Provision and accessibility to primary care services for immigrants experiencing homelessness in England: a sequential exploratory mixed method study

by

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Abstract

Background

Immigrant communities, like refugees, asylum seekers, and irregular immigrants, encounter unique health challenges, contributing to their suboptimal well-being. Accessing primary care services (PCS) is particularly challenging and exacerbated by homelessness. Research on homeless immigrants' access to PCS in the UK is a notable knowledge gap.

Aim

To investigate the perspectives and experiences of immigrants facing homelessness, along with stakeholders who provide and facilitate access to PCS. The research also identified priority strategies for enhancing access to PCS.

Methods

A sequential exploratory mixed-methods research design with two phases was used. The qualitative phase, guided by the Levesque framework of healthcare access and an intersectionality lens, preceded the quantitative phase (Delphi surveys). In-depth, semi-structured interviews were conducted with 30 homeless immigrants and 30 stakeholders. Data were organized in Nvivo 12 software and thematic analysis was conducted. The quantitative phase utilized a two-round Delphi approach to identify priority strategies for improving access to PCS. The top ten strategies were determined through participant rankings using a 5-point Likert scale. Twelve stakeholders participated in the Delphi surveys. Data analysis was conducted using STATA-15 software.

Findings

Dominant themes included low health literacy, language barriers, cultural norms, mistrust, fear of deportation, healthcare-related costs, long waiting times, partner violence, digital exclusion, inadequate culturally sensitive healthcare, competing priorities, and discrimination. The impact of the COVID-19 pandemic and accommodation instability were also identified. Alternative health-seeking approaches like self-medication and the use of emergency services were common. The three most prioritized strategies from the Delphi surveys were fighting discrimination and prejudice, improving mental health services, and empowering homeless immigrants on their rights to healthcare.

Conclusion

This study highlighted significant inequalities in access to PCS among homeless immigrants in the UK. This stresses the need to address systemic inequalities and their drivers in this sub-population. The top strategies identified may offer initial solutions to address healthcare inequalities. This study expands the understanding of immigrant experiences in accessing PCS by including a focus on homelessness.

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Dedication

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Declaration

I, **Carol Namata**, declare that:

This dissertation, unless otherwise indicated, is entirely my work and has not been previously submitted for any other academic degree at the Canterbury Christ Church University or any other educational institution. I take full responsibility for the content presented herein, acknowledging any explicit references made to the contributions of others.

I want to highlight that I have authored a paper derived from this thesis, and it has been published in the Journal of Primary Health Care Research and Development. The paper is titled "*Strategies for improving access to primary care services for homeless immigrants in England: a Delphi study*" and it is available at: https://doi.org/10.1017/S1463423623000646.

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Abbreviations

ABM	Andersen's Behavioral Model
BMA	British Medical Association
EEA	European Economic Area
EU	European Union
GP	General Practitioner
HEN	Health Evidence Network
ID	Identification
IOM	International Organization for Migration
NHS	National Health Services
NRPF	No Recourse to Public Funds
ONS	Office for National Statistics
PCS	Primary Care Services
UASC	Unaccompanied Asylum Seeking Children
UK	United Kingdom
UN DESA	United Nations Department of Economic and Social Affairs
UNHRC	United Nations Human Rights Commission
WHO	World Health Organisation

Definitions

Access	the capacity to recognize healthcare requirements, pursue healthcare services, access healthcare facilities, acquire or utilize healthcare services, and receive services tailored to one's specific care needs.
Asylum seeker	an individual who has departed their country of origin and formally requested asylum in another nation but whose application has not yet been resolved.
General practitioner	a personal physician who is primarily accountable for delivering comprehensive and ongoing general healthcare to any person seeking medical attention, regardless of age, gender, or health condition.
General practice	for the majority of individuals, it serves as the initial and most frequently utilized entry point to access the NHS.
Health inequalities	disparities in health status or in the prevalence of health determinants among different population groups.
A homeless person	an individual who does not have a stable and lawful residence or cannot reasonably find a suitable place to stay.
Homelessness	a household that lacks a suitable and reasonable place to live, both within the UK and anywhere else in the world.
Hostile environment	a series of policies primarily established through the Immigration Acts of 2014 and 2016. The primary aim of these policies was to incentivize irregular migrants to voluntarily depart from the UK and to discourage individuals from becoming irregular migrants. These policies mandate financial institutions, property owners, employers, and public service providers to withhold services if the applicant cannot establish their legal immigration status. (https://migrationobservatory.ox.ac.uk/wp-content/uploads/2020/09/Briefing-Irregular-Migration-in-the-UK.pdf.).
Immigration	from the standpoint of the receiving country, it entails relocating to a nation other than one's country of origin or typical residence, resulting in the destination country becoming the individual's new customary place of residence.
Immigration status	the legal classification of a migrant as per the immigration regulations of the host country.
Irregular migrant	an individual who resides in the UK without the legal authorization to do so. Irregular migrants typically do not have

	access to benefits, social housing, or free hospital care in most cases.
Marginalized groups	marginalized populations consist of groups that exist outside the mainstream society and are highly susceptible to systemic exclusion from both national and international policy-making platforms. These marginalized groups often include individuals such as the homeless, substance users, sex workers, refugees, and ethnic minorities.
Migrant	is a broad, non-legally defined concept that aligns with the general understanding of an individual who relocates from their usual place of residence, either within a single country or across international borders. This relocation can occur on a temporary or permanent basis and can be driven by a range of motivations.
Overstay	refers to the act of extending one's presence in a country beyond the authorized duration of their entry or stay.
Primary care	encompasses several key elements, including immediate accessibility when needed, a focus on long-term health rather than short-term illness, a wide range of services relevant to the community's prevalent health issues, and the coordination of additional specialized care as necessary.
Refugee	per the 1951 United Nations Convention Relating to the Status of Refugees, a refugee is defined as an individual who, due to a legitimate fear of persecution based on factors such as race, religion, nationality, membership in a particular social group, or political beliefs, finds themselves outside their home country and is either unable or unwilling to seek protection from that country. This definition also includes stateless individuals who have left their previous habitual residence due to similar circumstances and are unwilling or unable to return. (https://www.refugeecouncil.org.uk/information/refugee-asylum-facts/the-truth-about-asylum/).
Refused asylum applicant	an unsuccessful asylum applicant with no pending claims for protection.
Rough sleeping	refers to the act of sleeping outdoors in locations not intended for habitation, such as streets, bus shelters, and covered parking lots.
Sofa surfing	refers to the situation where individuals find temporary or insecure accommodations with friends or family, often sleeping on a sofa, due to a lack of alternative housing options.
Unaccompanied asylum-seeking children	these are minors and adolescents who are in the process of seeking asylum in the UK but have

	been separated from their parents or guardians. During the processing of their asylum claim, local authorities take responsibility for their care and welfare.
Vulnerable groups	are typically groups that are widely acknowledged to face marginalization and are often denied access to essential services.

Chapter One: Introduction

1.1 Introduction

Europe has been shaped by a long history of both internal migration flows and migrations from other continents. Since the beginning of 2015, there has been a substantial increase in the number of people migrating to Europe. For instance, the number of international migrants in Europe has increased steadily from 75 million in 2015 to more than 82 million in 2019 (International Organization for Migration (IOM), 2020) and this figure is expected to rise further. In the United Kingdom (UK), the number of people migrating to the country has increased since 1994 (Sturge, 2020). From 1995 to 2011, the population of migrants nearly doubled from 3.5 million to almost 7 million in the UK (Dustmann and Frattini, 2014). However, although an estimated 21 million people arrived in the UK in the year ending September 2021, this number decreased by about 69% compared with the previous year due to the travel restrictions imposed because of the COVID-19 pandemic (Home Office, 2021). Nonetheless, these statistics highlight the increasing trends of international migration both globally and in the UK.

The conceptualization of "migrant" and "immigrant" presents a nuanced understanding of international movement, encompassing legal, social, and cultural aspects. As noted by the United Nations Migration Agency, the term "migrant" serves as an umbrella term, lacking a precise international legal definition. However, it is commonly understood to encompass individuals who voluntarily or involuntarily relocate away from their habitual place of residence, either within their own country or across international borders, and for diverse reasons. This broad definition includes distinct legal categories such as migrant workers and international students, as well as those whose status or means of movement may not be explicitly defined under international law, such as smuggled migrants (IOM, 2019). While both "migrant" and "immigrant" are linked to the act of moving away from one's usual place of residence, they carry distinct connotations and legal implications. An "immigrant" specifically refers to a person who relocates to a country other than their country of nationality or habitual residence, signifying a fundamental change in their usual place of living. The key difference lies in the perspective taken: "migrant" is a broader term encompassing various types of movement, whereas "immigrant" is based on the viewpoint of the country of arrival, emphasizing the establishment of a new usual residence (IOM, 2019). It is essential to recognize the complexities surrounding immigration, extending beyond legal categorizations. Migration is a multifaceted phenomenon influenced by socio-economic, political, and cultural factors. People may choose to move internationally to seek better economic opportunities, flee political insecurities, reunite with family members, or pursue educational endeavors (Cummings *et al.*, 2015).

The routes used by immigrants into the UK have been a subject of debate, with proponents advocating for the establishment of legal and safe pathways, while others emphasize stricter border controls to curb unauthorized migration. The government's stance on providing legal routes for Channel migrants has been historically opposed, arguing that facilitating safe and legal entry might encourage further irregular migration. However, advocates of safe and legal routes contend that such measures could help reduce dangerous small-boat crossings and other forms of illegal migration (Gower, 2023). Presently, the UK operates various safe and legal immigration routes, each with its eligibility criteria and conditions for permission to stay. These include the UK Resettlement Scheme, Community Sponsorship, and the Mandate Scheme, which are specifically designed as refugee resettlement programs. Additionally, there are nationality-specific bespoke immigration routes catering to individuals from Afghanistan, Ukraine, and Hong Kong (Gower, 2023). However, it is crucial to note that not all these routes grant beneficiaries full refugee status and the associated rights and entitlements outlined in the 1951 Refugee Convention. The variation in the benefits provided can affect the experiences and rights of immigrants depending on the route they take, which raises questions about equity and fairness in the immigration system (Gower, 2023). Understanding the complexity of safe and legal immigration routes is crucial because immigrants may face challenges in navigating these pathways and accessing appropriate healthcare services. The varying benefits and legal statuses provided by different routes can impact the level of support available to immigrants in the UK, influencing their overall health and well-being.

On arrival, immigrants often present with a healthy status. However, their health status may worsen over time than that of the host population. The economic, cultural, and social challenges faced by migrants in their host countries, including language barriers, can have adverse effects on their overall well-being, potentially impacting their health negatively (Farcas and Gonçalves, 2017). Conversely, refugees frequently enter their new resettlement countries with a less favorable overall health condition, particularly in terms of mental health, when compared to immigrants. This disparity can be attributed to the traumatic experiences they have endured, including exposure to violence, conflict, sudden forced displacement, and prolonged periods of residing in refugee camps (Woodgate *et al.*, 2017). Furthermore, migrants often originate from regions where specific infectious diseases have a high prevalence, rendering them more susceptible to such infectious diseases (IOM, 2020b). This susceptibility adds to their diverse healthcare requirements, which may differ significantly from those of the host population (Schouler-Ocak *et al.*, 2016). While migrants may indeed have heightened healthcare needs, the challenge lies in their ability to access healthcare services effectively, and conversely, healthcare providers may face challenges in delivering suitable care. Their displacement from their home countries can introduce obstacles related to cultural disparities, limited familiarity with the host country's healthcare system, economic disadvantages, concerns about potential persecution, and fear of deportation. (Farcas and Gonçalves, 2017; Segal, 2019; Charitonos et al., 2020; Rowley, Morant and Katona, 2020). All these factors can potentially act as barriers, impeding their access to healthcare services, including primary care services (PCS).

According to the World Health Organization (WHO), Primary Care is characterized as the initial point of contact for healthcare services, readily available when needed. It encompasses continuous care with an emphasis on long-term health rather than short-term disease management. Primary Care provides a wide array of services tailored to address common health issues within a given population and plays a coordinating role in connecting patients with any specialized care they might require (WHO, 2020). While primary care services may vary in their delivery from one country to another, their fundamental purpose remains consistent. They typically serve as the initial point of entry into the broader healthcare system, addressing a wide range of health-related needs and concerns. Additionally, they play a crucial role in coordinating and integrating healthcare services offered by other providers or specialists, ensuring a comprehensive approach to patient care (Cheng, Drillich and Schattner, 2015; Gilliland et al., 2019) which can help reduce health inequalities (O'Donnell *et al.*, 2016a). Primary care services in the UK are delivered based on registered lists of patients at individual practices. While general practitioners (GPs) are a significant component of PCS, it's essential to recognize that primary care encompasses a broader spectrum of healthcare professionals and support staff. Beyond GPs, primary care teams involve various professionals, including nurses, pharmacists, receptionists, and practice managers (Newell, 2016a). Moreover, primary care extends beyond the confines of a single practice, encompassing community-based healthcare workers who actively participate in delivering essential primary care services. This collaborative and multidisciplinary approach ensures comprehensive and holistic healthcare for patients (Gilliland et al., 2019). To enhance the adaptability of primary care to the specific requirements and challenges encountered by migrants, a better understanding of their experiences in accessing these services is required (Raven, Butler and Bywood, 2013).

Migrants tend to encounter difficulties when utilising PCS. A study conducted by Woodgate et al. (2017) to delve into the encounters of African immigrant and refugee families in Canada when accessing PCS revealed substantial challenges. These families grappled with the complexities of comprehending and adapting to a novel healthcare system, which was fraught with numerous obstacles. These hindrances encompass extended waiting periods for medical attention, a scarcity of healthcare professionals, and the exorbitant expenses associated with medications and non-essential healthcare services. The study further reported that immigrant and refugee families experienced challenges related to transportation, weather, employment, and language and cultural differences, impacting their access to health care services (Woodgate et al., 2017). Similarly, a study by Kang, Farrington and Tomkow (2019) sought to understand the experiences of asylum seekers and refugees while navigating PCS in the UK. this study unveiled challenges confronting participants, including language barriers coupled with insufficient interpretation services. Additionally, participants grappled with the financial burden of dental care, prescription fees, and the costs associated with transportation to medical appointments. Moreover, there was a pervasive sense of perceived discrimination, which encompassed factors such as race, religion, and immigration status, adding to the complexity of their healthcare experiences (Kang, Farrington and Tomkow, 2019). Such challenges experienced in accessing primary care services might force migrants to utilise emergency health services at a higher rate compared to non-migrant individuals for conditions with lower acuity which would be better managed in primary care settings (Credé, Such and Mason, 2018). Moreover, these challenges may be exacerbated for migrants faced with homelessness who might find it twice as challenging to access primary care services.

Homelessness affects many people and this can have consequences for homeless individuals and the wider community (Wright and Tompkins, 2006). Wright and Tompkins (2006) describe homelessness as “(1) rooflessness which covers rough sleepers, newly arrived immigrants and victims of fire, floods or violence; (2) houseless which covers those living in emergency and temporary accommodation such as hostels, shelters, custodial establishments or foster homes with nowhere to go, and those released from psychiatric hospitals; and (3) people living in insecure or inadequate and overcrowded or substandard accommodation such as those staying with friends or relatives temporarily, tenants under notice to quit, and those whose security is threatened by violence and squatters". Homeless individuals tend to experience poorer general physical and mental health conditions than the general population. Many of them have higher rates of morbidity due to risk factors such as drug or alcohol overuse (Wright and Tompkins, 2006). Scholars propose that addressing the healthcare requirements of homeless individuals is imperative, and it involves promoting and facilitating their access to primary care. This is because registering with a GP provides them with entry to a spectrum of additional healthcare services (Riley *et al.*, 2003a). However, homeless people often experience challenges in accessing PCS such as residing beyond a reasonable walking distance from their GP and a lack of awareness regarding the necessity to register with a GP (E. Gunner *et al.*, 2019). Therefore, numerous individuals experiencing homelessness may resort to seeking healthcare via Accident and Emergency (A&E) services.

Access to primary care is crucial to marginalized groups because the under-use of these services may have significant repercussions on public health. The delay in seeking treatment can lead to the further spread of communicable diseases while untreated chronic conditions might deteriorate and lead to increased costs of treatment (Spitzer *et al.*, 2019). This discrepancy arises because, in contrast to secondary care, primary care is associated with lower expenses. The reason for this cost disparity is that secondary care involves specialized services that tend to be more costly, primarily attributed to the utilization of expensive technologies and curative approaches, as opposed to the preventive healthcare practices typically offered in primary care settings (Atun, 2004).

The Health Evidence Network (HEN) synthesis report by the WHO Regional Office for Europe examined the merits and drawbacks of reorienting healthcare systems towards a stronger emphasis on PCS. This report highlights the significance of primary care within the healthcare system. It underscores that having access to primary care physicians is more conducive to delivering consistent and all-encompassing healthcare, ultimately leading to enhanced health results. This shift towards primary care is associated with reduced hospital admissions, decreased reliance on specialists and emergency facilities minimized exposure to unwarranted medical interventions, and diminished requirements for costly, specialist-driven hospital treatments (Atun, 2004). This, therefore, illustrates the significance of accessing PCS.

1.2 Problem statement and justification

Access to healthcare is crucial to marginalized groups including homeless individuals, refugees, asylum seekers, and irregular migrants. This is because these groups have poorer health outcomes due to their life experiences compared to their host population (Schouler-Ocak *et al.*, 2016). Moreover, they face multiple challenges in accessing primary care services. The difficulty in accessing primary care services in the UK among immigrants has been created by the hostile environment. This was first mentioned in 2012 by the then Home Secretary who said that they did not want immigrants to overstay in the UK because they thought they could access everything they needed (Glennerster and Hodson, 2020). This hostile environment however penetrated the healthcare sector, where access to secondary care services in the UK has been made harder by introducing strict regulations. For secondary care services, entitlement to free healthcare is based on living lawfully in the UK on a properly settled basis. For instance, non-European Economic Area (EEA) nationals who do not have indefinite leave to remain may be required to pay for their care while in the UK (Public Health England, 2020a). While these immigration policies are designed to limit entry to secondary healthcare services, they inadvertently erect obstacles to obtaining primary healthcare services. They do so by confusing patients regarding their eligibility for GP services and among healthcare professionals regarding the individuals they should be providing care to (Public Health England, 2020a).

In July 2014, the UK government introduced the migrant health guide, aiming to provide healthcare professionals with guidance on addressing the health needs of migrant patients. According to the guide, consultations, treatments, and PCS offered by GPs, nurses, and other healthcare providers are free for all individuals registered with the NHS (Public Health England, 2020b) Similarly, the British Medical Association (BMA) advises that healthcare practices should not deny GP registration to patients based on a lack of identification, immigration status, or proof of address, emphasizing that practice staff are not immigration authorities (British Medical Association, 2020). However, it's important to note that while NHS guidelines permit anyone in the UK to register with and consult GPs without incurring charges, they also allow GP practices to request proof of identity and address during the registration process (Public Health England, 2020b). This provision may pose a limitation for some immigrants who do not possess the necessary documentation to complete the registration process.

In 2015, the proportion of patients who had their GP registration rejected because of their immigrant status in the UK was 45%. Although this percentage dropped to 35% in 2016, it increased to 37% in 2017 (Glennerster and Hodson, 2018). In addition, inconsistencies have been encountered between requirements in different practices as many demand excessive documentation often requested by the frontline staff hence confusing the immigrants (Poduval *et al.*, 2015; Glennerster and Hodson, 2018) about their rights to access primary care services. The same challenges with GP registration might exist for homeless individuals.

Homeless individuals, although eligible to register with a GP using temporary addresses, such as a friend's address, a day centre, or the practice address (British Medical Association, 2020), encounter various obstacles during the registration process. These challenges stem from their housing instability, living at a considerable distance from their designated GP, lack of awareness about the necessity of GP registration (Riley et al., 2003), and limited access to the internet (Gunner et al., 2019). Consequently, homeless individuals often resort to utilizing emergency healthcare services for conditions of lower acuity, resulting in additional costs for the healthcare system. Notably, statistics reveal that homeless individuals are 60 times more likely than the general population to seek emergency services for issues related to substance and alcohol misuse (Smith *et al.*, 2018). This situation emphasizes the importance of addressing the unique barriers faced by homeless individuals in accessing primary care services, as it not only impacts their health but also contributes to healthcare system costs associated with emergency care utilization.

The challenges associated with homeless immigrants' access to PCS can be further exacerbated by the adverse effects of homelessness on their overall health and well-being, as will be discussed later in this context. Nevertheless, while the health of migrants in the UK has been the subject of extensive research, much of this focus has centred on asylum seekers and refugees (Spencer *et al.*, 2007; Ochieng, 2013; Kang, Farrington and Tomkow, 2019a; Gleeson, Herring and Bayley, 2020; Rowley, Morant and Katona, 2020), leaving a noticeable gap in understanding the experiences of homeless immigrants concerning their access to primary care services. Primary care services, often considered the first point of contact within the healthcare system and serving as the gateway to the NHS, represent a pivotal aspect of individuals' healthcare experiences. They play an indispensable role in enhancing the overall health of the population (Newell, 2016). Moreover, engaging with primary care providers can facilitate subsequent access to specialized or allied healthcare services offered within hospital settings (Levesque, Harris and Russell, 2013). Therefore, my research study assumes critical significance as it contributes significantly to the existing knowledge base, shedding light on the health challenges faced by homeless migrants and their ability to access essential healthcare services. By bridging this knowledge gap, my research aims to provide valuable insights into the unique health dynamics of homeless immigrants and their interactions with healthcare systems.

1.3 Format of the thesis

Chapter Two positions this thesis within the wider academic literature encompassing i) migration, homelessness, and migrant homelessness, ii) the accessibility of healthcare services, iii) theoretical frameworks, and iv) the research questions. Employing a scoping review, I scrutinized the existing body of literature and deduced that there is a notable dearth of research on the subject of homeless immigrants and their access to PCS in the UK. This chapter culminated with the formulation of the research questions that underpin this study.

Chapter Three delves into the methodological underpinnings of the study. This chapter entailed two phases. Phase one encompassed a qualitative exploratory approach, aimed at delving into the vies and real-life experiences of homeless immigrants and an array of stakeholders, including healthcare providers, concerning the delivery and accessibility of PCS for homeless immigrants. In phase one, I expound upon the techniques employed for sampling, elucidate the intricacies of recruitment procedures, delineate the methods of data collection and analysis, assess data quality, and navigate the ethical considerations that have been instrumental in shaping this phase of the study. Building upon the insights gained during Phase one, I employed an online two-round Delphi technique to ascertain the ten most critical priority strategies aimed at enhancing access to PCS for the homeless population in England in Phase two. In Phase two, I expound upon the intricacies of the study design, encompassing site and settings, elucidate the development of study tools, delve into the processes of data collection and analysis for both rounds one and two of the Delphi survey, and underscore the ethical considerations that have been meticulously addressed throughout this phase of the study.

Chapter Four presents the outcomes derived from Phases one and two of the study. During Phase one, I employed the Levesque framework of healthcare access to guide the data analysis process. Within this chapter, the findings emerging from the lived experiences and views of 30 homeless immigrants and 30 stakeholders are detailed. The presentation of findings is structured around the five primary themes outlined in the Levesque framework. Furthermore, this chapter encapsulates findings that extend beyond the purview of the Levesque framework, providing a comprehensive exploration of the study's outcomes. Phase one served as the platform for presenting the outcomes derived from Phase two of the study. Within this Phase, I meticulously detail the findings stemming from the two distinct rounds of the Delphi survey, providing a comprehensive account of the insights and consensus reached through this methodological approach.

Chapter Five serves as an integrative exploration of the findings arising from both Phases of the study. Within this chapter, I engage in critical reflection on the research methodologies employed throughout the study. Additionally, I provide a comprehensive assessment of the study's strengths and limitations, shedding light on the nuances and areas of potential improvement.

Chapter Six delves into the far-reaching implications of the study on policy and practice, emphasizing the tangible impact it can have on shaping future healthcare strategies and service delivery. I also outline my distinctive contributions to the realm of research and propose future avenues of inquiry in the form of research questions. To culminate, I put forth a series of well-informed recommendations and draw the study to a conclusive closure.

Chapter Two: Literature review

2.1 Introduction

In alignment with the introductory section, this thesis delves into the firsthand experiences and viewpoints of homeless immigrants and various stakeholders in England regarding three critical aspects: (i) the determinants impacting homeless immigrants' access to PCS, (ii) the intricate interplay of their social identities in shaping PCS accessibility, and (iii) the strategies that can enhance PCS accessibility. The primary objective of this chapter is to position homeless immigrants within the existing body of knowledge not only concerning their healthcare access but also within the broader literature concerning migration, homelessness, and the health of migrants. To achieve this, the chapter unfolds in the following manner: It begins with an overarching exploration of migration, homelessness, and migrant health. It proceeds to an exhaustive scoping review of empirical evidence relating to the access of homeless immigrants to healthcare services. Finally, it investigates the application of theoretical frameworks in this study. The selection of the Levesque framework of access to health and the utilization of an intersectionality perspective to shed light on the disparities experienced by homeless immigrants in gaining access to PCS are thoroughly justified.

Through a critical analysis of the existing literature, this chapter highlights the noticeable lack of attention given to the determinants influencing the ability of homeless immigrants to access PCS. Instead, attention has predominantly been given to immigrants as a whole, neglecting the specific sub-minority groups within this population such as the homeless immigrants. The few instances where homeless immigrants are mentioned often relegate them to a peripheral role rather than being at the core of research. Consequently, the strategies aimed at enhancing their access to services continue to be generalized for all immigrants, without tailoring them specifically to the unique needs of homeless individuals within this group. Hence, the need for this current research to center its attention on homeless immigrants and devise targeted interventions that cater to their unique circumstances and challenges.

2.2 Scope of review and search strategy

The existing body of literature concerning homeless immigrants encompasses a wide spectrum of subjects, rendering this review inherently comprehensive. Given its expansiveness and the primary aim of contextualizing the research, I deemed a narrative approach as more fitting than a systematic review methodology. Centering on literature spanning migration, homelessness, healthcare access, and theoretical frameworks, the review was systematically structured into three principal sections, each addressing the following key facets:

1. Overview of migration, homelessness, and migrant health
2. Access to healthcare services; a scoping review of empirical evidence
3. Theoretical frameworks

While I did not employ a systematic review methodology, I conducted the literature search systematically, aiming to encompass both academic and grey literature sources. To achieve this, I employed a variety of strategies:

a) For sections 1 (overview of migration, homelessness, and migrant health) and 2 (theoretical frameworks), I constructed a series of search strings rooted in the aforementioned subjects. These search strings were subsequently employed to scour prominent databases in the realms of health and social sciences, including Web of Science, Medline, CINAHL, and Google Scholar. I augmented my sources with grey literature obtained through manual searches of publications hosted by various pertinent organizations, such as the NHS, Public Health England, the Office for National Statistics, the World Health Organization, and the UK Home Office.

b) For section 2, I applied the Scoping Review framework developed by framework Arksey and O'Malley (2005) to synthesize the existing evidence regarding the factors influencing homeless immigrants' access to healthcare services in high-income countries. Through the utilization of this well-established framework, I systematically identified pivotal themes, voids, and recurring patterns in the research landscape, thereby enhancing the critical exploration of the subject matter.

