker/Refugee- Any figures in the article relating to asylum seeker and refugee groups (as defined above)

Appendix 17: Ethics Approval

University of Glasgow | College of Medical, Veterinary & Life Sciences

9 August 2013

Professor Catherine O'Donnell
General Practice and Primary Care
University of Glasgow
1 Horselethill Road
Glasgow
G12 9LX

Dear Professor O'Donnell

MVLS College Ethics Committee

Project Title: Exploring how asylum seeking women respond to preventive health interventions: cervical screening as a case study. How is candidacy formed and maintained?
Project No:

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. It is happy therefore to approve the project, subject to the following conditions:

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Professor William Martin
College Ethics Officer

Professor William Martin
Professor of Cardiovascular Pharmacology

R507B Level 5
School of Life Sciences
West Medical Building
Glasgow G12 8QQ Tel:
E-mail: William.Martin@glasgow.ac.uk

Appendix 18: Gramnet Blog[13]: The Divides That Bond Us

The Divides That Bond Us

by Anna Matthews

The recent EU referendum has sparked an unwelcome change in British society. Racism and anti-immigration sentiment has always existed, but it has now become acceptable in everyday language, the media and in politics. This has become translated into actions such as verbal abuse towards ethnic minorities, posting 'go home' messages through people's doors and drawing swastikas on national monuments. However, there have been moments of light: pro-immigration and refugee marches, positive messages about immigration from the Scottish Government and outrage on social media.

In this particularly dark and divisive time I have been thinking about the unexpected bonds I have made over the last few years, in a place where I had assumed difference would dominate. I attend a women's group in the Govan area of Glasgow as part of my PhD, mostly attended by women who are either asylum seekers and refugees. I initially attended this for work purposes but 4 years later I am still going, due to the unexpected bonds and friendship that I found there.

Photo: Anna Matthews

[13] https://gramnet.wordpress.com/2016/07/12/the-divides-that-bond-us/

The first time that I attended this group I stood outside the drab high rise (since demolished) where the community flat was based and stared at the graffiti on the walls and the broken glass on the pavement. Why would anyone want to meet here? However, once inside it was a different matter the walls were colourful, there was loud chatter in different languages, including some broad Glaswegian, and the air was thick with the aroma of cardamom and spices. The dreich, grey day outside was forgotten.

I had expected to have little in common with the women in this group and indeed expected them to have little in common with each other, as all that initially linked them was the asylum process. They were from different countries, of varying ages, languages, cultures and religions and they had all made a different, often traumatic journey which led them to that community flat. All I had done was take a bus ride through the Clyde Tunnel.

However, despite these substantial differences, we were bonded by much more. We were bonded by our love for family and our roles as women: as mothers, daughters, sisters, wives and aunties. In preparing food together, we created a common language, a sharing of culture, memories and home. On reflection, I wonder whether the bonds between many of the women grew out of necessity, through a forced existence and dispersal through the asylum system, but if it was purely necessity would there be so much fun and laughter within the group?

I am also part of a book club, a group that did not grow out of necessity or shared trauma, but rather from 3 west end women trying to motivate themselves to read more. We are now 8 women, all professionals, all white and mostly of Christian or secular backgrounds. However, both of these groups have more in common with each other than you would initially think. In both groups the primary aim of the groups have been superseded by the importance of spending time with one another; hearing about love lives, families, jobs and any other pieces of gossip. In both groups, food is cooked, appreciated and shared. Both support each other through illness, fights with partners, break ups and happy times, such as marriage, graduations, charity work and the births of children. At book club we offer love life advice, analyse text messages, admire any new shoes and occasionally talk about the book: the women's group provide alibis to evade their household chores, gossip, learn new skills and use the Wi-Fi to do online shopping together.

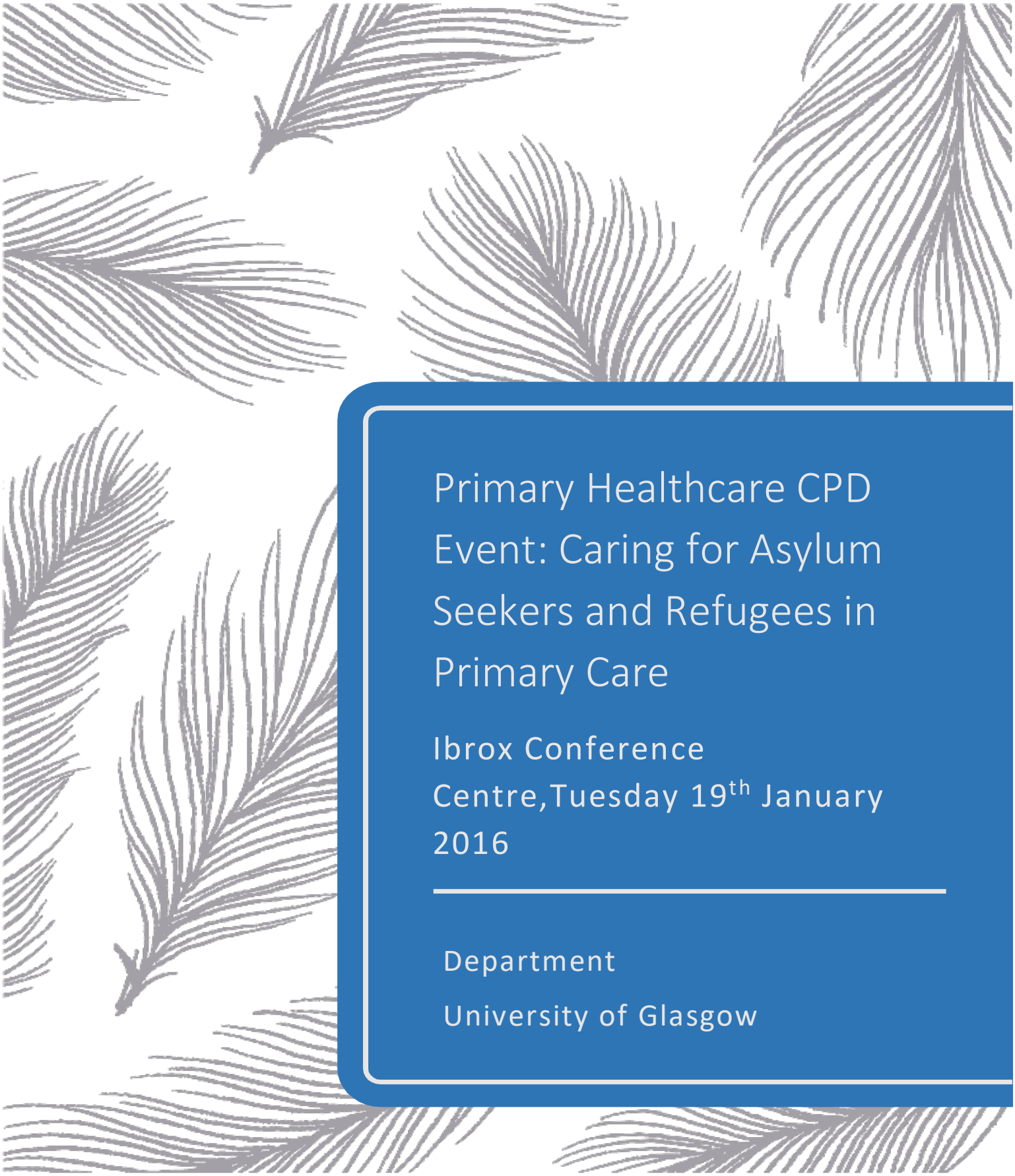
Photo: Anna Matthews

Just before my wedding I was lucky to have a number of hen parties, including one with book club and one at women's group. Both were remarkably similar, although different customs and traditions shone through, as they both marked a milestone in my life which was celebrated with other women. They were both important rite of passage with advice given from married women, good wishes for my life ahead, gifts, and a celebration of our friendships as women. Both hen parties were joyous occasions and although different in style, included dancing, dressing up as a bride (one in traditional Sari and one in a white dress) and a lot of laughter.

I left each hen party with gifts; henna on my hands from the women's group and silver sixpences from the book club. As I think about these now, in these particularly difficult times, I appreciate that in this world there is so much more that bonds us than divides us.

***Anna Matthews** is a final year PhD student in the department of General Practice and Primary Care at the University of Glasgow.*

Appendix 19: GP Training Feedback Report



University of Glasgow
Institute of Health & Wellbeing

Organisers

Anna Matthews: Department of General Practice and Primary Care, University of Glasgow

Supervised by Prof. Kate O'Donnell and Prof. Frances Mair, General Practice and Primary Care, University of Glasgow.

Sponsored by…

The Scottish Government

Special Thanks to…

Christine Fitzpatrick and Jane Goodfellow for all of their admin support.

All speakers

Blythe Robertson at the Scottish Government

Staff at Ibrox Conference Centre

Report Author

Anna Matthews
March 2016

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1. Background of this event

This event was organised in response to the recent Syrian Refugee Crisis, which has led to Syrian refugees being dispersed across Scotland. Glasgow has been receiving asylum seekers and refugees for around 15 years and within the areas receiving asylum seekers and refugees' community and health services have become specialised in dealing with their needs.

Anna Matthews has interviewed a number of primary healthcare workers who care for asylum seekers and refugees in Glasgow. They described feeling that there was a lack of training around caring for asylum seekers and refugees both at the time of initial dispersal of asylum seekers/refugees to Glasgow and now. Services interviewed felt that they 'learnt on the job' and would have appreciated more formal learning opportunities.

It was recognised that it was important to learn from the past and try to provide training as many of the refugees who are being dispersed from Syria, will be placed in areas where healthcare services have no previous experience of caring for this population. It was decided that this training would start at a basic point, giving a broad-brush overview of NHS Scotland's response to asylum seekers and refugees, their entitlement to healthcare, services, both clinical and community, which are available to them and the clinical needs of asylum seekers/refugees. There was a recognition that this was very much an introductory evening to caring for asylum seekers and refugees, and that further, more in-depth training may be needed afterwards. Hence, this was also an information gathering session to evaluate where the needs for training and support are.

2. Structure of Event

This was an evening event running from 6.30pm-9pm. Teas and coffee were provided for the first 30 mins and then the following 2 hours consisted of 8 short talks and a panel discussion. The agenda was as follows (see appendix for full agenda and speaker biography):

Time	Title of Talk	Speaker
7pm	Introduction from Chair	Dr Anna Matthews
7.05pm	Overview of NHS GGC Response to current Refugee Crisis	Ann Forsyth
7.15pm	Overview of role of Scottish Refugee Council	Martha Harding
7.25pm	Caring for Asylum Seekers and Refugees, Lessons from Research	Prof. Kate O'Donnell
7.35pm	Asylum Health Bridging Team	Ann Forsyth
7.45pm	A GP's Experience of working with asylum seekers and refugees	Dr Ruth Keir Dr Rebecca McFarlane
7.55pm	Advice from a Practice Manager	Michael Martin
8.05pm	Compass, NHSGGC: Working with the mental health effects of trauma	Dr Rachel Morley
8.15pm	Community Organisations: Govan and Craigton Integration Network	Isabel Harland
8.25pm	Close of Presentations by Chair	Dr Anna Matthews
8.35pm	Panel Discussion	

3. Attendees

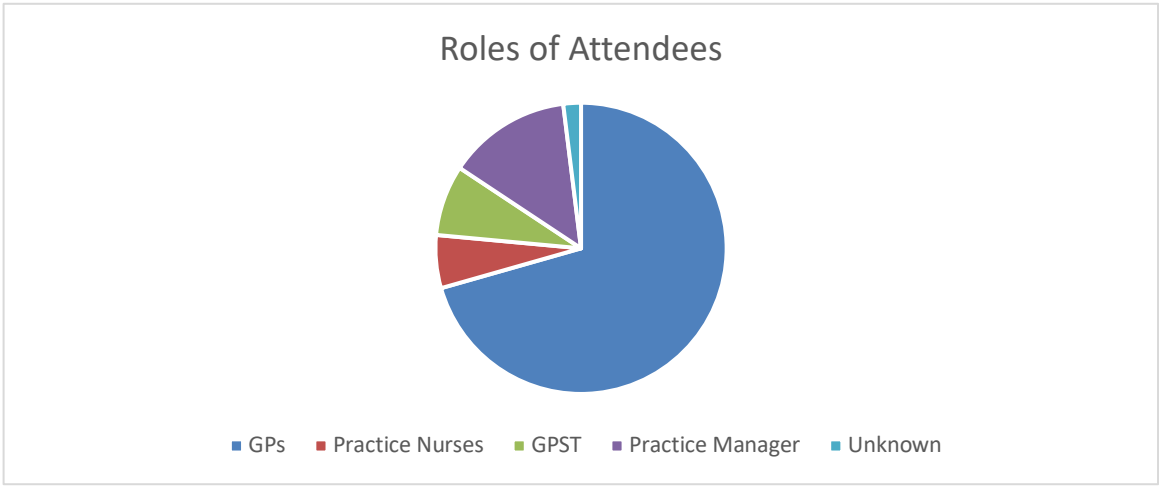
The department of General Practice and Primary Care (GPPC), University of Glasgow, runs a number of CPD events for GPs throughout the year on a variety of clinical issues which GPs pay a fee to attend, therefore the event was organised using this template.

This event was free, due to its important nature. GPs, Practice Nurses and Practice Managers were all invited to the event, as caring for asylum seekers/refugees requires a team-based approach and often practice nurses, managers and reception staff come into contact with patients before the GP. It was advertised on Eventbrite, through the West of Scotland Royal College of GPs (RCGP) mailing list and was shared by a number of other parties, such as the Scottish Junior International Committee.

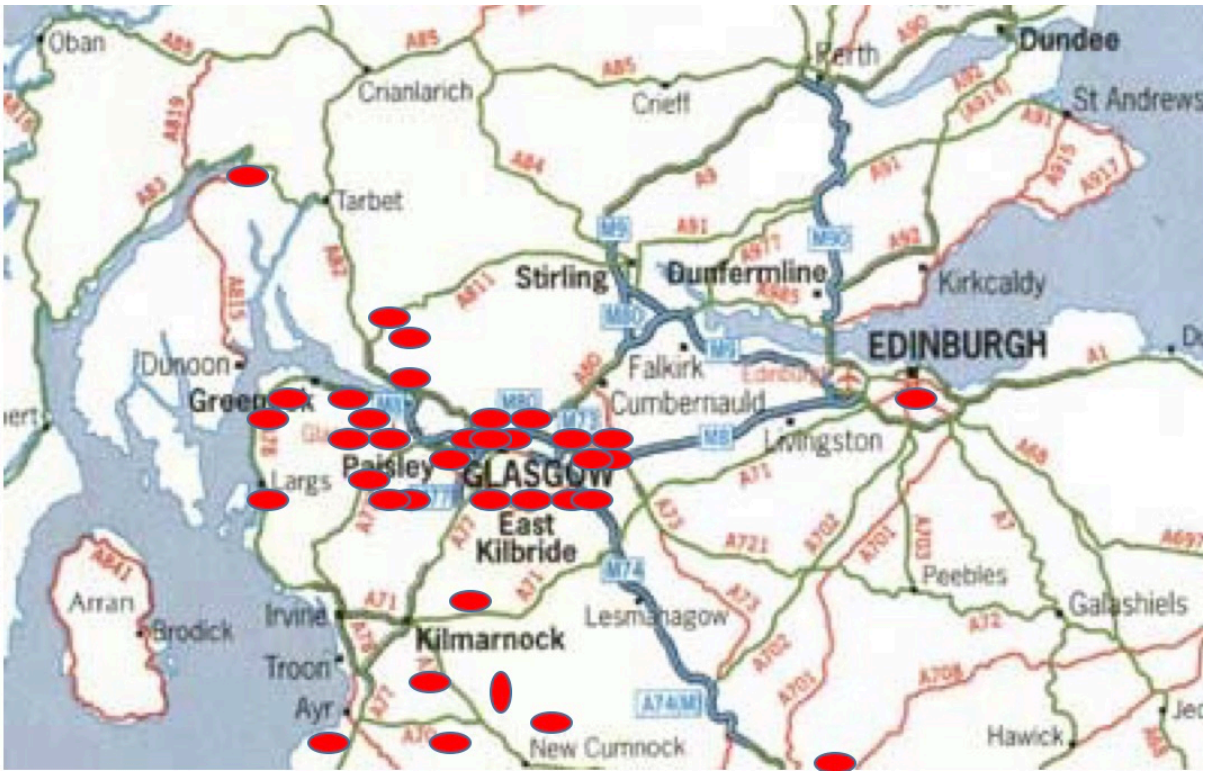
The conference room at GPPC holds 40 people which has previously been sufficient for CPD events. However, there was high demand for this event and 3 days after it being advertised there were 50 people on the waiting list, which was the maximum number the waiting list could hold. We also received emails from a number of GPs asking us to hold a second event or increase the capacity as they felt that they very much needed the training.

