A reflection on the NHS, health security, and refugees

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Abstract

In 2021 a sudden influx of refugees arrived in the UK from Afghanistan, at a time when the British public were being encouraged to access healthcare services to obtain COVID-19 vaccinations. This report examines the successes and failures of care provision in the NHS across the country, in particular Wolverhampton, whereby refugees accessed healthcare provision in a local Primary Care Network. The report considers the author's personal experiences while working within the local Primary Care Network, in addition to published research, in the context of health security. Furthermore, it highlights recommended improvements within the NHS to provide aid to the vulnerable, while preserving the system set out to create health security.

Keywords: Afghanistan refugees; COVID-19 vaccination; Health Security; NHS; Primary Care Network.

Introduction

The National Health Service (NHS) when introduced in 1948 was implemented to improve the health and wellbeing, both physical and mental, of the population of Britain, while "preventing, diagnosing, and treating illness" (The National Health Service Act, 1946). Since its creation over 60 years ago, the acute trust has expanded into a complex multi-organizational service, an integral part of British life (Maynard & Bloor, 2008). The NHS operates across the country with several acute Trusts representing local areas operating both primary and secondary care (Faulkner et al., 2003). During its operation, the NHS has encountered many epidemics (such as the 2003 SARS epidemic). While the government's advice to the public is ever-changing during these crises, the NHS continues to support those needing treatment by putting patient care at the highest level of importance (Shehata et al., 2020). The Primary Care Network (PCN) is the first point of call for care coordination, diagnosis, and treatment (Dunlop et al., 2020) for patients. The aim is for it to be an accessible service to all. The beginning of the COVID-19 pandemic added pressures to most services, primary care being one of them (Levene, 2020), with new ways of operating being implemented, more remote appointments and triaging and a new perspective for safety being considered: the COVID-19 vaccination. The vaccination was originally approved in the UK in December 2020 (Sasse & Hodgkin, 2022) creating a national-scale change to PCNs to ensure the administration of the vaccination to all eligible patients. Vaccination was a priority for public health, but the NHS still needed to remain operational with this extra workload, thus the creation of vaccination hubs adjoined to primary care services.

Adjacent to the COVID-19 pandemic, another crisis was beginning: the Afghanistan Refugee Crisis (Zhongming et al., 2021). After the removal of US troops in April 2021 (Malkasian, 2021), the Taliban had a quick and violent rise back to power causing a humanitarian crisis,

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as over the years of US occupation the Afghans had been trying to rebuild their country, however, after August 2021 their home was no longer a safe environment (Ahmed et al., 2021). With civilians being targeted and met with violence over their human rights, the country was put in a state of crisis with thousands needing to flee (Ahmed et al., 2021). These individuals became forced migrants or refugees (Zetter, 2007). A refugee can be anyone who no longer feels safe in their home country, regardless of the reason they fear for their safety, and is thus forced to flee (Steinbock, 1997). While the concept of "refugee" is not simple (Adelman, 1998), there is no doubt that the individuals fleeing Afghanistan would be considered refugees.

The aim of this article is to review the Royal Wolverhampton NHS Trust's clinics for refugees during 2021, thus bringing together the issues of refugees and health security.

Human security

The narrative of refugee crises will not be expiring any time soon, as war plagues the globe, with the most recent conflict zone being Ukraine. With Russia invading Ukraine in February 2022 (Lock et al., 2022), the country was plunged into a violent conflict zone, much like that in Afghanistan. Those living there were put in the awful position of having to decide how they are going to preserve their safety. While many countries sanction Russia, the Ukrainians were left waiting to see if that was enough to stop the violence (BBC News, 2022). In the meantime, with homes and families destroyed, many have only had one choice: to leave. As states never stop protecting themselves and their interests (Rousseau, 2006), a world of continuous peace is unlikely, meaning refugee crises will continue to happen and other states will continue to have the responsibility to help.

Refugeedom is unfortunately not a new phenomenon. Wherever there is insecurity there will be refugees. War, famine, and political unrest have always contributed to the creation of refugees. However, the concept of human security, more specifically health security, is new. In the 21st century, the focus on security has shifted from state security to a more comprehensive approach (Ogata & Cels, 2003). When viewing refugees who are no longer part of a state or collective, the only way to evaluate their security is individual.

While human security is a new concept, only developed in the last three decades, it has captured the attention of academics with the emphasis being on the security of the individual rather on than of the state. Kaldor (2007) focuses on the principles of the concept and its relationship with human rights. With the development of technology and social media, it is becoming easier to view the violations that commonly occur. Krause and Williams (1996) highlight the recurrent theme that state-centered security is too narrow for today's modern world. While many academics still adopt the state security approach, since the introduction of human security after the Cold War further research into the more inclusive concept is being undertaken by academics, such as Kaldor (2007), King and Murray (2001), and McDonald (2002). Contemporary borderless issues can no longer fit into a narrow state-centered way of thinking (Sharman, 2003). Abass (2010) conducted his research into human security in Africa, a large target population. There have been other areas of focus, for example, South-East Asia and a number of underdeveloped countries. Authors like Hampson (2012) and Liotta and Owen (2006) conclude that human security runs deeper than just violence, with economic, environmental, health, and other issues being a large contributor to security. Without human security, states are also unable of achieving security (Pitsuan & Caballero- Anthony, 2014).

Health security, refugees and the NHS

Youde (2005) explained that the basics of the concept are that individuals can access any care needed to sustain their health. A common theme within all components of human security is protection from threats. Within a health context, this would mean the prevention of health

conditions and treatment for any conditions an individual has, while others focus on health concerns to larger populations (Rodier et al., 2007) such as the COVID-19 pandemic (Kandel et al., 2020). McInnes and Lee (2006) also focus on that the health systems in place to aid security are not just hospitals but are multidisciplinary organizations working in conjunction with each other to restore health. This understanding gives inclusivity to health, with a common concept of health being a physically treatable one, but hides issues such as mental health, which is more common, with a larger impact and lasting longer than any other health condition (Public Health England, 2019).