2.3 Overview of migration, homelessness, and migrant health

2.3.1 **Overview of migration**

Within the contemporary global economy, where widespread access to global information and affordable transportation has significantly reduced geographical barriers, migration has emerged as a pivotal and multifaceted phenomenon. Annually, millions of individuals traverse national borders for a multitude of reasons, as we will delve into further in this section. The landscape of migration today involves numerous countries, each playing various roles as origin, destination, transit, or often a combination of these. By 2019, the global population of international migrants had reached a staggering 272 million, constituting approximately 3.5% of the world's total population (International Organisation for Migration (IOM), 2019). This figure reflects a substantial increase over the past half-century, surging from 153 million in 1990 to the aforementioned 272 million international migrants in 2019. (IOM, 2019).

In the European context, the region stands out as one of the continents with the highest concentration of international migrants when considering its population size. In 2019, Europe was home to over 82 million international migrants, marking a noticeable uptick of around 10% since 2015 when the figure stood at 75 million (IOM, 2019). Shifting our focus to the United Kingdom, we observe that in the year ending December 2019 alone, nearly 677,000 individuals arrived in the country, while 407,000 departed, resulting in a net migration figure of 270,000 (Office for National Statistics (ONS), 2020b). These statistics highlight the discernible upward trajectory in international migration on both a global scale and within the UK, reflecting the evolving dynamics of our interconnected world.

Although some migrants to the UK are British nationals, the biggest proportion of migrants is of different nationalities, with non-European Union (EU) nationals being more than half percent of all migrants. By the end of the year ending December 2019, 60% of the migrants to the UK were non-EU nationals, 29% were EU nationals, and only 11% were British nationals. Additionally, 6.2 million people of different nationalities were living in the UK by the end of December 2019, which equates to 9% of the total UK population (Sturge, 2020). This, therefore, indicates that nearly two-thirds of the immigrants in the UK are subject to immigration control. According to the Immigration Act 1971, individuals who are non-British citizens (such as those with limited leave, indefinite leave, asylum seekers, refugees, or irregular immigrants) are subject to immigration regulations and control (UK Government, 1971) which affects their access to benefits and services.

International migration is shaped by economic, geographic, and demographic factors. As some individuals are motivated to migrate for higher wages and better opportunities in host countries (Poduval *et al.*, 2015; Castelli, 2018), others are forced to leave their homes on accounts of violence, political insecurity, human rights violation, and persecution (IOM, 2019).

These underlying drivers of migration play a pivotal role in the classification of individuals based on their specific circumstances. For instance, individuals who cross international borders in pursuit of employment opportunities are categorized as migrant workers (International Labour Office, 2016). On the other hand, those who seek refuge in a foreign land and have submitted an international protection claim, which is still pending a final decision by the host country, fall into the category known as asylum seekers. Meanwhile, migrants who find themselves unable to return to their country of origin due to well-founded fears of persecution based on factors such as race, religion, nationality, or affiliation with a particular social or political group are accorded the designation of refugees (IOM, 2020a). Conversely, individuals who enter, work, or reside in a country without the legal authorization or documentation required by that nation's immigration laws are commonly referred to as irregular immigrants (International Labour Office, 2004). Importantly, it's worth noting that the legal classification of migrants can change over time. An asylum seeker, for instance, may ultimately be granted refugee status, while a migrant worker may inadvertently transition into the category of irregular immigrant. These shifts in legal status have profound implications for their access to essential services, thereby emphasizing the dynamic nature of migration-related legal frameworks and their associated consequences.

2.3.2 Overview of homelessness

The chronic shortage of adequate housing remains an enduring and widespread issue of global concern. Presently, it is estimated that a staggering 1.6 billion people around the world endure substandard housing conditions, and this dire situation is compounded by the fact that approximately 15 million people face forced eviction on an annual basis (United Nations Department of Economic and Social Affairs (UN DESA), 2020). It is important to note that while individuals experiencing inadequate housing technically have a place to reside, their living conditions are deplorable and unfit for human habitation. Consequently, such substandard housing conditions are encompassed within the broader category of homelessness Alarmingly, the issue of homelessness persists as a global challenge, even in high-income countries. Within the United Kingdom, for instance, the number of individuals classified as homeless has been steadily on the rise since 2010, surging from 120,000 in that year to a staggering 153,000 in 2017 (Fitzpatrick et al., 2019). This unsettling trend emphasizes the urgency and gravity of the issue, even in affluent nations, where homelessness continues to be a pressing and unresolved societal problem.

Homelessness is a focus of public health since homeless individuals face serious health and social inequalities. Mortality rates for those experiencing homelessness have increased by 7.2% from an estimated 726 deaths in 2018 to 778 estimated deaths in 2019 in both England and Wales (ONS, 2020a). Moreover, it is noteworthy that London, the bustling capital city of England, witnessed a disconcerting tally of approximately 144 deaths among its homeless population in 2019 alone. This figure constituted a staggering 18.5% of the total estimated homeless deaths throughout the United Kingdom for that year. Regrettably, this grim statistic firmly establishes London as one of the cities grappling with one of the highest counts of homeless fatalities in the UK during that period (ONS, 2020a).

Tragically, homeless individuals are susceptible to a wide spectrum of causes that can lead to premature mortality, including accidents, liver diseases, ischaemic heart diseases, various forms of cancer, and influenza and pneumonia. Nevertheless, it is vital to highlight that the most prevalent factors contributing to the demise of homeless individuals are drug poisoning, suicide, and causes directly attributed to alcohol abuse. To provide a more precise breakdown, the year 2019 witnessed a harrowing estimated total of 289 deaths among homeless individuals resulting from drug poisoning. This sobering statistic accounted for a distressing 37.1% of all recorded homeless deaths. In addition, suicide and alcohol-specific causes represented 14.4% and 9.8%, respectively, of the estimated deaths within the homeless population in the UK during the same period (ONS, 2020a). These alarming figures underscore the urgent need for comprehensive measures to address the complex challenges faced by homeless individuals, particularly in terms of mental health and substance abuse support.

Homelessness is a multifaceted and evolving issue, manifesting in various forms. In the UK, homelessness is typically classified into two primary categories: statutory and non-statutory (Riley et al., 2003). Statutory homelessness encompasses individuals who have been officially recognized as homeless. This group includes individuals with dependent children, those facing immediate homelessness due to emergencies like floods or fires, and vulnerable segments of the population, such as older adults, pregnant women, individuals with mental health conditions, and people with disabilities. In contrast, non-statutory homelessness encompasses individuals who are not officially registered as homeless. This category comprises rough sleepers, individuals residing in temporary accommodations such as hostels, people staying with friends or family, and squatters who inhabit properties to which they have no legal entitlement (UK Legislation, 1985; Riley et al., 2003).

The causes of homelessness are intricate and stem from a confluence of structural, societal, and individual factors that interact throughout individuals' lives. Some individuals may become homeless due to personal dissatisfaction with their living situations, while others are compelled to leave their homes. High housing costs may render accommodation unaffordable for some, while others may flee situations of domestic violence (Farrall, Gray and Jones, 2019). Mental health challenges also play a role in homelessness, with some individuals experiencing homelessness due to these conditions (Wilson and Barton, 2020). Importantly, it is worth noting that while mental health issues can precipitate homelessness, experiencing homelessness or being at risk of homelessness can significantly exacerbate individuals' mental and physical health. People grappling with homelessness are disproportionately susceptible to a spectrum of mental health challenges, including but not limited to depression, anxiety, substance use disorders, schizophrenia, and suicidal ideation (Habánik, 2018). Moreover, their physical health is often compromised, resulting in a higher prevalence of conditions such as limiting long-standing illnesses (Smith *et al.*, 2019) and infectious diseases like sexually transmitted infections (Gultekin *et al.*, 2020). These adverse health outcomes underscore the heightened necessity for individuals experiencing homelessness to access healthcare services.

2.3.3 Hidden homelessness

While some individuals seek assistance from local authorities and are officially recognized as 'statutory homeless,' there are other manifestations of homelessness that receive less attention and understanding. These variations are encapsulated by the term 'hidden' homelessness and encompass individuals who may be grappling with homelessness, yet their predicament does not manifest as visibly as those living on the streets or appear in official statistical records (Sales and de Déu, 2017). The Office for National Statistics ONS defines hidden homelessness as encompassing individuals who are contending with homelessness or housing-related challenges, irrespective of legal classifications or entitlements, but are not receiving support from their local authorities and are not accounted for in official data. This category includes individuals who opt to seek assistance from local authorities but do not receive a response that adequately addresses their needs. Consequently, they seek alternative solutions outside the formal framework of housing support and provision, and may not necessarily self-identify as homeless (ONS, 2023).

Given the inherent characteristics of hidden homelessness, individuals grappling with this form of housing instability often find themselves in housing arrangements that evade comprehensive inclusion in official statistical records. These arrangements may encompass practices like sofa surfing, squatting, or engaging in off-the-radar rough sleeping. The clandestine nature of these situations poses a challenge in accurately gauging the full extent of hidden homelessness throughout the United Kingdom and contributes to its limited comprehension (ONS, 2023). Available evidence indicates that specific demographic groups, such as women, young individuals, and ethnic minorities, face a heightened risk of experiencing hidden homelessness. These groups often encounter unique challenges that make them less conspicuous in official data due to the nuanced ways in which they experience homelessness (ONS, 2023). In particular, ethnic minority individuals face an elevated risk of hidden homelessness, driven by informal housing difficulties, reliance on social networks for shelter, and a reduced likelihood of self-identifying as homeless, consequently leading to diminished access to homelessness services (Kauppi et al., 2017). This highlights the disproportionate impact of hidden homelessness on already vulnerable communities and emphasizes the imperative for targeted interventions and support measures.

Effectively dealing with hidden homelessness necessitates timely identification through various channels, including social services, education, or healthcare systems. Additionally, it requires the implementation of preventive policies geared toward averting housing instability (Sales and de Déu, 2017). Effective preventive policies should focus on supporting vulnerable populations and providing accessible and culturally sensitive services to those experiencing hidden homelessness. Some homeless immigrants may fall into the category of individuals who do not approach local authorities for assistance or who do not necessarily identify as homeless (ONS, 2023). This might have led to the underrepresentation of homeless immigrants experiencing hidden homelessness in the study's sample. As such, it was crucial to adopt inclusive definitions of homelessness and employ multi-method approaches for the recruitment of the study respondents.

2.3.4 Migrant homelessness

In England, the number of migrants experiencing or at risk of homelessness is increasing, yet the crisis of migrant homelessness remains largely invisible. A report from Crisis that focused on understanding migrant homelessness highlighted a troubling trend. Approximately 67% of the 83 survey participants reported an increase in migrant homelessness in the areas where they had been working over the past year. When looking at specific migrant subgroups, 24% of the respondents noted a significant rise in homelessness over the same period, particularly among individuals with no access to public funds or irregular immigration status (Boobis, Jacob and Sanders, 2019). Furthermore, Shelter's analysis indicated that a substantial 39% of individuals living in temporary accommodations face significant barriers when trying to access crucial healthcare appointments (Shelter, 2023). For some people in the UK, their immigration status effectively traps them in homelessness, making it exceedingly difficult to escape this predicament (Boobis, Jacob and Sanders, 2019). Although a substantial number of these homeless individuals are believed to originate from outside the UK, it's important to note that there are significant gaps in the available data, and the precise number of homeless migrants in Britain remains uncertain (Boobis, Jacob and Sanders, 2019).

Migrants residing in the UK encounter similar factors that can contribute to homelessness as the broader population, including low wages and a shortage of affordable housing. However, the immigration system introduces both structural and individual factors that exacerbate these challenges. Structural factors may encompass the limited access to welfare benefits for certain migrants based on their immigration status, rendering them more susceptible to homelessness. Individual factors contributing to homelessness among migrants may include universal risk factors shared with the general homeless population, such as mental health issues, domestic abuse, and unemployment. Additionally, migrants may face compounded risk factors resulting from the immigration system, such as visa-related dependency on relationship status or debts incurred through migration costs or exploitative employment. Furthermore, unique factors affecting the migrant population can involve language barriers hindering employment opportunities and a lack of familiarity with the welfare and statutory support system, which can prevent them from seeking assistance or advice when needed (Boobis, Jacob and Sanders, 2019). Homeless individuals, regardless of their background, encounter difficulties when navigating the housing and welfare systems. However, migrants experiencing homelessness may confront similar challenges, further complicated by their immigration status and eligibility for benefits (Boobis, Jacob and Sanders, 2019).

2.3.5 Policy context: The 'hostile environment'

The primary objective of the UK Government's policy has been to reduce net migration to sustainable levels, driven by concerns related to housing, public services, and wages (Boobis, Jacob and Sanders, 2019). In 2012, then-UK Home Secretary Theresa May introduced a plan to create a hostile environment for irregular immigrants, to encourage their departure from the country. This plan was implemented through policies outlined in the 2014 and 2016 Immigration Acts (Webber, 2019). These policies are collectively known as the 'hostile environment,' designed to create harsh living conditions for migrants and refugees lacking legal permission to reside in the UK. Consequently, these policies strip individuals of their rights related to housing, healthcare, employment, family life, private life, protection from degrading treatment, and the right to human dignity and life (Webber, 2019). Central to this hostile environment approach is the concept of secondary immigration control, which assigns responsibility for immigration enforcement to citizens and public entities, including banks, landlords, and the NHS (Boobis, Jacob and Sanders, 2019). This entails certain obligations and duties on the part of these entities, as discussed below.

Housing: The 'right to rent' scheme mandates that private landlords conduct immigration checks on potential tenants, their families, and anyone expected to reside with them. Landlords can face penalties and even imprisonment if they rent their property to someone without legal permission to be in the UK (Webber, 2019). This can make it difficult for migrants without an ID or those experiencing homelessness to live in a privately rented sector (Boobis, Jacob and Sanders, 2019). *Employment*: Migrants without permission to be in the country as well as asylum seekers are banned from working. Employers who hire these individuals can incur substantial penalties. Asylum seekers are not allowed to work while their cases are pending, a process that can extend for several years (Webber, 2019). *Healthcare*: Individuals who cannot prove their legal status and those holding visitor status are billed for their medical expenses, while primary healthcare services remain free of charge for everyone, regardless of their immigration status (Webber, 2019). *Social security and asylum support*: Migrants entering the UK for various reasons such as tourism, employment, education, or family reunification face restrictions under the 'no recourse to public funds'

(NRPF) policy, which bars them from accessing government benefits. Asylum seekers, on the other hand, receive a weekly allowance, but this support is terminated if their asylum claim is rejected. Additionally, those eligible for asylum support often experience delays of several weeks or months in receiving assistance, leading to homelessness and destitution for many (Webber, 2019). The inability to access benefits can drive some migrants to seek employment out of desperation, putting them at risk of exploitation (Boobis, Jacob and Sanders, 2019). Despite these policies targeting individuals without legal immigration status, researchers argue that some migrants with valid rights can also become ensnared in the system, affecting their access to essential services (Boobis, Jacob and Sanders, 2019).

2.3.6 Migrant Health

As per the Office for Health Improvement and Disparities, the majority of migrants who come to the UK for work or study generally have good health. Nonetheless, there are specific vulnerable migrant groups whose healthcare requirements may be more extensive due to their experiences before, during, and after migration. These vulnerable migrant populations residing in the UK encompass asylum seekers, refugees, unaccompanied minors, individuals who have been victims of human trafficking, irregular migrants, and low-wage migrant workers (Office for Health Improvement and Disparities, 2017). A qualitative comparative case study spanning seven European countries revealed that refugees and recently arrived migrants encounter a range of health needs stemming from their migration journey and challenging living conditions in reception centres (van Loenen *et al.*, 2018). These identified healthcare issues encompass injuries, infections, pregnancy-related complications, and mental distress, all closely linked to the reasons for their migration, such as escaping conflict, as well as the arduous nature of their journey. Similarly, Taylor (2009) emphasizes that infectious diseases like HIV, tuberculosis, malaria, and other parasitic infections are often prevalent among immigrants, particularly those from sub-Saharan Africa. Conversely, chronic diseases such as diabetes and cardiovascular conditions are more common among refugees from Eastern Europe. Therefore, the physical health needs of migrants often mirror the endemic disease patterns prevalent in their countries of origin.

Furthermore, certain migrants are documented to face an elevated risk of developing mental health issues attributed to their experiences before, during, and after arriving in the UK, with specific vulnerable subgroups being particularly susceptible to psychological distress and mental disorders. For instance, issues like anxiety and sleep disorders may emerge when an individual is separated from their family and friends or when they are striving to integrate into a new community (Office for Health Improvement and Disparities, 2021). According to the World Health Organization, individuals who have encountered war or conflict in the past decade have a one-in-five chance of experiencing conditions such as depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia (Office for Health Improvement and Disparities, 2021). Furthermore, Taylor (2009) observes that refugees and asylum seekers have reported symptoms of depression, anxiety, and agoraphobia (a fear of being in situations where escape might be difficult or where help might not be readily available) due to stressors like bereavement, displacement, or torture. While the status of being a migrant alone may not substantially heighten an individual's vulnerability to stress-related disorders, migrants can encounter stressors in their host countries. These stressors can encompass concerns regarding their immigration status, financial hardships, difficulties in accessing services, experiences of discrimination, social isolation, and homelessness, all of which can significantly impact their mental well-being (Office for Health Improvement and Disparities, 2021).

Mental health challenges are not exclusive to the migrant homeless population, particularly among refugees and asylum seekers. The potential trauma associated with the necessity of leaving one's home country, the arduous journey, and the immigration system itself can be compounded by the adverse impact of homelessness on the well-being and mental health of any individual (Boobis, Jacob and Sanders, 2019). Homelessness can directly affect health through the physical and psychosocial hazards inherent to homelessness, including inadequate nutrition, harsh living conditions such as extreme cold, heat, or dampness, accidental injuries, and heightened rates of tobacco use (Fazel, Geddes and Kushel, 2014). These issues can lead to intricate mental health requirements, and individuals without access to public funds may have limited support options available to them (Boobis, Jacob and Sanders, 2019). Moreover, given that the accommodation for some migrants, such as asylum seekers, is frequently situated in areas characterized by existing socio-economic disadvantages, they may consequently encounter the same social determinants of poor health as the native population. However, they may face additional barriers to accessing healthcare services (Taylor, 2009).

2.3.7 Access to healthcare for migrants

Access to healthcare is a multifaceted and universal concern, underscored as a fundamental human right (Saurman, 2016a). Individual human rights are intrinsic to the broader social right to healthcare, and conversely, the right to healthcare is essential for the exercise of human rights (Abbing, 2005). The global recognition of the right to health gained momentum in 2001 when the United Nations Human Rights Commission (UNHRC) advocated for international acknowledgment of the duty to advance the right to health. This included the promotion of research and ensuring access to affordable essential medical care (Juškevičius and Balsienė, 2010). Withholding free hospital treatment from individuals in need who cannot establish their immigration status or lack secure legal status represents a violation of their right to attainable physical and mental health. This right is a fundamental entitlement of every human being, without discrimination (Webber, 2019).

Currently, the UK government's healthcare policy makes a clear distinction between access to primary care and secondary care, as well as between entitlement to routine and emergency treatment (Taylor, 2009). In recent years, there has been a growing trend of tightening restrictions on migrants' healthcare rights in the UK (Jayaweera, 2018). The tier-two system in the UK has created scenarios where healthcare may intentionally be withheld (Taylor, 2009). The 2014 Immigration Act has excluded certain legal migrants who lack permanent residence, such as family and labor migrants, and students, from accessing free secondary healthcare services. Additionally, irregular migrants, including undocumented migrants and those who have overstayed their visas, as well as refused asylum seekers, are not exempt from secondary healthcare charges (Jayaweera, 2018). Secondary and community care, which includes services like termination of pregnancy, palliative care, and mental health services, require upfront payment from patients who cannot demonstrate entitlement. Those who cannot afford to pay are denied access to medical care. Some of the existing exemptions, such as urgent or immediately necessary treatment, are considered poorly defined and insufficient, potentially leading to inconsistent implementation of the charging regulations (Hiam, Orcutt and Yates, 2019). For instance, in England, refused asylum seekers do not have free access to secondary NHS care, as their ability to receive care hinges on whether the care is deemed immediately urgent or non-urgent, as well as whether specific exemptions are applicable (BMA, 2019). However, even for urgent treatment, refused asylum seekers may later receive a bill. Furthermore, for non-urgent care, NHS Trusts and certain community services are mandated to charge refused asylum seekers who are not eligible for exemptions before providing the care (BMA, 2019).

Individuals who seek asylum in the UK typically face restrictions on their ability to work while their asylum claims are under consideration. Instead, they are provided with accommodation and support to cover their essential living needs if they would otherwise be destitute. However, if they are granted permission to work, this permission is revoked if their asylum claim is rejected and all appeals have been exhausted, as they are expected to leave the UK at that point (UK Visas and Immigration, 2021). The lack of employment opportunities can leave failed asylum seekers and irregular migrants unable to afford medical care, potentially resulting in denial of hospital treatment (Taylor, 2009). This situation can have repercussions on the health outcomes of vulnerable migrants who may be uncertain about their eligibility for free healthcare and apprehensive about seeking diagnosis and treatment due to their inability to pay (Jayaweera, 2018). Furthermore, by linking asylum applications to the provision of healthcare, the government may be inadvertently pushing healthcare professionals into a position where they must align with immigration policies. This can create a direct conflict between a doctor's duty, which prohibits discrimination based on race or background, and the government's directives (Taylor, 2009). Advocates for restricted access based on citizenship argue that providing treatment to those with uncertain or undocumented status could lead to increased migration and health tourism. However, as Taylor (2009) argues, there is limited evidence to support this claim, as most migration is influenced by a much broader set of socio-political factors than simply access to medical treatment.

In terms of PCS, such as GPs, the UK ensures free access for all individuals, regardless of race, gender, social class, age, religion, or immigration status. Nevertheless, there is evidence indicating that certain GP practices continue to deny registration to some patients, including homeless individuals and asylum seekers, citing a lack of identity or residence documentation as the reason (Jayaweera, 2018). In 2019, Hodson, Ford, and Cooper conducted a mixed-methods cross-sectional study to investigate how many London GP practice websites requested documentation without offering an alternative for those who couldn't provide it, and how they described the registration process in patient-facing materials (Hodson, Ford and Cooper, 2019). The study revealed that out of 100 practices, 75% requested documentation, and only 12% of these practices assured individuals without documentation that receptionists could assist them. There was considerable variation in the types of documents required by practices, ranging from tenancy agreements to driver's licenses and utility bills. Some practices that requested ID and proof of address failed to provide an alternative for people without such documentation, which goes against NHS guidelines. One practice even asked for three months of consecutive bills, potentially delaying registration until patients had spent four months in the area, which poses a particular problem for individuals with chronic illnesses requiring regular check-ups (Hodson, Ford, and Cooper, 2019). Contrary to NHS Standard Operating Principles and BMA guidelines, the study found evidence that certain practices threatened to withhold treatment until patients provided identification or attended a health check. Additionally, some practices restricted registration to a specific one-hour window in the late morning, and patients could not be seen for emergency treatment. Such limitations on treatment may put patients at risk and redirect them to more expensive emergency departments (Hodson, Ford and Cooper, 2019).

2.4 Access to health care services: a scoping review of empirical evidence

2.4.1 Aim and objective

Evidence shows that many immigrant and homeless populations experience challenges in accessing PCS (Gunner et al., 2019; Kang et al., 2019). However, knowledge of homeless immigrants' access to these services is limited. This review aimed to provide a synthesis of the evidence on factors associated with access to healthcare services among homeless immigrants in high-income countries.

2.4.2 Study design

A scoping review is shown to be useful in mapping existing literature in a field of interest, concerning the nature and characteristics of the primary research (Pham *et al.*, 2014). Some scholars recommend that conducting a scoping review can be an important initial step in understanding access to healthcare services among homeless immigrants (Pollard & Howard, 2021). This review was guided by Arksey and O'Malley's Scoping Review framework (Arksey and O'Malley, 2005). The framework has five stages and an optional sixth stage. The five-stage framework includes (i) identification of the research question, (ii) identification of the relevant studies, (iii) screening of studies, (iv) charting the data, and (v) synthesizing and reporting results. The optional sixth stage (consultation exercise) was not included in this review.

Stage 1: Identification of the research questions

This scoping review was conducted to answer the following specific questions: [1] What is currently known about access to healthcare services for homeless immigrants in high-income countries? [2] What are the knowledge gaps to guide the development of subsequent inquiries about access to PCS for homeless immigrants in the UK?

Stage 2: Identification of the relevant studies

This review focused on high-income countries because they tend to be the primary destination for immigrants from low-income regions, and many of these countries share similarities in their immigration policies. Immigrants in such settings may also have overlapping experiences (Malmusi, 2015). To be considered for inclusion in this scoping review, articles needed to be peer-reviewed empirical articles written in English, with a primary research focus on access to healthcare services among homeless immigrants. High-income countries were identified based on the World Bank's income classification (The World Bank, 2023). Articles were excluded if they did not primarily address access to healthcare services among homeless immigrants. Studies that focused solely on immigrants or homeless populations without specific reference to homeless immigrant participants were also excluded, as their unique experiences distinguish them from other population groups.

The search for relevant studies was conducted across seven databases: Ovid Medline, PubMed, Ovid PsychINFO, Ovid EMBASE, Google Scholar, CINAHL (EBSCO host), and Web of Science. This search took place from April to May 2023 and involved a three-step process (Marques *et al.*, 2020). First, a pilot search was conducted in PubMed to refine the search strategy and ensure its precision in capturing pertinent literature. During the pilot search, the following keywords were identified: destitute migrants, migrant homelessness, immigrants experiencing housing insecurity, family doctor, and general practitioner. Subject headings were employed in conjunction with keywords, and search terms were cross-referenced against MeSH terms to ensure the inclusion of related terms. The second step involved utilizing the final search strategy, developed in the preceding steps, to perform an exhaustive literature search across the seven databases. All identified articles were then imported into Mendeley reference management software, with subsequent removal of duplicate entries. In the third step, additional relevant references were manually sought by examining the reference lists of eligible studies and systematic reviews on the subject matter of interest.

Stage 3: Screening of studies

The initial screening of articles (after eliminating duplicates) involved a two-step process. First, articles were assessed based on their titles and abstracts, and then a full-text review was conducted to determine their eligibility, following the methodology employed by Mateen et al. (2013). This review encompassed empirical studies published in English that centered on the accessibility of primary care services for homeless immigrants residing in high-income countries. The participants in these studies included homeless immigrants themselves and/or individuals who worked with migrants or homeless populations in these settings. To provide a comprehensive overview of the existing evidence, original research articles were considered, irrespective of their publication year or study type. Articles were excluded only if the complete article was inaccessible, even after attempts were made to contact the authors.