At this point the Scottish Government offered to fund a larger venue and basic catering. Therefore, Ibrox Conference Centre was booked, and the capacity of the event was increased to 100.

On the night of the event 80 out of the 100 registered attended. From the 51 feedback forms that were returned the demographics of the audience can be estimated as 36 GPs, 3 Practice Nurses, 4 GP Trainees, 7 Practice Manager and 1 unknown. As can be seen from the chart below:



Due to the event being full after 3 days of advertisement locally, the event was not advertised nationally. However, as can be observed from the map below attendees came from outwith Glasgow. Attendees came as far from Arrochar, Greenock, Ayrshire, Dumfries and Galloway and Edinburgh.



From the 51 attendees who gave feedback, 31 had experience of working with asylum seekers/refugees. Most of this was from working within Glasgow but a number had more specific experience such as working at Dungavel Detention Centre, volunteering in a foodbank, and working in Calais and Lesbos. The other 21 attendees who provided feedback did not have any experience of working with asylum seekers and refugees, but many expressed that they expected to soon with the dispersal of asylum seekers and refugees.

4. Feedback from Event

An event pack was given to all attendees which contained the agenda and speaker biography (see appendix 1), a feedback form (see appendix 2), CPD certificate and a information sheet about the research that the organiser AM is conducting.

51 out of 80 feedback forms were returned at the end of the night. These have been analysed both quantatively, when scoring systems were in place and qualitatively with regards to the free text that was provided. Thematic analysis was performed on free text to find the common themes that came across in the feedback.

4.1 The event as a whole

Attendees were asked to rate the usefulness of the event overall, on a scale of 1-5, as can be seen below.

How useful did you find this event overall? (1=not useful, 5= very useful)				
1	2	3	4	5
Please add further comment….				

The mean score for the event overall was 4/5.

15 attendees added free text, which was very positive in its nature. One attendee questioned how useful this event would be for GP's working in this area regularly, but all other quotes were very positive:

4.2 Individual Speakers

Individual speakers were scored by attendees. They were asked to rate how helpful they found individual sessions from 1-5 (1=not helpful, 5= very helpful). The mean score for each session is shown below:

Ann Forsyth, NHSGGC: Overview of Situation	1	2	3	4	5
Ann Forsyth, NHSGGC: Asylum Health Bridging Team	1	2	3	4	5
Kate O'Donnell, Professor of Primary Care, GPPC	1	2	3	4	5
Scottish Refugee Council	1	2	3	4	5
Becky McFarlane and Ruth Keir: GP experience	1	2	3	4	5
Michael Martin: Practice Manager Perspective	1	2	3	4	5
Rachel Morley: COMPASS	1	2	3	4	5
Isabel Benito: Govan and Craigton Integration Network	1	2	3	4	5
Anna Matthews: GPPC and GCIN	1	2	3	4	5
Panel Discussion	1	2	3	4	5

All talks were popular, with all of them apart from the GP experience scoring a mean of 4/5. The talk entitled 'GP experience' by two GP's experienced in working with asylum seekers and refugees scored higher at a mean of 4.5/5. From the comments this was due to these talks being very clinically focused with lots of real examples.

4.3 Did the event improve attendees' confidence in caring for asylum seekers and refugees?

Attendees rated how confident they felt in caring for asylum seekers and refugees, again on a scale of 1-5 (1=not at all confident, 5=very confident). The mean rating prior to the event was 2.5/5, whereas after the event the mean rating was 3.6/5. Therefore, an increase in confidence of 1.1 in caring for asylum seekers and refugees due to the event.

Prior to this event how confident did you feel in caring for asylum seekers and refugees? (1=not at all confident, 5=very confident)

1	2	3	4	5

After this event how confident do you feel in caring for asylum seekers and refugees? (1=not at all confident, 5=very confident)

1	2	3	4	5

4.4 Take Home Messages

Attendees were asked 'what are the main messages that you will take home from this event?'

41/51 of the feedback forms had this box filled. It was quite striking how the answers had very similar and compassionate themes, as can be shown from this word cloud which was generated from the responses. The size of the word is in direct relation to the number of times it was said.

5. Time

Time was the most cited take home message by attendees. The importance of spending time and if able to giving double appointments to patients who are asylum seekers and refugees was discussed in the answers. Time was seen as the most effective way of building up a relationship, trust and improving care for the patient. However, it was suggested by a number of respondents that this needs to be supported from a higher level, as it was felt there is currently inadequate funding currently for longer appointments.

> 'I agree that this group of patients require more time-this needs to be discussed at a higher level to improve funding to Primary Care.' (GP, Dennistoun)

6. Support

Respondents cited increased knowledge of support services, both clinical and community, as a take home message from the event. Attendees were given information that they were not aware were available in the community, a better understanding of services and an awareness of the range of therapies offered by NHS services, such as Compass.

'There are community resources out there!' (GP, Cardonald)

However, some respondents did express worry regarding the long-term stability of these services.

'I am aware of a number of services/organisations but I am not confident that those services are stable in terms of operation and longevity in terms of funding/staffing' (GPST, Glasgow)

7. GP Role/ Communication

Respondents recognized the important role that Primary Care has in caring for asylum seekers and refugees.

'GP is a point of stability' (GP, East Ayrshire)

It was strongly conveyed that an important take home message had been to listen and, and understand the patient's story. This had a very human element to it in the answers, where the take home messages were seen as being less about illness/disease but more about communication, compassion and understanding.

'Welcome!' (GP, Arrochar)
'Multiple traumas/losses. Need time to understand patients' stories and build trust. Instilling some hope.' (GP, Maryhill)

By attending the event and hearing the speakers, one attendee expressed that it had inspired them to hear the speakers' enthusiasm.

'Heartening to listen to such a compassionate group of professionals working in this field.' (GP, Dennistoun)

The importance of the use of interpreters was identified as an important take home message by many respondents. Many discussed that after this event they were encouraged to use professional interpreters and to try the interpreting service.

8. Expectations of Healthcare

A take home message for many was that of being aware of 'how alien our health system is to people coming from other countries' (GP, Shettleston). A number of respondents wrote that they would now take extra care to explain the healthcare system to new arrivals in order to manage expectations.

9. Asylum System, Rights and Entitlements

Another recognised take home message was the background of the asylum system and the role that the GP can have within that.

Two GPs who are experienced in caring for asylum seekers noted that a take home message for them was that asylum seekers and refugees are entitled to free NHS healthcare at all stages of their journey.

'Good to know that all asylum seekers have the same rights to NHS care as any other resident.' (GP, Glasgow).

This is important both as feedback for the event but also as a finding for the importance of disseminating information to surgeries working with asylum seekers and refugees. As although they both detailed significant experience caring for asylum seekers and refugees, they had not been aware of the entitlement policy.

4.5 Change in Practice

Attendees were asked if this event would change their practice. From the 37 pieces of feedback given by attendees about this area, this event prompted a number of considerations in change of practice. These ranged from wider system changes, practice change and individual consultation change.

10. System Changes

2.1Time

Many of the respondents cited increasing appointment time as a change in practice that they deemed necessary.

"I will continue to organize longer appointments for patients in this group" (GP, Dennistoun)

"Make time" (GP, Ayrshire and Arran)

Ways in which extra time with these patients could be created was discussed.

"Will be more likely to arrange a series of return appointments." (Locum GP)

"Will try and persuade partners to increase appointment time" (GP, Paisley)

However, as was mentioned in the take home messages, the challenge of increasing appointment times was recognized. With regards to funding requirements, need for discussion at a higher political level and the effect on other patients within the practice.

"…longer GP appointments will affect other patient's access to GP services. GP services already stretched and there is a recruitment problem- will there be any more resources available?" (Practice Nurse, Ayrshire and Arran)

2.1GP's Role within the Asylum Process

Two of the respondents noted the importance of being more aware of the asylum process, as this would give them more awareness of what experiences their patient is likely to have had in the asylum process, including the agencies involved.

"Better understanding of their circumstances and how to support them." (GP Locum)

"Better understanding of what a patient will have experienced in terms of agencies involved." (GP Locum)

There was also recognition amongst the majority of respondents that other services play an important role in the immigration process that their patients are going through. A key planned change to practice was increased awareness and referral to these services both within the NHS, such as COMPASS, and third sector organisations such as the Govan and Craigton Integration Network.

"More awareness of local resources available-will be able to access these and direct others to them" (GP, Locum)

"Aware of the role of COMPASS better and when to use, if in doubt I can phone and check" (GP, Fellow)

However, there was worry about the stability of these services.

"I am aware of a number of services/organisations, but I am not confident that those services are stable in terms of operation and longevity, funding and staffing." (GP trainee)

11. Practice Change

A number of respondents, mostly Practice Managers, stated that they would feedback from this event to their practice. This was to practices both experienced and new to caring for this population. Allowing reflection about the care of asylum seekers and refugees to occur at a practice level, which may change processes within the practice.

"Presentation and reflection at a practice level" (Practice Manager, Partick)

"Take the key points back to the practice which has taken on two new Syrian refugee families" (GP, Locum)

"Review current processes, highlight areas we could improve in" (Practice Manager, Glasgow)

12. Consultation Change

Planned changes to individual consultations following this event covered three main areas: consultation skills, specific clinical presentations and language barriers.

Within changes to consultation skills respondents identified that they would take an altered approach to patients who are asylum seekers and refugees. The altered approach would include taking more interest, feeling more confident in approaching these consultations and considering their attitude towards these patients.

"Ensure to listen" (GP, Paisley)

"Explain system" (GP, Maryhill)

A number of specific needs for this population were noted. The majority of attendees found the common conditions and top tips talks given by two GP's the most helpful part of the session. Mental health needs, chronic conditions and screening for blood borne viruses were the most identified changes to disease specific practice.

"Chronic disease management challenging in such patients-need more time to explore it with them" (GP, Clydebank)

"Increased awareness of mental/physical health problems, e.g., Hep B" (GP, Dennistoun)

The utilisation of interpreters within General Practice was identified as being essential to consulting with asylum seekers and refugees, who do not have English as their first language. A number of respondents were planning to look into options for interpreting. Telephone interpreting was also introduced by one of the speakers and this had some mixed reaction.

"I have still to try using telephone interpreting service, so I plan to try using this" (GP, Dennistoun)

"Will try telephone interpreting-although no evidence this is helpful" (GP, Paisley)

4.6 Tweets

All attendees were asked to give an example of what they would tweet about this event. A number of attendees reported that they were, in fact, already tweeting about it positively. Examples of what others felt they would write are shown below:

Informative

Very useful and relevant evening, with a free chocolate bar thrown in

 # HOW HAS THIS HAPPENED!!!

Wish it was organised sooner!!

Consolidate care of asylum seekers and refugees and fund/staff it adequately

What struck me was that all speakers were compassionate, and they inspired me to look beyond the usual pressures I face in an ordinary surgery session.

 # SEE THE INDIVIDUAL

Instil hope in consultations!

Useful. Interesting. We are all human at the end of the day. The problems asylum seekers face could happen to anyone. They should be treated with respect.

13. Further Training Needs or Support

As this was the first specific training event for primary care that had been organised through the Department of General Practice and Primary Care, a

broad approach was taken to the topic, with speakers from many different backgrounds. The organisers were aware that this would only allow a brief overview of each area of caring for asylum seekers and refugees. Therefore, were keen to receive feedback from the audience regarding further training that they would like.

Attendees were very keen for further training in this area, particularly with a more clinical focus. A number of attendees requested further training using clinical scenarios and case-based discussions. This is in keeping with the high scoring of the talks from 2 GPs at the event which were very clinical.

"Further such evenings and more discussion of actual cases" (GP, Locum)

"More clinical training with more time for clinical scenarios" (GP Fellow)

Particular clinical areas that attendees requested to be focused on were consulting skills, female genital mutilation (FGM), mental health, torture, trauma and difficult consultations. GP's working with cases such as these and COMPASS were identified as being the best potential facilitators for these future sessions.

"Would love supportive training from COMPASS on difficult consultations" (GP, Paisley)

Training around using interpreting services was also identified as a future need, both for telephone and face-face interpreting.

"Training on consulting with different patient groups, especially via interpreters" (GP, Locum)

There were also requests for future training sessions to be open to all practice staff, including receptionists and also for more time for the training sessions to occur.

"Training for all practice staff, including reception staff" (Practice Manager, Ayrshire and Arran)

"I think the full team would benefit from attendance at a one-day training event" (Practice Manager, Port Glasgow)

A number of attendees also felt that training around the care for asylum seekers and refugees should be compulsory and built into protected learning time that is already there for primary care.

"This should be compulsory training for all practices, clinical and non-clinical staff. Often people have a positive attitude, but I have witnessed some negative behaviour most likely founded on frustration/ignorance/stereotyping." (GP trainee, Glasgow)

"This may have been better over a morning or afternoon four-hour period. Lots of interesting talks, however a bit rushed. Protected Learning Time events may be a good audience" (Practice Manager, Port Glasgow)

Suggestions for the format of future training included an online forum for resources and advice, e-modules and a knowledge network. The aim of which would be to keep primary care staff up to date, information packs for caring for refugees, protocols and information about local services.

"An online forum for resources/advice" (GP trainee, Glasgow)

"In terms of providing evidence (for the home office) could one of the organisers provide a useful template highlighting what information is most useful?" (GP, Dennistoun)

"Refugee information pack for dissemination" (GP, Locum)

14. Impact Observed So Far from Event

15. Community Support Services

Govan and Craigton Integration Network, who presented on the evening, have had an increase in the number of enquiries from GPs about their services. They have also had requests from a number of practices for medical students to visit their services as part of their placement

16. Inclusion in Health Inequalities Teaching for GP Trainees

NHS Education for Scotland (NES) runs a series of compulsory teaching days for GP trainees in the West of Scotland. One of these days' focuses on health inequalities and as a result of this teaching event there will now be a dedicated section on caring for asylum seekers and refugees in this teaching day.

17. Future Plans

Discussions are ongoing with regards to improving dissemination of information, perhaps through an internet forum. The Department of General Practice and Primary Care is also exploring ways in which to organise future training sessions. A steering group may be established with regards to this.