Migrants can come with large health implications for host countries, which are often ill-prepared to deal with the influx of people, some of whom are without previous adequate health treatment (Carballo & Nerukar, 2001). There is much evidence-based research into refugees and Post Traumatic Stress Disorder (PTSD). Nickerson et al. (2011) show that there is a higher vulnerability in this group after being involved in a large spectrum of traumatic situations. Furthermore, research also highlights that PTSD and other trauma response disorders can lower physical health. Ryder et al. (2018) concluded that those with PTSD have a higher risk of metabolic, musculoskeletal, and cardiovascular diseases. This already puts a large population of refugees at a higher vulnerability and at greater need for health security. Acerra et al. (2009) further identify Afghanistan's lack of health security, with integrated systems such as primary care unable to operate due to funding being unable to reach the right places under new government leadership. Thus, those refugees leaving Afghanistan, who have not had appropriate healthcare within their home country, are then subjected to very traumatic situations making their health much worse and leaving them very insecure. When viewing health security, Stoeva (2020) explains that it is individualized, meaning that to create effective human security each individual should be looked at holistically. The term refugee demonstrates a form of insecurity (Crisp, 2000); however, the understanding of how deep that insecurity runs must be investigated.

What is beneficial with research into refugees and human security is that there is a lot of recent research due to the substantial upheaval across the globe. Yet no two refugees' experiences are the same, so it is important to be mindful of where the research has taken place and with what sample (Benard, 1986). While Lofts (2022) research is very recent, it focuses on the crisis in Afghanistan, there will be crossovers with other crises such as the one currently happening in Ukraine. Cultural differences play an especially significant role when looking into refugees and security.

Refugees struggle to access healthcare within host countries. The qualitative study by Kang et al. (2019), using semi-structured interviews, found that language barriers, lack of understanding of the NHS, and the NHS not being a completely free system made them feel unable to successfully navigate the healthcare system. Kang et al. (2019) concluded that they hoped that the results would create more awareness of the aid refugees may need to access the NHS, with the BMJ (2022) memo for general practitioners (GPs) and Ukraine refugees emphasizing that refugees need support to navigate the healthcare system. Feldman (2006) noted that even when individuals were able to access healthcare, other factors such as social support, income, and housing needed to be stable to maintain health, reinforcing that just the NHS alone could not provide total health security. Feldman (2006) also noted that individual NHS Trusts created a gateway to care for refugees and asylum seekers, while it was not a standardized practice. Barnet offers a bespoke walk-in clinic to refugees with interpreters and full health checks. Places like Westminster, Chelsea, and Kensington all have health support teams that aim to register refugees with GPs by the end of their visits. The services above are not government-run projects or found in every trust, thus research such as Feldman's is important in giving inspiration and ideas around good practice to local Trusts, so they can implement these important services to aid refugees. While there are improvements to primary care services, the NHS expands much further. Taylor (2009)

explains the issues of only providing access to primary care services with the study of HIV. While refugees and those applying for asylum are eligible to be treated for sexually transmitted diseases, HIV is exempt from this. Unfortunately, the NHS and its policies toward displaced individuals are not without discrimination. These vulnerable people are not entitled to full healthcare, and thus full unbiased care, meaning there is a possibility this lack of care and treatment can cause long-term health insecurity and put a strain later on the NHS, should the refugees and asylum seekers become long-term UK residents.

It is easy to forget among government propaganda that all refugees were members of a functioning society when a power greater than them caused their displacement, aside from thinking that all refugees are a drain on our economy and resources. Everyone has something to offer and if nurtured and treated correctly they can return to similar lifestyles. Aside from a humanitarian obligation to protect those who are unable to protect themselves, the literature above highlights the fact that often the only difference between those reading this article and displaced individuals is the location of birth and residence. If there is insecurity in the world, there will continue to be refugees, and it is clear from the research already conducted that there needs to be much more work carried out to ensure they have a level of security when entering a new host country. There is no standardized practice for refugees across the NHS, but by producing more research, change will be more likely to occur. So continuing research into the topic of refugees and health security is essential. It is every country's duty to support those who have been displaced and support has to mean more than simple acceptance into the country.

The work experience

In 2016, The Royal Wolverhampton NHS Trust (RWT) began to implement the Vertically Integrated Primary Care Network, which was a unique model of healthcare in the UK (Yu et al., 2016). By linking GP practices and aligning them with the acute trust, the aim of the Vertical Integration model was identified to have many benefits for patients and for those employed within the model. These included standardizing the equity and level of care patients listed on GP registers within the designated, removing funding boundaries between primary care and the acute trust which increased access to care (Ahern et al., 2013), flexible working across the GP practices, for all disciplines, to ensure the resilience of service provision, and a wider prospect for opportunities to address recruitment and retention workforce challenges in the NHS (Yu et al., 2016). As primary care services such as GP practices are usually the first point of contact for those individuals with health difficulties (The Kings Fund, 2021), it is paramount that there are regulations in place to ensure they can provide the best quality of care. Standardization of practice is much more succinct when a group of healthcare professionals can work alongside each other and use evidence-based best practice to benefit patient care (Carlsen, 2010). Furthermore, the integration of the general practices allows services to be shared and spread across the area improving access and allowing patients with more opportunities to secure health security when, if compared to privately owned practice, it may not have been guaranteed. For example, a bespoke clinic may be available at one practice as they have resident healthcare professionals with a specific set of skills, thus patients across the PCN can also access this service due to being in the same PCN (Wilding, 2010). Furthermore, being aligned to the acute trust extends access for patients and education support and training for employees.