Stage 4: Charting the data

A data abstraction template was developed to guide the data extraction process. The following aspects of the eligible studies were extracted into the data abstraction template: lead author and publication year, country, the study aims, study design and methodology, model or conceptual framework used, analysis, primary care setting, and sample/population characteristics. **(see Table 1).**

Stage 5: Thematic analysis and reporting results

The findings of the selected studies were analysed thematically. Thematically summarizing and presenting results enables a more profound understanding of individuals' self-perceptions, particularly when their experiences encompass various cultural aspects like language and ethnicity (Omenka et al., 2020). This process involved identifying and grouping similar concepts from across studies thematically. The factors identified as being important in impacting the study population’s access to healthcare in each study were extracted and listed in **Table 2.**

2.4.3 Results

Scope, nature, and distribution of literature

Figure 1 displays the study selection process. Initially, 5,096 records were retrieved from the database searches. Following the removal of duplicates, 4585 references were excluded based on their titles and abstracts. Thereafter 20 more references were excluded after a thorough examination of the full texts. The reasons for exclusion are included in **Figure 1**. Ultimately, 11 eligible studies were identified from the database search and 2 more eligible articles were retrieved from the supplementary search of reference lists. Overall, a total of 13 eligible studies were included in the scoping review.

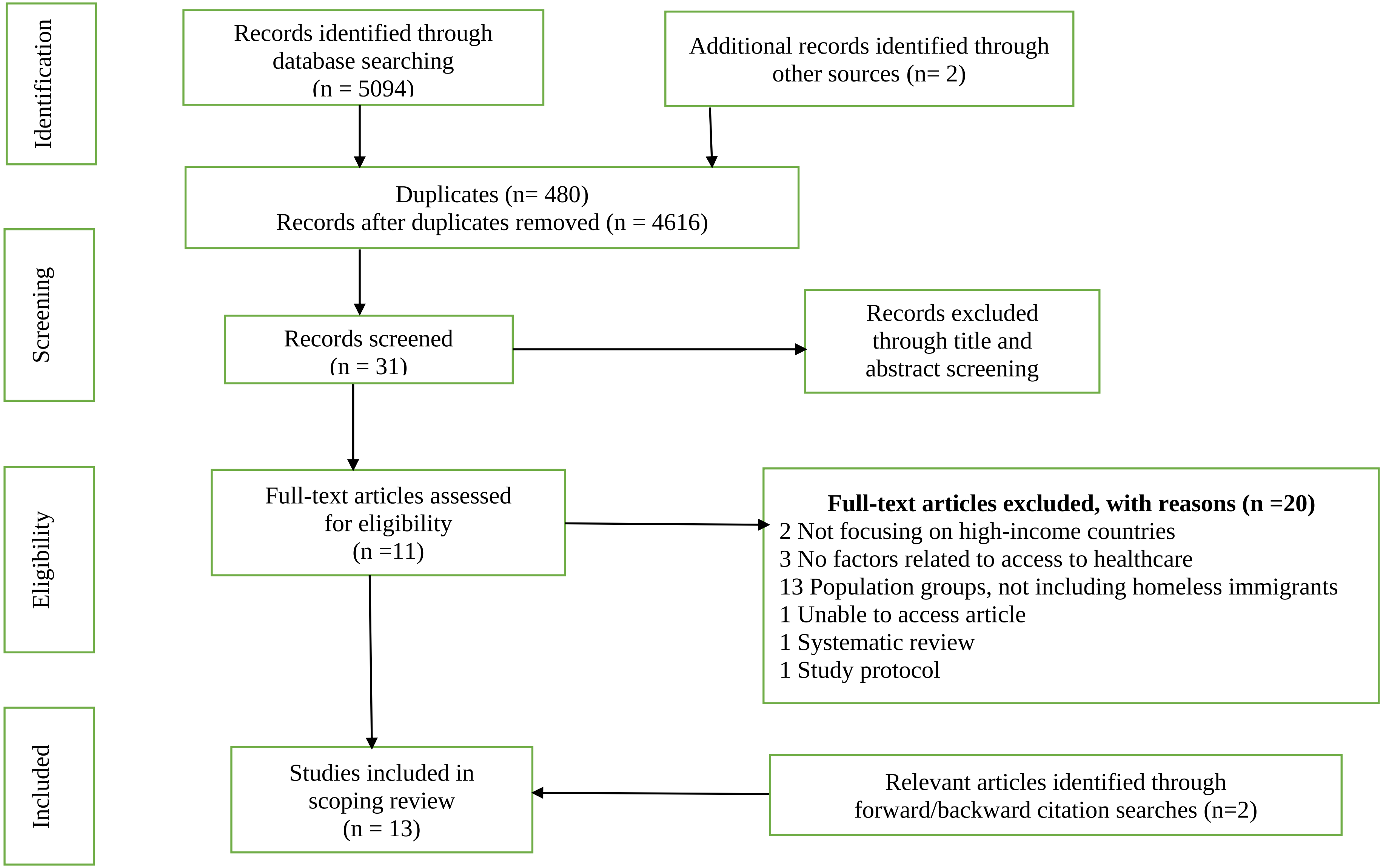


Figure 1: Preferred reporting items for Systematic reviews and Meta-Analyses (PRISMA) diagram

Characteristics of the included studies

The characteristics of each of the 13 articles included in the scoping review are summarized in **Table 1**. The studies were conducted in various countries, with England being the most represented (n = 4) (Collinson and Ward, 2010; Nyiri and Eling, 2012; Jolly, 2018; Feldman, 2021), followed by Spain (n = 3) (Navarro-Lashayas and Eiroa-Orosa, 2017; Gil-Salmeron, Smith and Yang, 2021; Jiménez-Lasserrotte, et al., 2023), France (n = 2) (Poncet et al., 2021; Crouzet et al., 2022), Italy (Silvestrini et al., 2017), Denmark (Ravnbøl, 2017), Canada (Hanley et al., 2019), and Australia (Robards et al., 2019) each having one study. Table 1 provides an overview of the research methods employed in the included studies. The majority of the studies utilized qualitative in-depth interviews and focus groups (n = 7) (Ravnbøl, 2017; Jolly, 2018; Hanley et al., 2019; Robards et al., 2019; Feldman, 2021; Crouzet et al., 2022a; Jiménez-Lasserrotte, et al., 2023), indicating a strong emphasis on capturing rich and detailed perspectives. One study employed mixed methods, combining qualitative and quantitative approaches (Navarro-Lashayas and Eiroa-Orosa, 2017), while five studies used quantitative methods to gather and analyse data (Collinson and Ward, 2010; Nyiri and Eling, 2012; Silvestrini et al., 2017; Gil-Salmeron, Smith and Yang, 2021; Poncet et al., 2021). The sample sizes of study participants varied significantly. The study sample sizes ranged from 6 migrant families to the largest sample size of 2604 homeless adults. This wide range of sample sizes may be because different methodologies comprise different sample size requirements. It may also reflect the hard realities of the underrepresentation of vulnerable sub-populations (i.e. homeless immigrants) in research.

Population/sample characteristics

The scoping review found that available studies have mostly focused on 4 different sub-populations, including immigrants (n = 3) (Nyiri and Eling, 2012a; Andy Jolly, 2018a; Feldman, 2021a), homeless populations (n = 3) (Silvestrini *et al.*, 2017a; Gil-Salmeron, Smith and Yang, 2021; Crouzet *et al.*, 2022a), homeless immigrants (n = 6) (Collinson and Ward, 2010a; Navarro-Lashayas and Eiroa-Orosa, 2017a; Ravnbøl, 2017a; Hanley *et al.*, 2019a; Poncet *et al.*, 2021a; Jiménez-Lasserrotte, Granero-Molina, Lardon Galindo, *et al.*, 2023), and marginalized groups (n = 1) (Robards *et al.*, 2019a) **(see Table 1).** These results indicate that the intersectionality between being homeless and an immigrant is sometimes not well explored in studies conducted among immigrant sub-populations. The need to identify immigrants who are homeless and explicitly understand how their homelessness impacts healthcare access and wellbeing in general is of high importance for solving health disparities (Chang, 2019). In the studies that focused on immigrants (Nyiri and Eling, 2012a; Andy Jolly, 2018a; Feldman, 2021a), it was found that some participants had experienced destitution or homelessness. This implies that while these studies touched on the experiences of immigrants who may have experienced homelessness, their main focus was not solely on homelessness, or the specific challenges faced by homeless immigrants. Similarly, in the studies that focused on homeless populations (Silvestrini *et al.*, 2017a; Gil-Salmeron, Smith and Yang, 2021; Crouzet *et al.*, 2022a), although some migrant groups were included, the primary focus was on homelessness rather than specifically addressing homeless immigrants. These findings highlight the need for studies that specifically concentrate on the distinct challenges faced by homeless immigrants. While some studies indirectly addressed aspects of homelessness within immigrant or homeless population samples, there is still a gap in the research dedicated solely to homeless immigrants. Understanding the unique experiences, barriers, and needs of this specific group is essential for developing targeted interventions and policies to address their complex healthcare and social needs.

Furthermore, based on the findings of this scoping review, few studies included stakeholder participant groups when examining access to PCS for homeless immigrants. Only two studies conducted in Canada (Hanley *et al.*, 2019a) and Spain (Navarro-Lashayas and Eiroa-Orosa, 2017a) interviewed service providers. This significant omission underscores a notable gap in the existing literature, as the perspectives of these crucial stakeholders remain largely unexplored. The inclusion of stakeholder perspectives is crucial for robust and impactful research. Their unique insights, diverse experiences, and practical expertise might play a crucial role in public health science, ensuring that research aligns with and tackles significant public health issues relevant to policymakers, practitioners, and the general public. Such input enhances the effectiveness of interventions by incorporating contextual information that can either hinder or facilitate implementation. Moreover, their inclusion in healthcare research might increase the likelihood of its integration into policies and practices, thereby maximizing its impact (Laird et al., 2020).

Context of the included studies

The scoping review revealed that studies covered a range of healthcare services such as COVID-19 (n = 2) (Crouzet et al., 2022; Jiménez-Lasserrotte, et al., 2023), maternal health (n = 2) (Navarro-Lashayas and Eiroa-Orosa, 2017; Feldman, 2021), HIV care (n = 1) (Poncet et al., 2021), TB treatment (n = 1) (Collinson and Ward, 2010a), and general healthcare services (n = 6) (Ravnbøl, 2017; Silvestrini et al., 2017; Jolly, 2018; Hanley et al., 2019; Robards et al., 2019; Gil-Salmeron, Smith and Yang, 2021). However, only one study specifically focused on primary care services for homeless immigrants (Nyiri and Eling, 2012) as highlighted in **Table 1.** This indicates a notable gap in the existing literature concerning the investigation of primary care services for homeless immigrants. This information calls for more studies that specifically examine primary care services for homeless immigrants, as addressing their healthcare needs within primary care settings is vital for improving their overall well-being and health outcomes.

Models/conceptual frameworks

Practitioner research model

Out of the 13 studies reviewed, only two of them incorporated a specific model or conceptual framework. One of these studies, conducted by (Andy Jolly, 2018a) in England, utilized the practitioner research model (**see Table 1).** This model entails research planned and conducted by practitioners in fields as varied as education, social work, health sector occupations, clinical psychology, and pharmacy (Shaw & Lunt, 2018).

Jolly conducted research that included immigrant parents attending project-based play sessions where the researcher was engaged. These parents were invited to take part in semi-structured interviews to delve into their experiences. Considering the limited available research on social work involving undocumented migrant families and the concealed nature of this user group, adopting an insider research approach, specifically the practitioner research model, offered several advantages. This approach helped establish a connection with participants who might have harbored suspicions toward unfamiliar researchers and were hesitant to openly discuss their circumstances with an outsider due to concerns about potential deportation (Andy Jolly, 2018a). By leveraging pre-existing relationships, the practitioner research model effectively addressed these challenges. However, it is crucial to recognize a potential drawback associated with practitioner research, namely, the power dynamics between the researcher, who holds an insider position of authority, and the participants, which could potentially make participants feel obligated to participate (Unluer, 2012).

Intersectionality perspective

In the second study carried out by Hanley et al. (2019), they employed an intersectionality framework to investigate the connection between health, housing instability, and homelessness among migrant women in Canada (refer to **Table 1**). The term 'intersectionality' denotes the interplay among factors such as gender, race, and other diverse categories within individuals' lives, social activities, institutional structures, and cultural beliefs. It also encompasses the consequences of these interactions in the context of power dynamics (Davis, 2008) Hanley et al.'s study emphasized that considering migration status alongside other social determinants of health contributes to an improved understanding of specific factors that drive vulnerability to suboptimal health outcomes among immigrants. This aligns with the central tenets of intersectionality, which recognize that various social categories and identities interact and intersect to shape individuals' experiences and outcomes (Museus and Griffin, 2011). By focusing on the intersection of health concerns with housing insecurity and homelessness among migrant women with diverse immigration statuses, Hanley et al.'s research shed light on the specific challenges and vulnerabilities they experienced. It acknowledged that health played a pivotal role, acting as a barrier preventing them from escaping poor housing situations. This recognition reflects the intersectional approach's aim to uncover the distinct experiences and dynamics at play for individuals with different intersecting identities and social positions (Jackson et al., 2021). Comparing the experiences of Canadian-born women facing housing insecurity and homelessness to those of migrant women (Hanley *et al.*, 2019a), the study illustrated how the interplay of health, migration status, and social location differed. This finding further highlights the importance of understanding the intersecting factors and acknowledging that the impact of housing insecurity and homelessness on health is shaped by individual circumstances and identities. By adopting an intersectional perspective, the research highlighted the nuanced experiences and vulnerabilities of this specific population, emphasizing the importance of tailored healthcare policies and services to address their unique needs (Corus & Saatcioglu, 2015).

Table 1: Characteristics of included studies

Author, year	Aims	Methodology and methods	Country	Care setting	Population details	Model	Analysis
(Jiménez-Lasserrotte, et al., 2023)	To describe and understand irregular migrants' experiences of health disparities while living in informal settlements during the COVID-19 pandemic.	Qualitative descriptive study, focus groups, in-depth interviews	Spain	COVID-19	34 irregular immigrants living in informal settlements	None	Thematic analysis with ATLAS.ti computer software.
(Crouzet *et al.*, 2022b)	To understand both the experiences and perceptions among vulnerable groups of the measures taken to limit the COVID-19 infection.	Qualitative, semi-structured interviews	France	COVID-19	26 homeless Individuals living in shelters aged ≥ 18 (19 of whom were migrants)	None	Coded using Nvivo Analysed using thematic content analysis
(Feldman, 2021b)	To explore the background to NHS charging, and how charging was carried out in the hospitals where the research participants received their maternity care.	Qualitative, semi-structured interviews	England	Maternity care	16 immigrant women (6 of whom were homeless)	None	Thematic analysis
(Poncet *et al.*, 2021b)	To investigate factors associated with each screening in a population of migrant women and determine the mean time since the last HIV testing according to duration of residence in France.	Quantitative, structured questionnaire	France	HIV care	469 homeless migrant women	None	Statistical analyses

(Gil-Salmeron *et al.*, 2021a)	To examine the differences in health status, health behavior, and healthcare utilization in a sample of Spanish immigrant and native homeless people	Quantitative, structured questionnaire	Spain	All healthcare	86 homeless participants (52 were homeless immigrants, 34 were homeless natives)	None	Statistical analyses using SPSS
(Robards *et al.*, 2019b)	To understand health system navigation, including the role of technology, for young people belonging to one or more marginalised groups, to inform youth health policy.	Qualitative longitudinal study, semi-structured interviews	Australia	All healthcare	41 marginalised young people aged 12-24 (1 was a homeless immigrant)	None	Analysis used Nvivo software and grounded theory.
(Hanley *et al.*, 2019b)	To analyze how health intersects with the experience of housing insecurity and homelessness, specifically for migrant women	Exploratory qualitative, semi-structured interviews	Canada	All health care	26 migrant women who experienced housing insecurity 5 service providers working in women's shelters	Intersectionality perspective	Coded using Nvivo Analysed using constant comparative method

(Andy Jolly, 2018b)	To understand the experiences of food poverty for families who were at risk of destitution because of their immigration status and identify transferable learning for practitioners to improve social work and social care practice with this service user group. Methodology	Qualitative, semi-structured interviews	England	All healthcare	6 migrant families that experienced destitution	Practitioner research model	Analysed inductively using content analysis
(Navarro-Lashayas and Eiroa-Orosa, 2017b)	To analyze how stressful life events, substance abuse, and psychological distress influence the current situation of homeless immigrants	Mixed methods, Focus group discussions, in-depth interviews, self-administered questionnaire	Spain	Mental health	107 homeless immigrants 8 care resource practitioners	None	Statistical Analyses using IBM SPSS Thematic content analysis
(Ravnbøl, 2017b)	To investigate health concerns and access to health services for Roma from Romania who live in homelessness in Copenhagen, Denmark.	Ethnographic research, semi-structured interviews, participant observation & document analysis	Denmark	All healthcare	40 homeless immigrants	None	Not clear
(Silvestrini *et al.*,	To determine the rate of utilization among migrants as	Quantitative, structured	Italy	All	2604 homeless adults (2379 were	None	Statistical analyses using

2017b)	compared to the Italian homeless.	questionnaires		healthcare	homeless migrants)		STATA
(Nyiri and Eling, 2012b)	To examine the challenges faced by destitute asylum seekers and refugee patients.	Quantitative, structured questionnaire	England	Primary care services (GP practices)	112 destitute asylum seekers and refugees (91 were homeless immigrants)	None	Statistical analysis
(Collinson and Ward, 2010b)	To describe and evaluate a nurse-led response to addressing the unmet health needs of homeless migrants in inner London	Quantitative, structured questionnaire	England	TB treatment	77 homeless migrants	None	Statistical analysesfinancial

Thematic analysis of the reviewed studies

The results from the scoping review highlight various themes that critically influence access to healthcare services for homeless immigrants in high-income countries (**see Table 2**).

Table 2: Key themes of the reviewed studies

Studies	Themes
(Jiménez-Lasserrotte et al., 2023)	• Fear of deportation • Affordability • Low health literacy • Language and cultural barriers
(Hanley et al., 2019)	• Affordability • Language and cultural barriers
(Robards et al., 2019)	• Affordability • Low health literacy • Digital exclusion • Discrimination • Availability of supportive social networks
(Feldman, 2021)	• Affordability
(Gil-Salmeron et al., 2021)	• Affordability
(Poncet et al., 2021)	• Low health literacy
(Collinson & Ward, 2010)	• Lack of stable accommodation
(Crouzet et al., 2022)	• Lack of stable accommodation • Impact of COVID-19
(Nyiri & Eling, 2012)	• Lack of documentation • Alternative healthcare-seeking strategies • Inadequate cultural awareness of HCP
(Jolly, 2018)	• Lack of documentation • Alternative healthcare-seeking strategies
(Ravnbøl, 2017)	• Lack of legal immigration status
(Navarro-Lashayas & Eiroa-Orosa, 2017)	• Lack of legal immigration status
(Silvestrini et al., 2017)	• Patient centred care

One key factor is the fear of deportation and lack of documentation which created a climate of fear and mistrust among homeless immigrants, deterring them from seeking healthcare services and exacerbating their vulnerability to health risks (Jiménez-Lasserrotte et al., 2023). Affordability was another factor documented in the studies which incorporated the lack of health insurance and incorporated inadequate financial resources that further lead to delayed or insufficient care, and perpetuating health disparities (Gil-Salmeron et al., 2021; Hanley et al., 2019; Jiménez-Lasserrotte et al., 2023; Robards et al., 2019). Language and cultural barriers were cited among other critical factors affecting access to healthcare for homeless immigrants. The literature also indicated that limited proficiency in the local language and unfamiliarity with cultural norms within the healthcare system impede effective communication and hinder understanding of available healthcare services (Hanley et al., 2019; Jiménez-Lasserrotte et al., 2023). Consequently, homeless immigrants face difficulties in navigating the healthcare system, leading to inadequate diagnoses, treatment, and care (Robards et al., 2019). Efforts to provide language assistance services, cultural competency training for healthcare providers, and tailored communication strategies can help address these barriers and improve access to healthcare services for this population (Handtke et al., 2019; Jongen et al., 2018). Additionally, the scoping review emphasized the impact of housing insecurity on healthcare access. Homeless individuals often lacked stable housing or lived in overcrowded conditions, which made it challenging to maintain social distancing and engage in preventive measures, particularly during public health crises such as the COVID-19 pandemic (Collinson & Ward, 2010; Crouzet et al., 2022). Addressing housing insecurity through affordable housing initiatives, shelter services, and supportive housing programs can help mitigate these barriers and improve healthcare access (Kottke, Abariotes and Spoonheim, 2018). The results from the scoping review also shed light on the impact of discriminatory practices and marginalization on healthcare access for homeless immigrants. Marginalized young people, especially though faced with multiple sources of marginalization based on race, ethnicity, sexuality, gender, etc., perceived and experienced discrimination within the healthcare system (Robards et al., 2019). Such discrimination can lead to the avoidance of seeking care and contribute to health disparities (Rivenbark and Ichou, 2020). Besides, when discrimination is exercised within the healthcare system, the quality of care received by marginalized groups is likely to be substandard and less likely to meaningfully address their needs (Wylie and McConkey, 2019). Furthermore, the scoping review highlights the influence of health insurance coverage and technology on healthcare access. Lack of health insurance poses significant barriers for homeless immigrants, limiting their ability to afford and access healthcare services (Gil-Salmeron et al., 2021; Hanley et al., 2019). Policies focusing on expanding health insurance coverage and eligibility for vulnerable populations can help alleviate this barrier (Fryling, Mazanec and Rodriguez, 2015). Additionally, the accessibility to technology plays a vital role in connecting homeless immigrants with remote healthcare services. The use of digital health platforms can improve access to healthcare, especially in situations where physical access is limited. However, digital poverty and poor digital literacy have been highlighted as notable independents to accessing digital healthcare interventions by vulnerable sub-populations, especially during the COVID-19 pandemic when the majority of services transitioned from in-person to virtual care (Robards et al., 2019). Taken together, the critical analysis of the findings from this scoping review emphasizes the complex interplay of various factors that impact healthcare access for homeless immigrants in high-income countries.

2.4.4 Knowledge gaps in the reviewed studies

This scoping review provides valuable insights into the factors that impact access to primary care services for homeless immigrants in high-income countries. However, several gaps need to be addressed in future research. These gaps can be categorized into three main areas: intersectionality of social identities, contextual relevance, and strategies to improve access to primary care services. These are described in detail below.

Intersectionality of social identities:

In this scoping review, only one study that was conducted in Canada specifically examined the intersectionality of social identities (Hanley *et al.*, 2019a). Intersectionality recognizes that individuals' experiences are shaped by the intersection of multiple social categories, such as race, gender, and sexuality (Yuval-Davis, 2015). To better understand the inequalities faced by homeless immigrants in accessing primary care services, future research should explore how various social identities create unique barriers and challenges. By considering the intersectional aspects of social identities, researchers can gain a deeper understanding of how multiple forms of discrimination and disadvantage are generated and maintained, as well as how they more specifically affect healthcare access for homeless immigrants.

Contextual relevance:

The scoping review highlighted that access to PCS for immigrants experiencing homelessness is an under-researched area, particularly in comparison with research into migrant health as a whole and research carried out with homeless populations. This underscores the need for a more comprehensive understanding of the drivers of access to PCS among homeless immigrants to develop targeted interventions and policies that can appropriately address their specific needs. Furthermore, since only two studies examined healthcare providers' views on providing healthcare (Navarro-Lashayas and Eiroa-Orosa, 2017a; Hanley *et al.*, 2019a), further research is needed to examine the views and experiences of healthcare providers to ensure that the research aligns with and tackles significant public health issues relevant not only to homeless immigrants but also to policy makers and service providers (Laird et al., 2020). Additionally, only one study researched primary care services (Nyiri and Eling, 2012a). As such, it would be beneficial for more research to be carried out on access to primary care services because strong primary care within national healthcare systems has been reported to be associated with improved health outcomes, lower health system costs, and better patient experience of care compared with settings where primary care is more weakly represented (Campbell and Salisbury, 2015). Based on this scoping review, there is also the need for research that uses robust analytical/theoretical models that further examine how such diverse factors impact access to PCS.

Strategies to improve access to primary care services:

While this scoping identified barriers that hinder access to healthcare services for immigrant and homeless populations, the studies included in the review do not comprehensively analyse recommendations suggested by immigrants and stakeholders or provide a synthesis of effective strategies to counter these barriers. Future research should include components examining homeless immigrants and stakeholders' recommendations for interventions, programs, and policies that could improve access to primary care services for homeless immigrants. Such research will fundamentally inform efforts/initiatives required to break health disparities.

2.5 Theoretical frameworks

2.5.1 Introduction

The need to enhance the evidence base and to guide the development of tailored strategies aimed at improving the provision and access to PCS for homeless immigrants requires an in-depth understanding of the factors that influence the delivery and accessibility of these services (Clark et al., 2020). Understanding access to primary care services among homeless immigrants is complex, as it touches on individuals with multiple vulnerabilities. Indeed, the findings from my scoping review conducted in chapter two of this thesis highlight that research on access to PCS for homeless immigrants is under-theorised, and this could potentially impede the development of effective interventions. This is so because access models are reported to play a crucial role in guiding research, and health policy development if they reflect real-world processes (Ricketts & Goldsmith, 2005). I argue that to conduct research that comprehensively explores the factors that influence provision and access to PCS, it is necessary to draw influences from a breadth of theoretical perspectives. Here I explore two theoretical frameworks:: Levesque, a framework used to explore access to healthcare services (Levesque et al., 2013), and intersectionality, a framework that highlights how social identities positively or negatively influence access to services (Philip et al., 2023). Before delving into the Levesque framework, I provide an overview of alternative healthcare access theories that I did not utilize in my study and briefly explain the rationale behind this decision. Subsequently, I concentrate on the dimensions of the Levesque framework, and its application in health research, and examine its relevance in the present study concerning access to PCS for homeless immigrants. Lastly, I explore the intersectionality framework and its application in this study.

2.5.2 Alternative theories on access to healthcare

In Section 2.4.5 and beyond, I extensively discuss the significance of utilizing the Levesque framework to explore access to PCS in this current research. Furthermore, I elucidate the application of the Levesque framework in the study. Nonetheless, it is worth acknowledging that there exist other theories that could have offered valuable insights but were not employed in this current research. As alternative theories to the Levesque framework, I provide a brief discussion of the two leading frameworks of access: Andersen's Behavioral Model (ABM) (Aday and Andersen, 1974) and Penchansky and Thomas's Theory of Access (Penchansky and Thomas, 1981). I also delve into the reasons behind my prioritizing of access theories over theories of migration in my research and provide a detailed discussion on this matter.