Newspaper Analysis Bibliography

Daily Mail. 2008a. Migrants blamed for rise of ‘super TB’. Daily Mail, 2/5/2008

Daily Mail. 2008b. Migrants bring added risk of TB; Health chiefs warn lung disease is on the rise. Daily Mail, 06/02/2008

Daily Mail. 2008c. Doctors’ cash call to treat migrants. Daily Mail, 17/04/2008

Daily Mail, 2008d. Migrant birth boom ‘heaps strain on NHS’. Daily Mail, 11/08/2008

Daily Mail. 2008e. Failed asylum seeker fights for free healthcare. Daily Mail, 11/04/2008

Daily Mail. 2008f. Migrants bring added risk of TB; Health chiefs warn lung disease is on the rise. Daily Mail, 06/02/2008

Daily Mail. 2008g. NHS training posts for EU doctors only. Daily Mail, 07/02/2008

Daily Mail. 2008h. Gurkha with sick wife faces deportation and an NHS bill. Daily Mail, 01/04/2008

Daily Mail. 2009a. A migrant a minute registers with GPs. Daily Mail, 22/12/2009

Daily Mail. 2009b. Failed Asylum Seekers ‘not entitled to free healthcare’. Daily Mail, 31/03/2009

Daily Mail. 2011a. Migrant Maternity Ward. Daily Mail, 07/05/2011

Daily Mail. 2011b. Health tourists told to pay up or be sent home. Daily Mail, 19/03/2011

Daily Mail. 2012a Hospitals Crack Down on the Health Tourists. Daily Mail, 29/05/2012

Daily Mail 2012b. GPs Told: You Must Treat Foreigners. The Daly Mail 13/10/2012

Daily Mail. 2012c. Hospitals crack down on the health tourists. Daily Mail, 29/05/2012

Daily Mail. 2012d GPs told: You must treat foreigners. Daily Mail, 13/10/2012

Daily Mail 2013a. Minister’s Tough Stance on New Influx from the East. Daily Mail 29/01/2013

Daily Record. 2010. £7million lost in translation: Parly should pay health boards bill say campaigners. Daily Record, 29/01/2010

Evening Times (Glasgow). 2008. Service will cut stress of illness. Evening Times, 04/01/2008

Mail on Sunday. 2008. Illegal migrants on our payrolls, admit hospitals. Mail on Sunday, 11/05/2008

The Daily Telegraph. 2009a. Failed immigrant loses NHS test case. The Daily Telegraph, 31/03/2009

The Daily Telegraph. 2009b. Migrants join a GP practice every minute; Influx of patients leaves surgeries 'straining at seams'. The Daily Telegraph, 22/12/2009

The Daily Telegraph 2010a 'We can't take any more people'; Slough has always welcomed immigrants, but as the population rises, its foreign workforce says: enough is enough. The Daily Telegraph, 25/02/2010

The Daily Telegraph. 2011. Bar on foreign staff bodes ill for NHS; Immigration cap may harm patients, writes Louisa Peacock. The Daily Telegraph, 20/01/2011

The Daily Telegraph. 2012a. Doctors ordered to treat foreign health tourists. The Daily Telegraph, 13/10/2012

The Daily Telegraph. 2012b. Immigrants fly children home to eastern Europe to beat NHS waiting lists. The Daily Telegraph, 10/05/2012

The Daily Telegraph. 2012c. Majority of struck-off doctors are foreigners. The Daily Telegraph, 30/04/2012

The Daily Telegraph 2013a. Benefits could become 'contributory' to deter immigrants from EU. The Daily Telegraph, 05/03/2013

The Daily Telegraph. 2013b. Doctors urge action to stop health tourists. The Daily Telegraph, 31/01/2013

The Daily Telegraph. 2013c. NHS treatment for migrants is too generous, say doctors. The Daily Telegraph, 18/01/2013

The Guardian. 2008. National: Britain is criticised for deporting HIV patients: MP says some people face virtual death sentence: Government failing to support G8 drugs pledge. The Guardian, 01/12/2008

The Guardian. 2011a. Reply: Letter: Questions raised by immigration rhetoric. The Guardian, 17/10/2011

The Guardian. 2011b. Minimum standards urged for EU doctors: Varied health systems put patients at risk, says GMC. The Guardian, 30/03/2011

The Guardian, 2011c. Comment: This bauble of an immigration cap should be sent back home: The coalition may gain a short-lived uplift from this sop to the right- but where's the data on its likely economic effect? The Guardian, 07/04/2011

The Guardian. 2012. HIV Move. The Guardian, 28/02/2012

The Guardian. 2013. Dispersal of asylum seekers 'puts pregnant women's health at risk', The Guardian, 25/02/2013

The Herald. 2008. U.K. training bar on non-EU doctors; Changes introduced after row over junior posts. The Herald, 07/02/2008

The Herald. 2010. Care must be taken in tackling NHS fraud. The Herald, 29/06/2010

The Observer. 2008. News: GPs defeat 'health tourist' clampdown: Doctors defend free treatment for asylum seekers. The Observer, 12/10/2008

Mail on Sunday. 2008a. Now doctors are warned: Don't refuse cigarettes from a Muslim; (And don't forget the right way to rub noses with an Afghan). Mail on Sunday, 29/06/2008

The Observer. 2012. Patient care 'will suffer' under plans to throw out migrant nurses. The Observer, 25/03/2012

Scotland on Sunday. 2009. London blocks Scotland's bid for doctors. Scotland on Sunday, 15/11/2009

The Scotsman. 2008a. Asylum seeker suffers from drug resistant form of TB. The Scotsman, 22/03/2008.

The Scotsman. 2009. Nearly 25% of refugee women have tried to kill themselves. The Scotsman, 19/06/2009

Bibliography

Aasbø, G. *et al.* (2019) 'Perspectives of non-attenders for cervical cancer screening in Norway: A qualitative focus group study', *BMJ Open*, 9(8). doi: 10.1136/bmjopen-2019-029505.

Abdi, I., Menzies, R. and Seale, H. (2019) 'Barriers and facilitators of immunisation in refugees and migrants in Australia: an east-African case study.', *Vaccine*. 37(44), pp. 6724–6729. doi: 10.1016/j.vaccine.2019.09.025.

Abdullahi, A. *et al.* (2009) 'Cervical screening: Perceptions and barriers to uptake among Somali women in Camden', *Public Health*. Elsevier Ltd, 123(10), pp. 680–685. doi: 10.1016/j.puhe.2009.09.011.

Abubaker, I. *et al.* (2018) 'The UCL-Lancet Commission on Migration and Health: the health of a world on the move', *The Lancet*, 392(10164), pp. 2606–2654. 10.1016/S0140-6736(18)32114-7.

Ager, A. and Strang, A. (2008) 'Understanding integration: A conceptual framework', *Journal of Refugee Studies*, 21(2), pp. 166–191. doi: 10.1093/jrs/fen016.

Åkerman, E. *et al.* (2017) 'Healthcare-seeking behaviour in relation to sexual and reproductive health among Thai-born women in Sweden: a qualitative study', *Culture, Health and Sexuality*. Taylor & Francis, 19(2), pp. 194–207. doi: 10.1080/13691058.2016.1214746.

Åkerman, E. *et al.* (2019) 'A missed opportunity? Lack of knowledge about sexual and reproductive health services among immigrant women in Sweden', *Sexual and Reproductive Healthcare*, 19(December 2018), pp. 64–70. doi: 10.1016/j.srhc.2018.12.005.

Aminisani, N. *et al.* (2012) 'Impact of organised cervical screening on cervical cancer incidence and mortality in migrant women in Australia', *BMC Cancer*, 12. doi: 10.1186/1471-2407-12-491.

Aminisani, N., Armstrong, B. K. and Canfell, K. (2012) 'Cervical cancer screening in Middle Eastern and Asian migrants to Australia: A record linkage study', *Cancer Epidemiology*. Elsevier Ltd, 36(6), pp. e394–e400. doi: 10.1016/j.canep.2012.08.009.

Amnesty International UK (2004) *Get it Right: How Home Office decisions making fails refugees*. Available at:https://www.amnesty.org.uk/resources/get-it-right-home-office-decisions-making-fails-refugees (last accessed 20/04/2022)

Amnesty International UK (2006) *Down and Out in London: The road to destitution for rejected asylum seekers*. Available at https://www.amnesty.org.uk/files/down_and_out.pdf (last accessed 20/04/2022)

Amnesty International UK (2013) *A Question of Credibility: Why so many initial asylum decisions are overturned on appeal in the UK*. https://www.amnesty.org.uk/resources/question-credibility-why-so-many-initial-asylum-decisions-are-overturned (last accessed 20/04/2022)

Anthias, F. (2008) 'Thinking through the lens of translocational positionality: an intersectionality frame for understanding identity and belonging', *Translocations: Migration and social change*, 4(1), pp. 5–20.

Anthias, F. (2012) 'Transnational Mobilities, Migration Research and Intersectionality: *Towards a translocational frame*', *Nordic Journal of Migration Research*, 2(2), p. 102. doi: 10.2478/v10202-011-0032-y.

Arbyn, M. *et al*. (2020) 'Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis', *The Lancet Global Health*, 8(2), pp. e191–e203. doi: 10.1016/S2214-109X(19)30482-6.

Armbruster, H. (2019) '"It was the photograph of the little boy": reflections on the Syrian Vulnerable Persons Resettlement Programme in the UK', *Ethnic and Racial Studies*. Taylor & Francis, 42(15), pp. 2680–2699. doi: 10.1080/01419870.2018.1554226.

Armenta, A. and Sarabia, H. (2020) ‘Receptionists, doctors and social workers: Examining undocumented immigrant women’s perceptions of health services’, *Social Science and Medicine*, 246. https://doi.org/10.1016/j.socscimed.2020.112788

Armstrong, N., James, V. and Dixon-Woods, M. (2012) ‘The role of primary care professionals in women’s experiences of cervical cancer screening: A qualitative study’, *Family Practice*, 29(4), pp. 462–466. doi: 10.1093/fampra/cmr105.

Asylum Aid (2011) *Unsustainable: The Quality of Initial Decision-Making in Women’s Asylum Claims*. Available at: https://www.refworld.org/docid/4d3435d12.html (last accessed 28/04/2022)

Asylum Matters (2018) *Submission to the United Nations Special Rapporteur on Extreme Poverty and Human Rights*. Available at: https://www.ohchr.org/sites/default/files/Documents/Issues/EPoverty/UnitedKingdom/2018/NGOS/Asylum_Matters.pdf (last accessed 28/04/2022)

Audit Commission (2000) ‘Another country: implementing dispersal under the Immigration and Asylum Act 1999’, *Library*. Available at: http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/anothercountry.pdf. (last accessed 01/06/2019)

Azuaga Martinez, A., Abdulcadir, J. (2020) Prevalence of cervical dysplasia among migrant women with female genital mutilation. Journal of Obstetrics and Gynaecology, 42 (2), pe22-e23. https://doi.org/10.1016/j.jogc.2019.11.048

Babatunde-Sowole, O. O. *et al*. (2020) ‘Health screening and preventative health care in refugee women: A qualitative analysis.’, *Contemporary nurse*. Faculty of Health, University of Technology Sydney, PO Box 123, Broadway, NSW 2007, Australia.: Taylor & Francis, pp. 1–18. doi: 10.1080/10376178.2020.1739543.

Baillot, H. and Connelly, E. (2018) *Women seeking asylum: Safe from violence in the UK? Refugee Council*. Available at: https://refugeecouncil.org.uk/wp-content/uploads/2019/03/Safe_from_violence_in_the_UK._ASAP-RC_report.pdf. (last accessed 25/06/2019)

Banks, J. (2012) ‘Unmasking Deviance: The Visual Construction of Asylum Seekers and Refugees in English National Newspapers’, *Critical Criminology*, 20(3), pp. 293–310. doi: 10.1007/s10612-011-9144-x.

Barbour, A. (2010) ‘Exploring some ethical dilemmas and obligations of the ethnographer’, *Ethnography and Eduction*, 5(2), pp. 159–173. https://doi.org/10.1080/17457823.2010.493399

Barclay, A. *et al*. (2003) ‘Asylum Seekers in Scotland’, *Scottish Executive*, pp. 103–126. doi: 10.4324/9780429446153-6.Available at: http://docs.scie-socialcareonline.org.uk/fulltext/sjrfinds2full.pdf (last accessed 28/04/2022)

Bauer, G. R. (2014) ‘Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity’, *Social Science and Medicine*. Elsevier Ltd, 110, pp. 10–17. doi: 10.1016/j.socscimed.2014.03.022.

Bennett, L. *et al*. (2015) ‘Press Coverage of the Refugee and Migrant Crisis in the EU: A Content Analysis of Five European Countries Report prepared for the United Nations High Commission for Refugees (December 2015)’, p. 277. Available at: https://www.unhcr.org/56bb369c9.pdf (last accessed 28/04/2022)

Bhugra, D. and Becker, M. A. (2005) ‘Migration, cultural bereavement and cultural identity’, *World Psychiatry*, 4(1), pp. 18–24.

Bischoff, A. *et al*. (2009) ‘Cervical cancer screening among immigrants in Switzerland’, *Diversity & Equality in Health and Care*. 2009;6:159–69

Blackwell, D., Holden, K. and Tregoning, D. (2002) ‘An interim report of health needs assessment of asylum seekers in Sunderland and North Tyneside’, *Public health*, 116(4), pp. 221–226. doi: 10.1038/sj.ph.1900852.

Blaikie, N. (2000) *Designing Social Research*. Cambridge: Polity.

Blane, D. N., Macdonald, S. and O’Donnell, C. A. (2020) ‘What works and why in the identification and referral of adults with comorbid obesity in primary care: A realist review’, *Obesity Reviews*, 21(4), pp. 1–18. doi: 10.1111/obr.12979.

Boeva, A. (2016) ‘Discursive Construction of Refugees, Migrants and Asylum Seekers in British and American News Sources’, *Procedia - Social and Behavioral Sciences*, pp. 53–58. doi: 10.1016/j.sbspro.2016.12.018.

Bowen, D. J., Mickus, M. and Rosales, A. N. (2018) ‘Factors Influencing Physician Assistant Students’ Attitudes Toward Deservingness of Care for Undocumented Mexicans’, *The Journal of Physician Assistant Education*, 29(1).

Bowleg, L. (2012) ‘The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health’, *American Journal of Public Health*, 102(7), pp. 1267–1273. doi: 10.2105/AJPH.2012.300750.

Bowring, J. and Walker, P. (2010) ‘The “Jade Goody effect”: What now for cervical cancer prevention?’, *Journal of Family Planning and Reproductive Health Care*, 36(2), pp. 51–54. doi: 10.1783/147118910791069420.

Bradby, H. *et al.* (2020) ‘“If there were doctors who could understand our problems, I would already be better”: dissatisfactory health care and marginalisation in superdiverse neighbourhoods.’, *Sociology of Health and Illness*, 42(4), pp. 739–757. doi: 10.1111/1467-9566.13061.

British Association of Social Workers (2021) *Written evidence submitted by the British Association of Social Workers (NBB05) . Nationality and Borders Bill 2021.*

British Medical Association (2019) *BMA refugee and asylum seeker health resource*. Available at: https://www.bma.org.uk/advice/employment/ethics/refugee-and-asylum-seekers-health-resource.(last accessed 28/04/2022)

Broberg, G. *et al.* (2018) ‘Socio-economic and demographic determinants affecting participation in the Swedish cervical screening program: A population-based case-control study’, *PLoS ONE*, 13(1), pp. 1–14. doi: 10.1371/journal.pone.0190171.

Brooks, L. (2020) ‘Hundreds of Glasgow asylum seekers still in “untenable” hotel

accomodation', *The Guardian*, 26 July.

Bruan, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101.

Bryman, A. (2012) *Social Research Methods*. 4th Edition. Oxford University Press

Bryman, A. (2015) *Social Research Methods*. Fifth edition. Oxford University Press.

Buchanan, S., Grillo, B. and Threadgold, T. (2003) *What's the Story?Media representation of refugees and asylum seekers in UK*, *Article 19*. Available at: https://www.article19.org/data/files/pdfs/publications/refugees-what-s-the-story-.pdf. (last accessed 28/04/2022)

Cadman, L. *et al*. (2012) 'Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study', *BMJ Sexual and Reproductive Health*, 38, pp. 214–220. doi: 10.1136/jfprhc-2012-100378.