The first of the NHS constitution principles is to be "a comprehensive service, available to all" (GOV.UK, 2022c). Regardless of background, everyone in need should be able to obtain health care with the focus being on the "clinical needs, not the individual's ability to pay" (GOV.UK, 2022c). The NHS is funded by taxpayers' money (The Kings Fund, 2021) and that those with nothing are still able to gain primary healthcare (NHS Business Services Authority, 2022) with the NHS being free at the point of access (Delamothe, 2008), unlike other countries across the globe (Dickman et al., 2017). More specifically, refugees and

asylum seekers or those receiving support under section 90 of the immigration act (Immigration and Asylum Act, 1999) are exempt from charges for healthcare (GOV.UK, 2022b). Access to health care for those individuals who have been internationally displaced is paramount (Cheng et al., 2015), especially at the height of the pandemic. With COVID-19 being a highly transmissible disease, those traveling have an exceedingly elevated risk of contracting and then spreading the virus (Güner et al., 2020). COVID-19 has proven a deadly disease, especially for those who are unable to access health care and basic wellbeing items (Singh & Singh, 2020). With refugees fleeing from their home countries, they are unlikely to have access to clean handwashing facilities, hand sanitizer, sterile masks and COVID-19 tests, allowing for further vulnerability to the virus (Brickhill-Atkinson & Hauck, 2021). At a time when COVID-19 was rampant, it was vital to provide as many vaccines as possible regardless of the background of the individual (Roberts & Kelman, 2022). This was a step toward ensuring health security, which was encouraged by the government and Public Health England.

The author's key position while working within the PCN was at a community based COVID-19 vaccination hub. A health center was modified to provide a safe environment while addressing infection prevention mandates (Pegram & Bloomfield, 2015). Existing staff within the PCN, many bank staff (RWT's own workforce agency), redeployed nurses from hospital services that had been put on hold so that priority areas were made more resilient and leadership was provided by a modern matron who was seconded to the project. The integration of services provided access to a sufficient workforce that ensured a safe and efficient service for the patients of Wolverhampton. The staff members are comprised of GPs, registered nurses, pharmacists, pharmacy technicians, administration, health care assistants, and volunteers. While vaccinating the general population of Wolverhampton, the vaccination hub also partnered up with other local organizations to reach those who were underrepresented in vaccination numbers. This included the recent Afghan refugees who were temporarily residing in a central Wolverhampton hotel.

The clinic aimed to first provide vaccinations to those who were eligible, and while they were observed for 15 minutes post-vaccination, all refugee patients were registered to the local GP surgery free of charge. Multiple agencies worked together to ensure the project was a success. This included healthcare, local authority and government, voluntary sector, and interpreting service and refugee center staff who came together to provide an avenue for health security (GOV.UK, 2022a). By registering with a GP surgery, the individual gained an NHS number allowing easy access to free health care and the ability to have records of their healthcare. Many refugees enter their host country with untreated long-term conditions (Morris, 2009). Diabetes and heart disease are common among the refugee population especially if their home country has been unstable for a while (Morris, 2009), entering the host country may be their first experience of health security (Müller et al., 2018). Despite the vaccination administration being a short process, relevant language translators aided communication and allowed a safe space for individuals to express concerns. One of the important processes to enable the clinic's success is to ensure that there are appropriate translators for the new patients (Squires, 2019). It is important to note that there are many dialects within the Afghanistan refugee population, between 40 and 59 (Translators Without Borders, 2022). This meant several translators with different dialect skillsets were needed, and detailed conversations were needed to be had to gain an optimum understanding for all parties involved. For many, this was their first time being able to speak to a healthcare professional or even another person outside of their support bubble in a long time. Furthermore, GP registration is an excellent time to assess and implement safeguarding measures. Unfortunately, one patient revealed during her registration that she was pregnant, had not received any anti-natal care, and that she was fearful of the consequences of her husband finding out. This created an avenue to begin safeguarding this patient from any danger she may have been in, creating a relationship and safe space for her to receive support.

Completing the screening questions with the refugees identified that many had not been able to access any form of COVID-19 care. Others grasped at anything they were offered. One refugee explained his story of stepping onto a port in France to a clinic offering vaccinations before they even reached land properly. He explained how grateful he was to be able to get the vaccine. For those attending the clinic, there was a fear of COVID-19, and all were eager to obtain a vaccination.

When administering the vaccination or any other form of health care, it is important to know the patient's medical history to ensure there are no contraindications to the vaccination, or any other treatment they are about to be given. Due to the circumstances of the refugees' situations, their home country may not have medical records, have poorly kept records, or the refugees may be unable to access them (Broughton et al., 2013). To ensure patient safety, it was extremely important to obtain all possible information from the patients about their medical history or current medical state. For the COVID-19 vaccination, there were approximately eight questions which would determine if the patient would be exempt from the vaccination and five questions which would be needed to understand if the vaccination could continue, but with caution. During the vaccination clinic, there were four translators, each with a few dialect specialties. A list of screening questions was provided to translate information from the patient to the clinician and administrator to allow for the completion of the necessary documentation and record keeping.