2.5.3 Andersen's Behavioral Model (ABM)

(Levesque et al., 2013).Andersen’s Behavioral Model is another relevant theoretical model, besides the Levesque framework, which could be applicable when exploring factors influencing access to PCS. The model was developed in 1968 by the US medical sociologist and health services researcher Ronald M. Andersen to describe patterns of healthcare utilization across different settings (Babitsch et al., 2012). Andersen and his colleagues noted that earlier concepts of healthcare utilization focused on two main dimensions: population characteristics and delivery system characteristics (Ricketts & Goldsmith, 2005). These two dimensions incorporated three core factors explaining healthcare utilisation: predisposing factors (e.g., age, sex, ethnicity, occupation, and education), enabling factors (e.g., income, hospital density, transportation, and waiting times for healthcare), and need factors (e.g., health status and need for medical care) (Lederle et al., 2021), which align with certain aspects of the Levesque framework's perspective on healthcare access (Levesque et al., 2013).

The ABM is widely recognized as one of the primary models in healthcare services research, with broad applications across different care settings, diseases, and target groups. A recent scoping review of 77 studies that provided an overview of the suitability of ABM in qualitative research found that 29 publications regarded it as an appropriate framework due to its ability to effectively code and classify qualitative data in a valid, consistent, and unbiased manner (Lederle, Tempes and Bitzer, 2021). The model's strength was also found in its consideration of both patient-related and environmental factors, facilitating transparent comparisons with findings from other studies (Heidari et al., 2019; Schatz et al., 2019). Noteworthy, the Levesque framework is also recognized as suitable for qualitative research and is considered a patient-centred framework (Cu et al., 2021).

Nevertheless, some publications have found the ABM lacking in some aspects, particularly in representing cultural factors in healthcare for minority groups (Bayuo, 2017). About my current research project, this limitation suggests that the ABM may not fully capture the unique challenges and barriers faced by homeless immigrants, who often belong to marginalized populations. In contrast, the Levesque framework, with its emphasis on social and cultural acceptability, provides a more culturally sensitive lens to explore access for these specific populations (Levesque et al., 2013). Additionally, the Levesque framework incorporates additional factors that are not covered by the ABM, such as health literacy (Heidari *et al.*, 2019; Isaak *et al.*, 2020) competing priorities, fear, mistrust, and previous experiences (Artuso *et al.*, 2013) which have an impact on healthcare utilization. Through the consideration of these additional dimensions, the Levesque framework offers a more comprehensive and nuanced understanding of the complexities surrounding access (Cu et al., 2021) for homeless immigrants as discussed in section 3.3 of this thesis. While Andersen's Behavioral Model shares similarities with the Levesque framework in regards to focusing on population characteristics and delivery system characteristics, using the Levesque framework appeared prudent due to its comprehensive inclusion of these additional factors that are not covered by the ABM (Lederle et al., 2021).

2.5.4 Penchansky and Thomas' Model

In 1981, Penchansky and Thomas introduced a different perspective on comprehending access, drawing inspiration from the utilization theory proposed by Andersen and other researchers (Ricketts and Goldsmith, 2005). At the core of this framework lies the concept of "fit" between a patient's requirements and the healthcare system's ability to fulfill those requirements. This alignment is assessed through five dimensions: availability, accessibility, acceptability, accommodation, and affordability, which, to some degree, interconnect, ultimately influencing client satisfaction (Ngwakongnwi, 2017).

However, both the Andersen Behavioral Model and the Levesque framework have been considered more suitable for exploring access compared to Penchansky and Thomas' model. While Penchansky and Thomas offer an alternative "fit" approach, the Andersen Behavioral Model has been more commonly employed in research and evaluation studies on access, indicating a higher level of trust in Andersen's model for understanding access-related issues (Ricketts & Goldsmith, 2005). Moreover, the Levesque framework provides a notable advantage by including the dimension of approachability (or awareness), which is absent in the Penchansky and Thomas framework (Saurman, 2016b). Awareness plays a crucial role in access to healthcare services as it encompasses both the service's understanding of the local context and population needs and the patients' knowledge of available services. By considering awareness, the Levesque framework acknowledges the significance of effective communication and health literacy, enabling informed decisions by patients and providers. This recognition of effective communication and health literacy strengthens the Levesque framework's ability to comprehensively assess PCS access (Levesque et al., 2013). Furthermore, the patient-centred approach emphasized in Levesque’s framework, through the concept of "approachability," aligns with the growing emphasis on patient empowerment and involvement in healthcare decisions. By promoting service visibility and making services easily identifiable to patients, the framework aims to address patients' knowledge gaps and improve health literacy. This patient-centred perspective recognizes the importance of empowering patients to navigate the healthcare system effectively and access appropriate care (Levesque et al., 2013). In contrast, the Penchansky and Thomas framework does not explicitly incorporate this patient-centric view (Saurman, 2016).

Nevertheless, the Penchansky and Thomas framework possesses some strengths. One of its merits lies in its ability to identify the effects of health policies on specific populations. By considering client satisfaction with access as a factor influencing healthcare utilization, the framework provides insights into the impact of policy decisions on service delivery and uptake. This perspective allows for a deeper understanding of how broader healthcare systems and policies may shape access for homeless immigrants (Karikari-Martin, 2010). However, it is important to note that the Levesque framework also incorporates this aspect of client satisfaction (Levesque et al., 2013), thereby suggesting that this strength does not necessarily outweigh the limitations of Penchansky and Thomas framework, such as the absence of the awareness dimension. For this reason, the Penchansky and Thomas framework did not offer an ideal fit as a theoretical framework to use in my research. In section 3.3, I provide a detailed explanation for the choice of the Levesque framework.

2.5.5 Levesque framework

The primary objective of this thesis was to investigate the factors influencing the delivery and accessibility of PCS for homeless immigrants. To accomplish this, I incorporated Levesque's access to healthcare framework as a theoretical foundation for this study. Levesque and colleagues introduced this conceptual framework in 2013, following an extensive review of existing healthcare access literature (Levesque et al., 2013). This framework builds upon prior access conceptualizations, including the Andersen Behavioral Model and the Penchansky and Thomas Model (Aday and Andersen, 1974; Penchansky and Thomas, 1981; Frenk and White, 1992; Haddad and Mohindra, 2002; Shengelia, Murray and Adams, 2003), making it a comprehensive model for understanding access.

Definition of access

The Levesque model also introduces a temporal dimension and organizes each dimension sequentially to align with a patient's healthcare journey. Consequently, the Levesque framework defines healthcare access as the "opportunity to recognize healthcare needs, to actively seek healthcare services, to physically access healthcare resources, to acquire or utilize healthcare services, and to receive services tailored to care needs." From their perspective, access empowers individuals to navigate the stages that lead them to engage with and receive healthcare. As a result, the authors propose that disparities in access are conceptualized in terms of variations in the perception of care needs, healthcare-seeking behaviors, accessibility to healthcare resources, time taken to obtain services (or delays in obtaining them), and the nature and extent of services received. These distinct stages in the continuum signify critical junctures where factors facilitating or hindering access to healthcare services can become apparent (Levesque et al., 2013) (see **Figure 2**).

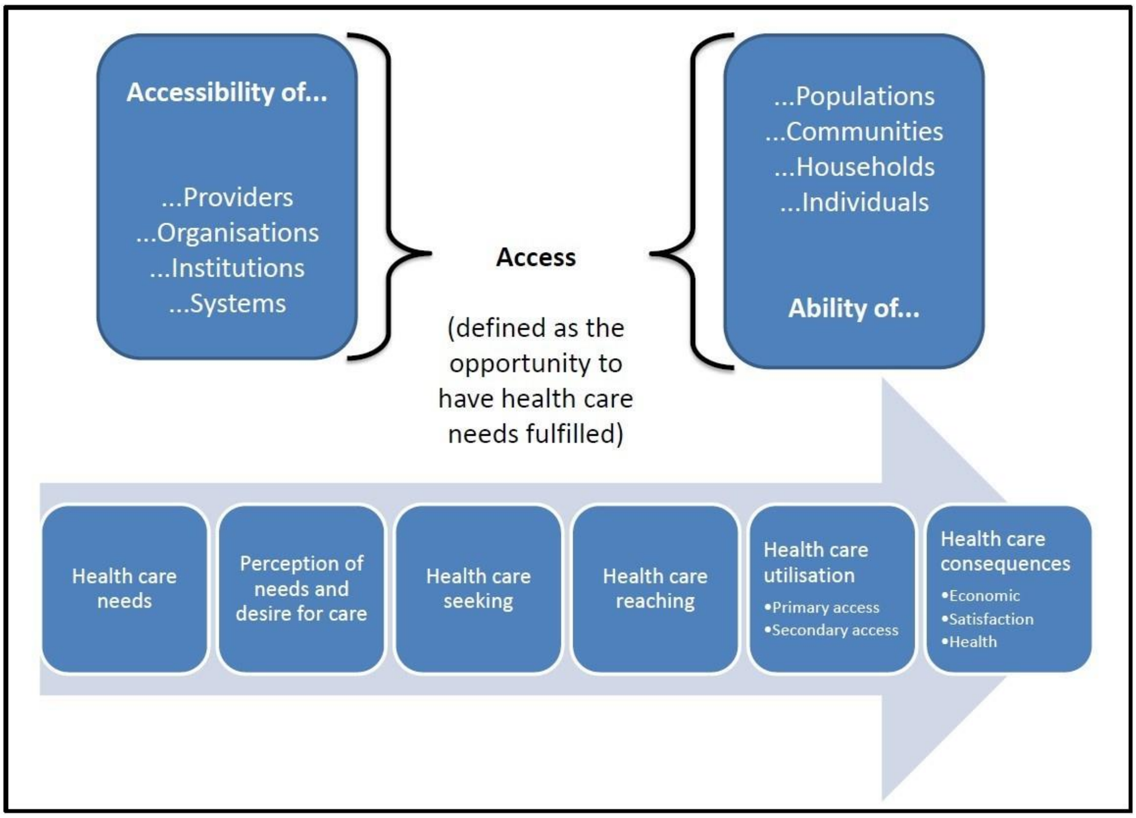


Figure 2 Levesque et al.'s definition of access to healthcare

Dimensions of the Levesque framework

Expanding upon a comprehensive view of access that encompasses factors related to the healthcare system, individuals, and context, the Levesque framework incorporates both supply-side and demand-side elements into its access model. This enables the operationalization of access along the continuum of healthcare utilization, spanning from the recognition of need to the outcomes of service utilization. The framework comprises five dimensions associated with healthcare providers (approachability, acceptability, availability and accommodation, affordability, appropriateness) and corresponds with five corresponding capabilities of patients and populations to access healthcare (capability to perceive, capability to seek, capability to reach, capability to pay, and capability to engage) (Levesque et al., 2013) (see **Figure 3**).

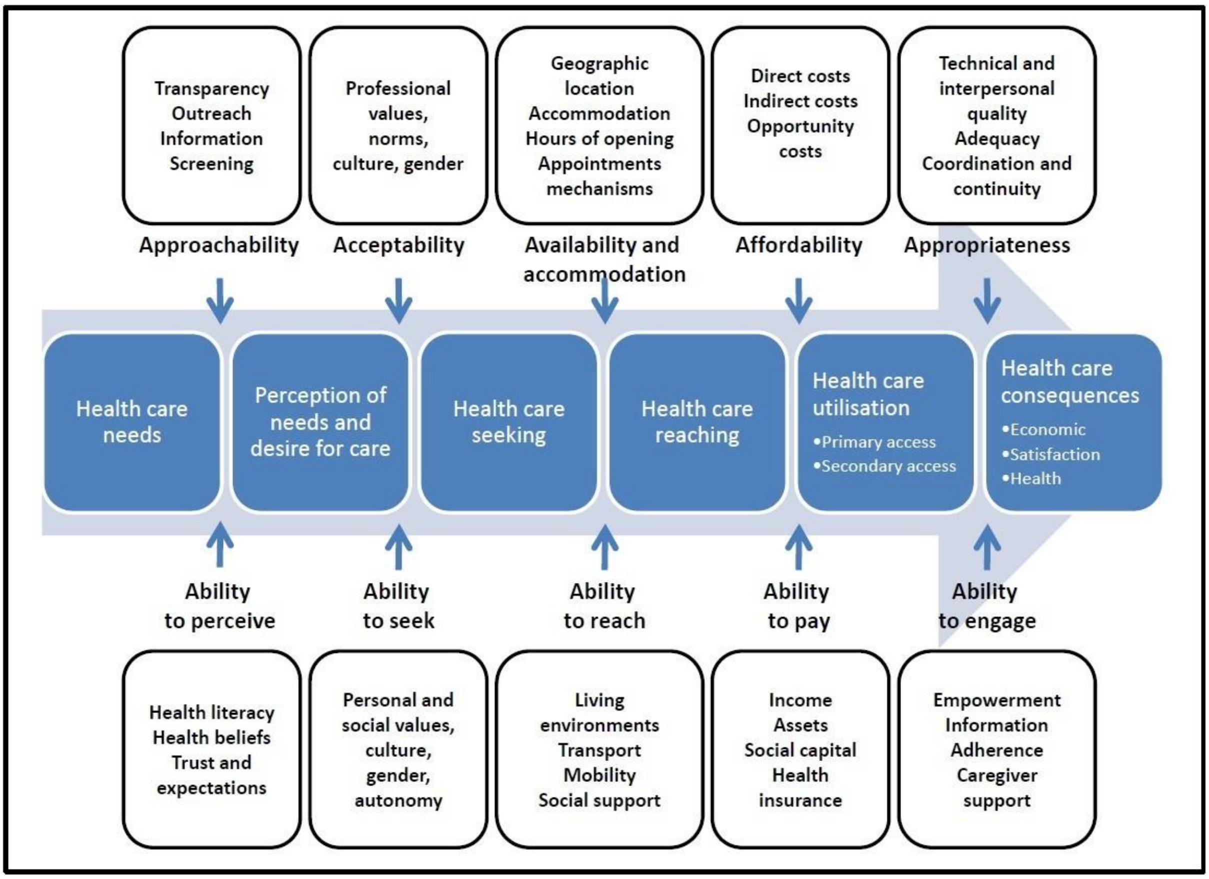


Figure 3 Levesque's conceptual framework of access to healthcare

These dimensions of access are considered interdependent constructs, and the movement between stages is continuous and fluid. Operational definitions of each access dimension are described in **Table 1** (Levesque et al., 2013).

Table 1 Operational definitions of access dimensions of health systems and corresponding abilities of populations to access healthcare

Supply-side dimensions of health systems	Definitions	Demand-side abilities of populations to access healthcare	Definitions
Approachability	Approachability of services relates to the fact that people facing healthcare needs can identify that some form of service exists, can be reached, and has an impact on their health.	Ability to perceive	The ability to perceive translates into the ability of people to identify their care needs.
Acceptability	Acceptability of services relates to social and cultural factors determining the possibility for people to accept the aspects of a service	Ability to seek	The ability to seek healthcare relates to factors that would determine expressing the intention to obtain healthcare.
Availability and accommodation	Availability and accommodation refer to the fact that health services (either the physical space or those working in healthcare roles) can be reached both physically and promptly	Ability to reach	The ability to reach healthcare relates to factors that would enable one person to physically reach service providers.
Affordability	Affordability reflects the economic capacity of people to spend resources and time to use appropriate services	Ability to pay	The ability to pay for healthcare is described as the capacity to generate economic resources to pay for healthcare services without the catastrophic expenditure of resources required for necessities.
Appropriateness	Appropriateness denotes the fit between services and clients' needs, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided	Ability to engage	The ability to engage in healthcare relates to the participation and involvement of the client in decision-making and treatment decisions, which is in turn strongly determined by the capacity and motivation to participate in care and commit to its completion

Supply-side dimensions of access to health care

Within the Levesque framework, the initial dimension on the supply side is termed "approachability." This dimension encompasses various factors contributing to the accessibility of healthcare services, including the dissemination of information about available treatments and services, as well as outreach efforts designed to enhance service accessibility. The second dimension, "acceptability," pertains to factors influencing the acceptability of care from the perspective of individuals. These factors encompass cultural considerations and the gender composition of healthcare professionals, as well as the culture within healthcare organizations. For instance, if cultural norms discourage close physical contact between unmarried men and women, the acceptability of care may be diminished for women if the majority of healthcare providers are male (Levesque et al., 2013).

The third dimension, "availability and accommodation," encompasses characteristics of healthcare facilities, urban contexts, and individuals. This dimension includes considerations such as facility density, building accessibility, transportation systems within urban areas, and factors related to individual access, such as the duration and flexibility of healthcare facility hours. It also encompasses aspects of healthcare providers, such as the presence of qualified healthcare professionals, and the methods by which healthcare services are delivered, including contact procedures and the availability of virtual consultations. Access can be impeded when healthcare resources are distributed unevenly across a country or when specialty care disproportionately outweighs primary care resources (Levesque et al., 2013).

The dimension of "affordability" relates to the cost of healthcare services, including the direct prices of services and associated expenses. It also takes into account the ability to generate the necessary resources to cover healthcare costs, such as payment methods and resource mobilization. Additionally, affordability considers opportunity costs related to income loss resulting from seeking care. The final dimension, "appropriateness," assesses the alignment between healthcare services and the needs of clients. It encompasses adequacy, which pertains to the suitability of services provided and their quality, as well as their integrated and continuous nature. Access can be constrained when individuals are limited to utilizing only low-quality services. It is important to recognize that the opportunity to access services provided by untrained practitioners, such as traditional birth attendants, should not be equated with the opportunity to access highly specialized services if these services result in different health outcomes or satisfaction levels. Therefore, the dimension of appropriateness holds significant relevance in the context of healthcare service accessibility (Levesque, Harris and Russell, 2013) (see **Figure 3**).

Demand-side dimensions of access to health care

Within the Levesque framework, the five dimensions on the supply side correspond to their counterparts on the demand side. The demand-side factors encompass the capabilities that potential clients need to possess to access healthcare. The "approachability" dimension of healthcare necessitates the ability to recognize a need for healthcare and includes determinants such as health literacy, health beliefs, trust in healthcare providers, and expectations regarding healthcare outcomes. The "acceptability" dimension of healthcare requires the capacity to actively seek healthcare. This dimension encompasses a client's personal and social values, cultural background, gender considerations, and autonomy in making healthcare decisions. It also encompasses knowledge about available healthcare options and individual rights, all of which influence the expression of an intention to seek healthcare. Ensuring that healthcare caters to the needs of diverse cultural, socioeconomically disadvantaged, and vulnerable populations is a critical aspect of acceptability (Levesque et al., 2013).

The dimension of "availability and accommodation" pertains to the ability to physically access healthcare. This includes determinants such as personal mobility, the availability of transportation, occupational flexibility, and knowledge about healthcare services that enable individuals to physically reach healthcare providers. For instance, challenges may arise for elderly individuals or those living with disabilities who face restricted mobility, or for casual workers who struggle to take time off work to consult with medical providers. "Affordability" refers to the capacity to financially cover healthcare expenses. It involves the ability to generate economic resources through various means, such as income, savings, borrowing, or loans, to pay for healthcare services without experiencing catastrophic financial burdens, such as selling one's home. Factors such as poverty, social isolation, or existing indebtedness can restrict an individual's capacity to afford healthcare services (Levesque et al., 2013).

Lastly, the "appropriateness" dimension of healthcare services requires the ability to actively engage in healthcare. This dimension relates to a client's participation and involvement in healthcare decision-making and treatment adherence. It is strongly influenced by an individual's capacity and motivation to engage in care and follow through with treatment plans. Effective communication, health literacy, self-efficacy, and self-management skills are all integral to this dimension. Additionally, it underscores the importance of receiving care that aligns with an individual's unique resources and skills. Accessing optimal care ultimately hinges on a person's full engagement with the healthcare process, which is influenced by the nature of the service provided (Levesque et al., 2013).

These five dimensions of healthcare access and the five abilities of potential users are integral to the healthcare utilization process and are interconnected with the causes and consequences of interacting with healthcare providers and utilizing services. They can serve as either facilitators or barriers to healthcare access at various stages of the continuum of care, offering guidance for policies aimed at addressing gaps in patients' abilities to enhance access. Moreover, these dimensions are not isolated constructs, as they often exert mutual influence on each other and operate at different junctures during an episode of illness and care. For example, the geographical location of primary care services (PCS) may interact with the affordability of transportation, collectively influencing access to healthcare services (Levesque et al., 2013).

Application of the Levesque Framework in health research

The Levesque framework has gained significant traction in healthcare access research in recent years. It has proven to be an effective tool for investigating, evaluating, and quantifying access across various healthcare services and contexts (Duran-Kiraç et al., 2021; Gallardo et al., 2020; Haj-Younes et al., 2022; Richard et al., 2016; Suurmond et al., 2016). Researchers Cu et al. (2021) conducted a comprehensive scoping review aimed at identifying and analyzing empirical studies that applied Levesque's conceptual framework for healthcare access. Additionally, they explored the experiences and challenges encountered by researchers who employed this framework to develop assessment tools. This review exhibited global coverage, encompassing nine low-income countries and twenty-two high-income countries, including nations like Australia, Germany, Canada, the United Kingdom, the United States, the Netherlands, and others. Cu et al.'s scoping review identified over thirty studies that utilized the Levesque framework for investigating healthcare access. Respondents cited several reasons for their preference for Levesque's framework over other access frameworks. They underscored that, presently, the Levesque framework stands as the most comprehensive tool for examining healthcare access, representing a notable improvement compared to existing theoretical frameworks in the field. This assertion is rooted in the fact that the development of the Levesque framework was informed by an exhaustive review of the literature on other access theories (Levesque et al., 2013). Its comprehensiveness allows for a detailed examination of healthcare access as a dynamic, process-oriented concept, spanning from the recognition of the need for care to the approachability of healthcare services, and onward to the delivery of services by healthcare providers and their receipt by patients. This perspective portrays access as a continuous journey rather than a static concept.

Another compelling factor favoring the adoption of the Levesque framework is its incorporation of both the healthcare system/provider and patient/client perspectives on access. While other access frameworks also consider access as a function of supply and demand (Aday and Andersen, 1974; Penchansky and Thomas, 1981), the Levesque framework uniquely integrates the corresponding element of individuals' or populations' abilities. This aspect has been a significant consideration for researchers seeking to explore access from the vantage point of individuals. Moreover, given that each access dimension aligns with a corresponding ability, the framework encourages the recognition that both health systems and population contexts must always be taken into account within the healthcare access process (Cu et al., 2021).

The Levesque access framework has found application in health research in two distinct approaches, as delineated by Cu et al. (2021). In one approach, it serves as an a priori tool, whereby the framework is employed in the development of data collection instruments, including interview guides, focus group discussion outlines, and questionnaires. For the present study, I employed the Levesque framework in an a posteriori manner, employing it to structure and analyze the data that had been gathered. One notable advantage of the Levesque framework is its capacity to accommodate both the health systems' perspective on access, as characterized by its dimensions, and the perspective of the population or patients regarding access, as represented by their abilities to access healthcare services. Consequently, researchers have leveraged the Levesque framework in a partial capacity, focusing solely on either the dimensions of access or the abilities of access. Alternatively, it has been used as a comprehensive framework, as exemplified in this current study, where both dimensions and abilities of access were explored (Cu et al., 2021).

Justification for employing the Levesque Framework in this study

The justification for employing the Levesque framework of access to healthcare in this study can be derived from several key factors outlined in the preceding sections. Also, in summary, the scoping review conducted in Chapter Two of this thesis indicates that research on access to PCS, specifically among homeless immigrants is under-theorized. Through bridging this gap in the literature, my research can boost efforts in designing effective interventions and in the provision of policy, options to improve access to healthcare and livelihood among homeless immigrants. Access models are reported to play a crucial role in guiding research and policy development if they reflect real-world processes (Ricketts and Goldsmith, 2005). The Levesque framework has been widely and successfully used in healthcare services research across different care settings, diseases, and target groups (Cu et al., 2021). Its success in comprehensively exploring health access factors across contexts and target groups provides strong merit for its utility in a dynamic sub-population of homeless immigrants. Besides, when comparing the Levesque framework with alternative access theories, such as Andersen's Behavioral Model and Penchansky and Thomas's Theory of Access, the Levesque framework presents several comparative advantages. While these models share similarities with the Levesque framework in focusing on population characteristics and delivery system characteristics, the Levesque framework incorporates additional dimensions such as health literacy, competing priorities, fear, mistrust, and previous experiences which are not adequately covered by the previous models. These additional dimensions in the Levesque framework are crucial in understanding access for homeless immigrants, who often belong to marginalized populations (Lederle et al., 2021). Therefore, by employing the Levesque framework, this current study comprehensively explored the factors influencing the provision and access to PCS and provided useful insights to support the development of tailored strategies aimed at improving healthcare services for homeless immigrants. Additionally, whereas theories specific to migration (such as the neoclassical theory of migration and transnational migration) can provide important contextual insights (Kurekova, 2011), they may not adequately have captured the intricacies of access to primary care services the homeless immigrants in my study setting, yet, the Levesque framework offered a focused lens on healthcare services, enabling a detailed examination of barriers and potential interventions (Cu et al., 2021).

2.5.6 Intersectionality framework

In the realm of health promotion, researchers acknowledge that addressing the underlying causes of health inequalities necessitates the application of theoretical frameworks capable of elucidating how social systems of power such as racism, classism, sexism, and others interact to maintain health inequalities of individuals within a population (Heard *et al.*, 2020), hence the need for the intersectionality lens. In the preceding section (2.4.5), I examined the utilization of the Levesque framework in organising and analysing data. In this study, the Levesque framework served as a posteriori tool employed at the semantic level to conduct a descriptive analysis. Nonetheless, to gain a more profound understanding of the research findings and surpass the boundaries of descriptive analysis, an intersectionality lens was employed. In this particular section, I investigate the intersectionality framework, encompassing its origins, underlying assumptions, justifications, and application within the current research context.

Origins of Intersectionality

The term "intersectionality" was likely first introduced by Kimberle´ Crenshaw, a legal scholar, in the early 1990s, as she delved into the distinctive and compounded experiences of discrimination encountered by Black women in the United States (Abrams *et al.*, 2020). Over the past four decades, intersectionality theory has undergone evolution and expansion, embracing a variety of social issues and acknowledging the intricate interplay of multiple identities and the social structures of power across diverse contexts. Scholars, activists, and professionals from various academic disciplines, including the social sciences, political science, gender studies, sociology, law, education, and health-related fields, have embraced and adapted intersectionality theory to address a wide spectrum of concerns (Heard et al., 2020). By recognizing the constraints of single-axis approaches, intersectionality theory broadens our comprehension of oppression and inequality by taking into account the intersections of different social identities and systems of power. It originated from grassroots activism and scholarship and has since been embraced and refined by experts and practitioners from various fields. This theory provides valuable insights into intricate social problems and advocates for a more inclusive and comprehensive approach to tackling disparities. This critical assessment of the origins and applications of intersectionality theory underscores its relevance and potential to enhance thinking and practice across diverse academic disciplines and social change endeavors (Heard et al., 2020; Thomas et al., 2021).