Calvo, R., Jablonska-Bayro, J. M. and Waters, M. C. (2017) 'Obamacare in action: how access to the health care system contributes to immigrants' sense of belonging', *Journal of Ethnic and Migration Studies*, 43(12), pp. 2020–2036. doi: 10.1080/1369183X.2017.1323449.

Carroll, J. *et al*. (2007) 'Caring for Somali women: Implications for clinician-patient communication', *Patient Education and Counseling*, 66(3), pp. 337–345. doi: 10.1016/j.pec.2007.01.008.

Casey, G. M. *et al*. (2013) 'Celebrities and screening: A measurable impact on high-grade cervical neoplasia diagnosis from the "Jade Goody effect" in the UK', *British Journal of Cancer*. Nature Publishing Group, 109(5), pp. 1192–1197. doi: 10.1038/bjc.2013.444.

Catto, A., Gorman, D. and Higgins, M. (2010) 'The impact of recent Central and Eastern European migration on the Scottish health service: A study of newspaper coverage 2004-2008', *Health and Place*. Elsevier, 16(5), pp. 765–775. doi:

10.1016/j.healthplace.2009.12.006.

Ceneda, S. (2003) ‘Women asylum seekers in the UK: A gender perspective’, Feminist review 73.1 (2003): 126-128.

Chase, L. E. *et al.* (2017) ‘The gap between entitlement and access to healthcare: An analysis of “candidacy” in the help-seeking trajectories of asylum seekers in Montreal’, *Social Science and Medicine*, 182, pp. 52–59. doi: 10.1016/j.socscimed.2017.03.038.

City of Sanctuary UK (2022) *Destitution*. Available at: https://cityofsanctuary.org/by-theme/destitution/ (Accessed: 3 April 2022).

Clark, A. *et al.* (2009) ‘Learning to see: Lessons from a participatory observation research project in public spaces’, *International Journal of Social Research Methodology*, 12(4), pp. 345–360. doi: 10.1080/13645570802268587.

Collins, P. (2000) *Black feminist thought: Knowledge, consciousness, and the politics of empowerment (perspectives on gender)*, *Routledge*.

Collins, P. H. (2015) ‘Intersectionality’s Definitional Dilemmas’, *Annual Review of Sociology*, 41, pp. 1–20. doi: 10.1146/annurev-soc-073014-112142.

Commons Library Briefing (2021) *‘Asylum support’: accommodation and financial support for asylum seekers. Briefing Paper. Number 1909*. Available at: https://researchbriefings.files.parliament.uk/documents/SN01909/SN01909.pdf. (last accesesed 28/04/2022)

Coole, C. (2002) ‘A warm welcome? Scottish and UK media reporting of an asylum-seeker murder’, *Media, Culture and Society*, 839.

Cooper, G., Blumell, L. and Bunce, M. (2020) ‘Beyond the “refugee crisis”: How the UK news media represent asylum seekers across national boundaries’, *International Communication Gazette*, pp. 1–22. doi: 10.1177/1748048520913230.

Cooper, M. *et al.* (2012) ‘A chronic disease is a disease which keeps coming

back. it is like the flu: Chronic disease risk perception and explanatory models among French- and Swahili-speaking African migrants', *Ethnicity and Health*, 17(6), pp. 597–613. doi: 10.1080/13557858.2012.740003.

COSLA (2017) Elected Members Briefing on Syrian Refugee Resettlement. http://www.migrationscotland.org.uk/uploads/em-briefing-humanitarian-protection.pdf (last accessed 28/02/2022)

Crawley, H. (2010) *Chance or Choice? Understanding why asylum seekers come to the UK. Refugee Council*. Available at: https://www.refugeecouncil.org.uk/wp-content/uploads/2010/04/Chance-or-choice-2010.pdf (last accessed 28/04/2022)

Crawley, H. and Skleparis, D. (2018) 'Refugees, migrants, neither, both: Categorical fetishism and the politics of bounding in Europe's "migration crisis"', *Journal of Ethnic and Migration Studies*. Taylor & Francis, 44(1), pp. 48–64. doi: 10.1080/1369183X.2017.1348224.

Crawshaw, A. F. *et al.* (2021) 'Defining the determinants of under-vaccination in migrant populations in Europe to improve routine and COVID-19 vaccine uptake: a systematic review', *The Lancet Infectious Diseases, 1473-3099 (22) https://doi.org/10.1016/S1473-3099(22)00066-4*

Crenshaw, K. (1991) 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color', *Stanford Law Review*, 43(6), p. 1241. doi: 10.2307/1229039.

Creswell, J. W., Fetters, M. D. and Ivankova, N. V. (2004) 'Designing A Mixed Methods Study In Primary Care', *Annals of Family Medicine*, 2(1). doi: 10.1136/bmj.325.7354.22.

Curtice, J. and Montagu, I. (2018) *British Societal Attitudes: Do Scotland and England &Wales have different views about immigration? ScotCen: British and Scottish Social Attitudes*. Available at: https://natcen.ac.uk/our-research/research/do-scotland-and-england-wales-have-different-views-about-immigration/ (last accessed 28/04/2022)

Damiani, G. *et al.* (2012) 'Socioeconomic disparities in the uptake of breast and cervical cancer screening in Italy: A cross sectional study', *BMC Public Health*. BioMed Central Ltd, 12(1), p. 99. doi: 10.1186/1471-2458-12-99.

Davidson, N. *et al.* (2022) 'Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: a systematic review', *BMC Public Health*, 22(403), pp. 1–37.

Davis, K. (2008) 'Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful', *Feminist Theory*, 9(1), pp. 67–85. doi: 10.1177/1464700108086364.

Davis, J., Marsh, N. (2020) Practice Guidance: Initial meetings with young people: an intersectional and systematic approach. Community Care Inform Children. Available at https://www.ccinform.co.uk/practice-guidance/initial-meetings-with-young-people-an-intersectional-and-systemic-approach/ (last acccessed 01/05/2022)

Davison, C., Davey Smith, G. and Frankel, S. (1991) 'Lay epidemiology and the prevention paradox: the implications of coronary candidacy for health education', *Sociology of Health & Illness*, 13(1).

Dejonckheere, M. and Vaughn, L. M. (2019) 'Semistructured interviewing in primary care research: a balance of relationship and rigour', *Family Medicine and Community Health*, 7(2).

Denzin, N. (1978) *'The research act'*. New York: McGraw-Hill Book Company.

Dicicco-Bloom, B. and Crabtree, B. F. (2006) 'The Qualitative Research Interview', *Medical Education*, 40, pp. 314–21.

Dixon-Woods, M. *et al.* (2005) 'Vulnerable groups and access to health care : a critical interpretive review', *Report for the National Coordinating Centre for NHS Service Delivery and Organisation R&D(NCCSDO)*, p. 483. Available at: https://www.menshealthforum.org.uk/sites/default/files/pdf/sdovulnerablegroups2005.pdf (last access 28/04/2022)

Dixon-Woods, M. *et al.* (2006) 'Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups', *BMC Medical Research Methodology*, 6, pp. 1–13. doi: 10.1186/1471-2288-6-35.

Doctors of the World (2018) 'Registration refused : A study on access to GP registration in England'. Available at: https://www.doctorsoftheworld.org.uk/wp-content/uploads/2019/08/Registration-Refused-final.pdf (last accessed 28/04/2022)

Doctors of the World (2020) 'A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic', (May), p. 102. Available at: http://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/05/covid19-full-rna-report.pdf. (last accessed 28/04/2022)

Doctors Without Borders (2021) *Written evidence submitted by Medecins Sans Frontieres/Doctors Without Borders to the Nationality and Borders Bill Committee*. Available at: https://publications.parliament.uk/pa/cm5802/cmpublic/NationalityBorders/memo/NBB42.htm (last accessed 28/04/2022)

Douglas, E. *et al.* (2016) 'Socioeconomic inequalities in breast and cervical screening coverage in England: Are we closing the gap?', *Journal of Medical Screening*, 23(2), pp. 98–103. doi: 10.1177/0969141315600192.

Doyle, L. (2008) *More Token Gestures A report into the use of vouchers for asylum seekers claiming Section 4 support: The Refugee Council*. Available at: https://stillhumanstillhere.files.wordpress.com/2009/01/rc_more_token_gestures_oct_2008.pdf (last accessed 28/04/2022)

Dudhia, P. (2020) *Will I every be safe?: Asylum-seeking women made destitute in the UK: Women for Refugee Women*. Available at: https://www.refugeewomen.co.uk/campaign/research/ (last accessed 28/04/2022)

Eberl, J.-M. *et al.* (2018) 'The European media discourse on immigration and its

effects: a literature review', *Annals of the International Communication Association*. Taylor & Francis, 42(3), pp. 207–223. doi: 10.1080/23808985.2018.1497452.

Ebneyamini, S. and Sadeghi Moghadam, M. R. (2018) 'Toward Developing a Framework for Conducting Case Study Research', *International Journal of Qualitative Methods*, 17(1), pp. 1–11. doi: 10.1177/1609406918817954.

Eddo-Lodge, R. (2020) *Why I'm no longer talking to white people about race*. Bloomsbury Publishing.

Edmonds, S. *et al.* (2021) 'Associations Between Sexual Assault and Reproductive and Family Planning Behaviours and Outcomes in Female Veterans', *Obstetrics and Gynecology*, 137(3), pp. 461–470. doi: 10.1097/AOG.0000000000004278.

Edwards, R. (1990) 'Connecting method and epistemology: A White Woman Interviewing Black Women', *Women's Studies International Forum*, 13(5), pp. 477–490.

Ekechi, C. *et al.* (2014) 'Knowledge of cervical cancer and attendance at cervical cancer screening: A survey of Black women in London', *BMC Public Health*, 14(1), pp. 1–9. doi: 10.1186/1471-2458-14-1096.

Equality Network (2021) *Intersectionality*. Available at: https://www.equality-network.org/our-work/intersectional/ (last accessed 28/04/2022)

Erez, E., Adelman, M. and Gregory, C. (2009) 'Intersections of immigration and domestic violence: Voices of battered immigrant women', *Feminist Criminology*, 4(1), pp. 32–56. doi: 10.1177/1557085108325413.

Eurostat (2019) *File: Distribution of first instance decisions on (non-EU) asylum applications, 2018 (%)*. Available at: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Distribution_of_first_instance_decisions_on_(non-EU)_asylum_applications,_2018_(%25)_YB19_3.png (last accessed 28/04/2022)

Farrington, R. (2020) 'Consternation and complexity: learning from people who

seek asylum.', *Education for primary care,* 31(1), pp. 2–6. doi: 10.1080/14739879.2019.1704633.

Fernbach, M. (2002) 'Exploration of factors linked with high cervical cancer rates in women from the former Yugoslavia in Victoria, Australia', *Ethnicity and Health*, 7(3), pp. 209–220. doi: 10.1080/1355785022000042033.

Fetters, M. D. and Molina-Azorin, J. F. (2017) 'The Journal of Mixed Methods Research Starts a New Decade: Principles for Bringing in the New and Divesting of the Old Language of the Field', *Journal of Mixed Methods Research*, 11(1), pp. 3–10. doi: 10.1177/1558689816682092.

Finney, N., Robinson, V. (2008). Local press, dispersal and community in the construction of asylum debates. Social and Cultural Geography, 9 (4), p.397-413. https://doi.org/10.1080/14649360802077038

Finocchario-Kessler, S. *et al*. (2016) 'Cervical cancer prevention and treatment research in Africa: A systematic review from a public health perspective', *BMC Women's Health*. BMC Women's Health, 16(1). doi: 10.1186/s12905-016-0306-6.

Floyd, A. and Sakellariou, D. (2017) 'Healthcare access for refugee women with limited literacy: layers of disadvantage', *International journal for equity in health*, 16(195).

Fulton, R. (2010) 'Ethnic monitoring: is health equality possible without it?', *A Race Equality Foundation Briefing Paper*, 21(November). Available at: https://raceequalityfoundation.org.uk/wp-content/uploads/2018/03/health-brief21.pdf (last accessed 28/04/2022)

Fusch, P. I. and Fusch, G. E. (2017) 'How to Conduct a Mini-Ethnigraphic Case Study: A Guide for Novice Researchers', *The Qualitative Report*, 22(3), pp. 923–941.

Gabrielatos, C. and Baker, P. (2008) 'Fleeing, sneaking, flooding: A corpus analysis of discursive constructions of refugees and Asylum Seekers in the UK Press, 1996-2005', *Journal of English Linguistics*, 36(1), pp. 5–38. doi:

10.1177/0075424207311247.

Gakidou, E., Nordhagen, S. and Obermeyer, Z. (2008) ‘Coverage of cervical cancer screening in 57 countries: Low average levels and large inequalities’, *PLoS Medicine*, 5(6), pp. 0863–0868. doi: 10.1371/journal.pmed.0050132.

Gale, N. K. *et al.* (2013) ‘Using the framework method for the analysis of qualitative data in multi-disciplinary health research’, *BMC Medical Research Methodology*. BMC Medical Research Methodology, 13(1), p. 1. doi: 10.1186/1471-2288-13-117.

Garton, A. (2021) ‘Glasgow triumphant as Home Office forced to back down on dawn raid detentions’, *The National*, May.

Gerring, J. (2004) What is a case study and what is it good for? Americal Political Science Review, 98 (2) http://www.jstor.org/stable/4145316.

Gil Lacruz, A. I., Gil Lacruz, M. and Gorgemans, S. (2014) ‘Female preventive practices: Breast and smear tests’, *Health Policy*, 118(1), pp. 135–144. doi: 10.1016/j.healthpol.2014.04.012.

Gilder, M. E. *et al.* (2019) ‘“I can’t read and don’t understand”: Health literacy and health messaging about folic acid for neural tube defect prevention in a migrant population on the Myanmar-Thailand border.’, *PloS one*, 14(6) doi: 10.1371/journal.pone.0218138.

Ginsburg, O. *et al.* (2017) ‘The global burden of women’s cancers: a grand challenge in global health’, *The Lancet*. Elsevier Ltd, 389(10071), pp. 847–860. doi: 10.1016/S0140-6736(16)31392-7.

Ginsburg, O. and Horton, R. (2020) ‘A Lancet Commission on women and cancer’, *The Lancet*. Elsevier Ltd, 396(10243), pp. 11–13. doi: 10.1016/S0140-6736(20)31479-3.

Ginsburg, O. and Paskett, E. D. (2018) ‘Ethnic and racial disparities in cervical cancer: lessons from a modelling study of cervical cancer prevention’, *The Lancet Public Health* 3(1), pp. 8–9. doi: 10.1016/S2468-2667(17)30233-5.

Given, L. M. (2008) The SAGE Encyclopedia of Qualitative Research Methods. (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963909

Glasgow City Council (2019) 'Asylum Task Force: Asylum Seeking'. Available at: https://glasgow.gov.uk/CHttpHandler.ashx?id=44501&p=0. (last accessed 07/08/2019)

GLIMER (2019) *Asylum and refugee accomodation governance in Scotland: Key findings and recommendations. GLIMER Policy Brief 1: Scotland.* Available at: https://www.glimer.eu/wp-content/uploads/2019/02/Scotland-WP3.pdf. (last accessed 28/04/2022)

Gorman, D. R. and Porteous, L. A. (2018) 'Influences on Polish migrants' breast screening uptake in Lothian, Scotland', *Public Health*. Elsevier Ltd, 158, pp. 86–92. doi: 10.1016/j.puhe.2017.11.026.

Gott, M. *et al*. (2004) '"Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care', *Family Practice*, 21(5), pp. 528–536. doi: 10.1093/fampra/cmh509.

Greenaway, C. *et al*. (2020) 'COVID-19: Exposing and addressing health disparities among ethnic minorities and migrants', *Journal of Travel Medicine*, 27(7), pp. 1–3. doi: 10.1093/JTM/TAAA113.