Adjacent to the vaccination clinic at the GP surgery, a second clinic was running at the RWT Maternity Unit. This was to provide vaccinations to pregnant refugees and their partners or those who were supporting them. Furthermore, an anti-natal support was offered alongside the vaccination service. Conflict in Afghanistan has been ongoing since before the 1990s (Alexiev, 1988) with a further wave of violence arising in 2021, creating an influx of refugees. In view of this, many of the pregnant women had not received any form of antenatal care, and many not knowing a due date. Antenatal care is paramount for the safety of the mother and baby during pregnancy and labor, ensuring the health of both parties (NICE Guidelines, 2021). Through no fault of their own, these women had been unable to access healthcare to support their pregnancies. Heslehurst et al. (2018) highlight that migrant women are much more vulnerable to negative perinatal results, as they have not had an equal healthcare experience, struggle with translation, cultural clashes, and discrimination. The mother's body adjusts its immunity to ensure the fetus is not rejected (Abu-Raya et al., 2020), however, this leaves them vulnerable to a whole host of other diseases, viruses, and infections. This uncontrolled environment can be detrimental to both mother and baby, thus healthcare intervention at the earliest possible point in the pregnancy is important (NICE Guidelines, 2021). Moreover, this type of clinic is another avenue into health security for the refugees, by creating a safe environment with proper translation facilities in which expectant mothers can ask questions, reveal any medical history and explore the health care they may need. Furthermore, their mental health can be reviewed (Frautschi et al., 1994).

The treatment of refugees within the NHS: lessons learned

Before the National Health Service Act (1946) came into effect in 1948, healthcare consisted of several private practices and charity insurance programs. From primary care services to secondary care, such as operations and long-term health treatment. Now the NHS is one of the UK's largest taxpayer-funded organizations, with its founding principle being no charge for treatment of basic health needs (Maynard & Bloor, 2008). The NHS has many specialist departments catering for all health concerns, from mental to physical health concerns, with education about health conditions also available. The NHS also has connections to several other organizations to ensure that all patients get the best quality of care. More specifically those who are vulnerable or who cannot advocate for themselves. The fundamentals of the

NHS are to be safe and effective, inclusive, and provide respect, dignity, and compassion for all patients (NHS Health Careers, 2022).

When looking at ethics within a healthcare setting, Beauchamp and Childress (2001) outline four principles within biomedical ethics which are fundamental to practice. The four principles are autonomy, non-maleficence, benevolence, and justice. Each of these principles can be found throughout the work of the NHS and the vaccination hub. The concept of autonomy reflects an individual's ability to control and determine their own life; the refugees in their home country did not have autonomy, as the conflict and violence which caused their displacement was out of their control. As Dworkin (1988) reflects, the concept is "a moral, political and social ideal", meaning it can be applied to all aspects of an individual's life. Beauchamp and Childress (2001) explain non-maleficence, as doing no harm, whether it be international or accidental. This principle is upheld by laws and policies within the NHS to create a safe environment, for example, the use of screening questions before vaccination is implemented to ensure no harm is done to the patient. Benevolence is understood as doing good, or positively contributing to their health and wellbeing (Beauchamp & Childress, 2001), which could be viewed in the fact that the COVID-19 vaccination actively boosts immunity (Shen, 2022) thus positively affecting the health of the patient. Lastly, justice is creating a fair and equitable environment (Beauchamp & Childress, 2001), thus providing a bespoke clinic that gave the same opportunity for vaccinations as the rest of the general population. This model is easy to use and apply to everyday situations, moreover, it aligns with the workings of the NHS. Despite this, a limitation of the model as the different principles may cross over with one another, for instance, the NHS sometimes must use covert medication (Welsh & Deahl, 2002) to ensure benevolence, a practice which contradicts the principle of autonomy.

While the work the Royal Wolverhampton Trust conducted with the recently displaced Afghan refugees was successful, in that all those who wanted to be vaccinated were vaccinated (an example of patient autonomy), it was a pilot project so there were plenty of learning opportunities. The first is a more thorough need for the education of the individuals. Those who declined the vaccination very often simply did not understand what it was or did not quite understand the issue of the pandemic, meaning they could not produce informed consent – an essential part of autonomy (Beauchamp & Childress, 2001). Armed conflict is one of the largest reasons for internal and external displacement for Afghan refugees (UNHCR, 2020), so the immediate threat of violence would have been more concerning to them than the worry of the global pandemic, which confirms Dworkin's (1988) theory regarding autonomy being controlled by social and political climates. Carballo and Nerukar. (2001) highlight that one of the biggest issues across the board regarding healthcare concerns has been a lack of education. Upon reflection, before the clinic, a registered professional that had been working with the vaccination hub should have been available at the hotel in which the group of refugees were residing alongside the appropriate translators to explain, gain consent, and answer any questions, before the proposed clinic day. This would have helped the trust and communication among the refugees, and would have aided them in making an informed decision, instead of simply being asked if they wanted the vaccination (Ratna, 2019), producing an element of autonomy, in a very uncertain time. Furthermore, literature was overlooked. The Public Health England (2022) website (Coronavirusresources. phe.gov) has a wealth of resources for all manners of healthcare-related issues in a wide variety of languages. Moreover, the literature is provided for the target audience. Despite it being produced in the UK, each piece of literature has a model that is accurate to the representation of the target audience. Therefore, the provision of this information makes it accessible to refugees which can make a significant difference in their ability to access healthcare (Matlin et al., 2018) and in their autonomy (Beauchamp & Childress, 2001). After being internationally displaced, and losing all possessions and lifestyle, spending time deliberating the COVID-19 vaccination would not have been a priority. Literature and education regarding

vaccinations may not have been accessible (Howard & Krishna, 2022), and by adopting these extra measures they would have used more resources and required more planning. However, the additional efforts would have created more benefits in the long term.