Assumptions of the Intersectionality

In this section I discuss the assumptions of intersectionality theory, emphasizing interdependency, the need to move away from additive analysis, and a focus on advancing social justice. The first assumption is that identities are interdependent, meaning experiences cannot be understood in isolation but are influenced by multiple intersecting identities. The additive approach, which treats identities as separate and independent, fails to capture the complexity of oppression and privilege (Abrams *et al.*, 2020). An individual's formation is a product of their entire range of life experiences. When we fragment and deal with singular identity categories, we tend to neglect crucial interactions between various social positions. These interactions often result in the accumulation of experiences involving both oppression and privilege (Heard et al., 2020). The second assumption highlights the significance of advancing social justice. Intersectionality theory encourages us to tackle the intertwined and context-specific aspects of numerous types of discrimination and oppression. At the same time, it prompts us to recognize instances of privilege within these complex dynamics. Single-axis analyses are seen as incomplete and inadequate in understanding and addressing the extensive injustices experienced by marginalized groups. Hence, researchers and practitioners strive to achieve health equity by considering the intersecting nature of identities and working towards social justice (Heard et al., 2020). Therefore, intersectionality theory challenges conventional approaches that treat identities as independent and overlook the complexities of oppression. It underscores the interdependence of identities and the need to move beyond additive analysis, emphasizing the importance of social justice in addressing inequalities. By adopting an intersectional lens, researchers and practitioners can gain a more comprehensive understanding of the experiences of marginalized groups and work towards equitable and inclusive solutions.

Justification of intersectionality

Intersectionality theory proved to be a suitable framework for examining the accessibility of primary care services among homeless immigrants for several compelling reasons. Firstly, intersectionality recognizes that socially constructed categories, such as immigrant status, gender, and cultural norms, don't operate in isolation; instead, they interact on multiple levels, contributing to a complex system of oppression and societal disparities. This perspective helps uncover the intricate nature of these interactions and their consequences on the ability to access PCS (Etowa et al., 2021). Secondly, policymakers should move beyond a simplistic binary view of immigrant status (immigrants versus native-born individuals) and instead acknowledge and confront the unique obstacles and vulnerabilities faced by minority immigrants, especially those experiencing homelessness, in their pursuit of healthcare services. Intersectionality theory provides a valuable framework for understanding how various aspects of identity, such as race, gender, and socio-economic status, intersect with broader systems of power, leading to disparities in health (Heard et al., 2020). Applying an intersectional perspective enables the identification of concealed issues and distinct subgroups within vulnerable populations, shedding light on their unique challenges. Consequently, embracing this approach allows for the customization of healthcare services to cater to the specific needs of different subgroups within vulnerable populations, fostering cultural sensitivity and mitigating health disparities (Shibli et al., 2021).

Application of intersectionality lens

When employing intersectionality as both a theoretical perspective and a methodological framework, researchers have the flexibility to make deliberate choices regarding the timing and manner of integrating intersectionality into their study. For instance, researchers can opt to use intersectionality as a guiding theory throughout the entire research process, or they may choose to introduce this framework during the data analysis phase. In the present study, I chose to apply the intersectionality perspective during a later stage of data analysis to avoid influencing the data collection process with any potential bias (Abrams et al., 2020).

Within the study's context, the amalgamation of the intersectionality and Levesque frameworks becomes apparent in the analysis of the healthcare access experiences of marginalized communities. To illustrate, in a systematic review conducted by Philip et al. (2023), both the Levesque and intersectionality frameworks were applied to investigate the real-life encounters of individuals with disabilities living with HIV. This review revealed that the challenges in accessing HIV services for this group were influenced by a complex interplay of intersecting identities, including gender, economic status, stigma, and societal beliefs. The findings indicated that women with disabilities living with HIV encountered more disadvantages in their relationships compared to their male counterparts, resulting in disparities in their ability to access HIV-related services. The integration of the Levesque and intersectionality frameworks was found to offer an impartial assessment of the access barriers experienced by individuals with disabilities living with HIV. This showcased the adaptability of the Levesque framework in conjunction with other approaches such as intersectionality, underscoring the rationale for integrating both frameworks in my study (Philip et al., 2023).

According to Braun & Clarke (2006), data analysis is typically conducted at the semantic level, which involves organizing and analyzing data based on its explicit and surface-level meaning. In this particular study, the semantic-level data analysis focused on examining and structuring the information at face value using the Levesque framework, taking into consideration only what participants explicitly conveyed through their spoken or written expressions. While this approach holds its merit, there is an added dimension of insight that can be gained by delving deeper into the underlying aspects of spoken or written content. This is where the incorporation of the intersectionality lens at the latent level of my data analysis becomes significant. Analyzing data at the latent level, which is achieved through interpretative analysis, empowers researchers to go beyond the surface and unearth the assumptions, beliefs, thought patterns, and conceptualizations that underlie the semantic content (Braun & Clarke, 2006). Consequently, by integrating an intersectional lens at the latent level of my data analysis, I was able to achieve a more comprehensive and nuanced examination of my research findings (Abrams et al., 2020).

2.6 Summary

The scoping review had the purpose of comprehensively understanding the current state of knowledge concerning healthcare access for homeless immigrants in high-income countries, with a specific focus on the UK context. The review examined empirical studies that explored the factors influencing healthcare access for this vulnerable population. Through this investigation, several important gaps in the existing literature came to light: First, the review underscored the insufficient attention given to homeless immigrants. While there is existing evidence on the challenges faced by immigrants and homeless individuals separately, there is a distinct lack of dedicated research specifically focusing on the healthcare access issues of homeless immigrants. The unique experiences and difficulties encountered by this specific group have not been thoroughly explored. Secondly, there was a notable absence of stakeholder perspectives, particularly those of service providers, in the studies examined. This limitation hindered the development of effective policies and interventions that could cater to the specific needs of homeless immigrants. Gaining insights from stakeholders is crucial for understanding the complexities of healthcare access and crafting relevant solutions. Thirdly, the review identified a lack of comprehensive research specifically focused on access to primary care services for homeless immigrants. Since primary care serves as the initial point of contact in the healthcare system, understanding the barriers to access is essential for improving the health outcomes of this population. Furthermore, most of the studies in the scoping review did not explicitly explore the influence of intersectionality on access to healthcare services for homeless immigrants. Gaining an understanding of how various forms of discrimination intersect can provide a more nuanced comprehension of the challenges faced by homeless immigrants. Furthermore, the scoping review in Chapter Two highlighted a lack of theoretical underpinning in research on access to PCS for homeless immigrants. To address this gap, my study employed the Levesque framework of access to healthcare, a widely successful model known for its comprehensive exploration of health access factors across diverse contexts and target groups, particularly in the dynamic sub-population of homeless immigrants. The Levesque framework was employed in this study because it incorporates additional dimensions that are not adequately covered by the previous models of healthcare access. Lastly, research was scarce on strategies to improve access to healthcare services. While barriers to access have been identified, there is limited research on effective strategies to address these issues and enhance healthcare access for homeless immigrants. Future research should explore recommendations and interventions suggested by homeless immigrants and stakeholders to develop evidence-based solutions. By mapping the existing literature and gaining insights into the current knowledge about access to healthcare services for homeless immigrants, the review played a crucial role in guiding the development of research questions for this thesis. The research questions aimed to fill the knowledge gaps, with specific emphasis on access to primary care services, the inclusion of stakeholders' perspectives, highlighting the inequalities faced by homeless immigrants and developing strategies to address these barriers.

2.7 Research questions

2.7.1 Broad research aim

This sequential exploratory mixed methods study aimed to delve into the firsthand experiences and viewpoints of immigrants and stakeholders concerning the provision and access to PCS among individuals experiencing homelessness in Southeast England. The study also aimed to identify the most prioritized strategies for improving access. The study comprised two phases: a qualitative phase, guided by the Levesque framework of healthcare access, and an intersectionality lens, which preceded the quantitative phase involving Delphi surveys. Offering a platform for immigrants facing homelessness and various stakeholders to articulate their experiences and perspectives, the study unveiled insights crucial to comprehending the overall healthcare encounters of homeless immigrants. Additionally, it played a vital role in identifying the top ten prioritized strategies for enhancing access to PCS for this population. Moreover, the findings of this study may be of significance to policy makers and stakeholders involved in the provision of PCS, and stakeholders advocating for equity of access and health systems strengthening.

2.7.2 Specific research questions

1. What factors influence the provision and accessibility of PCS for homeless immigrants?
2. How does intersectionality impact access to PCS for homeless immigrants?
3. What are the most prioritized strategies for enhancing the provision and accessibility of PCS among homeless immigrants?

Chapter Three: Methodology

3.1 Introduction

This chapter serves as the framework for situating my research methodologically and offers insights into the process of planning and analyzing the sequential exploratory mixed methods study I conducted. Within this section, I present the specific research design employed in my study and delve into the diverse research paradigms. I also elucidate the ontological and epistemological stances that inform my research. Subsequently, I delve into the detailed methods utilized throughout this thesis, encompassing aspects such as sampling techniques, participant recruitment, methods of data collection, data management and analysis procedures, and mechanisms for ensuring data quality.

3.2 Research design

This study was conducted through the implementation of a sequential exploratory mixed-methods approach, where the qualitative component precedes the quantitative element (Cabrera, 2011). This design is ideal for explorations of new phenomena. As there is little empirical understanding of access to PCS for homeless immigrants in the UK, the sequential exploratory mixed-methods approach served as the ideal design for this inquiry (Cabrera, 2011). This is because qualitative research methodologies are used to explore why or how a phenomenon occurs or describe the nature of an individual's experience, while quantitative methodologies address questions about causality, generalizability, or magnitude of effect (Fetters, Curry and Creswell, 2013). Therefore, mixed methods research draws on the strengths of both qualitative and quantitative research.

This sequential exploratory mixed-methods approach involved two distinct phases. The first phase of this study focused on qualitative data collection and analysis to explore the views and experiences of homeless immigrants and stakeholders in the provision and access to PCS. Qualitative research, distinct from hypothesis testing, aims to offer fresh insights that may have previously been overlooked. It accomplishes this by actively involving the researcher in expanding their conceptual tools, enabling them to pose new questions and provide novel explanations of a given reality from a unique perspective (Reiter, 2017; Haines et al., 2019). The qualitative approach permitted me to pose broad research questions geared toward exploring, interpreting, or comprehending the social context. It involved the recruitment of participants through non-random methods, selecting individuals who possessed crucial information relevant to the research inquiries. Data collection techniques, such as interviews, were employed to establish close connections with the participants (Nguyen, Cao Thanh and Thi Le Thanh, 2015). By conducting a qualitative study, I had the opportunity to delve into and comprehend how individuals articulate their personal experiences and the significance they attach to these encounters regarding the provision and access to PCS (Abdullah and Siti, 2019).

The results of the first phase were used as a foundation for creating a two-round online survey for the second, quantitative phase of the study. The survey was deployed to stakeholders to identify the most prioritised strategies in improving access to PCS for homeless immigrants in the UK. The Delphi method is widely recommended as a means for collecting and synthesizing expert opinion on a given issue in the field of their expertise (Devillé *et al.*, 2011; Barrios *et al.*, 2021). The Delphi method was chosen for this study because (i) it is regarded as a powerful and cost-effective way to obtain information and opinions anonymously from a heterogeneous group of people with various experiences and expertise (William C.W. Wong *et al.*, 2014), (ii) it is considered where there is limited evidence or where evidence is contradictory in a given area (Vernon, 2009), (iii) it determines the extent of agreement over a given issue (consensus measurement) and in doing so, to overcome the disadvantages normally found in group or committee decision making (Vernon, 2009), (iv) and it supports the lack of geographical limitations because the questionnaires are usually completed by mail (Karamitri *et al.*, 2013). Therefore, this sequential exploratory mixed-methods approach was valuable for providing a comprehensive and well-informed understanding of the research questions (Cabrera, 2011).

Mixed methods approach

A mixed-methods approach constitutes a distinct research methodology with its philosophical assumptions and methods of inquiry, guiding the collection and analysis of data from various sources within a single study. This research design amalgamates the post-positivist and interpretivism frameworks, intricately intertwining qualitative and quantitative data to meaningfully address complex research issues (Dawadi, Shrestha and Giri, 2021). By leveraging both types of data, mixed-methods research enables researchers to delve into research questions with depth and breadth, facilitating the generalization of findings to a broader population. The quantitative approach facilitates data collection from a large participant pool, enhancing the potential for broader generalization, while the qualitative approach provides a nuanced understanding of the investigated issue, valuing the perspectives of participants (Dawadi, Shrestha and Giri, 2021). This design capitalizes on the strengths of both methods, compensating for their respective weaknesses, and offers a comprehensive view of phenomena, contributing to the generation of substantive theories. Importantly, it allows for the development of more effective and refined conclusions by using the results from one method to inform the use of another, as exemplified by a sequential design exploring childhood obesity factors through quantitative predictors followed by qualitative exploration (Dawadi, Shrestha and Giri, 2021). Considering my research, which aims to explore the factors that influence provision and access to PCS, and to identify strategies to improve this access among homeless immigrants, the mixed-methods approach emerged as a promising methodology, offering a holistic perspective and the flexibility to draw on the strengths of both qualitative and quantitative data for a nuanced understanding of the research questions.

Key considerations

Selecting an appropriate mixed-methods research design involves careful consideration of three key aspects, posing challenges for many researchers. The first aspect revolves around determining the relative priority of qualitative and quantitative approaches in addressing research questions, with options ranging from quantitative priority, and qualitative priority, to equal priority, depending on the research goals and participants' needs (Dawadi, Shrestha and Giri, 2021). In my study, qualitative priority was established, emphasizing the importance of qualitative data collection and analysis. The second decision focuses on the level of interaction between the two data sets, with the researcher deciding whether they should remain independent or interact with each other. Independence implies mixing the approaches only after data analysis, highlighting the importance of understanding the interplay between qualitative and quantitative components (Dawadi, Shrestha and Giri, 2021). The third decision centers on the timing of qualitative and quantitative approaches, involving a choice between sequential and concurrent combinations. In my research, a sequential exploratory mixed methods design was adopted, with a qualitative method preceding quantitative methods to allow for detailed information collection and the development of specific quantitative procedures as highlighted in Figure 4 below (Dawadi, Shrestha and Giri, 2021). This strategic selection of a mixed-methods design aligns with my study's goal of understanding the provision and access to PCS for homeless immigrants, ensuring a comprehensive exploration through prioritized qualitative insights and a sequential combination for optimal research outcomes.

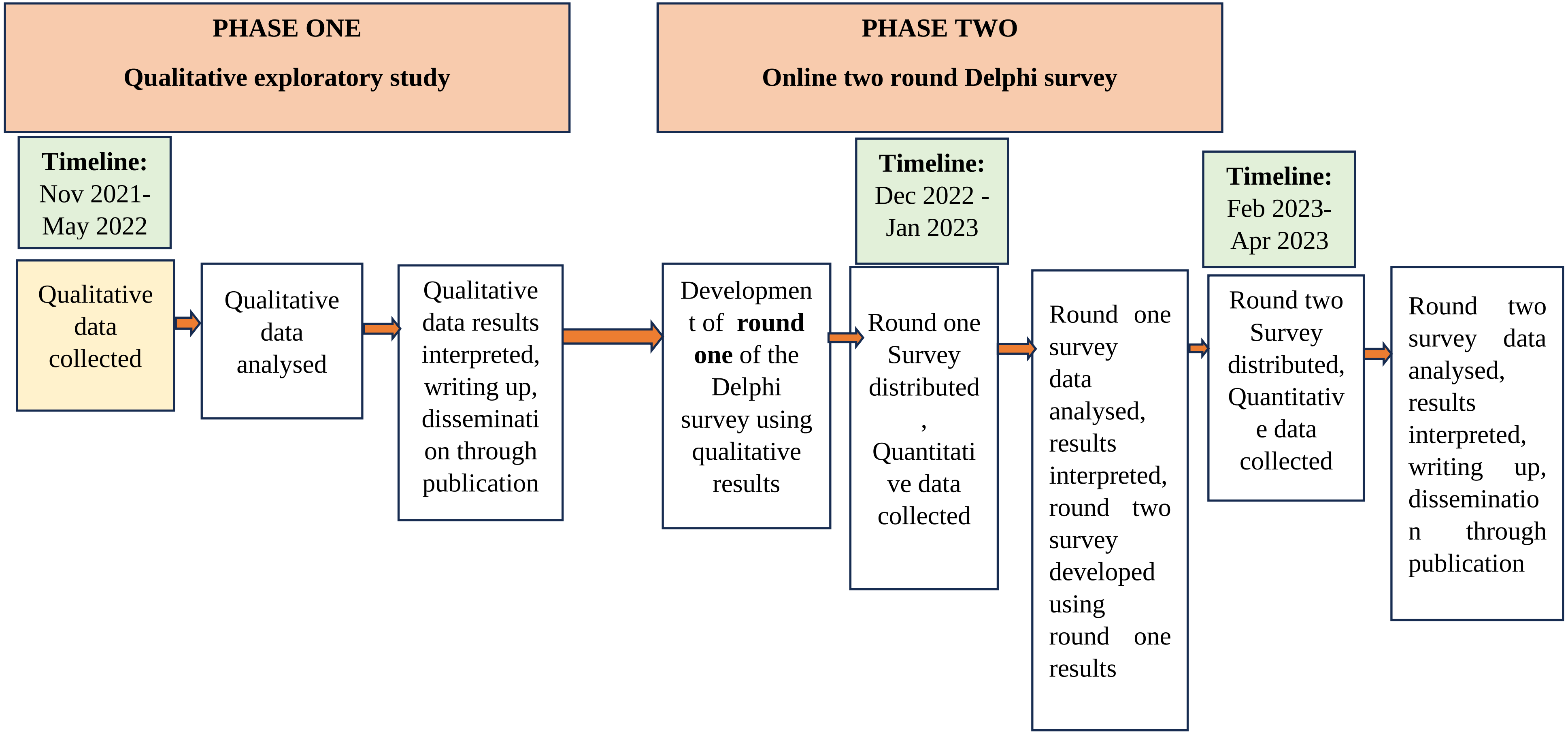


Figure 4: Sequential exploratory mixed methods research design

3.3 Philosophical assumptions

A research study typically operates within the framework of a research paradigm, which encompasses the researchers' fundamental philosophical perspectives on truth and reality in a general sense, as well as their specific views on the research topic at hand (Dawadi et al., 2021). Essentially, a research paradigm reflects a philosophical stance regarding the world and the nature of reality, shaping how researchers approach and comprehend it (Dawadi et al., 2021). This paradigm involves assumptions about ontology, dealing with the essence of truth and the nature of reality, and epistemology, addressing the nature and forms of human knowledge and how we ascertain reality (Dawadi et al., 2021). Depending on their objectives, researchers may adopt diverse approaches to unveil truth and knowledge. Mixed-methods research, as a methodology, integrates multiple methods in a principled manner to address research questions, involving the collection, analysis, interpretation, and reporting of both qualitative and quantitative data (Creswell, 2014). A comprehensive grasp of research paradigms is crucial for researchers, as it influences their methodological decisions in data collection, analysis, interpretation, and reporting of findings. In essence, novice researchers need to comprehend the available research designs to effectively address their research problems and guide them throughout the research process (Dawadi et al., 2021).

Two predominant research paradigms, positivism and interpretivism, offer distinct philosophical perspectives on the nature of knowledge and reality. Positivism, a widely adopted paradigm, asserts that knowledge can only be confirmed through sensory perception (Bryman, 2016). This paradigm emphasizes an objective approach to research, advocating for the acquisition of knowledge through the collection of objectively verifiable facts using quantitative methods. Consequently, quantitative researchers align with positivism, employing quantitative tools to attain objective findings in their studies (Dawadi et al., 2021). On the other hand, interpretivism, in stark contrast to positivism, embraces a diverse understanding of reality, positing the existence of multiple realities (Bryman, 2016). Scholars following interpretivism reject the application of the scientific or positivist model to their studies and instead focus on the subjective meanings embedded in social actions (Dawadi et al., 2021). Consequently, interpretivists employ qualitative research methods such as interviews, focus groups, and participant observation to comprehend and elucidate social phenomena, aligning with interpretivism as their chosen research paradigm (Dawadi et al., 2021). These paradigms, with their differing epistemological foundations, guide researchers in shaping their methodological decisions and approaching the study of knowledge and reality.

The final paradigm is the paradigm of pragmatism. It diverges from a fixed philosophical stance and challenges the dichotomy between positivism and interpretivism, proposing an inclusive view of reality as both singular and multiple (Creswell, 2007). Pragmatism operates under a pluralistic and practical orientation, prioritizing "what works" in research practices (Creswell, 2007). It rejects the quantitative/qualitative divide and advocates for methodological choices guided by research problems rather than rigid paradigms (Dawadi et al., 2021). Researchers adopting a pragmatist position have the flexibility to select methods that best address their research questions, valuing both objective and subjective knowledge to achieve research objectives. Pragmatism employs a mixed-methods design, incorporating qualitative approaches for an in-depth understanding of situations through tools like in-depth interviews, and quantitative approaches for deriving objective findings, such as using a Delphi survey (Dawadi et al., 2021). Ontologically, pragmatists acknowledge an external world independent of the mind, while epistemologically, they reject a definitive determination of 'truth,' embracing both objective and subjective orientations throughout the research process (Subedi, 2016). Thus, a pragmatist position was adopted for my research study for a pluralistic approach in gathering diverse data to effectively address research questions, transcending the traditional paradigms. The subsequent sections discuss the qualitative and quantitative components of this current research study.

PHASE ONE: QUALITATIVE RESEARCH

3.4 Qualitative research approach

Given that my research was structured as a sequential exploratory mixed methods approach, the initial stage of the study involved the qualitative phase. Qualitative research, distinct from hypothesis testing, aims to offer fresh insights that may have previously been overlooked. It accomplishes this by actively involving the researcher in expanding their conceptual tools, enabling them to pose new questions and provide novel explanations of a given reality from a unique perspective (Reiter, 2017; Haines et al., 2019). The qualitative research approach permitted me to pose broad research questions geared toward exploring, interpreting, or comprehending the social context. It involved the recruitment of participants through non-random methods, selecting individuals who possessed crucial information relevant to the research inquiries. Data collection techniques, such as interviews, were employed to establish close connections with the participants (Nguyen, Cao Thanh and Thi Le Thanh, 2015). By conducting a qualitative study, I had the opportunity to delve into and comprehend how individuals articulate their personal experiences and the significance they attach to these encounters (Abdullah and Siti, 2019). According to Nguyen, Cao Thanh and Thi Le Thanh (2015) when a researcher aims to grasp the experiences of a specific group, the most suitable approach is the qualitative research methodology. Consequently, for a comprehensive exploration of the determinants impacting access to PCS, the qualitative research approach was the most appropriate for this study as it empowered individuals to openly share their narratives (Creswell and Creswell, 2007). Figure 5, which follows, provides a visual representation of the methods applied within this thesis.

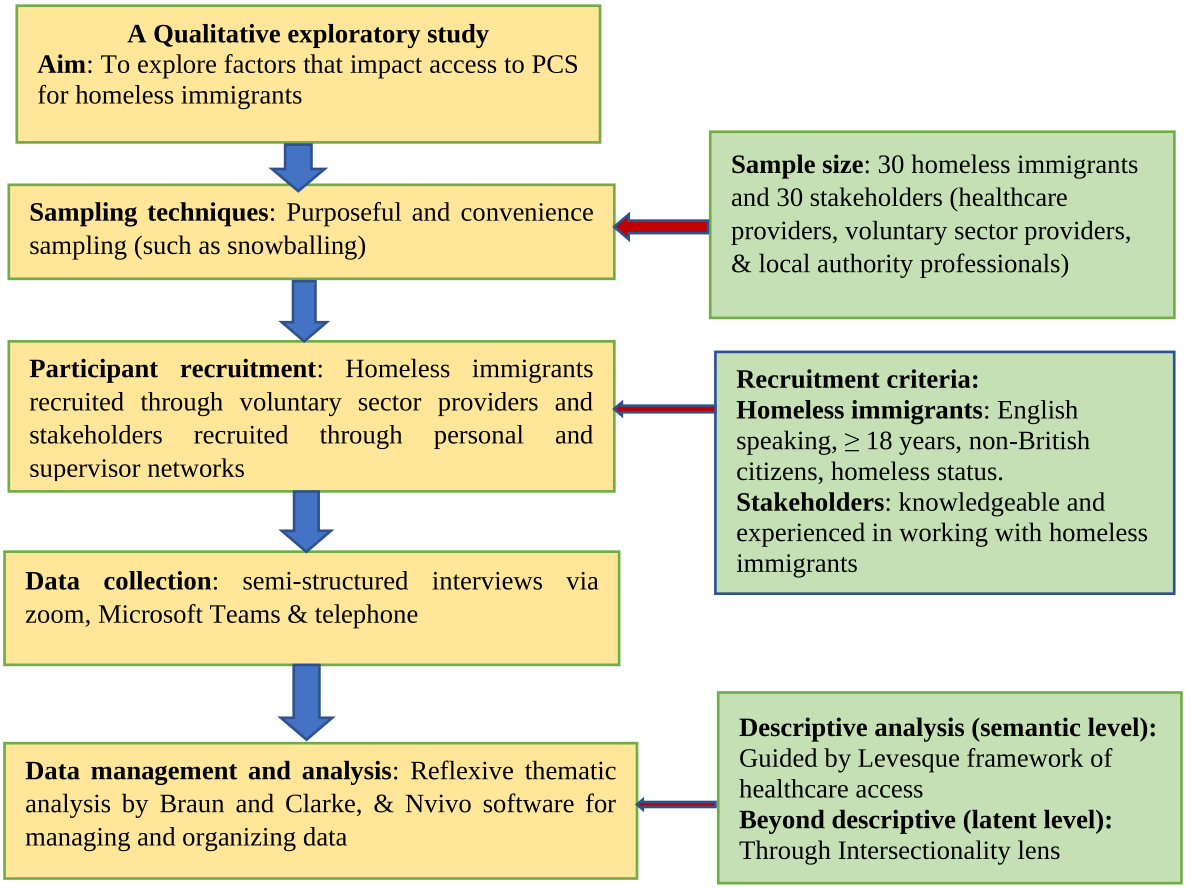


Figure 5: Qualitative exploratory research design for phase 1

3.5 Sampling techniques

In this study, I utilised a deliberate and convenience sampling approach to carefully select participants who could provide valuable insights into the factors influencing access to PCS. Purposeful sampling, a non-random method primarily employed in qualitative research, was employed to identify and choose individuals who possessed substantial knowledge or personal experience related to the phenomenon under investigation (Palinkas et al., 2015). The selection of participants for inclusion in the sample was based on specific criteria, including their specialized knowledge about the research topic and their willingness to participate in the study (Rai and Thapa, 2015).