Greenhalgh, T. and Peacock, R. (2005) 'Effectiveness and efficiency of search methods in systematic reviews of complex evidence: Audit of primary sources', *British Medical Journal*, 331(7524), pp. 1064–1065. doi: 10.1136/bmj.38636.593461.68.

Grix, J. (2002) 'Introducing Students to the Generic Terminology of Social Research', *Politics*, 22(3), pp. 175–186.

Hall, A. L. and Rist, R. C. (1999) 'Methods (or Avoiding the Precariousness of a One- Legged Stool)*', *Psychology*, 16(4), pp. 291–304.

Hancock, A. M. (2007) 'Intersectionality as a Normative and Empirical Paradigm', *Politics and Gender*, 3(2), pp. 248–254. doi: 10.1017/S1743923X07000062.

Hankivsky, O. *et al*. (2010) 'Exploring the promises of intersectionality for advancing women's health research preliminary examination of the role and transformative potential of feminist theory', *International Journal for Equity in Health*, 9(5), pp. 1–15.

Hankivsky, O. and Jordan-Zachery, J. S. (2019) *The palgrave handbook of intersectionality in public policy*. Springer International Publishing.

Hanson, S. *et al*. (2019) 'Cancer risk in socially marginalised women: An exploratory study', *Social Science and Medicine*. Elsevier, 220(June 2018), pp. 150–158. doi: 10.1016/j.socscimed.2018.11.009.

Harris, K. (2015) 'A Secret Punishment: The misuse of segregration in immigration detention', *Medical Justice*. Available at: http://medicaljustice.org.uk/a-secret-punishment-the-misuse-of-segregation-in-immigration-detention/ (last accessed 28/04/2022)

Hathaway, J. (1991) *Law of Refugee Status*. Toronto: Butterworths Law.

Heidenreich, T. *et al*. (2019) 'Media Framing Dynamics of the "European Refugee Crisis": A Comparative Topic Modelling Approach', *Journal of Refugee Studies*, 32 (Special Issue 1), pp. 1172–1182. doi: 10.1093/jrs/fez025.

Henderson, L. *et al*. (2011) '"A false sense of security" understanding the role of the HPV vaccine on future cervical screening behaviour: A qualitative study of UK parents and girls of vaccination age', *Journal of Medical Screening*, 18(1), pp. 41–45. doi: 10.1258/jms.2011.010148.

Hertzum-Larsen, R. *et al*. (2019) 'Participation in cervical cancer screening among immigrants and Danish-born women in Denmark', *Preventive Medicine*. Elsevier, 123(January), pp. 55–64. doi: 10.1016/j.ypmed.2019.02.023.

Heslehurst, N. *et al*. (2018) 'Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews', *BMC Medicine*, 16(89). https://doi.org/10.1186/s12916-018-1064-0

Hiam, L., Steele, S. and McKee, M. (2018) 'Creating a "hostile environment for migrants": The British government's use of health service data to restrict immigration is a very bad idea', *Health Economics, Policy and Law*, 13(2), pp. 107–117. https://doi.org/10.1017/S1744133117000251.

Hilton, S., Patterson, C. and Teyhan, A. (2012) 'Escalating coverage of obesity in UK newspapers: The evolution and framing of the "obesity epidemic" from 1996 to 2010', *Obesity*, 20(8), pp. 1688–95. https://doi.org/10.1038/oby.2012.27

Holmes, S. M. (2012) 'The clinical gaze in the practice of migrant health: Mexican migrants in the United States', *Social Science and Medicine*, 74(6), pp. 873–881. https://doi.org/10.1016/j.socscimed.2011.06.067.

Holmes, S. M. *et al.* (2021) 'Deservingness: migration and health in social context', *BMJ Global Health*, 6. https://doi.org/10.1136/bmjgh-2021-005107.

Home Office (2017) *Syrian Vulnerable Persons Resettlement Scheme (VPRS): Guidance for local authorities and partners*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/631369/170711_Syrian_Resettlement_Updated_Fact_Sheet_final.pdf (last accessed: 28/04/2022)

Home Office (2019) *Immigration Statistics, year ending June 2019. Second Edition*. Available at: https://www.gov.uk/government/statistics/immigration-statistics-year-ending-september-2019. (last accessed 28/04/2022)

Home Office (2021) *Immigration Statistics: Asylum and Resettlement- Asylum appeals lodged and determined*. Available at: https://www.gov.uk/government/statistical-data-sets/asylum-and-resettlement-datasets (last accessed 28/04/2022)

Hsieh, E. (2006) 'Conflicts in how interpreters manage their roles in provider-patient interactions', *Social Science and Medicine*, 62(3), pp. 721–730. https://doi.org/10.1016/j.socscimed.2005.06.029.

Hsieh, E. (2008) '"I am not a robot!" interpreters' views of their roles in health care settings', *Qualitative Health Research*, 18(10), pp. 1367–1383 https://doi.org/10.1177/1049732308323840.

Hughes, D. and Griffiths, L. (1997) '"Ruling in" and "Ruling out": Two approaches to the micro-rationing of health care', *Social Science and Medicine*, 44(5), pp. 589–599. https://doi.org/10.1016/S0277-9536(96)00207-9

Hunt, K. *et al.* (2000) 'Are perceptions of a family history of heart disease related to health-related attitudes and behaviour?', *Health Education Research*, 15(2), pp. 131–143. https://doi.org/10.1093/her/15.2.131.

Hunt, K. and Batty, G. (2009) 'Gender and socioeconomic inequalities in mortality and health behaviours: an overview', in *Graham, H. (ed.) Understanding Health Inequalities.* Open University Press, pp. 141–161.

Huschke, S. (2014) 'Performing deservingness. Humanitarian health care provision for migrants in Germany', *Social Science and Medicine*. Elsevier Ltd, 120, pp. 352–359. https://doi.org/10.1016/j.socscimed.2014.04.046.

Information Services Division and NHS National Services Scotland (2019) *Scottish Cervical Screening Programme Statistics 2018/19: Annual update to 31 March 2019.* Available at: https://www.isdscotland.org/Health-Topics/Cancer/Publications/2019-09-03/2019-09-03-Cervical-Screening-Report.pdf?25324648619 (last accessed 28/04/2022)

Information Services Division and NHS National Services Scotland (2020) *Scottish Cervical Call Recall System (SCCRS).* Available at: https://www.ndc.scot.nhs.uk/National-Datasets/data.asp?SubID=75 (last accessed 28/04/2022)

Ingleby, D. (2012) 'Ethnicity, Migration and the "Social Determinants of Health" Agenda.', *Psychosocial Intervention*, 21(3), pp. 331–341. https://doi.org/10.5093/in2012a29

Innes, A. J. (2010) 'When the threatened become the threat: The construction of

asylum seekers in British media narratives', *International Relations*, 24(4), pp. 456–477. https://doi.org/10.1177/0047117810385882.

International Organisation for Migration (2018) *World Migration Report 2018*.Available at: https://www.iom.int/sites/g/files/tmzbdl486/files/country/docs/china/r5_world_migration_report_2018_en.pdf (Last accessed 28/04/2022)

IOM (2019) *International Migration Law: Glossary on Migration No 34. International Organization for Migration (IOM)*. Available at: https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf (last accessed 28/04/2022)

Isaacs, A. *et al*. (2020) '"I don't think there's anything I can do which can keep me healthy": how the UK immigration and asylum system shapes the health and wellbeing of refugees and asylum seekers in Scotland', *Critical Public Health*, pp. 0–1. doi: https://doi.org/10.1080/09581596.2020.1853058.

Ivanov, L. L., Hu, J. and Leak, A. (2010) 'Immigrant women's cancer screening behaviors', *Journal of Community Health Nursing*, 27(1), pp. 32–45. https://doi.org/10.1080/07370010903466163.

James, D. (2020) 'Health and health-related correlates of internalized racism among racial/ethnic minorities. A review of the literature', *Journal of racial and ethnic health disparities*, pp. 1–22. https://doi.org/10.1007/s40615-020-00726-6

Jansen, E. E. L. *et al*. (2020) 'Effect of organised cervical cancer screening on cervical cancer mortality in Europe: a systematic review', *European Journal of Cancer*, 127, pp. 207–223. https://doi.org/10.1016/j.ejca.2019.12.013.

Jassim, G., Obeid, A. and Al Nasheet, H. A. (2018) 'Knowledge, attitudes, and practices regarding cervical cancer and screening among women visiting primary health care Centres in Bahrain', *BMC Public Health*. BMC Public Health, 18(1), pp. 1–6. https://doi.org/10.1186/s12889-018-5023-7.

Jayaweera, H. and Quigley, M. A. (2010) 'Health status, health behaviour and

healthcare use among migrants in the UK: Evidence from mothers in the Millennium Cohort Study', *Social Science and Medicine*. Elsevier Ltd, 71(5), pp. 1002–1010. https://doi.org/10.1016/j.socscimed.2010.05.039.

Johnson, H. C. *et al.* (2018) 'Effect of HPV vaccination and cervical cancer screening in England by ethnicity: a modelling study', *The Lancet Public Health*. The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY 4.0 license, 3(1), pp. e44–e51. https://doi.org/10.1016/S2468-2667(17)30238-4.

Johnson, M. R. D. *et al.* (2019) 'A glossary for the first World Congress on Migration, Ethnicity, Race and Health', *Public Health*, 172, pp. 85–88. https://doi.org/10.1016/j.puhe.2019.05.001.

Johnson, R. ., Onwuegbuzie, A. . and Turner, L. A. (2007) 'Toward a Definition of Mixed Methods Research', *Journal of Mixed Methods Research*, 1(2), pp. 112–133. https://doi.org/10.1177%2F1558689806298224

Joint Committee on Human Rights (2007) *The Treatment of Asylum Seekers Tenth Report of Session 2006-07 Volume II- Oral and written evidence*. Available at: https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81ii.pdf (last accessed 28/04/2022)

Jones, C. (2000) 'Levels of racism: a theoretic framework and a gardener's tale.', *American Journal of Public Health*, 90(8), p. 1212. https://dx.doi.org/10.2105%2Fajph.90.8.1212

Kammeyer-Mueller, J. D. (2009) 'The role of core self-evaluations in the coping process', *Journal of Applied Pscyhology*, 94(1), p. 177. https://doi.org/10.1037/a0013214

Kang, C., Farrington, R. and Tomkow, L. (2019) 'Access to primary health care for asylum seekers and refugees: A qualitative study of service user experiences in the UK', *British Journal of General Practice*, 69(685), pp. 537–545. https://doi.org/10.3399/bjgp19X701309.

Kapilashrami, A., Hill, S. and Meer, N. (2015) 'What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach?', *Social Theory and Health*. Nature Publishing Group, 13(3–4), pp. 288–307. https://doi.org/10.1057/sth.2015.16.

Kelaher, M. *et al.* (1999) 'The Transtheoretical Model and Cervical Screening: its application among culturally diverse communities in Queensland, Australia', *Ethnicity and Health*, 4(4), pp. 259–276. https://doi.org/10.1080/13557859998047

Keygnaert, I. and Temmerman, M. (2007) 'Gender-Based Violence Against Refugees, Asylum Seekers and Undocumented Migrants in Europe', *Entre Nous: The European Magazine for Sexial and Reproductive Health. WHO Reproductive Health and Research Programme*, p. 12. Available at: https://www.euro.who.int/__data/assets/pdf_file/0007/296899/356637_Entre_Nous_83_150.pdf (last accessed 28/04/2022)

Khosravinik, M. (2009) 'The representation of refugees, asylum seekers and immigrants in British newspapers during the Balkan conflict (1999) and the British general election (2005)', *Discourse and Society*, 20(4), pp. 477–498. https://doi.org/10.1177/0957926509104024.

Kitzinger, J. (1995) 'Qualitative Research: Introducing focus groups', *BMJ (Online)*, 311(299). https://doi.org/10.1136/bmj.311.7000.299

Klassen, A. C. *et al.* (2008) 'A healthy mistrust: How worldview relates to attitudes about breast cancer screening in a cross-sectional survey of low-income women', *International Journal for Equity in Health*, 7, pp. 1–19. https://doi.org/10.1186/1475-9276-7-5.

Kline, N. (2019) 'When deservingness policies converge: US immigration enforcement, health reform and patient dumping', *Anthropology and Medicine*. Routledge, 26(3), pp. 280–295. https://doi.org/10.1080/13648470.2018.1507101.

Knights, F. *et al.* (2021) 'Impact of COVID-19 on migrants' access to primary care

and implications for vaccine roll-out: a national qualitative study', *British Journal of General Practice*, p. BJGP.2021.0028. https://doi.org/10.3399/bjgp.2021.0028.

Koehn, S. (2009) 'Negotiating candidacy: Ethnic minority seniors' access to care', *Ageing and Society*, 29(4), pp. 585–608. https://doi.org/10.1017/S0144686X08007952.

Koirala, S. and Eshghavi, M. (2017) 'Intersectionality in the Iranian Refugee Community in the United States', *Peace Review*. Taylor & Francis, 29(1), pp. 85–89. https://doi.org/10.1080/10402659.2017.1272316.

Kovandžić, M. *et al*. (2011) 'Access to primary mental health care for hard-to-reach groups: From "silent suffering" to "making it work"', *Social Science and Medicine*, 72(5), pp. 763–772. https://doi.org/10.1016/j.socscimed.2010.11.027.

Krippendorff, K. (2018) *Content analysis: An introduction to its methodology*. Sage Publications.

Kushner, T. (2003). Meaning nothing but good: Ethics, history and asylum-seeker phobia in Britain. Patterns of Prejudice, 37 (3), p 257-276. https://doi.org/10.1080/00313220307593

Kushner, T. (2010) 'Patterns of Prejudice Meaning nothing but good : ethics , history and asylum-seeker phobia in Britain Meaning nothing but good : ethics , history and asylum-seeker phobia in Britain', *Patterns of Prejudice*, (April 2012), pp. 37–41. https://doi.org/10.1080/0031322032000127996.

Kyriakidou, M. (2020) 'Hierarchies of deservingness and the limits of hospitality in the "refugee crisis"', *Media, Culture and Society*, 43(1), pp. 133–149. https://doi.org/10.1177%2F0163443720960928

Labeit, A. M. and Peinemann, F. (2017) 'Determinants of a GP visit and cervical cancer screening examination in Great Britain', *PLoS ONE*, 12(4). https://doi.org/10.1371/journal.pone.0174363.

Landy, R. *et al.* (2016) 'Impact of cervical screening on cervical cancer mortality: Estimation using stage-specific results from a nested case-control study', *British Journal of Cancer*, 115(9), pp. 1140–1146. https://doi.org/10.1038/bjc.2016.290.

Larchanché, S. (2012) 'Intangible obstacles: Health implications of stigmatization, structural violence, and fear among undocumented immigrants in France', *Social Science and Medicine*. Elsevier Ltd, 74(6), pp. 858–863. https://doi.org/10.1016/j.socscimed.2011.08.016.

Leanza, Y. *et al.* (2021) 'Training and Integrating Public Service Interpreters in a Refugee Health Clinic: A Mixed-Method Approach to Evaluate and Innovative Program', *Refuge*, 37(2). https://doi.org/10.25071/1920-7336.40691

Lehane, D. and Campion, P. (2018) 'Interpreters: why should the NHS provide them?', *British Journal of General Practice*, 68(677), pp. 564–565. https://dx.doi.org/10.3399%2Fbjgp18X699905

Leinonen, M. K., Campbell, S., Ursin, G., *et al.* (2017) 'Barriers to cervical cancer screening faced by immigrants: A registry-based study of 1.4 million women in Norway', *European Journal of Public Health*, 27(5), pp. 873–879. https://doi/org/10.1093/eurpub/ckx093.