Primary care services are a form of prevention within the healthcare system (Fortin et al., 2013). It is the first step within healthcare, catering for many individual needs, and creating a level of equity and justice. From education on disease prevention to advice on medication and care coordination (Joy, 2020). Over the pandemic, the way primary care services operate has changed, to protect both patients and health care professionals. Appointments made through GP Surgeries must be triaged based on the need and urgency of the appointment, with telephone and video call appointments being popularized over the past two years (Green et al., 2022). Despite face-to-face appointments no longer being routine, the service needs to be mindful of all patients. This is why the GP practice hosting the vaccination clinic ensured they were there onsite to register refugees who may not have had a starting point for gaining health security. This shows a level of justice and equity, as refugees did not have the same opportunities and knowledge regarding the NHS that the general population did. Credé et al. (2018) highlight the fact that migrants have a higher usage of emergency departments for issues that could be easily treated within primary care services, however, due to lack of access they have to turn to emergency departments. Access does not always mean that if there is a local GP that is open, they are able to access health care; it runs much deeper with Grant & Deane (1995) finding that 38% of refugees found issues when trying to register with a GP. There needs to be an understanding that they are going to receive the same quality care as locals, and that they should be able to understand and communicate with receptionists to be able to book appointments. Having receptionists on hand with the translators at the pop-up clinic automatically made health care more accessible, patients were able to understand the process of seeing a clinician, what the GP can be used for, and what other services were available.

The vaccination clinic orchestrated by RWT was not a government-led incentive. Unlike the vast amount of other vaccination enrollment and encouragement (Krans, 2021), there was no national drive for refugees to get their vaccinations or enroll in any other form of healthcare. Forward-thinking and partnership working were founded by refugee charities. It was latterly supported by the World Health Organization which arranged financial incentives in March 2022 (WHO, 2022). This should have been a national occurrence, as the UNHCR (2020) states, because each country has a responsibility to support refugees and facilitate care. However, throughout 2021 it was made clear by the Home Office and Priti Patel (the Home Secretary), that they felt no form of obligation, moral or otherwise, to facilitate any form of a scheme to help these incredibly vulnerable people, with even Tory voters believing the crisis was not handled adequately (Savage & Helm, 2021). Patel appealed to the desperate and vulnerable Afghans to not flee to the UK and wait for safe routes and schemes to open, a promise that she did not keep (Bullman, 2021). The clear stance from the Home Secretary highlights that without local schemes created by the NHS there would have been little to no support for refugees. Long term this is dangerous for both refugees and the NHS as a system. NHS emergency departments are already under severe pressure (BMA, 2022) with wait times increasing. Lack of access for refugees to primary care services will only increase the pressure in Accident and Emergency departments (Guess et al., 2019). This ensures additional unnecessary pressure that a small amount of time and cooperation between multiple agencies can mitigate. This has been proven by the success of the RWT vaccination clinics. Moreover, COVID-19 vaccinations and other care are often driven by financial incentives. Funding to provide services for refugees could easily be taken from vaccination incentive incomes and would ensure justice within the health care system (Beauchamp & Childress, 2001), meaning that integrating the services would make the clinic time-efficient but also cost-efficient.

Relating literature to professional exposure within this topic has afforded a deeper understanding of the challenges and benefits that multi-agency working can provide. After being displaced, with often no choice or idea as to where they are going next, refugees are subjected to language barriers and many cultural differences in all aspects of life, not just within healthcare. Due to the internal conflict between the country and the Taliban regime, the healthcare system became ineffective (Acerra et al., 2009), thus not comparable to the healthcare system in the UK. When in a conflict-ridden country health treatment usually only covers war wounds and emergency conditions, not long-term, or health maintenance, such as Keelan's (2016) experience in Palestine. Health education, women's health, and sexual health are not immediate priorities. Mudyarabikwa et al.'s (2022) analysis of refugees' experiences explains that those who had resided in the UK for over ten years felt more comfortable using primary care services. There is also a large fear of deportation when interacting with official services (Sourander, 2003). Moreover, it is a frequent finding that refugees will turn to drugs and alcohol as a response to the trauma that they have endured (Carballo & Neruka, 2001). This can also make them less likely to seek care, for fear of getting in trouble with the authorities.

The influx in 2021 of Afghan refugees was unique compared to past migration to the UK. During the height of the pandemic when travel, even nationally, was sanctioned, the entire globe faced serious health challenges, due to the obligation of states to help those displaced alongside the obligation to keep the rate of COVID-19 low and protect their population. Despite the need to continue to protect the host population, international refugee laws still needed to be followed (UNHCR, 2020) and ensure the protection of those vulnerable people. Walsh (2021) explains how the pandemic made it exceedingly difficult for refugees to enter many countries, especially the UK, however, due to the continuing need for support, simply not accepting refugees was not viable. The pandemic made many practices increasingly more difficult for the entire population including refugees. Furthermore, most healthcare services reduced face-to-face consultations and changed to remote contact and telephone consultation. This created another barrier for refugees, who need a professional interpreter with an understanding of medical terminology, to reduce the risk of miscommunication (Carroll et al., 2007). Family or friends are not favored to act as translators, due to the need to maintain confidentiality and maintain safeguarding (Adair et al., 1999).

Conclusion

When working directly with refugees, it is clear to see that they are both vulnerable and often in a state of insecurity, especially in terms of health security. Due to their circumstances, they have no ability to be autonomous both in and out of the healthcare setting. However, health security can be obtained. The vaccination hub and maternity clinics both provided safe avenues to health security. By ensuring that all four principles outlined by Beauchamp and Childress (2001) are considered and followed it is possible to put refugees on a path to health security. Moreover, by conducting more outreach programs, including more agencies and reviewing the literature of other Trusts, much more can be done to make the path easier. It is within the Trust and the Government's duty to do better.

References

Abass, A. ed. (2010) Protecting Human Security in Africa. Oxford: Oxford University Press.

Abu-Raya, B., Michalski, C., Sadarangani, M., & Lavoie, P.M. (2020) Maternal immunological adaptation during normal pregnancy. Frontiers in Immunology, p. 2627. Available at: www.frontiersin.org/articles/10.3389/fimmu.2020.575197/full?&utm_source=Email_to_authors_&utm_medium=Email&utm_content=T1_11.5e1_author&utm_campaign=Email_publication&field=&journalName=Frontiers_in_Immunology&id=575197 (Accessed 1 April 2022).