In contrast, probability sampling techniques, such as simple random sampling commonly used in quantitative research, prioritize the generalizability of findings. They aim to minimize selection bias and control for known and unknown confounding variables, ensuring that the knowledge acquired is representative of the larger population from which the sample is drawn (Palinkas et al., 2015). Unlike probability sampling methods, purposive sampling does not seek to achieve generalizability; thus, the selected sample is not meant to be a reflection of the entire population (Rai and Thapa, 2015). One of the significant advantages of purposeful sampling is its flexibility, allowing researchers to employ various sampling techniques across different qualitative research designs. Some examples of purposeful sampling approaches include extreme or deviant sampling to investigate unusual instances of the phenomena of interest, maximum variation sampling to capture diverse perspectives, homogenous sampling to reduce variability, and snowball sampling, among others (Palinkas et al., 2015).

In this research study, I employed snowball sampling to identify relevant cases by initially selecting individuals who were acquainted with others sharing similar characteristics. Subsequently, these individuals were asked to recommend additional participants with similar characteristics, creating a chain or "snowball" of referrals (Palinkas et al., 2015). For instance, in this study, key informants such as the voluntary sector organisations, local authorities, and health care providers that were contacted identified colleagues to participate in the research study. However, while snowball sampling is effective in certain contexts, it can inadvertently lead to unwanted sample homogeneity. For instance, since it starts with an initial participant and then expands through their social connections, researchers can encounter issues when the initial sample itself lacks diversity. This limitation highlights the potential biases inherent in snowball sampling (Ellard-Gray *et al.*, 2015). However, despite its biases, researchers highlight that snowball sampling becomes indispensable when dealing with populations that are genuinely hidden or when the research topic is sensitive. While there isn't a universally optimal approach for every hard-to-reach, hidden, or vulnerable population, researchers advise not to heavily rely on a single sampling strategy. Recognizing the infinite diversity within these populations, a combination of methods is reported to provide a more comprehensive and representative sample, mitigating the limitations of individual approaches (Ellard-Gray *et al.,* 2015).

In this research, I employed a combination of snowball sampling and convenience sampling techniques. Convenience sampling was utilized to facilitate the collection of data from participants who were readily accessible (Palinkas et al., 2015). While convenience sampling is widely used, scholars point out that it lacks a deliberate and strategic approach. Nevertheless, it offers advantages in terms of affordability, simplicity, and the availability of subjects (Etikan, 2016). For instance, I recruited some stakeholders from a stakeholder meeting I attended. However, even though these stakeholders were chosen for their convenience, their selection was aligned with the study's objectives, with the expectation that each participant would contribute valuable and insightful information to the research (Etikan, 2016).

Purposeful sampling techniques place a strong emphasis on achieving data saturation, which entails continuing the sampling process until no new significant information is obtained. This approach aims to gain a comprehensive understanding of the phenomenon under investigation (Etikan, 2016). Data saturation typically occurs when further data collection yields little in terms of new themes, insights, perspectives, or additional information related to the research topic. Furthermore, as highlighted by Suri (2011), the likelihood of reaching data saturation is higher when data collection is conducted purposefully. In this particular study, the determination of the sample size was contingent upon the achievement of data saturation. Approximately 30 homeless immigrants and 30 key informants (stakeholders) were interviewed, aligning to attain a thorough understanding of the research topic and ensure that data saturation was reached.

3.6 Recruitment of participants

In this research, the process of enlisting study participants unfolded across four distinct phases, as outlined in the study conducted by Bonisteel et al. (2021). The initial phase entailed the development of a comprehensive recruitment plan. This encompassed the project's initial planning steps, including the identification of the study's objectives, the determination of eligible participants, the selection of an appropriate data collection method, and the acquisition of ethical approval from the University's ethics panel. Moving into the second phase, the recruitment plan was put into action. This involved a range of tasks, from strategizing the timing of recruitment activities to gathering contact information for potential participants, ultimately culminating in the decision on when to conclude the recruitment process. The third phase of participant recruitment was centered on maintaining engagement with participants even after data collection had taken place. This ongoing engagement allowed researchers to effectively communicate any post-data collection issues, such as the Delphi follow-up survey if they were to arise. Finally, the fourth phase encompassed the post-recruitment assessment. During this phase, I evaluated the entire recruitment process, scrutinizing the various activities that had transpired. The goal was to extract valuable insights and lessons learned from the recruitment activities, ultimately contributing to a more informed approach to future endeavors. It's worth noting that, while Bonisteel et al. (2021) delineate the activities associated with each of these phases comprehensively, I selectively adopted those activities that were most relevant and essential to the specific objectives of this study, as delineated in Table 2 below.

Table 2 Activities in the four phases of participant recruitment implemented in this study (Bonisteel *et al.*, 2021)

Activities by Bonisteel et al. (2021)	**Activities implemented in the study**
Phase 1: Development of the recruitment plan	
Identifying study objectives	Study objectives were identified
Meeting funding requirements	I requested £20 vouchers from the finance team to be given to homeless immigrants as a token of appreciation for their participation in the study
Identifying eligible participants	I used a to identify eligible participants
Determining the method of data collection	In-depth and semi-structured interviews
Considering the eligible participant population size	The sample size was dependent on data saturation
Determining when to contact participants and when data collection would occur	Participants were contacted and data collection occurred after gaining ethical approval
Determining what would be asked of participants	Interview guides were developed to assist in data collection
Determining what participants would receive for their participation	Participants were given £20 gift vouchers as a token of appreciation for their participation in the study
Determining how to contact participants, including the number of attempted contacts	Participants were contacted through emails and telephone
Determining who will contact participants	I contacted the participants
Developing recruitment instruments	Flyers, information, and consent forms were developed
Reviewing the appropriateness of the recruitment plan	The recruitment plan was reviewed before the recruitment of the participants
Applying for ethical and institutional approvals	I applied for ethical approval from the University Ethics panel
Adjusting the recruitment plan to meet ethics board requirements	Amendments were made to the ethics application to meet the ethics panel requirements

Securing ethical and institutional approvals to contact eligible participants	Ethical approval was obtained from the University Ethics panel
Phase 2: Implementing the recruitment plan	
Reconsidering the timing for implementing the recruitment plan	I developed a work plan
Securing contact information for potential participants	Contact information about potential participants was secured from organisational websites, stakeholder meetings, other stakeholders, and supervisor networks
Contacting potential participants	Potential participants were contacted through email and telephone
Screening participants for eligibility	Participants were screened for eligibility by asking them initial questions using the recruitment criterion
Dealing with issues arising from contacting people not eligible for the study	I did not recruit participants who could not be interviewed in English
Arranging for data collection	Information about the study and consent forms were sent to the participants before data collection
Explaining study aims, risks, and benefits	This was done before and during the interviews
Obtaining informed consent	Consent was obtained before conducting interviews
Monitoring recruitment	Recruitment was monitored to ensure participants were recruited according to the criterion
Adjusting recruitment plan	The recruitment plan was adjusted to include gift vouchers
Submitting protocol amendments to ethics boards	Protocol amendments were submitted to the ethics board
Conducting activities to further enhance recruitment	Activities such as follow-up emails were sent to participants to enhance recruitment
Determining the end of the recruitment	This was determined by data saturation
Phase 3: Maintaining participant engagement	
Communicating any issues with the study to participants	Stakeholders were contacted to request their participation in the Delphi follow-up survey
Providing updates to study participants	This will be conducted through report writing
Disseminating findings to participants	This will be conducted through report writing and publications
Phase 4: Post-recruitment assessment	
Disseminating lessons learned from recruitment assessment to the research	Lessons learned were included in this thesis

community	

3.6.1 Recruitment criteria for homeless immigrants

Immigrants experiencing homelessness were recruited with the support of key informants. A flyer containing information about the study was shared with various stakeholders to distribute to the various immigrant and homeless groups that they support. Immigrants who are interested in participating in the study contacted me using the information on the flyer by email or telephone.

Inclusion criteria

In this study, an immigrant was a non-British citizen. This is because according to the Immigration Act of 1971, individuals who are not British citizens (such as those with limited leave, indefinite leave, asylum seekers, refugees, or irregular immigrants) are subject to immigration regulations and control (UK Government, 1971), which might affect their access to services. According to Public Health England (2019), homelessness is comprised of four main categories which include; “rooflessness (without a shelter of any kind, sleeping rough); houselessness (with a place to sleep but temporary, in institutions or a shelter); living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as ‘sofa surfing’); and living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)”. Therefore, in this study, a homeless immigrant was a non-British citizen experiencing any of the above forms of homelessness. Homeless immigrants who were recruited were adults aged 18 or above. They were also English-speaking individuals to address the problem of the language barrier between me and the participants.

Recruitment of hidden homeless immigrants

Recruiting hidden homeless immigrants demanded a strategic and nuanced approach. Hidden homelessness, characterized by unconventional living situations like sofa surfing or squatting, contributes to an underestimation of its extent in official statistics, creating a challenge in identifying participants (ONS, 2023). Additionally, the complexities of reaching vulnerable and hard-to-reach populations further complicate recruitment efforts, necessitating thoughtful strategies. I recognized the need to engage voluntary sector providers who understand the population's experiences and concerns. These providers acted as gatekeepers, fostering trust and helping to bridge the gap between researchers and participants, particularly those hesitant due to mistrust. This approach acknowledges the significance of local networks in overcoming the reluctance of hidden homeless immigrants (Ellard-Gray *et al.*, 2015)

Additionally, I acknowledged the challenges in scheduling meetings or maintaining communication with transient and resource-limited populations like homeless immigrants. By employing multiple communication channels such as phone, and email, I ensured accessibility and ongoing engagement with homeless immigrants. Further strategies to mitigate attrition and absenteeism included reminder and confirmation calls, texts, or emails, hence demonstrating a proactive approach to participant retention. Moreover, the emphasis on rapport-building with gatekeepers enabled the establishment of a connection rooted in trust, which was essential for involving hidden homeless immigrants (Ellard-Gray *et al.*, 2015). However, it's important to recognize that even with voluntary sector providers, reaching most hidden homeless immigrants remained a challenge. I acknowledge that voluntary sector providers might not have had access to every hidden homeless immigrant which reflects a potential limitation in relying solely on this strategy. However, by leveraging voluntary sector provider partnerships, various communication modes, and rapport-building techniques, I amplified participant engagement and ensured meaningful representation, contributing to a more accurate understanding of the challenges faced by this marginalized group.

3.6.2 Recruitment criterion for stakeholders

Stakeholders were recruited through contacts obtained from supervisors and personal networks, and through their organisations’ websites. Emails containing information about the study were sent to the various stakeholders and those interested in participating in the study contacted me indicating their interest through email. These stakeholders also supported the recruitment of homeless immigrants except for the health care providers, because I did not recruit service users due to ethical issues. The stakeholders shared flyers containing information about the study with the immigrant and homeless groups that they support.

Inclusion criteria

Stakeholders that were recruited for the study included voluntary sector providers (such as support staff and managers), local authority professionals, and health care professionals (nurses, general practitioners, managers, and receptionists at GP practices). These stakeholders were contacted because they act as a bridge in accessing primary care services and possess the knowledge and experiences about access to and provision of these services.

3.7 Methods of data collection

Since a qualitative study from the interpretive point of view requires rich, detailed data where participants can tell their stories and express their ideas and concerns freely and reflectively, the most appropriate type of interviews for this study were the narrative face-to-face interviews (Ramsook, 2018). Narrative interviews are in-depth interviews that place participants at the centre of the study process and privilege the meanings they assign to their own stories. They also ask the how? why? and what? questions that are common in qualitative research. Narrative interviews prioritize the participants' perspectives rather than imposing the researcher's agenda. Since these interviews can be done together with semi-structured interviews (Anderson and Kirkpatrick, 2016), this current study used semi-structured interviews as they are not only easy to manage, give participants space to speak and be heard, but also allow the researcher and participants to engage in a dialogue where initial questions are modified in the light of participants' responses (Smith, Flowers and Larkin, 2009).

An interview schedule with open-ended questions was developed to guide data collection and ensure that the collected data was related to the research questions. The schedule allowed flexibility for participants to steer the discussion without foreclosing on potentially insightful narratives. The interview schedule allowed about 6 to 10 open questions with possible prompts. The interview schedule also helped me to prepare for more reserved participants who preferred a slightly more structured approach. Interviews were conducted virtually through video or telephone calls to limit physical contact with participants due to the COVID-19 safety measures. Appointments were scheduled with participants who chose a convenient time and date for the interview. All interviews were anticipated to last between 45 and 60 minutes. At the beginning of the interview, rapport was developed to ensure that participants were comfortable and that I could gain their trust.

Procedures for data collection

The narrative interviews were conducted as described by Anderson and Kirkpatrick's (2016) study. Firstly, I explained the interview process to the participants. For example, I gained informed consent from the participants to audio-record the interview and informed them that

I was interested in hearing their stories in their own words regarding access to primary care services. Secondly, I narrated their story as I used non-verbal encouragement such as smiles, saying hhmm, and encouraging the interviewees to speak freely, without interruptions until they finished their story. Thirdly, I followed up on some issues of interest based on the interviewee's story. For example, I asked questions such as, what happened then/before/after? or can you say a bit more about..?. Finally, I concluded the interview and explained the next steps such as transcribing and asking the interviewees if they had any further input (Anderson and Kirkpatrick, 2016).

3.8 Data management and analysis

3.8.1 Reflexive thematic analysis

In my analysis, I employed reflexive thematic analysis, following the methodology outlined by Braun and Clarke (2006). This approach allowed me to identify, examine, and articulate recurring patterns or themes within the dataset, ultimately enabling a comprehensive depiction of the data and facilitating a nuanced exploration of various aspects of the research topic. As highlighted by Braun and Clarke, thematic analysis is a versatile analytical method that can be effectively applied to a wide array of research questions, including those related to individuals' experiences and understandings. It is equally adaptable for analyzing various types of data, ranging from interview transcripts to datasets of varying sizes. Moreover, thematic analysis can be approached from either a data-driven or theory-driven perspective, making it a valuable tool for summarizing key features within a substantial body of data and offering a rich description of the dataset (Clarke and Braun, 2013; Majumdar, 2019). Furthermore, this method is known for its ability to bring out both similarities and differences across the dataset, potentially yielding unexpected insights. This characteristic makes it particularly valuable for producing qualitative analyses that can inform the development of policies and interventions, as it provides a nuanced understanding of complex issues (Braun and Clarke, 2006). However, it's important to acknowledge that thematic analysis has its limitations. As Braun and Clarke, (2006) point out, it may lack interpretative power beyond mere description if not employed within an established theoretical framework that can support and contextualize the analytical claims being made. In light of this, I chose to utilize the Levesque framework to guide the data analysis in this study, providing a theoretical foundation to anchor the analysis.

I adopted a hybrid approach, incorporating elements of both inductive and deductive methods, recognizing the argument by Braun and Clarke (2022) that a purely inductive thematic analysis is practically unfeasible. My inductive coding predominantly followed a data-driven approach, allowing the participants' experiences and perspectives to emerge naturally from the data. For this aspect of the analysis, I revisited the data, identifying themes related to the provision and accessibility of primary care services, all the while refraining from imposing pre-existing themes identified in prior research on the topic. This approach enabled a comprehensive exploration of the entire dataset. In contrast, the deductive approach involved integrating the data-driven codes into the Levesque framework of healthcare access. Additionally, I applied an intersectionality lens during the interpretation stage to underscore the significance of the patterns and themes that emerged (Braun and Clarke, 2006).

3.8.2 Step-by-step guide to reflexive thematic analysis

In my reflexive thematic analysis, I followed a structured process consisting of six iterative phases, as outlined by Braun and Clarke (2021). These phases encompassed the following steps: becoming familiar with the data, coding, generating initial themes, reviewing and refining these themes, further honing and defining them, and finally, the process of writing up the findings. For the fieldwork component of my study, I conducted interviews with a diverse group of participants, including stakeholders and individuals experiencing homelessness. Due to the substantial size of my dataset, which included a total of 60 participants, I undertook phases one through five separately for each group—stakeholders and homeless individuals. This approach allowed me to thoroughly analyze each dataset, ensuring that I extracted a comprehensive understanding of the entire dataset. In the concluding phase, which involved writing up and producing the research report, I strategically selected relevant data excerpts from both datasets. This synthesis of data from both stakeholder and homeless participant perspectives contributed to a comprehensive and nuanced analysis of the research findings.

Table 3 Phases of thematic analysis

Phase	Description of the process
1. Familiarization	Transcribing data, re-reading data, noting down initial ideas
2. Coding	Coding interesting features of the data across the data set, collating data relevant to each code
3. Generating initial themes	Collating codes into potential themes, gathering data relevant to potential themes
4. Reviewing and developing themes	Checking if themes work about the coded extracts (level 1) and the entire data set (level 2), generating a thematic map of the analysis
5. Refining, defining, and naming themes	Ongoing analysis to refine the specifics of each theme, and incorporate the identified themes into the Levesque framework
6. Writing up	Selection of compelling extract examples, the final analysis of selected extracts, relating of the analysis to the research question and literature, producing a scholarly report of the analysis

Phase 1: familiarization

The initial phase of the thematic analysis involved several key steps, including data transcription, revisiting the data, and recording initial thoughts and ideas. Given that my data primarily consisted of verbal content obtained from interviews, I transcribed it both manually and digitally using transcription software like Microsoft Teams. Manual transcription served as an essential means of immersing myself in the data. Braun and Clarke emphasize that there are no strict rules for creating transcripts, but they do advocate for a meticulous and comprehensive approach. Their suggestion is to produce a transcript that faithfully captures all verbal and non-verbal expressions, maintaining the integrity and original nature of the content. Consequently, I followed their recommendation by conducting a verbatim account of all verbal and non-verbal elements in the data (Braun and Clarke, 2006). The process of data immersion, as emphasized by Braun and Clarke, involves thoroughly engaging with the data to gain a deep and wide understanding of its content. In my analysis, data immersion consisted of repeatedly reading through the data actively, with a focus on identifying meanings and patterns. I ensured that I read the entire dataset at least once before commencing the coding phase, as this allowed ideas to take shape and potential patterns to emerge during this preparatory stage (Braun and Clarke, 2006).

Phase 2: coding

Phase 2 commenced following a thorough familiarization with the data and the initial generation of ideas about the data's content and intriguing aspects. As Braun and Clarke suggest, this phase centered on the creation of preliminary codes derived directly from the data, with these codes aimed at identifying elements within the data that held relevance to the provision and accessibility of primary care services. My approach to data coding was driven by the content of the data itself, a method known as data-driven coding. Additionally, since my goal was to provide a comprehensive description of the entire dataset, I opted to code the entirety of the dataset rather than singling out specific features for coding (Braun and Clarke, 2006). Braun and Clarke point out that coding can be conducted manually or facilitated by software programs. In my case, I employed Nvivo 12 software for the coding process. While many of my codes were primarily semantic and descriptive, some possessed interpretative elements that proved pertinent in addressing my research inquiries (Braun and Clarke, 2012). The coding process involved segments of varying sizes, both large and small, with certain segments left uncoded altogether. I diligently coded each data transcript in its entirety before moving on to the next. This approach allowed me to capture anything potentially relevant to my research questions as they surfaced during the analysis, recognizing that the significance of certain elements might become apparent later in the process (Braun and Clarke, 2012). Furthermore, individual data extracts were coded into as many different themes as they corresponded with, meaning that an extract could be uncoded or coded once or multiple times, depending on its relevance (Braun and Clarke, 2006).

Phase 3: generating initial themes

This stage commenced once all the data had undergone coding. During this phase, the focus shifted from the specific codes to a broader level of analysis centered on identifying themes. The primary objective was to organize the various codes into potential themes and assemble all the relevant data excerpts that had been coded under these identified themes. To aid in this organizational process, I utilized mind-maps, which served as a visual tool to arrange codes into thematic groupings (Braun and Clarke, 2006). Within this phase, certain initial codes evolved into primary themes, while others took on the role of sub-themes. Some codes, however, did not neatly align with any specific category and were grouped under a broader theme referred to as "miscellaneous." At this juncture, I refrained from discarding any elements, as it was essential to scrutinize all the data excerpts to determine whether the themes held as they were or required further refinement, amalgamation, separation, or elimination (Braun and Clarke, 2006). The generated initial themes captured important data about the provision and access to primary care services and represented some level of patterned response or meaning within the data set. The resultant initial themes effectively encapsulated significant data related to the provision and accessibility of primary care services, representing discernible patterns or meaningful content within the dataset. This phase culminated in the creation of a thematic map outlining these candidate themes, alongside the collection of all relevant data excerpts associated with each theme. Subsequently, this phase set the stage for a thorough review and evaluation of the identified themes (Braun and Clarke, 2012).

Phase 4: reviewing and developing themes

This phase was initiated once I had established a set of initial themes. During this stage, I critically assessed these candidate themes, identifying those that might not truly qualify as themes. Some themes lacked sufficient data to substantiate them, while others exhibited data that was too diverse or disparate. Consequently, I embarked on a process that entailed collapsing certain themes into one another and disaggregating others into separate themes. This phase comprised two distinct levels of reviewing and refining themes. In the first level, I meticulously reviewed the coded data extracts associated with each theme. My objective was to determine whether these extracts collectively formed a coherent and meaningful pattern. If they did, I proceeded to the second level of this phase. However, if a candidate theme appeared disjointed or did not align with the data, I contemplated whether the theme itself posed issues or if certain data extracts within it simply did not belong. In such cases, I undertook the task of reworking the themes, creating new ones, finding appropriate categories for data extracts that did not fit within existing themes, or, in some instances, discarding them from the analysis. My primary aim was to ensure that my candidate themes effectively captured the nuances present in the coded data. Once I was satisfied that my candidate themes accurately represented the patterns observed in the coded data, I advanced to the second level of this phase. At this second level, I repeated a similar process, but this time, it encompassed the entire dataset. I assessed the validity of individual themes concerning the dataset as a whole, considering not only whether these themes were faithful to the data at the micro-level but also whether they authentically reflected the overarching meanings discernible in the dataset as a comprehensive entity (Braun and Clarke, 2006).

Phase 5: refining, defining, and naming themes

This phase commenced once I had established a satisfactory thematic map of my dataset. In this stage, I integrated these themes into the Levesque framework of healthcare access, as proposed by Levesque, Harris, and Russell (2013). For each theme, I conducted an in-depth analysis, delving into the narrative conveyed by each theme and how it contributed to the broader storyline I was constructing regarding my dataset—specifically, concerning the provision and accessibility of primary care services. I aimed to ensure that there was minimal redundancy or overlap between the themes. This process was instrumental in identifying the unique points of interest within each theme and elucidating the reasons for their significance, rather than merely restating the content of the data extracts (Braun and Clarke, 2006). Additionally, I scrutinized whether any of the themes contained sub-themes, as these proved valuable in providing structure to large and intricate themes. They also served to illustrate the hierarchy of meaning within the dataset. By the conclusion of this phase, I had successfully delineated the precise boundaries of my themes, distinguishing what they encompassed from what they did not. Furthermore, I crafted concise and impactful names for these themes, designed to offer readers an immediate sense of the theme's content and focus (Braun and Clarke, 2006).

Phase 6: writing up

This phase was initiated once I had fully developed and refined the themes, and it encompassed the final stages of analysis and report composition. During this phase, my objective was to craft a narrative that effectively conveyed the significance and validity of the analysis to the reader. The report included data excerpts, offering substantial evidence of the presence and prevalence of the identified themes within the dataset. To bolster the credibility of my analysis, I transitioned from a primarily descriptive and semantic level of analysis to an interpretative and latent one. This involved establishing connections between my claims and the existing body of literature and relevant theories, as recommended by Braun and Clarke (2006). At this interpretative level, I embraced the intersectionality perspective to explore how various social identities interacted and intersected, ultimately influencing the access to primary care services for homeless immigrants in the UK. Throughout all the phases of my reflexive thematic analysis, I maintained a continuous writing process. Additionally, I adhered to the practice of reporting using a first-person active tense, a methodology suggested by Braun and Clarke as the most effective way to convey qualitative research findings (Braun and Clarke, 2012).

3.9 Data Quality

It is crucial to consider trustworthiness criteria during the research planning, implementation, and documentation stages to persuade readers and examiners of the study's high quality (Ponelis, 2015). Hence, in this study, data quality was maintained by utilizing the trustworthiness criteria of credibility, transferability, dependability, and confirmability as highlighted by Sparkes and Smith (2009).

3.9.1 Credibility

To achieve credibility, an appropriate research methodology was adopted. The qualitative exploratory approach was employed to explore the factors that affect provision and access to primary care services (Chowdhury, 2015). Furthermore, the research ensured triangulation through the collection of data from various key informants such as healthcare providers, voluntary sector organisations, and local council professionals which allowed comprehensiveness and encouraged a more reflective analysis of the data (Mays and Pope, 2000; Chowdhury, 2015). Negative case analysis was also conducted where contradicting findings in the study were discussed (Mays and Pope, 2000).

3.9.2 Transferability

Transferability concerns the extent to which the study enables readers to apply its findings from the investigated scenarios to similar situations (Ponelis, 2015). To enhance the transferability of the findings, I took measures such as providing a comprehensive account of the study's background, methodology, and results. Additionally, I employed purposive sampling, as suggested by Chowdhury (2015). This method facilitated the selection of participants with rich and informative experiences, thus opening the door to the inclusion of new perspectives that held relevance to the research topic. Furthermore, by utilizing the Levesque framework of healthcare access as a guide for data analysis, I enhanced the potential for the research findings to apply to other homeless immigrants at the national level, thus bolstering their transferability (Grbich, Kitto and Chesters, 2008).

3.9.3 Dependability

Dependability hinges on the quality of both data collection and analysis, and it is demonstrated by establishing that the research methodically examined what it claimed to investigate (Ponelis, 2015). To ensure dependability, I provided an extensive account of how the data collection process unfolded, including details on participant recruitment, the interviewing process, duration of interviews, the nature of interview questions, and how the collected data was handled and analyzed (Grbich, Kitto and Chesters, 2008). To maintain a dependable research process, I maintained thorough audit trails throughout the data analysis stage. These audit trails encompassed various forms of data, such as audio files, transcripts, and field notes. They were consistently referenced and consulted during the data analysis and interpretation phases. Furthermore, I took the step of inputting all transcripts into NVivo 12 software and conducted the analysis using reflexive thematic analysis, as described by James et al. (2020). This meticulous approach was aimed at reinforcing the dependability of the research process.

3.9.4 Confirmability

To establish confirmability, several measures were taken to mitigate the impact of investigator bias. These included the acknowledgment of the study's limitations and the provision of a comprehensive methodological description that allowed for the scrutiny of the research findings' integrity (Chowdhury, 2015). Additionally, reflexivity played a vital role in this regard. I engaged in a reflective process wherein I examined how my sociocultural identity as an immigrant researcher in the UK may have influenced both the data collection and analysis processes of the study. This involved introspection on how my pre-existing assumptions, personal experiences, and beliefs may have shaped the data collected (Mays and Pope, 2000; Chowdhury, 2015). Furthermore, to ensure evaluative rigor, I placed a strong emphasis on addressing the ethical considerations inherent in research. This encompassed obtaining appropriate ethical approval from the university ethics panel, which covered key principles such as informed consent, confidentiality, beneficence, and non-maleficence (Grbich, Kitto and Chesters, 2008). These ethical safeguards were instrumental in upholding the rigor and trustworthiness of the study.