Leinonen, M. K., Campbell, S., Klungsøyr, O., *et al.* (2017) 'Personal and provider level factors influence participation to cervical cancer screening: A retrospective register-based study of 1.3 million women in Norway', *Preventive Medicine*. The Authors, 94, pp. 31–39. https://doi/org/10.1016/j.ypmed.2016.11.018.

Leudar, I. *et al.* (2008) 'Hostility themes in media, community and refugee narratives', *Discourse and Society*, 19(2), pp. 187–221. https://doi/org/10.1177/0957926507085952.

Lewis, H. (2007) *Destitution in Leeds: The experiences of people seeking asylum*, *Joseph Rowntree Charitable Trust*. Available at: https://www.jrct.org.uk/userfiles/documents/Destitution in Leeds (research

report full).pdf. (last accessed 10/06/2015)

Lindenmeyer, A. *et al.* (2016) 'Experiences of primary care professionals providing healthcare to recently arrived migrants: a qualitative study: Table 1', *BMJ Open*, 6(9). https://doi.org/10.1136/bmjopen-2016-012561.

Lipsky, M. (1980) *Street Level Bureaucracy. Dilemmas of the individual in public services*. New York: Russell Sage Foundation.

Litosselit, L. (2004) *Using focus groups in research*. London: Consortium.

Lombardi, L. (2020) *SWIM-Safe Women in Migration. Stengthen GBV protection for migrant and asylum seeker women. The qualitative analysis*. https://doi.org/10.13140/RG.2.2.12928.87045.

Low, E. L. *et al.* (2012) 'What do British women know about cervical cancer symptoms and risk factors?', *European Journal of Cancer*. Elsevier Ltd, 48(16), pp. 3001–3008. https://doi.org/10.1016/j.ejca.2012.05.004.

Lu, M. *et al.* (2012) 'A systematic review of interventions to increase breast and cervical cancer screening uptake among Asian women', *BMC Public Health*. BMC Public Health, 12(1), p. 1. https://doi.org/10.1186/1471-2458-12-413.

Ludman, E. J. *et al.* (2010) 'Breast and Cervical Cancer Screening', *American Journal of Preventive Medicine*, 38(3), pp. 303–310. https://doi.org/10.1016/j.amepre.2009.10.039.

Lynn, N. and Lea, S. (2003) '"A phantom menace and the new Apartheid": The social construction of asylum-seekers in the United Kingdom', *Discourse and Society*, 14(4), pp. 425–452. https://doi.org/10.1177/0957926503014004002.

Macdonald, S. *et al.* (2016) 'Illness identity as an important component of candidacy: Contrasting experiences of help-seeking and access to care in cancer and heart disease', *Social Science and Medicine*, 168, pp. 101–110. https://doi.org/10.1016/j.socscimed.2016.08.022.

MacFarlane, A. *et al*. (2020) 'Barriers to the use of trained interpreters in consultations with refugees in four resettlement countries: a qualitative analysis using normalisation process theory', *BMC Family Practice*, 21(259). https://doi.org/10.1186/s12875-020-01314-7

Macfarlane, J. (2021) '"Refugees are welcome here": what is Scotland's attitude to immigration- and is it more positive than the rest of the UK?', *National World*. Available at: https://www.nationalworld.com/news/politics/refugees-are-welcome-here-what-is-scotlands-attitude-to-immigration-and-is-it-more-positive-than-the-rest-of-the-uk-3241594 (last accessed 28/04/2022)

Mackenzie, M. *et al*. (2012) 'Is "Candidacy" a useful concept for understanding journeys through public services? A critical interpretive literature synthesis', *Social Policy and Administration*, 47(7), pp. 806–825. https://doi.org/10.1111/j.1467-9515.2012.00864.x.

MacKenzie, M. *et al*. (2012) 'Reaching the hard-to-reach: Conceptual puzzles and challenges for policy and practice', *Journal of Social Policy*, 41(3), pp. 511–532. https://doi.org/10.1017/S0047279412000074.

MacKenzie, M. *et al*. (2014) 'Intersections and multiple "candidacies": Exploring connections between two theoretical perspectives on domestic abuse and their implications for practicing policy', *Social Policy and Society*, 14(1), pp. 43–62. https://doi.org/10.1017/S1474746414000244.

Macnamara, J. (2005) 'Media content analysis: its uses, benefits and best practice methodology', *Asia-Pacific Public Relations Journal*, 6(1), pp. 1–34. Available at: http://hdl.handle.net/10453/10102 (last accessed 28/04/2022)

Madden, K. *et al*. (2022) 'Understanding the relationship between sexual assualt and cervical screening uptake', *European Journal of Health Psychology*. https://doi.org/10.1027/2512-8442/a000109.

Mahumud, R. A. *et al*. (2020) 'Wealth-related inequalities of women's knowledge of cervical cancer screening and service utilisation in 18 resource-constrained

countries: Evidence from a pooled decomposition analysis', International Journal for Equity in Health, 19(1), pp. 1–15. https://doi.org/10.1186/s12939-020-01159-7.

Marlow, L. A. V., Waller, J. and Wardle, J. (2007) 'Public awareness that HPV is a risk factor for cervical cancer', *British Journal of Cancer*, 97(5), pp. 691–694. https://doi.org/10.1038/sj.bjc.6603927.

Marlow, L. A. V., Waller, J. and Wardle, J. (2015) 'Barriers to cervical cancer screening among ethnic minority women: A qualitative study', *Journal of Family Planning and Reproductive Health Care*, 41(4), pp. 248–254. https://doi.org/10.1136/jfprhc-2014-101082.

Marlow, L., Vrinten, C. and Waller, J. (2016) 'Cancer stigma among ethnic minority women', *European Journal of Surgical Oncology (EJSO)*. Elsevier Ltd, 42(11), p. S238. https://doi/org/10.1016/j.ejso.2016.07.086.

Marrow, H. B. (2012) 'Deserving to a point: Unauthorized immigrants in San Francisco's universal access healthcare model', *Social Science and Medicine*. Elsevier Ltd, 74(6), pp. 846–854. https://doi/org/10.1016/j.socscimed.2011.08.001.

Martin, S. and Weerasinghe, S. (2017) *Global Migration Governance Frameworks: Existing architecture and recent developments*, *World Migration Report 2018*. Available at: https://www.iom.int/sites/default/files/country/docs/china/r5_world_migration_report_2018_en.pdf. (last accessed 28/04/2022)

McCall, L. (2005) 'The complexity of intersectionality', *Signs: Journal of women in culture and society*, 30(3), pp. 1771–1800. Available at: http://www.jstor.org/stable/10.1086/426800 (last accessed 28/04/2022)

McKee, K., Pearce, A. and Leahy, S. (2020) *The Unequal Impact of Covid-19 on Black, Asian, Minority Ethnic and Refugee Communities, UK Collaborative Centre for Housing Evidence*. Available at: https://housingevidence.ac.uk/the-unequal-impact-of-covid-19-on-black-asian-minority-ethnic-and-refugee-

communities/ (Accessed: 23 July 2021).

McSherry, L. A. *et al.* (2012) '"It's a can of worms": Understanding primary care practitioners' behaviours in relation to HPV using the theoretical domains framework', *Implementation Science*, 7(1). https://doi/org/10.1186/1748-5908-7-73.

Medecins du Monde (2016) *International Network 2016 Observatory Report: Access to healthcare for people facing multiple vulnerabilities in health in 31 cities in 12 countries*. Available at: https://mdmeuroblog.files.wordpress.com/2016/11/observatory-report2016_en-mdm-international.pdf. (accessed 10/01/2018)

Meltzer, G. *et al.* (2018) 'Rapid Response to: Challenge anti-migrant policies with evidence, doctors are told', *British Medical Journal*, 361. https://doi.org/10.1136/bmj.k2266

Mengesha, Z. B. *et al.* (2018) 'Talking about sexual and reproductive health through interpreters: The experiences of health care professionals consulting refugee and migrant women', *Sexual and Reproductive Healthcare*. pp. 199–205. https://doi.org/10.1016/j.srhc.2018.03.007.

Methley, A. *et al.* (2016) The value of the theoretical framework of candidacy in exploring access and experiences of healthcare services. Health Psychology Update, 25 (1).

Migration Scotland (2014) *Migration in Scotland: Asylum Seekers*. Available at: http://www.migrationscotland.org.uk/migration-information/migration-statistics/asylum-seekers (Accessed: 31 August 2020).

Mollard, C. (2001) *Asylum: the Truth Behind the Headlines, Oxfam*. Available at: http://policy-practice.oxfam.org.uk/publications/asylum-the-truth- behind-the-headlines-111959.(last accessed 06/05/2013)

Moon, K. and Blackman, D. (2014) 'A Guide to Understanding Social Science Research for Natural Scientists', *Conservation Biology*.

https://doi.org/10.1111/cobi.12326

Morgan, D. . (1996) ‘Focus Groups’, *Annual Review of Sociology*, 22, pp. 129–152. https://doi.org/10.1146/annurev.soc.22.1.129

Morgan, R. (2016) *Sexual and reproductive health and rights*, *The Palgrave Handbook of International Development*. https://doi.org/10.1057/978-1-137-42724-3_27.

Moser, K., Patnick, J. and Beral, V. (2009) ‘Inequalities in reported use of breast and cervical screening in Great Britain: Analysis of cross sectional survey data’, *BMJ (Online)*, 338(7709), pp. 1480–1484. https://doi.org/10.1136/bmj.b2025.

Mulvey, G. (2009) ‘Refugee and Asylum Seeker in Scotland A Literature Review’, Scottish Refugee Council. Available at https://www.scottishrefugeecouncil.org.uk/wp-content/uploads/2019/10/Literature_Review_2009-March.pdf (last accessed 28/04/2022)

Mulvey, G. (2010) ‘When policy creates politics: The problematizing of immigration and the consequences for refugee integration in the UK’, *Journal of Refugee Studies*, 23(4), pp. 437–462. https://doi.org/10.1093/jrs/feq045.

Murfin, J. *et al.* (2020) ‘Education, income and occupation and their influence on the uptake of cervical cancer prevention strategies: A systematic review’, *Journal of Clinical Nursing*, 29(3–4), pp. 393–415. https://doi.org/10.1111/jocn.15094.

Muscat, D. M. *et al.* (2016) ‘Incorporating health literacy in education for socially disadvantaged adults: An Australian feasibility study’, International Journal for Equity in Health, 15(1), pp. 1–10. https://doi.org/10.1186/s12939-016-0373-1.

National Audit Office (2020) ‘Asylum accommodation and support’, (3 July 2020).Available at: https://www.nao.org.uk/report/asylum-accommodation-and-support/ (last accessed 28/04/2022)

Nazroo, J. Y. (2003) ‘The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism’, *American Journal of Public Health*, 93(2), pp. 277–284. https://doi.org/10.2105/AJPH.93.2.277.

Netto, G. *et al.* (2010) ‘How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions’, *Health Promotion International*, 25(2), pp. 248–257. https://doi.org/10.1093/heapro/daq012.

Netto, G. and Fraser, A. (2009) ‘Navigating the Maze: Refugee Routes to Housing Support and Settlement in Scotland’, *Scottish Refugee Council*, pp. 1–92.Available at: https://www.scottishrefugeecouncil.org.uk/wp-content/uploads/2019/10/Navigating-the-maze-Refugee-routes-to-housing-support-and-settlement-in-Scotland.pdf (last accessed 28/04/2022)

NHS Inform (2018) *Health care for asylum seekers and refugees in Scotland.* Available at: https://www.nhsinform.scot/care-support-and-rights/health-rights/access/healthcare-for-refugees-and-asylum-seekers (last accessed 28/04/2022)

NHS Inform (2020) *HPV Vaccine*. Available at: https://www.nhsinform.scot/healthy-living/immunisation/vaccines/hpv-vaccine (Accessed: 21 September 2020).

NHS Scotland (2011) ‘Sexual Health Improvement Interventions in Scotland Mapping Exercise’. Available at http://www.healthscotland.com/uploads/documents/15966-Sexual%20Health%20Improvement%20Interventions%20in%20Scotland%20-%20Mapping%20Exercise.pdf (last accessed 28/04/2022)

Nielsen, M. H., Frederiksen, M. and Larsen, C. A. (2020b) ‘Deservingness put into practice: Constructing the (un)deservingness of migrants in four European countries’, *British Journal of Sociology*, 71(1), pp. 112–126. http://doi.org/10.1111/1468-4446.12721.

Nugus, P. and Braithwaite, J. (2010) ‘The dynamic interaction of quality and

efficiency in the emergency department: Squaring the circle?', *Social Science and Medicine*. Elsevier Ltd, 70(4), pp. 511–517. http://doi.org/10.1016/j.socscimed.2009.11.001.

Nyumba, T. O. *et al.* (2018) 'The use of focus group discussion methodology: Insights from two decades of application in conservation', *Methods in Ecology and Evolution*, 9(1), pp. 20–32. http://doi.org/10.1111/2041-210X.12860

O'Donnell, C. *et al.* (2008) 'Asylum seekers' expectations of and trust in general practice: A qualitative study', *British Journal of General Practice*, 58(557), pp. 870–876. http://doi.org/10.3399/bjgp08X376104.

O'Donnell, C. A. *et al.* (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', *BMC Health Services Research*, 7, pp. 1–11. http://doi.org/10.1186/1472-6963-7-75.

O'Donnell, C. A. *et al.* (2008) 'Asylum seekers' expectations of and trust in general practice: a qualitative study.', British Journal of General Practice, 58(557), pp. e1-11. http://doi.org/10.3399/bjgp08X376104.

O'Donnell, C. A. *et al.* (2016) 'Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe', *Health Policy*, 120(5), pp. 495–508. https://doi.org/10.1016/j.healthpol.2016.03.012.

O'Donnell, C. a *et al.* (2011) 'The new GMS contract in primary care: the impact of governance and incentives on care', National Institute for Health Research, pp. 1–8. Available at: https://www.researchgate.net/publication/228770063_The_new_GMS_contract_in_primary_care_the_impact_of_governance_and_incentives_on_care (last accessed 28/04/2022)

Oakley, A. (2016) 'Interviewing women again: Power, time and the gift.', *Sociology*, 50(1), pp. 195–213. http://doi.org/10.1177%2F0038038515580253

Oakley, A. and Roberts, H. (1981) '"Doing feminist research."', *Doing feminist*

research, London Routledge pp. 30–61.

Ochieng, B. M. N. (2013) 'Black African migrants: The barriers with accessing and utilizing health promotion services in the UK', *European Journal of Public Health*, 23(2), pp. 265–269. doi: 10.1093/eurpub/cks063.

Ogbonna, F.S., (2017) Knowledge, attitude and experience of cervical cancer and screening among sub-saharan African female students in a UK University. Annuals of African Medicine, 16 (1), 18-23. doi: 10.4103/aam.aam_37_16: 10.4103/aam.aam_37_16

Onyigbuo, C. C., Alexis-Garsee, C. and van den Akker, O. (2018) 'Predicting attitudes towards seeking medical care among Nigerian immigrants in the UK.', *Mental Health, Religion & Culture*, 21(8), pp. 810–824. http://doi.org/10.0.4.56/13674676.2018.1551343.

Van Oorschot, W. (2006) 'Making the difference in social Europe: deservingness perceptions among citizens of European welfare states', *Journal of European Social Policy*, 16(1), pp. 23–42. http://doi.org/10.1177%2F0958928706059829

Parajuli, J., Horey, D. and Avgoulas, M.-I. (2019) 'Access to breast cancer screening-perception, and perceived barriers among older Bhutanese refugee women resettled in Australia: a qualitative study.', *Australian Journal of Cancer Nursing*, 20(1), pp. 14–18. http://doi.org/10.33235/ajcn.20.1.14-18

Parker, S. (2015) 'Unwanted invaders': The representation of refugees and asylum seekers in the UK and Australian print media. ESharp. Issue 23: Myth and Nation (1), p 1-21.