Acerra, J.R., Iskyan, K., Qureshi, Z.A., & Sharma, R.K. (2009a) Rebuilding the health care system in Afghanistan: An overview of primary care and emergency services. International Journal of Emergency Medicine, 2(2), 77–82.

Adair, R., Nwaneri, M.O., & Barnes, N. (1999) Health care access for Somali refugees: Views of patients, doctors, nurses. American Journal of Health Behavior, 23(4), 286–292.

Adelman, H. (1998) Implementation of Peace Agreements in Civil Wars: The Problem Of Refugee Repatriation. York: York Library.

Ahern, C.M., van de Mortel, T.F., Silberberg, P.L., Barling, J.A., & Pit, S.W. (2013) Vertically integrated shared learning models in general practice: a qualitative study. BMC Family Practice, 14(1), 1–11.

Ahmad, A., Rassa, N., Orcutt, M., Blanchet, K., & Haqmal, M. (2021) Urgent health and humanitarian needs of the Afghan population under the Taliban. The Lancet, 398(10303), 822–825.

Alexiev, A. (1988) The United States and the war in Afghanistan. Available at: https://apps.dtic.mil/sti/citations/ADA216845 (Accessed 7 April 2022).

BBC News (2022) What sanctions are being imposed on Russia over Ukraine invasion? Available at: www.bbc.co.uk/news/world-europe-60125659 (12 April 2022).

Beauchamp, T.L. & Childress, J.F. (2001) Principles of Biomedical Ethics. New York: Oxford University Press.

Benard, C. (1986) Politics and the refugee experience. Political Science Quarterly, 101(4), 617–636.

BMA (2022) NHS under pressure. Available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/an-nhs-under-pressure (Accessed 2 April 2022).

BMJ (2022) Ukraine War: GPs get updated guidance on treating refugees and returning citizens. Available at http://dx.doi.org/10.1136/bmj.o671. (Accessed 12 April 2022).

Brickhill-Atkinson, M. & Hauck, F.R. (2021) Impact of COVID-19 on resettled refugees. Primary Care: Clinics in Office Practice, 48(1), 57–66.

Broughton, EI., Ikram, AN., & Sahak, I. (2013) How accurate are medical record data in Afghanistan's maternal health facilities? An observational validity study. BMJ Open. Available at: doi: 10.1136/bmjopen-2013-002554 (Accessed 10 April 2022).

Bullman, M. (2021) Priti Patel urges Afghans to flee to the UK and wait for safer routes. The Independent, 26 August. Available at: www.independent.co.uk/news/uk/home-news/afghanistan-refugees-priti-patel-uk-b1909283.html (2 April 2022).

Carballo, M. & Nerukar, A. (2001) Migration, refugees, and health risks. Emerging infectious diseases, 7(3 Suppl), 556.

Carlsen, B. (2010) The last frontier? Autonomy, uncertainty and standardisation in general practice. Health Sociology Review, 19(2), 260–272.

Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., & Jean-Pierre, P., (2007). Caring for Somali women: implications for clinician–patient communication. Patient Education and Counseling, 66(3), 337–345.

Cheng, I.H., Wahidi, S., Vasi, S., & Samuel, S. (2015) Importance of community engagement in primary health care: The case of Afghan refugees. Australian Journal of Primary Health, 21(3), 262–267.

Credé, S.H., Such, E., & Mason, S. (2018) International migrants' use of emergency departments in Europe compared with non-migrants' use: a systematic review. The European Journal of Public Health, 28(1), 61–73.

Crisp, J. (2000) A state of insecurity: The political economy of violence in Kenya's refugee camps. African Affairs, 99(397), 601–632.

Delamothe T. (2008) A centrally funded health service, free at the point of delivery. BMJ (Clinical research ed.), 336(7658), 1410–1412. Available at: https://doi.org/10.1136/bmj.a292 (12 April 2022).

Dickman, S.L., Himmelstein, D.U., & Woolhandler, S. (2017) Inequality and the health-care system in the USA. The Lancet, 389(10077), 1431–1441.

Dunlop C., Howe A., Li D., & Allen L.N. (2020) The coronavirus outbreak: the central role of primary care in emergency preparedness and response. BJGP Open, 2020(4).

Dworkin, G. (1988) The Theory and Practice of Autonomy. Cambridge: Cambridge University Press.

Faulkner, A., Mills, N., Bainton, D., Baxter, K., Kinnersley, P., Peters, T.J., & Sharp, D. (2003) A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. British Journal of General Practice, 53(496), 878–884.

Feldman, R. (2006) Primary health care for refugees and asylum seekers: a review of the literature and a framework for services. Public Health, 120(9), 809–816.

Fortin, M., Chouinard, M.C., Bouhali, T., Dubois, M.F., Gagnon, C., & Bélanger, M. (2013) Evaluating the integration of chronic disease prevention and management services into primary health care. BMC Health Services Research, 13(1), 1–13.

Frautschi, S., Cerulli, A., & Maine, D. (1994) Suicide during pregnancy and its neglect as a component of maternal mortality. International Journal of Gynecology & Obstetrics, 47(3), 275–284.

GOV.UK (2022a) Covid-19 communications, working with partners. Available at: https://local.gov.uk/our-support/guidance-and-resources/comms-hub-communications-support/covid-19-communications/covid-8 (Accessed 10 April 2022).

GOV.UK (2022b) NHS entitlements: migrant health guide. Available at: www.gov.uk/guidance/nhs-entitlements-migrant-health-guide (10 April 2022).

GOV.UK. (2022c) The NHS Constitution for England. Available at: www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england (Accessed 1 April 2022).