3.10 Ethical considerations

Ethical approval to conduct the study was obtained from Canterbury Christ Church University. Key aspects of research ethics such as informed consent, anonymity, confidentiality, privacy, beneficence, and non-maleficence, were ensured for this research.

3.10.1 Informed consent

I actively sought informed consent, either in written or verbal form, from all participants involved in the study. I took care to provide participants with comprehensive information about the research, including its purpose, the assurance of anonymity and confidentiality, potential risks, and possible benefits of their participation. These details were explicitly outlined in the participant information forms, which can be found in the appendices. I intended to ensure that participants were well-informed and fully understood the nature of the study, thereby empowering them to make voluntary decisions regarding their participation, including the option to withdraw from the study at any time without the need to provide a reason (Guraya, London and Guraya, 2014). Informed consent was specifically obtained for various aspects of participation, including agreeing to take part in data collection, consenting to have the interviews audio-recorded, and granting permission for verbatim extracts of their statements to be included in published reports (Smith, Flowers and Larkin, 2009). This rigorous approach was implemented to uphold ethical standards and protect the rights and autonomy of the study's participants.

3.10.2 Anonymity and confidentiality

To maintain confidentiality, I collected only data that was required for the study, and all data was kept strictly confidential and used solely for the study. Pseudonyms such as identification numbers were utilized to achieve anonymity during writing. Transcribed data was properly secured on the university personal account and protected using an encrypted format to make it impossible for others to access these files except for myself (Guraya, London and Guraya, 2014).

3.10.3 Privacy

I ensured that participants' rights regarding the level of information they chose to share during the interviews were upheld, emphasizing their willingness to share rather than any form of coercion (Guraya, London and Guraya, 2014).). It is important to note that participants possess a right to privacy. However, Greaney et al. (2012) suggest that this right may not be absolute if there is a concern for the safety or well-being of the participants. In cases where sensitive information, such as instances of abuse, was disclosed during the interviews, I held both a moral and legal obligation to report such information to my supervisor. It's worth noting, though, that no instances of sensitive information disclosure occurred during the data collection process. This approach was adopted to ensure the ethical conduct of the study while respecting the boundaries of participant privacy.

3.10.4 Beneficence and non-maleficence

As outlined in the Belmont report, which is referenced in Greaney et al. (2012), the principle of beneficence places the responsibility on researchers to safeguard the well-being of participants, while the principle of non-maleficence obliges researchers to prevent harm to participants. Beneficence necessitates that researchers strive to maximize potential research benefits while minimizing any potential harm. In line with these principles, a comprehensive risk-benefit assessment was conducted and submitted to the university ethics panel as part of the ethical approval process. It's important to note that while the research did not foresee any physical harm befalling participants (Häyry, 1998), I was nonetheless committed to closely monitoring the impact of the interviews on participants. Given my ethical obligations to the participants, if any individuals were to experience significant distress during the interviews, I would have promptly suspended the interview process. This decision would have been rooted in my primary responsibility, which was to ensure the well-being and welfare of the participants, in line with the principles outlined by Greaney et al. (2012). Furthermore, for the homeless immigrants who expressed interest, I provided them with links to organizations that offer support specifically tailored to homeless individuals and immigrants. This additional support measure was implemented to further promote the welfare and safety of the participants involved in the study.

3.10.5 Justice

While the principle of distributive justice highlights the importance of not excluding minority vulnerable groups, such as those who do not speak English fluently, from research, practical challenges emerged in attempting to include these individuals in the study. The complexity arose from the diverse range of ethnicities among potential participants and the anticipated difficulties in securing interpreters. Consequently, this research opted to exclude non-English-speaking individuals from participation (Greaney *et al.*, 2012).

3.10.6 Financial incentives

In this study, I utilised £20 vouchers as a gesture of gratitude for the time contributed by homeless immigrants as research participants. The implementation of financial incentives in the study might have raised certain ethical considerations. Firstly, offering financial incentives, such as £20 vouchers, to homeless immigrants could raise concerns regarding coercion, undue influence, exploitation, and biased enrollment of research participants. Given that homeless individuals belong to a potentially disadvantaged group, they might be more susceptible to feeling compelled to participate in the study due to their need for financial incentives, even if they are initially unwilling to do so (Reid *et al.*, 2021). Consistent with existing literature, I used financial incentives as a fair inducement for participation and as a way to acknowledge the time and effort of homeless immigrants (Roa and Biller-Andorno, 2022). As discussed earlier, since all other ethical criteria were met, the incentives provided to homeless immigrants were considered benign, as highlighted by other researchers (Grant and Sugarman, 2004).

Another ethical concern revolved around fair compensation when offering financial incentives to vulnerable populations (Surmiak, 2020). Determining an appropriate incentive amount proved challenging, as it required striking a balance between providing fair compensation for participants' time and effort and avoiding undue inducement. Although lower amounts of money were generally considered a safer option than higher ones, offering too little might contradict the principle of fair return for research participation, particularly when informants require financial support (Surmiak, 2020). Therefore, a significant concern in this regard was deciding the appropriate level of amount needed to avoid undue pressure on research participants while still serving as a fair and adequate incentive for their participation (Surmiak, 2020). To address this issue, consultations were conducted with my supervisor and the Graduate College team to determine fair compensation. The use of £20 vouchers was ultimately approved by the University ethics review panel as appropriate compensation for homeless immigrants.

Furthermore, since homeless immigrants belong to a vulnerable population, special care was taken to ensure their protection and well-being throughout the study. A thorough health and safety risk assessment was carried out, carefully considering the potential risks associated with their participation. This assessment was submitted to and approved by the University ethics panel. Additionally, informed consent was diligently obtained from all participants, providing clear explanations about the study's purpose, the voluntary nature of participation, potential risks, and the use of financial incentives. Participants were fully informed of their right to withdraw from the study at any point before data analysis without facing any penalties.

PHASE TWO: TWO-ROUND DELPHI SURVEY

3.11 Introduction

Since my research followed a sequential exploratory mixed methods approach, I previously emphasized the qualitative phase in the preceding section. Now, in this segment, I delve into the quantitative phase, encompassing two rounds of online Delphi surveys. This stage succeeded the qualitative phase, with insights gleaned from the initial phase guiding the development of the Delphi surveys for this subsequent phase. Access to PCS is a fundamental aspect of healthcare and an essential component of promoting population health and wellbeing. However, for marginalized and vulnerable populations, such as homeless immigrants, barriers to accessing healthcare can be particularly pronounced, exacerbating health disparities and increasing social inequalities (Hookey, 2012). To understand the challenges faced by homeless immigrants in accessing PCS, phase 1 of my study involved data collection and analysis through semi-structured interviews with both stakeholders and homeless immigrants. These interviews identified the barriers to healthcare access and potential solutions. Thematic analysis of the interview data revealed 58 distinct strategies that were categorized into 14 main themes, providing a comprehensive understanding of the multifaceted issues surrounding healthcare access for this vulnerable population.

The provision of healthcare services to homeless immigrants is characterized by a patchwork of resources and programs offered by various stakeholders, including healthcare providers, voluntary sector organizations, and local councils. Findings from the semi-structured interviews revealed that collaboration and coordination among stakeholders are vital for ensuring the effective delivery of PCS. Innovative approaches, such as drop-ins, mobile clinics, outreach teams, and culturally competent healthcare providers, can play a significant role in enhancing access to PCS for homeless immigrants. Additionally, ensuring the availability of interpreters and cultural mediators can facilitate effective communication and patient-provider relationships. Other strategies included raising awareness of immigrants regarding the UK healthcare system, increasing opportunities for asylum seekers to engage in employment, and ensuring that GP staff respect, create trust, and treat everybody equally without prejudice regardless of their immigration status or homelessness, among others. While these findings from Phase 1 were valuable, I recognized the need to prioritize and build a consensus around the most effective strategies.

A follow-up survey was deemed necessary to obtain input from both homeless immigrants and stakeholders to identify the most prioritized strategies. However, due to digital exclusion, only stakeholders could be included in the survey. These stakeholders were experts in the field of migrant health and social issues and played a crucial role as gatekeepers to PCS. In this context, the Delphi approach was adopted as a suitable technique to reach a consensus among stakeholders. The Delphi method is widely recognized for its ability to synthesize expert opinions and prioritize strategies by iteratively collecting and analyzing feedback systematically and anonymously (Barrios et al., 2021). By leveraging the expertise and diverse perspectives of stakeholders, the study aimed to identify the most effective strategies for improving access to PCS for homeless immigrants. The findings from this study can inform evidence-based policies and coordinated service delivery, ultimately promoting health equity and social inclusion for homeless immigrants in the region (Hookey, 2012). Policy-makers and service providers should take note of these findings to work collaboratively towards addressing the healthcare access challenges faced by homeless immigrants in Southeast England.

3.12 Aim

The specific objective of this follow-up survey was to identify the top ten most prioritized strategies for improving access to primary care services for homeless immigrants.

3.13 Methods

3.13.1 Study design, site, and participants

Twenty-two stakeholders from the initial semi-structured interviews were approached in writing via email and invited to participate in the Delphi survey. Participants were ensured anonymity for their opinions. All the participants were required to have working experience in migrant health or social issues and be actively involved in service provision at the time this study was being conducted. The stakeholders who were healthcare providers, voluntary sector providers, and local council professionals were purposely contacted by various organisations in Kent and London to ensure that different perspectives were represented (Thomas, Jolly and Goodson, 2019).

3.13.2 Study tool development

Initially, semi-structured interviews were conducted between November 2021 and May 2022 with homeless immigrants and stakeholders to identify the factors that impact access to PCS for homeless immigrants. A list of suggestions/actions to improve access to PCS for homeless immigrants was identified through thematic analysis of the data from the semi-structured interviews. This list was used to inform the development of the Delphi survey. The Delphi survey tool was vetted by a panel of experienced researchers and service providers involved in immigrant health to ascertain its content and face validity. The tool was pretested among two stakeholders who were not to take part in the final survey. The Delphi method is widely recommended as a means for collecting and synthesizing expert opinion on a given issue in the area of their expertise (Devillé *et al.*, 2011; Barrios *et al.*, 2021).

3.13.3 Data collection

The Delphi survey for this study was carried out in two separate rounds, utilizing the Jisc online survey platform (www.jisc.ac.uk) spanning from December 2022 to April 2023.

In the initial round of the Delphi survey, the primary objective was to establish consensus among stakeholders regarding the relative significance of strategies aimed at enhancing access to Primary Care Services (PCS) for homeless immigrants. Invitations, including comprehensive study details and a direct link to the online questionnaire, were dispatched via email to 22 identified stakeholders, with a request for their participation in the first round of the Delphi Survey. This initial round featured a total of 58 items categorized into 14 distinct groups (refer to Appendix 15 for details). Participants were tasked with assigning relative importance rankings to each of the 58 items, employing a 5-point Likert scale (ranging from 1= Not important at all to 5= Very important). Furthermore, after each of the 14 categories, participants had the opportunity to provide additional comments or reflections, should they find them pertinent. On average, respondents took approximately 20-30 minutes to complete the first-round Delphi survey. Data collection for the first round spanned from December 2022 to January 2023. To encourage participation, reminders were sent to non-respondents at intervals of two weeks, four weeks, and six weeks.

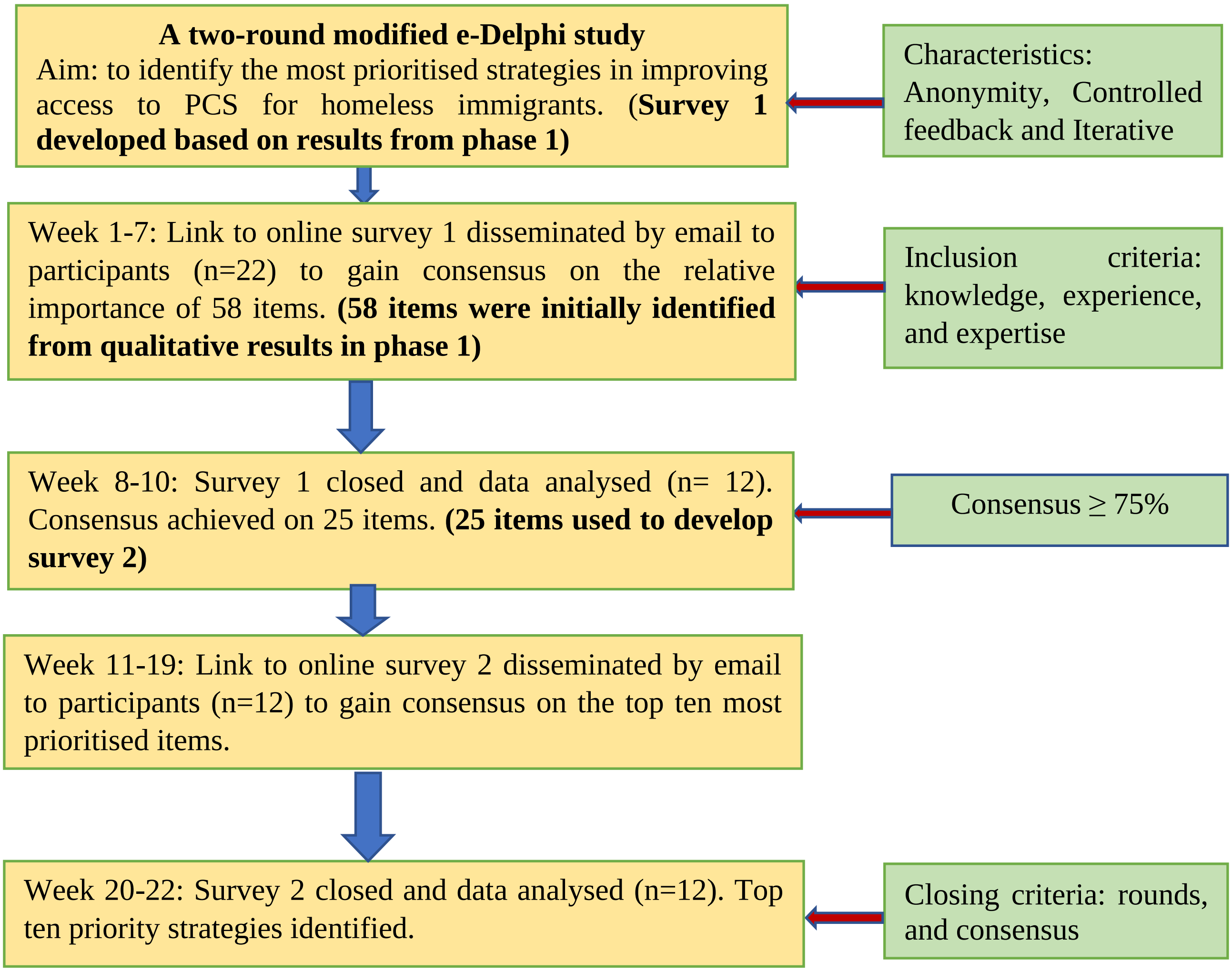
The second round of the Delphi survey occurred between February and April 2023. Eligibility for participation in this stage was contingent upon completion of the first round. Participants were once again invited like the initial round. However, this time, the second round featured a more condensed set of items, which had been preselected based on participants' rankings of their importance in the first round, as elaborated in the analysis section. The primary objective in this second round was to identify the ten most crucial and prioritized items or suggestions for enhancing access to PCS. As with the first round, non-respondents received reminders after two weeks, four weeks, and six weeks. On average, participants spent approximately 10-15 minutes completing the second-round Delphi survey.

3.13.4 Data processing and analysis

To summarize participants' demographic characteristics and the outcomes from both rounds of the Delphi survey, I employed descriptive statistics, encompassing percentages and means, alongside their corresponding standard deviations.

In the initial round of the Delphi survey, items that garnered rankings of "important" or "very important" from 75% or more of the respondents were deemed to have achieved a consensus. This 75% consensus threshold aligns with the approach utilized in other Delphi studies involving healthcare professionals, as evidenced by Orsini et al. (2023). Items that failed to attain consensus were excluded from consideration in the second round. Additionally, we calculated the mean Likert score for the items that achieved consensus and retained those with a mean score of 4.5 or higher for inclusion in the second round of the Delphi survey. The utilization of a cut-off point based on mean/median scores of 4.5 on a 5-point Likert scale finds precedent in previous health-related research studies, as exemplified by Hobbelen et al. (2006).

In the final round (second round), we computed the mean scores and their standard deviation and selected 10 items that had the highest mean scores. These 10 items were ultimately considered as the top priority strategies identified by stakeholders for improving access to PCS for homeless immigrants. All the data analysis was conducted in the STATA-15 software package. A flow diagram of the methods is shown in Figure 6 (Currie et al., 2022).



A two-round modified e-Delphi study
Aim: to identify the most prioritised strategies in improving access to PCS for homeless immigrants. (**Survey 1 developed based on results from phase 1)**

Characteristics: Anonymity, Controlled feedback and Iterative

Week 1-7: Link to online survey 1 disseminated by email to participants (n=22) to gain consensus on the relative importance of 58 items. **(58 items were initially identified from qualitative results in phase 1)**

Inclusion criteria: knowledge, experience, and expertise

Week 8-10: Survey 1 closed and data analysed (n= 12). Consensus achieved on 25 items. **(25 items used to develop survey 2)**

Consensus ≥ 75%

Week 11-19: Link to online survey 2 disseminated by email to participants (n=12) to gain consensus on the top ten most prioritised items.

Week 20-22: Survey 2 closed and data analysed (n=12). Top ten priority strategies identified.

Closing criteria: rounds, and consensus

Figure 6: Flow diagram of the Delphi process

3.14 Ethical considerations

Before participating in the Delphi survey, I secured written informed consent from all the individuals involved in the study. To safeguard confidentiality and anonymity, I employed study-specific codes instead of personal identifying information. Furthermore, it is worth noting that this research received approval from the ethics review board at Canterbury Christ Church University.

3.15 Overall summary of the methodology chapter

This chapter highlighted the methodological framework for my sequential exploratory mixed methods study. It discussed the research design, paradigms, ontological and epistemological stances, and specific methods used, including sampling, participant recruitment, data collection, and analysis. In Phase 1, I laid the foundation for a qualitative exploratory study on access to PCS for homeless immigrants, employing the Levesque framework. Purposeful and convenience sampling, along with snowball sampling, were used, and recruitment occurred in four phases. Narrative face-to-face interviews were chosen for data collection, and reflexive thematic analysis was employed for data analysis.

In Phase 2 of the methodological chapter, I aimed to identify the most prioritized strategies for improving access to PCS for homeless immigrants in Southeast England. Building on the findings from Phase 1, which identified a list of 58 distinct strategies across 14 main themes, I recognized the need to pinpoint the most effective and impactful approaches. To achieve this, I conducted a two-round Delphi survey involving 22 stakeholders with expertise in migrant health and social issues. The Delphi method, known for its ability to synthesize expert opinions and prioritize strategies through systematic and anonymous feedback collection, was the ideal approach for this task. This phase represented a crucial step toward evidence-based policymaking and coordinated service delivery. Stakeholders' expertise and consensus-building played a vital role in addressing the complex challenges faced by homeless immigrants in accessing healthcare in Southeast England. The findings from this phase could be instrumental in shaping future actions and initiatives aimed at promoting the well-being of this vulnerable population.

Chapter Four: Findings

4.1 Introduction

Within this chapter, I present the findings of both the qualitative phase one and the quantitative phase two, involving two rounds of Delphi surveys. This chapter unfolds with a discussion of the qualitative findings, followed by an exploration of the results derived from the two rounds of the Delphi survey.

PHASE ONE: QUALITATIVE FINDINGS

4.2 Layout of the results

Chapters four and five provide an in-depth exploration of the outcomes of this qualitative study. Phase 1 delves into the factors influencing access to PCS, drawing upon the framework developed by Levesque et al. (2013). In contrast, phase 2 utilizes the Delphi approach to examine the priority strategies identified for enhancing access to PCS among homeless immigrants in the UK.

4.3 The study participants

4.3.1 Homeless immigrants

In total, I conducted interviews with 30 homeless immigrants, encompassing a diverse group. While they shared the common experiences of being immigrants and experiencing homelessness in the UK, they exhibited variations across several dimensions, including age, gender, country of origin, ethnicity, and length of stay in the UK, as outlined in Table 4. For instance, the homeless immigrants' average age was 40 years, spanning from 22 to 64 years, with an average duration of residence in the UK at the time of the interview being 10.3 years, ranging from 6 months to 21 years. Among the participants, the largest group consisted of asylum seekers (n = 14, 45%), followed by refugees (n = 9, 30%). The remaining participants included individuals whose asylum claims had been rejected (n = 2, 7%), those with indefinite leave (n = 2, 7%), 1 overstay, 1 dependent spouse, and 1 student. The majority of participants in this study were female (n = 20, 67%). Their countries of origin encompassed a wide range, including Algeria, China, Eritrea, Ethiopia, Ghana, Iraq, Kenya, Malaysia, Nigeria, Pakistan, Palestine, Sierra Leone, Syria, Trinidad and Tobago, and Uganda, with the majority hailing from African backgrounds. The participants reported various forms of homelessness, including rooflessness (such as rough sleeping on streets and in buses), houselessness (residing in hostels, shelters, and churches), living in insecure housing (often involving threats of domestic violence or staying with family and friends), and living in inadequate housing (marked by severe overcrowding, unhygienic conditions, lack of windows, and infestations of bedbugs and cockroaches). This diversity among participants contributed significantly to the wide range of perspectives on access to primary care services, enhancing the depth and richness of the study's findings and offering a nuanced understanding of the experiences of homeless immigrants and stakeholders. While some participants readily shared their thoughts without much prompting, others primarily focused on describing their current situations and did not emphasize access to primary care services during the interviews.

Table 4 Demographic information about homeless immigrants

Participants	Gender	Age	Country of origin	Immigration status at the time of the interview	Form of homelessness reported by participants during their stay in the UK	Ethnicity	Length of stay in the UK (years)
Participant 1	Male	53	Trinidad and Tobago	Asylum seeker	Rough sleeping, living in hostels, staying with friends	Caribbean	7.5
Participant 2	Male	28	Trinidad and Tobago	Asylum seeker	Rough sleeping, staying with friends, staying in a hotel, living in unfit housing	Caribbean	1.25
Participant 3	Female	41	Algeria	Asylum seeker	Living in insecure housing threatened by domestic violence, staying with family, living in inadequate housing with extreme overcrowding	Arab	5
Participant 4	Female	39	Iraq	Asylum seeker	Living in hostels, staying in a friend's shop, living in inadequate housing that is dirty and overcrowded	Arab	5
Participant 5	Female	55	Pakistan	Asylum seeker	Rough sleeping, staying with a friend, sleeping in a night shelter	Asian	16
Participant 6	Male	44	Kenya	Asylum seeker	Homeless	African	10
Participant 7	Female	40	Kenya	Asylum seeker	Staying with friends, Sleeping on the streets, staying in buses	African	7
Participant 8	Female	38	Nigeria	Asylum seeker	Staying with friends, staying in temporary accommodation	African	5
Participant 9	Male	47	Malaysia	Asylum seeker	Sleeping in parks, staying in inadequate	Asian	19

					accommodation that is dirty without windows		
Participant 10	Female	28	Nigeria	Asylum seeker	Staying with the employer, sleeping on night buses, staying in a ‘safe house’, staying in inadequate accommodation that is overcrowded and dirty	African	10
Participant 11	Female	32	Nigeria	Asylum seeker	Staying in temporary accommodation, staying in hotels, staying in inadequate accommodation that is damp	African	-
Participant 12	Female	36	Nigeria	Asylum seeker	Staying in temporary accommodation, staying in inadequate accommodation that is overcrowded	African	6
Participant 13	Male	35	Ghana	Asylum seeker	Staying with a friend	African	7
Participant 14	Male	56	Sierra Leone	Failed asylum seeker	Staying with family and friends, in shelters, staying in inadequate housing that is dirty and overcrowded	African	11
Participant 15	Male	47	Sierra Leone	Failed asylum seeker	Staying in Home Office accommodation, sleeping on night buses, sleeping in winter night shelters, sleeping in churches	African	19
Participant 16	Male	22	Eritrea	UASC (Young person)	Staying in hostel	African	7
Participant 17	Female	59	Palestine	Indefinite leave	Staying with family and friends, living in inadequate housing in unfit housing	Arab	20
Participant 18	Female	64	Uganda	Indefinite leave	Staying with friends, staying in inadequate accommodation that is overcrowded, staying	African	21

					in temporary accommodation		
Participant 19	Female	28	Syria	Dependent spouse visa	Staying in inadequate housing that is overcrowded	Arab	0.5
Participant 20	Male	51	Uganda	Refugee status for 5 years	Staying with friends	African	20
Participant 21	Female	48	Nigeria	Refugee status for 2.5 years	Staying in temporary accommodation, staying in inadequate accommodation that is overcrowded and dirty	African	12
Participant 22	Female	38	Ethiopia	Refugee	Staying in temporary accommodation	African	15
Participant 23	Female	29	Nigeria	Refugee	Staying in emergency accommodation, staying in inadequate accommodation that is overcrowded and dirty.	African	5
Participant 24	Female	31	Nigeria	Refugee	Staying with friends, living in inadequate accommodation that is too small and dirty	African	16
Participant 25	Female	29	Nigeria	Refugee	Staying in a shelter, staying in inadequate accommodation that is overcrowded and dirty	African	8
Participant 26	Female	45	Nigeria	Refugee	Staying in unsuitable accommodation that is overcrowded and dirty, staying in temporary accommodation	African	11
Participant 27	Female	38	Nigeria	Refugee	Staying with friends, sleeping on night buses, living in temporary accommodation that is damp and dirty	African	8
Participant 28	Female	32	Nigeria	Refugee	Staying on the streets, sleeping in homeless shelters, staying in inadequate accommodation that is overcrowded, staying	African	12

					in unfit accommodation that floods, and has cockroaches		
Participant 29	Female	24	Ghana	Student visa	Living in inadequate housing characterized by overcrowding and noise pollution	African	4
Participant 30	Male	49	China	Overstay	Living on the streets, staying in winter night shelter, staying in hostels	Asian	20
	Male- 10			**30**		**Female - 20**	

4.3.2 Stakeholder groups

In total, I conducted interviews with 30 stakeholders. The stakeholders comprised 16 voluntary sector providers, such as the managers, project workers, mentoring coordinators, youth ambassadors, and a counsellor; 3 local council professionals that included a senior social worker, public health specialist, and a rough sleeping manager; and 11 health practitioners such as the practice manager, nurse and general practitioners, mental health specialist, social prescriber and specialist caseworker. The majority of the stakeholders were females as shown in **Table 5** below. The variety of experts allowed for the diversity of insight into individual statements and opinions about homeless immigrants' access to primary care services. During my interviews with professional stakeholders, I posed similar inquiries as those presented during the interviews with homeless immigrants. This approach was employed to determine the degree of agreement or divergence in viewpoints. While many of these discussions revolved around topics like access, service utilization, or delivery, equally pertinent were dialogues concerning tactics for enhancing access to primary care services. Among the professional participants, there was a diversity of interests, with some concentrating on the health of immigrants and homeless individuals, while others operated in various domains that encompassed substantial populations of immigrants and homeless individuals.