Patterson, C. *et al.* (2015) 'A quantitative content analysis of UK newsprint coverage of proposed legislation to prohibit smoking in private vehicles carrying children', *BMC Public Health*, 15(1). http://doi.org/10.1186/s12889-015-2110-x

Pearce, J. M. and Charman, E. (2011) 'A social psychological approach to understanding moral panic', *Crime, Media, Culture*, 7(3), pp. 293–311. doi: 10.1177/1741659011417607.

Pearce, J. M. and Stockdale, J. E. (2009) 'UK responses to the asylum issue: A comparison of lay and expert views', *Journal of Community and Applied Social Psychology*, 19(2), pp. 142–155. http://doi.org/10.1002/casp.982

Perna, R. (2018) 'Re-bounding EU citizenship from below: practices of healthcare for "(Il)legitimate EU Migrants" in Italy', *Journal of Ethnic and Migration Studies*, 44(5), pp. 829–848. http://doi.org/10.1080/1369183X.2017.1362977.

Pfeffer, N. (2004) 'Screening for breast cancer: Candidacy and compliance', *Social Science and Medicine*, 58(1), pp. 151–160. http://doi.org/10.1016/S0277-9536(03)00156-4.

Philo, G., Briant, E. and Donald, P. (2013) *Bad News for Refugees*. London: Pluto Press.

Piacentini, T. *et al*. (2019) 'Moving beyond the "language problem": developing an understanding of the intersections of health, language and immigration status in interpreter-mediated health encounters', *Language and Intercultural Communication*, 19(3), pp. 256–271. http://doi.org/10.1080/14708477.2018.1486409.

Press Complaints Commission (2003) *Refugees and Asylum Seekers*. Available at: http://www.pcc.org.uk/advice/editorials-detail.html?article=OTE (Accessed: 2 December 2014).

Prinz, A. (2019) 'Migration, Cultural Identity and Diasporas: An Identity Economics Approach', *Journal of Development and Migration*, 10(1). https://doi.org/10.2478/izajodm-2019-0001

Pruitt, L. J. (2019) 'Closed due to "flooding"? UK media representations of refugees and migrants in 2015–2016 – creating a crisis of borders', *British Journal of Politics and International Relations*, 21(2), pp. 383–402. https://doi.org/10.1177/1369148119830592.

Public Health England (2014) *NHS entitlements: migrant health guide*.Available at

https://www.congreso.es/docu/docum/ddocum/dosieres/sleg/legislatura_12/spl_23/pdfs/24.pdf (last accessed 02/12/2017)

Public Health Scotland (2020) *Cervical Cancer Screening*.Available at: https://publichealthscotland.scot/publications/scottish-cervical-screening-programme-primary-care-resources/ (last accessed 10/10/2020)

Public Health Scotland (2021a) *Cervical Screening*. Available at: http://www.healthscotland.scot/health-topics/screening/cervical-screening#:~:text=Cervical cancer is the most,cancers are caused by HPV. (Accessed: 24 May 2021).

Public Health Scotland (2021b) *Vaccine Uptake by ethnicity*. Available at: https://www.publichealthscotland.scot/news/2021/march/vaccine-uptake-by-ethnicity/ (Accessed: 23 July 2021).

Randhawa, G. and Owens, A. (2004) 'The meanings of cancer and perceptions of cancer services among South Asians in Luton, UK', *British Journal of Cancer*, 91(1), pp. 62–68. https://dx.doi.org/10.1038%2Fsj.bjc.6601892

Rasinger, S. M. (2010) '"Lithuanian migrants send crime rocketing": Representation of "new" migrants in regional print media', *Media, Culture and Society*, 32(6), pp. 1021–1030. doi: 10.1177/0163443710380311.

Ravn, S. *et al.* (2020) 'Shaping the "Deserving Refugee": Insights from a Local Reception Programme in Belgium', *In Glorius, B. , Doomernik, J. (eds) Geographies of Asylum in Europe and the Role of European Localities*. Springer, Cham. doi: https://doi.org/10.1007/978-3-030-25666-1_7.

Razai, M. S. *et al.* (2021) 'Mitigating ethnic disparities in covid-19 and beyond', *The BMJ*, 372, pp. 1–5. doi: 10.1136/bmj.m4921.

Refugee Action (2019) *Government failings are leaving vulnerable people seeking asylum homeless and hungry*. Available at: https://www.refugee-action.org.uk/government-failings-are-leaving-vulnerable-people-seeking-asylum-homeless-and-hungry/ (last accessed 28/04/2022)

Refugee Action (2020) ‘Worsening asylum wait times combined with work ban creating a perfect storm for extreme poverty and homelessness’. Available at: https://www.refugee-action.org.uk/worsening-asylum-wait-times-combined-with-work-ban-creating-a-perfect-storm-for-extreme-poverty-and-homelessness/ (Accessed: 3 April 2022).

Refugee Council (2012a) *Levenson Inquiry: Submission of Evidence*. Available at: https://discoverleveson.com/evidence/Submission_by_Refugee_Council/13563/media (last accessed 28/04/2022)

Refugee Council (2012b) *The Experiences of Refugee Women in the UK*. Available at: https://www.refugeecouncil.org.uk/information/resources/the-experiences-of-refugee-women-in-the-uk/ (last accessed 28/04/2022)

Refugee Council (2020) *The Truth About Asylum*. Available at: https://www.refugeecouncil.org.uk/information/refugee-asylum-facts/the-truth-about-asylum/ (last accessed: 25 August 2020).

Refugee Council (2021a) *Our key policy calls to the Home Office in response to Covid-19*. Available at: https://www.refugeecouncil.org.uk/latest/news/our-key-policy-calls-to-the-home-office-in-response-to-covid-19/ (last accessed 28/04/2022)

Refugee Council (2021b) *Written evidence submitted by the Refugee Council (NBB08). Nationality and Borders Bill 2021022- Public Bill Committee*. Available at https://refugeecouncil.org.uk/information/resources/nationality-and-borders-bill-public-bill-committee-refugee-council-written-evidence/ (last accessed 28/04/2022)

Refugee Council (2022) *Support payments for asylum seekers living in poverty to increase by all of 17p a day, decides Home Office*. Available at: https://www.refugeecouncil.org.uk/latest/news/support-payments-for-asylum-seekers-living-in-poverty-to-increase-by-all-of-17p-a-day-decides-home-office/ (Accessed: 3 April 2022).

Right to Remain (2018) *Credibility in Asylum Claims*. Available at:

https://righttoremain.org.uk/credibility-in-asylum-claims/ (last accessed 28/04/2022)

Rimmer, A. (2020) 'Can patients use family members as non-professional interpreters in consultations?', *The BMJ*, 368. doi: https://doi.org/10.1136/bmj.m447.

Robb, K. *et al*. (2010) 'Ethnic disparities in knowledge of Cancer Screening Programmes in the UK', *Journal of Medical Screening*, 17(3), pp. 125–131. doi: 10.1258/jms.2010.009112.

Rogstad, K. and Dale, H. (2004) 'What are the needs of asylum seekers attending an STI clinic and are they significantly different from those of British patients?', *International Journal of STD and AIDS*, 15(8), pp. 515–518. https://doi.org/10.1258/0956462041558230

Rollock, N. (2014) 'Race, Class and "The Harmony of Dispositions"', *Sociology*, pp. 445–451. doi: 10.1177/0038038514521716.

Rooke, C. and Amos, A. (2014) 'News media representations of electronig cigarettes: an analysis of newspaper coverage in the UK and Scotland', *Tobacco Control*, 23(6), pp. 507–12. https://doi.org/10.1136/tobaccocontrol-2013-051043

Rooney, R. (2010) 'News media and ideology in the UK', in *Conference Paper presented at a lecture series organised at Girne American University, Turkish Republic of Northern Cyprus 22*. Available at https://www.scribd.com/document/27250311/UK-News-Media-and-Ideology-Richard-Rooney (last accessed 28/04/2022)

Roshan, N. (2005) *Supporting new communities: A qualitative study of health needs among asylum seekers and refugee communities in north Glasgow, NHS Greater Glasgow and Clyde*. Available at https://www.stor.scot.nhs.uk/bitstream/handle/11289/578799/nhsgg_supporting_new_communities_full_report.pdf?sequence=1&isAllowed=y (last accessed 28/04/2022)

Ryan, F., Coughlan, M. and Cronin, P. (2013) 'Interviewing in qualitative research: The one-to-one interview', *International Journal of Therapy and Rehabilitation*, 16(6). https://doi.org/10.12968/ijtr.2009.16.6.42433

Ryan, M., Marlow, L. and Waller, J. (2019) 'Socio-demographic correlates of cervical cancer risk factor knowledge among screening non-participants in Great Britain', *Preventive Medicine*. 125, pp. 1–4. doi: 10.1016/j.ypmed.2019.04.026.

Sabates, R. and Feinstein, L. (2006) 'The role of education in the uptake of preventative health care: The case of cervical screening in Britain', *Social Science and Medicine*, 62(12), pp. 2998–3010. doi: 10.1016/j.socscimed.2005.11.032.

Sargent, C. (2012) 'Special Issue Part I: "Deservingness" and the politics of health care', *Social Science and Medicine*, 74(6), pp. 855–857. doi: 10.1016/j.socscimed.2011.10.044.

Sassetti, F. (2017) 'The "F" Word: How Britain is failing women seeking asylum', *UNA-UK*. Available at: https://una.org.uk/magazine/2017-2/how-britain-failing-women-seeking-asylum (last accessed 28/04/2022)

Sayers, A. (2008) 'Tips and tricks in performing a systemic review', *British Journal of General Practice*, 58(547), p. 136. doi: 10.3399/bjgp08X277168.

Scottish Executive (2005). One Scotland Campaign: Post Campaign evaluation. Available at http://www.scotland.gov.uk/Resources/Doc/76169/0019421.pdf (last accessed 11/12/2012)

Scottish Government (2020) *Policy: Refugees and Asylum Seekers*. Available at: https://www.gov.scot/policies/refugees-and-asylum-seekers/ (Accessed: 31 August 2020).

Scottish Refugee Council (2013) *Asylum in Scotland: The Facts*. Available at: http://www.migrationscotland.org.uk/scottish-refugee-council-2013-asylum-scotland-facts (last accessed 28/04/2022)

Scottish Refugee Council (2020) *Written evidence to the Home Affairs committee enquiry into asylum accomodation and preparedness for Covid-19*. Available at: https://committees.parliament.uk/writtenevidence/6653/html/ (last accessed 28/04/2022)

Scottish Refugee Council (2021) *Asylum Accomodation*. Available at: https://www.scottishrefugeecouncil.org.uk/working-for-change/policy-campaigns/asylum-accommodation/ (Accessed: 23 July 2021).

Scottish Refugee Council (2022) *Asylum Accommodation*. Available at: https://www.scottishrefugeecouncil.org.uk/working-for-change/policy-campaigns/asylum-accommodation/ (Accessed: 3 April 2022).

Seale, C. (2017) *Researching Society and Culture*. 4th Editio. Sage Publications.

Shakespeare, T. (2006) 'Labels and badges: the politics of disability identity', in *Disability Rights and Wrongs*. Routledge, pp. 68–82.

SHRC (2021) *Call for inputs- Special Rapporteur on the rights to freedom of peaceful assembly and of association*, *Scottish Human Rights Commission*. Available at: https://www.scottishhumanrights.com/media/2185/call-for-inputs-to-special-rapporteur-on-freedom-of-assembly-final.pdf (last accessed 28/04/2022)

Silverman, D. (2001) *Interpreting Qualitative Date*. Second Edi. London: Sage Publications.

Silverman, D. (2019) *Interpreting Qualitative Data*. 6th Editio. Edited by A. Owen. Sage Publications.

Sim, D. and Bowes, A. (2007) 'Asylum seekers in Scotland: The accommodation of diversity', *Social Policy and Administration*, 41(7), pp. 729–746. doi: 10.1111/j.1467-9515.2007.00582.x.

Simpson, L. (2014) *DYNAMICS OF DIVERSITY : How has ethnic diversity changed in Scotland ? How has ethnic diversity changed.*, *Joseph Rowntree Foundation*.

Available at: http://hummedia.manchester.ac.uk/institutes/code/briefings/dynamicsofdiversity/code-census-briefing-scotland_v2.pdf. (last accessed 04/04/2015)

Smart, K. *et al.* (2005) *Reporting asylum: The UK Press and the Effectiveness of PCC Guidelines, Information Centre about Asylum Seekers and Refugees (ICAR)*. Available at: https://www.crimeandjustice.org.uk/publications/reporting-asylum-uk-press-and-effectiveness-pcc-guidelines (last accessed 28/04/2022)

Smith, S. A. (2016) 'Migrant encounters in the clinic: Bureaucratic, biomedical, and community influences on patient interactions with front-line workers', *Social Science and Medicine*. Elsevier Ltd, 150, pp. 49–56. doi: 10.1016/j.socscimed.2015.12.022.

Smithson, J. (2010) 'Using and analysing focus groups: Limitations and possibilities', *International Journal of Social Research Methodology*, 3(2), pp. 103–119. https://doi.org/10.1080/136455700405172

Sparks, C. (1995) 'The media as a power for democracy', *Javnost - The Public*, 2(1), pp. 45–61. doi: 10.1080/13183222.1995.11008585.

Spencer, A. M. *et al.* (2014) 'Sociodemographic factors predicting mother's cervical screening and daughter's HPV vaccination uptake', *Journal of Epidemiology and Community Health*, 68(6), pp. 571–577. doi: 10.1136/jech-2013-202629.

Springer, K. W., Hankivsky, O. and Bates, L. M. (2012) 'Gender and health: Relational, intersectional, and biosocial approaches', *Social Science and Medicine*, 74(11), pp. 1661–1666. doi: 10.1016/j.socscimed.2012.03.001.

Stanley, L. and Wise, S. (1979) 'Feminist research, feminist consciousness and experiences of sexism', *Women's Studies International Quarterly*, 2(3), pp. 359–374. https://doi.org/10.1016/S0148-0685(79)91580-X

Stanley, L. and Wise, S. (1990) 'Method, methodology and epistemology in feminist research processes', in *Feminist Praxis: Research, theory and*

epistemology in feminist sociology, pp. 20–60.

Steven, D. *et al.* (2004) 'Knowledge, attitudes, beliefs, and practices regarding breast and cervical cancer screening in selected ethnocultural groups in Northwestern Ontario.', *Oncology nursing forum*, 31(2), pp. 305–311. doi: 10.1188/04.ONF.305-311.

Stewart, E. (2012) 'UK dispersal policy and onward migration: Mapping the current state of knowledge', *Journal of Refugee Studies*, 25(1), pp. 25–49. doi: 10.1093/jrs/fer039.

Strang, A. B., Baillot, H. and Mignard, E. (2018) '"I want to participate." transition experiences of new refugees in Glasgow.', *Journal of Ethnic & Migration Studies*. Routledge, 44(2), pp. 197–214. Available at: http://10.0.4.56/1369183X.2017.1341717.

Suleman, M. *et al.* (2021) *Unequal pandemic , fairer recovery The COVID-19 impact inquiry report*. Available at: https://www.health.org.uk/publications/reports/unequal-pandemic-fairer-recovery (last accessed 28/04/2022)

Sutton, S. and Rutherford, C. (2005) 'Sociodemographic and attitudinal correlates of cervical screening uptake in a national sample of women in Britain', *Social Science and Medicine*, 61(11), pp. 2460–2465. doi: 10.1016/j.socscimed.2005.07.017.