Grant, C. & Deane, J. (1995) Stating the Obvious – Factors Which Influence the Uptake and Provision of Primary Care Services to Refugees. London: Brixton Challenge, Lambeth, Southwark and Lewisham Health Authority.

Green, M.A., McKee, M., & Katikireddi, S.V. (2022) Remote general practitioner consultations during COVID-19. The Lancet Digital Health, 4(1), 7.

Guess, M.A., Tanabe, K.O., Nelson, A.E., Nguyen, S., Hauck, F.R., & Scharf, R.J. (2019) Emergency department and primary care use by refugees compared to non-refugee controls. Journal of Immigrant and Minority Health, 21(4), 793–800.

Güner, H.R., Hasanoğlu, İ., & Aktaş, F. (2020) COVID-19: Prevention and control measures in community. Turkish Journal of Medical Sciences, 50(SI-1), 571–577.

Hampson, F.O. (2012) Human security. In Security Studies (pp. 301–316). London: Routledge.

Hanlon, R.J. & Christie, K. (2016) Freedom From Fear, Freedom From Want: An Introduction to Human Security. Ontario: University of Toronto Press.

Heslehurst, N., Brown, H., Pemu, A., Coleman, H., & Rankin, J. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC Medicine, 16(1), 1–25.

Howard, S. & Krishna, G. (2022) The world's refugees remain last in line for covid-19 vaccines. BMJ, 376(1).

Immigration and Asylum Act (1999) C.90. Available at: www.legislation.gov.uk/ukpga/1999/33/section/90 (Accessed 10 April 2022).

Joy, R. (2020) What is primary care and why do you need it? Available at: www.healthline.com/find-care/articles/primary-care-doctors/what-is-primary-care (Accessed 20 March 2022).

Kaldor, M. (2007) Human Security. Wiley: New Jersey.

Kandel, N., Chungong, S., Omaar, A., & Xing, J. (2020) Health security capacities in the context of COVID-19 outbreak: An analysis of International Health Regulations annual report data from 182 countries. The Lancet, 395(10229), 1047–1053.

Kang, C., Tomkow, L., & Farrington, R. (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), e537–e545.

Keelan, E. (2016) Medical care in Palestine: working in a conflict zone. The Ulster Medical Journal, 85(1), 3.

King, G. & Murray, C.J. (2001) Rethinking human security. Political Science Quarterly, 116(4). pp. 585–610.

Krans, B. (2021) How you encourage others to get vaccinated, makes a big difference. Available at: www.healthline.com/health-news/how-you-encourage-others-to-get-vacci nated-makes-a-big-difference (Accessed 7 March 2022).

Krause, K. & Williams, M. C. (1996) Broadening the agenda of security studies: Politics and methods. Mershon International Studies Review, 40(2), 229–254. Available at: https://doi.org/10.2307/222776 (Accessed 30 March 2022).

Levene, L.S., Seidu, S., Greenhalgh, T., & Khunti, K., (2020) Pandemic threatens primary care for long term conditions. BMJ, 371(1).

Liotta, P.H. & Owen, T. (2006) Why human security. Whitehead J. Dipl. & Int'l Rel., 7(1), 37.

Lock, S., Singh, M., Oladipo, G., Rankin, J., & Homes, O. (2022) Fears Moscow plans to encircle and threaten Kyiv – as it happens. The Guardian, 25 February. Available at: www.theguardian.com/world/live/2022/feb/24/russia-invades-ukraine-declares-war-latest-news-live-updates-russian-invasion-vladimir-putin-explosions-bombing-kyiv-kharkiv (Accessed 15 April 2022).

Loft, P. (2021) Afghanistan: Refugees and Displaced People in 2021. Research Briefing. (HC 9296 2021). Available at: https://hlrn.org/img/violation/Afghan_Refugees_Displaced_2021.pdf (4 April 2022)

Malkasian, C. (2021) The American war in Afghanistan: A History. Oxford: Oxford University Press.

Matlin, S.A., Depoux, A., Schütte, S. et al. (2018). Migrants' and refugees' health: towards an agenda of solutions. Public Health Rev, 39(27). Available at: https://doi.org/10.1186/s40985-018-0104-9 (Accessed 2 February 2022).

Maynard, A. & Bloor, K. (2008) The NHS at 60: The next 60 years. Journal of the Royal Society of Medicine, 101(7), 345–349.

McDonald, M. (2002) Human security and the construction of security. Global Society, 16(3), 277–295.

McInnes, C. & Lee, K., (2006). Health, security and foreign policy. Review of International Studies, 32(1), 5–23.

Morris, M.D., Popper, S.T., Rodwell, T.C., Brodine, S.K., & Brouwer, K.C. (2009) Healthcare barriers of refugees post-resettlement. Journal of Community Health, 34(6), 529–538.

Mudyarabikwa, O., Regmi, K., Ouillon, S., & Simmonds, R., (2022). Refugee and immigrant community health champions: A qualitative study of perceived barriers to service access and utilisation of the National Health Service (NHS) in the West Midlands, UK. Journal of Immigrant and Minority Health, 24(1), 199–206.

Müller, M., Khamis, D., Srivastava, D., Exadaktylos, A.K., & Pfortmueller, C.A. (2018) April. Understanding refugees' health. Seminars in Neurology, 38(2), 152–162.

National Health Service Act 1946. (C 81). London: Crown Copyright.

NHS Business Service Authority (2022) Getting benefits. Available at: www.nhsbsa.nhs.uk/check-if-youre-eligible-help/getting-benefits (Accessed 1 April 2022).

NHS Health Careers (2022) The NHS Values. Available at: www.healthcareers.nhs.uk/working-health/working-nhs/nhs-constitution (Accessed 21 March 2022).

NICE Guidelines (2021) Antenatal care: Recommendations. Available at: www.nice.org.uk/guidance/ng201/chapter/Recommendations. (Accessed 7 April 2022).