Taha, D. (2019) 'Intersectionality and Other Critical Approaches in Refugee Research An Annotated Bibliography', *Local Engagement Refugee Research Network Paper No. 3*, (3). Available at: https://carleton.ca/lerrn/wp-content/uploads/Intersectionality-and-Other-Critical-Approaches-in-Refugee-Research.pdf (last accessed 28/04/2022)

The Children's Society (2012) 'A briefing from The Children ' s Society Highlighting the gap between asylum support and mainstream benefits'. Available at https://publications.parliament.uk/pa/cm201314/cmselect/cmhaff/71/71vw320

08_HC71_01_VIRT_HomeAffairs_ASY-88.htm (last accessed 28/04/2022)

The Guardian (2020) ‘Glasgow asylum seekers moved into hotels where distancing is “impossible”’.

The Leveson Inquiry (2012) *An inquiry into the culture, practices and ethics of the press*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270939/0780_i.pdf (last accessed 28/04/2022)

The Scottish Government (2010) ‘Overseas Visitors’ Liability to Pay Charges for NHS Care and Services CEL09 (2010)’, 09(April), p. 21. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf.

The Scottish Government (2017) *New Scots: Integrating Refugees in Scotland’s Communities 2014 - 2017 Final Report*, *Scottish Government*. Available at: https://www.gov.scot/publications/new-scots-integrating-refugees-scotlands-communities-2014-2017-final-report-9781786526960/ (last accessed 28/04/2022)

The Scottish Government (2018) New Scots Refugee Integration Strategy 2018-2022. Scottish Government. Available at https://www.gov.scot/publications/new-scots-refugee-integration-strategy-2018-2022/ (last accessed 01/05/2022)

The Scottish Government (2018) *NHS Circular: Patient Registration*. Available at: https://www.sehd.scot.nhs.uk/pca/PCA2018(M)10.pdf (last accessed 28/04/2022)

The Scottish Government (2020) *Healthcare for Overseas Visitors: Immigration Health Surcharge*. Available at: https://www.nhsinform.scot/care-support-and-rights/health-rights/access/healthcare-for-overseas-visitors (last accessed 28/04/2022)

The Scottish Government (2021a) *National Taskforce for Human Rights Leadership Report*. Available at: https://www.gov.scot/publications/national-taskforce-human-rights-leadership-report/ (last accessed 28/04/2022)

The Scottish Government (2021b) *New Human Rights Bill*. Available at: https://www.gov.scot/news/new-human-rights-bill/ (Accessed: 3 May 2021).

Thomas, J. and Harden, A. (2008) 'Methods for the thematic synthesis of qualitative research in systematic reviews', *BMC Medical Research Methodology*, 8, pp. 1–10. doi: 10.1186/1471-2288-8-45.

Thomas, V. N. (1997) 'Cancer and minority ethnic groups: Factors likely to improve nurse-patient communication and facilitate the delivery of sensitive care', *Journal of Cancer Nursing*, 1(3), pp. 134–140. doi: 10.1016/S1364-9825(97)80086-7.

Thomas, V. N., Saleem, T. and Abraham, R. (2005) 'Barriers to effective uptake of cancer screening among Black and minority ethnic groups', *International journal of palliative nursing*, 11(562), pp. 564–571. https://doi.org/10.12968/ijpn.2005.11.11.20096

Tomkow, L. (2020) 'Health and hostile hospitality: Understanding asylum applicants' narratives of life and health in the UK', *Social Science and Medicine*, 265. Available at: https://doi.org/10.1016/j.socscimed.2020.113509.

Tomkow, L. J. *et al*. (2020) 'Healthcare access for asylum seekers and refugees in England: a mixed methods study exploring service users' and health care professionals' awareness', *European Journal of Public Health*, 30(3), pp. 527–532. https://doi.org/10.1093/eurpub/ckz193

Tschalaer, M. (2020) 'Victimhood and femininities in Black lesbian asylum cases in Germany', *Journal of Ethnic and Migration Studies*, pp. 1–18. doi: 10.1080/1369183X.2020.1772735.

Tyler, I. (2013) *Revolting Subjects: social abjection and resistance in neoliberal Britain*. 1st edition. Zed Books ltd

UK Government (2020) *Asylum Support*. Available at: https://www.gov.uk/asylum-support/what-youll-get (Accessed: 23 April 2021).

UNHCR (2022) *Figures at a Glance*, *UNHCR*. Available at: https://www.unhcr.org/figures-at-a-glance.html (Accessed: 3 April 2022)

UNHCR: The UN Refugee Agency (2018) *Policy on Age, Gender and Diversity Accountability*. Available at: https://www.unhcr.org/uk/protection/women/5aa13c0c7/policy-age-gender-diversity-accountability-2018.html (last accessed 28/04/2022)

UNHCR: The UN Refugee Agency (2022) *The Nationality and Borders Bill*. Available at: https://www.unhcr.org/uk/uk-immigration-and-asylum-plans-some-questions-answered-by-unhcr.html (last accessed 28/04/2022)

UNHCR (2020) *Asylum in the UK*, *The UN Refugee Agency*. Available at: UNHCR (2020) *Asylum in the UK*, *The UN Refugee Agency*. (last accessed 28/04/2022)

United Nations (1951) *Convention and Protocol Relating to the Status of Refugees*, *United Nations General Assembly Resolution 429 (V)*. Available at: https://www.unhcr.org/uk/3b66c2aa10 (Accessed: 25 August 2020).

United Nations Division for the Advancement of Women, Office of the High Commissioner for Human Rights and United Nations Development Fund for Women (2000) *Gender and racial discrimination. Report of the Expert Group Meeting*. Available at: https://www.un.org/womenwatch/daw/csw/genrac/report.htm. (last accessed 01/12/2012)

Vahabi, M. and Lofters, A. (2016) 'Muslim immigrant women's views on cervical cancer screening and HPV self-sampling in Ontario, Canada', *BMC Public Health*. BMC Public Health, 16(1), pp. 1–13. doi: 10.1186/s12889-016-3564-1.

Vaismoradi, M., Turunen, H. and Bondas, T. (2013) 'Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study', *Nursing and Health Sciences*, 15(3), pp. 398–405. doi: 10.1111/nhs.12048.

Van Oorschot, W. (2006) Making the difference in social Europe: deservingness perceptions among citizens of European welfare states. Journal of European

Social Policy, 16 (1), p 23-42. https://doi.org/10.1177%2F0958928706059829

Vanthuyne, K. *et al*. (2013) 'Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege?', *Social Science and Medicine*. Elsevier Ltd, 93, pp. 78–85. doi: 10.1016/j.socscimed.2013.06.008.

Viladrich, A. (2019) '"We Cannot Let Them Die" Undocumented Immigrants and U.S. Media Framing of Health Deservingness', *Qualitative Health Research*, 29 (10), pp. 1447–1460. https://doi.org/10.1177/1049732319830426

Viruell-Fuentes, E. A., Miranda, P. Y. and Abdulrahim, S. (2012) 'More than culture: Structural racism, intersectionality theory, and immigrant health', *Social Science and Medicine*. Elsevier Ltd, 75(12), pp. 2099–2106. doi: 10.1016/j.socscimed.2011.12.037.

Vu, A. *et al*. (2014) 'The prevalence of sexual violence among female refugees in complex humanitarian emergencies: a systematic review and meta-analysis', *PLoS currents*, 6. https://dx.doi.org/10.1371%2Fcurrents.dis.835f10778fd80ae031aac12d3b533ca7

Walby, S. (2007) 'Complexity theory, systems theory, and multiple intersecting social inequalities', *Philosophy of the Social Sciences*, 37(4), pp. 449–470. doi: 10.1177/0048393107307663.

Walby, S., Armstrong, J. and Strid, S. (2012) 'Intersectionality: Multiple inequalities in social theory', *Sociology*, 46(2), pp. 224–240. doi: 10.1177/0038038511416164.

Waller, J. *et al*. (2009) 'Barriers to cervical cancer screening attendance in England: A population-based survey', *Journal of Medical Screening*, 16(4), pp. 199–204. doi: 10.1258/jms.2009.009073.

Walsh, B., Silles, M. and O'Neill, C. (2011) 'The importance of socio-economic variables in cancer screening participation: A comparison between population-based and opportunistic screening in the EU-15', *Health Policy*, 101(3), pp. 269-

276. doi: 10.1016/j.healthpol.2011.02.001.

Walsh, P. W. (2020) *Briefing: Asylum and refugee resettlement in the UK 2nd Edition*, *The Migration Observatory*. Available at: https://migrationobservatory.ox.ac.uk/wp-content/uploads/2020/12/Briefing-Asylum-and-refugee-resettlement-in-the-UK.pdf. (last accessed 02/02/2021)

Weerasinghe, S. (2012) 'Inequities in visible minority Immigrant Women's Healthcare accessibility', *Ethnicity and Inequalities in Health and Social Care*, 5(1), pp. 18–28. doi: 10.1108/17570981211286750.

WHO (2010) 'Poverty and social exclusion in the WHO European Region: health systems respond', *World Health Organisation, Europe*, p. 63;331. Available at: http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/social-determinants/publications/poverty-and-social-exclusion-in-the-who-european-region-health-systems-respond. (last accessed 03/04/2014)

WHO and IOM (2010) – *THE WAY FORWARD Report of a global consultation*. Available at: https://apps.who.int/iris/bitstream/handle/10665/44336/9789241599504_eng.pdf?sequence=1&isAllowed=y (last accessed 28/04/2022)

Wilding, S. *et al*. (2020) 'What factors are most influential in increasing cervical cancer screening attendance? An online study of UK-based women1', *Health Psychology and Behavioral Medicine*, 8(1), pp. 314–328. doi: 10.1080/21642850.2020.1798239.

Willems, B. and Bracke, P. (2018) 'Participants, Physicians or Programmes: Participants' educational level and initiative in cancer screening', *Health Policy*, 122(4), pp. 422–430. doi: 10.1016/j.healthpol.2018.02.001.

Willen, S. S. (2012a) 'How is health-related " deservingness" reckoned? Perspectives from unauthorized im/migrants in Tel Aviv', *Social Science and Medicine*, 74(6), pp. 812–821. doi: 10.1016/j.socscimed.2011.06.033.

Willen, S. S. (2012b) 'Migration, "illegality," and health: Mapping embodied

vulnerability and debating health-related deservingness', *Social Science and Medicine*, 74(6), pp. 805–811. doi: 10.1016/j.socscimed.2011.10.041.

Willen, S. S. *et al.* (2017) 'Syndemic vulnerability and the right to health', *The Lancet*, 389(10072), pp. 964–977. doi: 10.1016/S0140-6736(17)30261-1.

Williams, L. (2006) 'Social Networks of Refugees in the United Kingdom: Tradition, Tactics and New Community Spaces.', *Journal of Ethnic & Migration Studies*. Routledge, 32(5), pp. 865–879. Available at: http://10.0.4.56/13691830600704446.

Williams, P. and Dickinson, J. (1993) '"Fear of crime: Read all about it? The relationship between newspaper crime reporting and fear of crime', *The British Journal of Criminology*, 33(1), pp. 33–56.

Wohlin, C. (2014) 'Guidelines for snowballing in systematic literature studies and a replication in software engineering', *ACM International Conference Proceeding Series*. doi: 10.1145/2601248.2601268.

Wolcott, H. F. (1990) 'Making a Study "more ethnographic"', *Journal of Contemporary Ethnography*, 19, pp. 44–72. https://doi.org/10.1177%2F089124190019001003

Women's Rights National Historic Park (2017) *Sojourner Truth: Ain't I A Woman?* Available at: https://www.nps.gov/articles/sojourner-truth.htm (Accessed: 17 May 2021).

Women for Refugee Women (2021) 'Written evidence submitted by Women for Refugee Women: Evidence to the Nationality and Borders Public Bill Committee'. Available at: https://bills.parliament.uk/publications/42825/documents/705 (last accessed 28/04/2022)

Woods, L. M., Rachet, B. and Coleman, M. P. (2006) 'Origins of socio-economic inequalities in cancer survival: A review', *Annals of Oncology*. Elsevier Masson SAS, 17(1), pp. 5–19. doi: 10.1093/annonc/mdj007.

Woolley, C. *et al.* (2007) 'United Kingdom cervical cancer screening and the costs of time and travel', *International Journal of Technology Assessment in Health Care*, 23(2), pp. 232–239. doi: 10.1017/S026646230707016X.

World Health Organisation (2014) *Health Literacy Toolkit: For Low- and Middle-Income Countries*. Available at https://apps.who.int/iris/bitstream/handle/10665/205244/B5148.pdf?sequence=1&isAllowed=y (last accessed 28/04/2022)

World Health Organisation (2020) *Cervical Cancer Overview*. Available at: https://www.who.int/health-topics/cervical-cancer#tab=tab_1 (Accessed: 8 November 2020).

World Health Organization (2018) *Report on the Health of refugees and migrants in the WHO European Region, World Health Organization European Region (WHO)*. Available at: https://apps.who.int/iris/bitstream/handle/10665/311347/9789289053846-eng.pdf?sequence=1&isAllowed=y. (last accessed 28/04/2022)

Wren, K. (2007) 'Supporting asylum seekers and refugees in Glasgow: The role of multi-agency networks', *Journal of Refugee Studies*, 20(3), pp. 391–413. doi: 10.1093/jrs/fem006.

Yacob-Haliso, O. (2016) 'Intersectionality and Durable Solutions for Refugee Women in Africa', *Journal of Peacebuilding and Development*, 11(3), pp. 53–67. doi: 10.1080/15423166.2016.1236698.

Yin, R. K. (2003) *Case study research: Design and methods. 3rd edition*. Sage.

Yin, R. K. (2009) *Case study research: Design and methods*. 4th edn. Thousand Oaks, CA: Sage.

Young, B. *et al.* (2018) 'Factors influencing the decision to attend screening for cancer in the UK: A meta-ethnography of qualitative research', *Journal of Public Health (United Kingdom)*, 40(2), pp. 315–339. doi: 10.1093/pubmed/fdx026.

Yun, K. *et al.* (2012) 'High Prevalence of Chronic Non-Communicable Conditions Among Adult Refugees: Implications for Practice and Policy', *Journal of Community Health*, 37(5). https://doi.org/10.1007/s10900-012-9552-1

Zavratnik, S. and Krilic, C. S. (2018) 'Addessing Intersectional Vulnerabilities in Contemporary Refugee Movements in Europe', *Druzboslovne Razprace*, 34(87), pp. 85–106.

Zeferino, L. C. and Derchain, S. F. (2006) 'Cervical cancer in the developing world', *Best Practice and Research: Clinical Obstetrics and Gynaecology*, 20(3), pp. 339–354. doi: 10.1016/j.bpobgyn.2006.01.018.

Zhang, Y. *et al.* (2017) 'Provider Perspectives on Promoting Cervical Cancer Screening Among Refugee Women', *Journal of Community Health*, 42, pp. 583–590. doi: 10.1007/s10900-016-0292-5.

Ziebland, S. and McPherson, A. (2006) 'Making sense of qualitative data analysis: An introduction with illustrations from DIPEx (personal experiences of health and illness)', *Medical Education*, 40(5), pp. 405–414. doi: 10.1111/j.1365-2929.2006.02467.x.

Zimmerman, C., Kiss, L. and Hossain, M. (2011) 'Migration and Health: A Framework for 21st Century Policy-Making', *PLoS Medicine*, 8(5). doi: 10.1371/journal.pmed.1001034.

Zwi, K. J. *et al.* (2017) 'The impact of health perceptions and beliefs on access to care for migrants and refugees', *Journal of Cultural Diversity*, 24(3), pp. 63–72.

Legislation

Immigration and Asylum Act (1999). Available at: https://www.legislation.gov.uk/ukpga/1999/33/contents (last accessed 01/05/2022)

Equality Act (2010). Available at https://www.legislation.gov.uk/ukpga/2010/15/contents (last accessed 01/05/2022)

Scottish Elections (Franchise and Representation) Act (2020). https://www.legislation.gov.uk/asp/2020/6/contents/enacted (last accessed 01/05/2022)

Nationality and Borders Bill (2021) Available at: https://bills.parliament.uk/bills/3023.(last accessed 10/04/2022)