Nickerson, A., Bryant, R.A., Silove, D., & Steel, Z. (2011) A critical review of psychological treatments of posttraumatic stress disorder in refugees. Clinical Psychology Review, 31(3), 399–417.

Ogata, S. & Cels, J. (2003) Human security-Protecting and empowering the people. Global Governance, 9(1), 273.

Pegram, A. & Bloomfield, J., (2015). Infection prevention and control. Nursing Standard, (2014+), 29(29), 37.

Pitsuwan, S. & Caballero-Anthony, M. (2014) Human security in Southeast Asia: 20 years in review. Asian Journal of Peacebuilding, 2(1). Available at: https://doi.org/10.18588/201411.000028 (Accessed 21 March 2022).

Public Health England (2022) Coronavirus resource center. Available at: https://coronavirusresources.phe.gov.uk/ (Accessed 11 March 2022).

Public Health England (2019) Health profile for England: 2019. Available at: www.gov.uk/government/publications/health-profile-for-england-2021 (Accessed 12 April 22).

Ratna, H. (2019) The importance of effective communication in healthcare practice. Harvard Public Health Review, 23, 1–6.

Roberts, S.L. & Kelman, I. (2022) Global health security and islands as seen through COVID-19 and vaccination. Global Public Health, 17(4), 601–613.

Rodier, G., Greenspan, A.L., Hughes, J.M., & Heymann, D.L., (2007). Global public health security. Emerging Infectious Diseases, 13(10), 1447.

Rousseau, D.L. (2006) Identifying threats and threatening identities: The social construction of realism and liberalism. California: Stanford University Press.

Ryder, A.L., Azcarate, P.M., & Cohen, B.E. (2018) PTSD and physical health. Current Psychiatry Reports, 20(12), 1–8.

Sasse, T, & Hodgkin, R. (2022) Coronavirus vaccine rollout. Available at: www.instituteforgovernment.org.uk/explainers/coronavirus-vaccine-rollout#:~:text=On%202%20December%202020%2C%20the,authorised%20anywhere%20in%20the%20world. (Accessed 10 April 2022).

Savage, M., & Helm, T. (2021) Tory anger grows over Priti Patel's failure to start resettling stranded Afghans. The Guardian, 28 November. Available at: www.theguardian.com/world/2021/nov/28/tory-anger-grows-over-priti-patels-failure-to-start-resettling-stranded-afghans (Accessed 2 April 22).

Sharman, J.C. (2003) Culture, strategy, and state-centered explanations of revolution, 1789 and 1989. Social Science History, 27(1), 1–24.

Shehata, M., Zhao, S., & Gill, P. (2020) Epidemics and primary care in the UK. Family Medicine and Community Health, 8(2).

Shen, X. (2022) Boosting immunity to Omicron. Nature Medicine, 28(3), 445–446.

Singh, J. & Singh, J. (2020) COVID-19 and its impact on society. Electronic Research Journal of Social Sciences and Humanities, 2(1).

Sourander, A. (2003) Refugee families during asylum seeking. Nordic Journal of Psychiatry, 57(3), 203–207.

Squires, A. (2019) Health translators and interpreters in national healthcare systems. In Multicultural Health Translation, Interpreting and Communication (pp. 25–36). London: Routledge.

Steinbock, D.J. (1997) Interpreting the refugee definition. In: Immigration and Nationality Law Review (p. 733). Cincinnati: William S. Hein & Co.

Stoeva, P. (2020) Dimensions of health security – A conceptual analysis. Global challenges, 4(10), p. 1700003.

Taylor, K., (2009) Asylum seekers, refugees, and the politics of access to health care: A UK perspective. British Journal of General Practice, 59(567), 765-772.

Translators Without Borders (2022) Language data for Afghanistan. Available at: https://translatorswithoutborders.org/language-data-for-afghanistan (Accessed 10 April 22).

The Kings Fund. (2021) How the NHS is funded. Available at: www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded (2 April 2022)

UNHCR (2020) Global Trends: Forced Displacement in 2020. Available at: www.unhcr.org/flagship-reports/globaltrends/ (Accessed 7 March 2022).

Walsh, P.W., (2021) Asylum and refugee resettlement in the UK. Migration Observatory Briefing. Oxford: COMPAS

Welsh, S. & Deahl, M. (2002) Covert medication–ever ethically justifiable? Psychiatric Bulletin, 26(4), 123–126.

World Health Organization (2022). Strengthening Covid-19 Vaccine demand and uptake in refugees and migrants. Available at: https://apps.who.int/iris/bitstream/handle/10665/352415/WHO-2019-nCoV-immunization-demand-planning-refugees-and-migrants-2022.1-eng.pdf (3 April 2022)

Wilding, H. (2010). Integrating care: From horizontal to vertical integration. Journal of Integrated Care, 18(3), 15–20.

Youde, J. (2005) Enter the fourth horseman: health security and international relations theory. Whitehead J. Dipl. & Int'l Rel., 6(1)m 193.

Yu, V., Wyatt., Woodall, M., Mahmud, S., Klaire, V., Bailey, K. & Amin, M. (2016) Hospital admissions after vertical integration of general practices with an acute hospital: a retrospective synthetic matched controlled database study. British Journal of General Practice, 70(699), 705–713.

Zetter, R. (2007) More labels, fewer refugees: Remaking the refugee label in an era of globalization. Journal of Refugee Studies, 20(2), 172–192.

Zhongming, Z., Linong, L., Xiaona, Y., Wangqiang, Z., & Wei, L. (2021) With the evacuation over, Afghanistan is left to contend with a worsening refugee crisis. Available at: http://resp.llas.ac.cn/C666/handle/2XK7JSWQ/337268 (Accessed 7 April 2022).