Table 5: Demographic information about stakeholder participants

Stakeholders	N(30)	(%)	Female	Male
Voluntary sector providers	**16**	**53**	**12**	**4**
Mentoring coordinators	3		2	1
Project workers	6		5	1
Youth ambassadors	2		1	1
Counsellor	1		1	-
Managers	4		3	1
Local council professionals	**3**	**10**	**2**	**1**
Social worker	1		1	-
Public health specialist	1		-	1
Rough sleeping manager	1		1	-
Healthcare providers	**11**	**37**	**7**	**4**
Practice manager	1		-	1
Nurse practitioners	4		3	1
General practitioners	3		2	1
Mental health specialist	1		1	-
Social prescriber	1		-	1
Specialist caseworker	1		1	-

4.4 Summary of the results

4.4.1 Differing perspectives among homeless immigrants

Homeless immigrants exhibited a degree of consensus regarding the factors influencing access to PCS, as detailed in the subsequent sections. However, it is important to acknowledge that within this population, there were also contrasting perspectives on certain factors. These divergent views can be attributed to the wide range of backgrounds and experiences among homeless immigrants. Among the contributing factors to these dissimilarities are the level of awareness about their entitlements, the role of social networks in facilitating access, and the nature of interactions with healthcare providers. The recognition of these disparities assumes paramount importance for healthcare providers and policymakers alike. It underscores the necessity of formulating tailored and targeted strategies to address the specific hurdles faced by this vulnerable demographic. By taking into account these individual variations, healthcare services can be better designed to cater to the diverse needs of homeless immigrants, ensuring more equitable access to PCS and improving overall healthcare outcomes for this underserved population.

Awareness about rights to access GP services

One notable difference among the views of homeless immigrants lies in their level of awareness regarding their rights to access GP services regardless of their immigration status. Some immigrants reported being unaware of their rights, especially those who were new to the country. This lack of awareness resulted in difficulties in accessing PCS as they were unsure about their entitlements. On the other hand, some homeless immigrants displayed a high level of awareness and confidently asserted their right to register with a GP even without documentation. This awareness facilitated their access to primary care services. This discrepancy in awareness suggests that there might be a need for more effective information dissemination and education programs targeting immigrants, particularly those who are newly arrived. By providing clear and comprehensive information about their entitlements and rights to healthcare services, the access to and utilization of PCS for homeless immigrants could be significantly improved.

Role of social networks in facilitating access

Another significant difference lies in the role of social networks in facilitating access to GP services. For some homeless immigrants, social networks such as social workers and charities helped them overcome barriers to registration. These organizations played a crucial role in providing medical consultation and guiding homeless immigrants through the registration process. Their involvement and assistance were crucial in ensuring that homeless immigrants gained access to the PCS they required. In contrast, there were instances where some homeless immigrants encountered reluctance from their social networks, including family and friends, to assist them in the registration process. This reluctance was primarily driven by fears related to the homeless immigrants' immigration status. Family and friends were concerned that providing their home address for registration could lead to legal repercussions, and they might be questioned or penalized for housing irregular immigrants. Consequently, this lack of support pushed some homeless immigrants towards self-medication, relying on over-the-counter painkillers such as paracetamol to alleviate their health issues. Others, finding themselves without proper registration, resorted to using accident and emergency services as their only means of healthcare access. The contrasting roles of supportive and unsupportive social networks highlight the significance of collaborative efforts to enhance healthcare access for homeless immigrants. Encouraging partnerships between healthcare providers and charitable organizations can be instrumental in bridging the gap and ensuring that homeless immigrants receive the necessary support to access GP services. By working together, these entities can create comprehensive and tailored solutions that address the specific challenges faced by homeless immigrants. Additionally, raising awareness among social networks about the rights and entitlements of homeless immigrants to access healthcare can help foster a more supportive environment, enabling individuals to seek the primary care they require without fear of repercussions. These collective efforts can lead to improved healthcare outcomes and reduced disparities among homeless immigrant populations.

Homeless immigrants' interactions with healthcare providers

Homeless immigrants had mixed experiences with healthcare providers, with some reporting positive interactions and others facing negative encounters, often perceiving racial discrimination. Positive interactions were characterized by doctors who were attentive, respectful, and supportive, fostering a sense of trust and facilitating access to primary care services. These positive experiences played a crucial role in making homeless immigrants feel valued and supported in their healthcare journey. However, negative interactions were prevalent among some homeless immigrants who perceived discrimination based on their migrant status, language difficulties, or homelessness. Such negative experiences left them feeling disregarded and not taken seriously, creating significant barriers to accessing PCS. As such some homeless immigrants displayed hesitancy in engaging with healthcare providers and services. Hence, this potentially leads to self-neglect and isolation, which could have serious implications for their overall health and well-being. Recognizing the discrepancies in interactions with healthcare providers underscores the importance of cultural competency training for healthcare professionals. By enhancing awareness and sensitivity to the diverse backgrounds and experiences of homeless immigrants, healthcare providers can create a more inclusive and supportive environment for this vulnerable population. Hence, reducing health disparities and enhancing the overall well-being of this marginalized group.

4.4.2 Differing perspectives between homeless immigrants and stakeholders

While homeless immigrants and stakeholders exhibited certain common viewpoints on various aspects such as the limited familiarity with the roles of the GPs, challenges posed by language barriers, competing priorities in their lives, and insufficient provision of culturally sensitive care, among other factors, it is important to note that they also held contrasting opinions. These disparities in perspectives encompassed crucial matters such as the sharing of personal information of homeless immigrants, long waiting times for appointments, and instances of denying GP registration to those without proper documentation as discussed below.

Sharing of Immigrants' Personal Information

Some homeless immigrants expressed fear that their personal information, including immigration status and accommodation details, would be shared with the Home Office, leading to potential arrest and deportation. This fear impacted their trust in GP services and hindered them from seeking necessary PCS. This perspective arises from their experiences and observations, including instances where the Home Office requested medical histories. On the other hand, all healthcare providers interviewed denied sharing immigrants' personal information and emphasized patient confidentiality. They asserted that GP surgeries are not affiliated with immigration matters and their focus is on providing care without questioning immigration status. It is imperative to acknowledge, however, that there were instances where healthcare providers shared patient information. These situations arose under specific circumstances, such as benefits fraud, criminal investigations, or child protection purposes. This implies that despite healthcare providers' declarations of non-collaboration with the Home Office, the concerns articulated by homeless immigrants are not unfounded, but rather rooted in legitimate apprehensions.

Long Waiting Times for Appointments

Homeless immigrants expressed dissatisfaction with long waiting times for GP appointments. They felt that they had no choice but to wait, even though delays could adversely affect their health. However, some healthcare providers reported repercussions stemming from these prolonged wait times. Some immigrant clients perceived the delays as indicative of discriminatory attitudes. In response, these healthcare providers contended that the long waiting times were not an issue unique to immigrants alone but rather, to the broader patient population. This assertion is not without merit, as healthcare systems in various contexts have been grappling with the challenge of managing appointment queues to accommodate the needs of a diverse array of patients. This broader context, however, does not diminish the specific struggles faced by homeless immigrants, who often contend with additional barriers in accessing care.

Denial of GP Registration Due to Lack of Documentation

Some homeless immigrants reported facing challenges with GP registration due to a lack of documentation such as identification and proof of address. They reported feeling unfairly treated and discriminated against based on their immigration status. Refugees with biometric cards found it easier to register, whereas others faced barriers. This perspective highlighted the difficulties homeless immigrants encountered when trying to access PCS. However, there were mixed reactions from stakeholders on this issue. Some healthcare providers staunchly asserted that they never turned away immigrants without documentation seeking registration. Instead, they devised an alternative approach, utilizing the address of the GP surgery as a designated home address to facilitate the registration of homeless immigrants. This practice, they contend, circumvented the potential documentation hurdles while ensuring that necessary healthcare services were made available. On the other hand, a different faction of healthcare providers presented an alternative perspective, revealing a contrasting facet of the registration process. According to their accounts, the insistence on documentation during registration has become deeply ingrained among the receptionists at GP practices. Despite receiving directives to accommodate individuals lacking proof of identification or address, these receptionists reportedly continued to solicit such documentation, sometimes in a manner that is perceived as unwelcoming. Consequently, instances have been documented where immigrants, lacking the stipulated documentation, have been denied registration due to this prevailing practice. A layer of intricacy is further introduced when considering immigrants grappling with language barriers. For these individuals, the process becomes even more daunting as they struggle to comprehend the specific requirements articulated by receptionists. Hence, amplifying their struggles in navigating the registration process successfully and accessing PCS. These factors are discussed in detail in the subsequent sections.

Table 6: Themes according to the Levesque framework

Dimensions of the Levesque framework	**Supply-side factors of health systems**	**Corresponding abilities**	**Demand-side factors of homeless immigrants**
Approachability of PCS	Availability of outreach activities, drop-in health clinics, and safe surgeries ➨ Availability of outreach activities ➨ Availability of safe surgeries ➨ Availability of drop-in health clinics ➨ Impact of outreach activities and drop-in health clinics ➨ Reluctance to engage in outreach activities and drop-in health clinics	Ability to perceive the need for PCS	Low health literacy ➨ Misinformation: Disclosing personal information to the Home Office; Fear of being detained & deported ➨ Lack of awareness of their health status & needs ➨ Inadequate understanding of the UK healthcare system: Unfamiliarity with the GP roles; Language difficulties that make it difficult to navigate the healthcare system; Insufficient information about the UK healthcare system Homeless immigrants’ mistrust & unmet & diverging expectations ➨ Homeless immigrants’ mistrust ➨ Unmet & diverging expectations: Expectation of a directive healthcare approach from the GP; Expectation that the GP surgery is a one-stop shop; Expectations influenced by previous experiences from home countries Availability of supportive social networks in navigating the healthcare system

Acceptability of PCS	Inadequate culturally sensitive care ➨ Inadequate culturally sensitive mental health services ➨ Language difficulties that hinder access to culturally sensitive healthcare ➨ Inadequate cultural awareness among some healthcare providers Preferred gender of healthcare providers	The ability of homeless immigrants to seek PCS	Partner violence ➨ Restricted access to GP services for homeless immigrant women by their partners ➨ Stigmatization of divorced women ➨ Unfamiliarity with the UK systems Alternative healthcare-seeking strategies ➨ Self-medication ➨ Ordering medicine from home countries ➨ Utilisation of accident & emergency services Homeless immigrants' competing priorities Health-related beliefs ➨ Cultural and social stigma towards mental illness ➨ Cultural beliefs towards treatment methods ➨ Cultural differences

PCS Availability	Appointments with HCPs ➨ Inadequate number of appointments with HCPs: Insufficient GP appointments; Insufficient dentist appointments ➨ Limited consultation times ➨ Long waiting times for appointments ➨ Availability of supportive social ➨ Availability of appointments with HCPs: Availability of walk-in appointments at the GP; GP registration ➨ Availability of supportive social networks ➨ Lack of documentation for GP registration ➨ Awareness about rights to access GP services Geographical location of GP surgeries Inadequate number of HCPs	The ability to reach PCS	Digital exclusion ➨ Inadequate digital devices, phone credit, & data ➨ Low digital literacy ➨ Availability of supportive social networks
Financial support & basic needs from the government and organisations	Availability of asylum support from the UK government ➨ Financial support & accommodation ➨ Free prescriptions Lack of recourse to public funds ➨ Ineligibility for housing & financial support ➨ Ineligibility for free prescriptions ➨ Ineligibility for free secondary care ➨ Impact on immigrants’ health Availability of financial support from charities	Ability to pay out of pocket for health-related costs	Insufficient personal financial resources Limited knowledge about benefits and financial support Financial support from charities
Appropriateness	Coordination and continuity of care	Homeless	Communication difficulties

of PCS	➨ Availability of referral services ➨ Lost to follow-up ➨ Coordination among GP practices	immigrants' ability to engage in PCS	➨ Language barrier ➨ Difficulties in navigating the healthcare system ➨ Perceived discrimination and negative attitudes towards immigrants: Perceived discrimination; Negative attitudes towards immigrants ➨ Impact of language barrier on the provision of mental health services
	Interpretation services ➨ Availability of interpretation services ➨ Difficulties with three-way conversations ➨ Low availability of interpretation services ➨ Limited time for consultations ➨ Long waiting times for an interpreter ➨ Lack of awareness about the availability of interpretation services ➨ Availability of supportive social networks: Relying on charities; Relying on family and friends		Homeless immigrants' Interaction with HCPs ➨ Positive interactions with healthcare providers ➨ Negative interactions with healthcare professionals: Perception of racial discrimination; Denied GP registration due to immigration status; Discrimination due to homelessness ➨ Hesitant to engage with healthcare providers and services

Table 7: Themes beyond the Levesque framework

Themes	***Corresponding factors***
Impact of COVID-19 pandemic on access to PCS	Inadequate face-to-face appointments Long waiting times for treatment Impact on health Closure of community day centres
Homeless immigrants’ accommodation	Unstable accommodation ➨ Impact on homeless immigrants’ livelihoods ➨ Impact on GP registration ➨ Impact on appointments with HCPs ➨ Impact on continuity of healthcare Inadequate and unfit accommodation ➨ Availability of supportive social networks ➨ Impact on health

Theme 1: Approachability of primary care services and the ability to perceive the need for care

4.5 Introduction

The following section elaborates on the perspectives of homeless immigrants and stakeholders regarding the accessibility of PCS for homeless immigrants in South East England. This discussion encompasses the concept of "approachability" concerning both the availability of primary care services (a supply-side aspect of the healthcare system) and the ability of homeless immigrants to recognize the necessity for healthcare (a demand-side aspect among homeless immigrants) (Levesque et al., 2013).

Approachability pertains to whether homeless immigrants with unmet health needs are aware of the existence of primary care services, believe they can access them, and perceive that these services can positively impact their health (Levesque et al., 2013). Stakeholders, including healthcare providers, voluntary sector providers, and local authority professionals, play a role in making homeless immigrants more or less aware of primary care services. According to the findings, factors such as the availability of outreach programs, drop-in health clinics, and secure medical facilities were reported to influence homeless immigrants' access to PCS.

In addition to the concept of approachability, the ability of homeless immigrants to recognize their need for healthcare is crucial. This ability is influenced by factors such as low health literacy, mistrust among homeless immigrants, unmet and varying expectations, and the presence of supportive social networks. These factors will be discussed in greater detail in the following section.

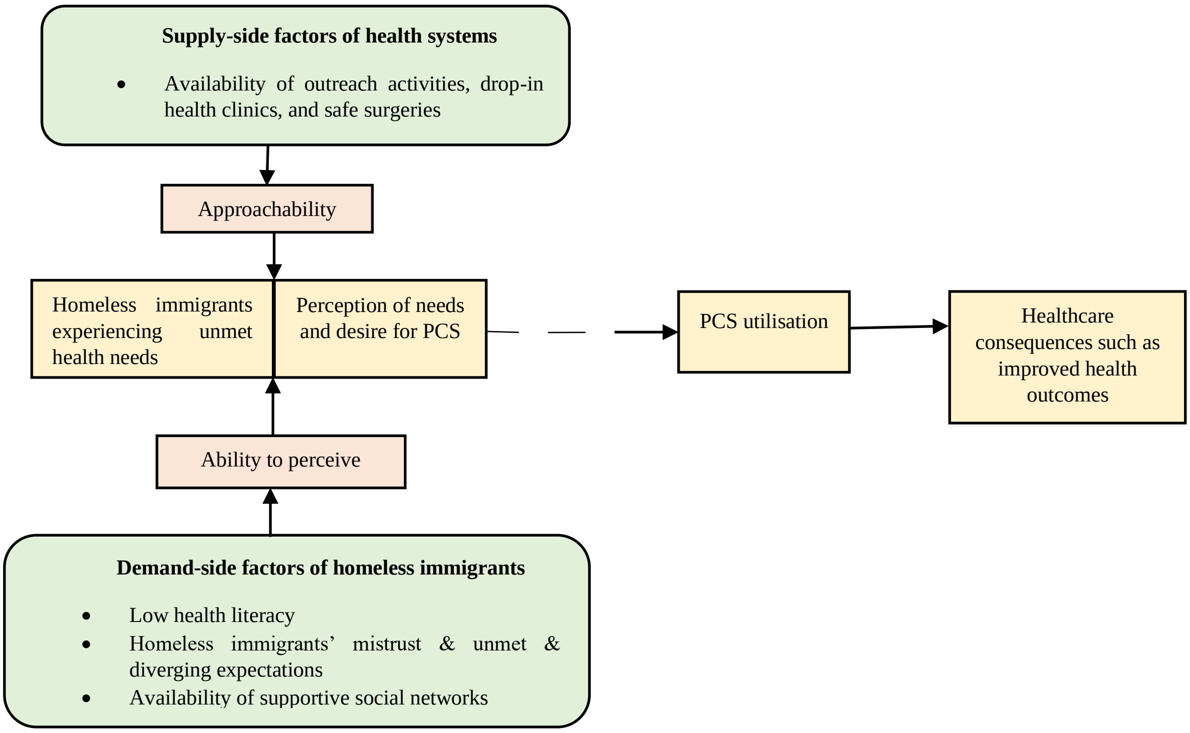


Figure 7 Theme 1: Approachability of PCS (supply side) and the ability to perceive the need for care (Demand side)

4.6 Low health literacy

From the present study, the majority of the immigrant and stakeholder respondents reported that low health literacy was a deterrent to accessing primary care services. Low health literacy entailed an inadequate understanding of the UK healthcare system stemming from unfamiliarity with the roles of the general practitioners (GP), insufficient information on how the healthcare system is organized, and a language barrier that makes it difficult to navigate the healthcare system. Low health literacy also entailed misinformation whereby many of the participants believed that they would be detained or deported if they accessed GP services without legal status in the UK. There were also views that GP practitioners shared homeless immigrants' data such as their immigration status and address with the Home Office, which could lead to their arrest and deportation. Taken together, the factors were perceived to impact homeless immigrants' access to primary care services, especially GP services. Additionally, insufficient knowledge about homeless immigrants' health and the available services was perceived to cause some homeless immigrants to overlook important health issues, thereby leading to delays or complete disregard for seeking medical care. These aspects of low health literacy are explained in more detail in the proceeding section.

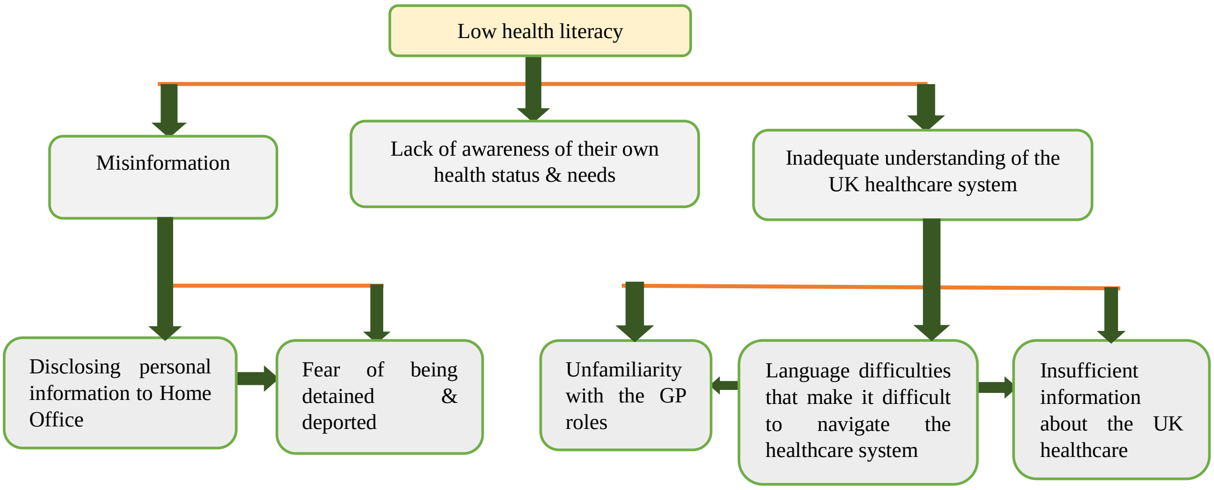


Figure 8 Sub-theme: Low health literacy

4.6.1 Inadequate understanding of the UK healthcare system

Unfamiliarity with the roles of the general practitioners

Being unfamiliar with the GP roles was common among recent immigrants. Owing to this unfamiliarity, many homeless immigrants found it difficult to express and discuss their medical needs, including the need for counselling or psychiatric therapy. Some individuals mistakenly believed that GPs were only supposed to attend to their physical health concerns and not their mental health needs. As a result of these misconceptions, homeless immigrants exhibited hesitancy in discussing their mental health concerns with their GPs. Instead, they opted to seek appropriate mental health services from charitable organizations due to their uncertainty surrounding the roles of GPs. The confusion about which healthcare services to use might lead to delays in accessing safe and appropriate care, potentially exacerbating health conditions and increasing the demand for more costly emergency care (Tomkow et al., 2020).

> *"I've never mentioned it to my GP because I don't know what the GPs are capable of. Like, can you call your GP to recommend you to a counsellor? I don't fully know the role of the GPs here, I'm not aware"* (Male asylum seeker 8).

The unfamiliarity with the roles of general practitioners among homeless immigrants was supported by insights from other healthcare providers. These providers reported that some immigrants misunderstood the role of NHS gatekeepers and bypassed GPs to directly access emergency services before being directed back to GPs. While this may be perceived as a faster route to care, it can result in longer waiting times and may not be the most appropriate level of care for their condition. This highlighted the complexity of navigating the UK healthcare system, particularly for immigrants from countries with different healthcare systems, hence contributing to unmet expectations among homeless immigrants. Thus, efforts should be made to enhance awareness and navigation of the UK healthcare system, particularly for immigrants from diverse backgrounds. By bridging these gaps in knowledge and support, the unmet expectations of homeless immigrants can be mitigated, leading to improved healthcare experiences and outcomes.

> *"I think a lot of them, their first contact is with emergency services and then they get sent back to us. But again, it's about knowing what the services are, why can't it be done from A&E, and why does it have to be through a GP? And to be honest, I think, a lot of people ... don't understand what different services are for, and there are so many different services. So, it is quite a difficult thing to navigate it all"* (Female general practitioner).

Language barriers that make it difficult to navigate the healthcare system

In addition to the challenge of being a newcomer, difficulties in reading and writing or in understanding English worsened some homeless immigrants' access to primary care services. The inability to speak English was perceived as a paralyzing factor, hindering homeless immigrants with communication difficulties from obtaining essential healthcare services and support. Some stakeholders validated these concerns and highlighted how language barriers impeded some immigrants from effectively navigating the healthcare system. The subsequent sections will further explore and discuss the impact of language barriers on accessing PCS.

> *"So how do you know where to go to for help?... You know, if you don't speak English, I think you are kind of paralysed"* (Male asylum seeker 20).

Insufficient information about the UK healthcare system

An additional barrier to accessing primary care services for homeless immigrants, including English-speaking individuals, was the lack of sufficient information about the UK healthcare system. Some homeless immigrants expressed that information regarding these services was not adequately advertised or signposted, making it challenging to access GP services. Consequently, this insufficient information resulted in a lack of knowledge among homeless immigrants about scheduling appointments or contacting their general practitioners, leading to impaired access and potential treatment delays.

> "*If it's your first time here, even I find it as an English-speaking person, I mean, sometimes you don't know what you don't know. Because it's not advertised or signpost or anything*" (Male asylum seeker 20).

> *"The GP was another difficult one. I didn't know the system. I didn't know how to make an appointment like I didn't understand that you have to book"* (Female, Indefinite leave 2).

The information gap hindering immigrants, particularly new arrivals, from accessing healthcare, social care, and entitled benefits was confirmed by some stakeholders. However, they highlighted their collaborative efforts with other organizations to provide information and support to new immigrants residing in temporary accommodations, such as those operated by the Home Office. Although this collaborative approach indicates a commitment to improving access to healthcare services for this vulnerable population, further details regarding the specific strategies and outcomes of these collaborative efforts would provide a more comprehensive analysis of their effectiveness.

> "*If they're brand new into the country and come into one of your accommodations or hotels …. they are very unaware of the UK system and how it works in terms of health, social care, and benefits ... it's about them navigating what they're entitled to and knowing that information, who's the best people to give that information to them. So hopefully through our team, we can do that for them and in conjunction with other organizations who are very supportive*" (Homeless and inclusion project lead).

4.6.2 Misinformation

Misinformation was identified by most of the study participants as one of the key hindrances to access to primary care services by homeless immigrants, especially GP services. The majority of the immigrant participants believed that they would be detained and deported if they accessed GP services without legal status in the UK. There was also a perception among immigrants that GP practices shared their personal information, such as their immigration status and addresses which could lead to the immigrants' arrest and deportation. Although a majority of the stakeholders strongly argued against sharing patients' personal information with third parties, they reported that this was done for other reasons such as to confirm a patient's health diagnosis to claim benefits but not to report their lack of legal status in the country. These aspects of misinformation are explained in more detail in the proceeding section.

Fear of being detained and deported

The majority of homeless immigrants reported that the fear of being detained and deported acted as a deterrent to accessing primary care services, particularly GP services. This fear was prevalent among irregular immigrants without legal status, who avoided utilizing primary care services due to the risk of detention and arrest. Many immigrants expressed feeling threatened and hesitant to seek medical assistance because visiting a GP might involve sharing their information with the Home Office, potentially leading to detention. This unfounded fear of deportation prevented irregular homeless immigrants from registering for primary care services, even when they had serious illnesses, resulting in delays and deterioration of chronic conditions. Some healthcare providers confirmed how the fear of detention and deportation contributed to immigrants' overall apprehension about engaging with primary care services. Immigrants were wary of GP registration due to the intrusive personal questions on registration forms, such as their arrival date in the UK and country of origin, which could potentially expose their uncertain immigration status and invite further scrutiny.

> *"I think there's fear of the health services in general … There's an element of it that if they register with a doctor's surgery, that officially means that they might be put on the system and they might be asked why they're here. I know on registration forms, the GP surgeries ask them for arrival dates in the UK, when they first got here, and where did they come from? where were they born? And that might be a bit scary for some people"* (Male social prescriber).

The fear of being detained and deported not only deterred immigrants from seeking primary care services but also extended to other essential services such as education and housing. Concerns were raised by stakeholders about how irregular immigrants were afraid to send their children to school due to the fear of their undocumented status being reported. Similarly, some homeless immigrant respondents expressed fear of staying in temporary accommodation provided by the Home Office due to the perceived ease of deportation if their asylum claims were denied and their home address was known. This indicates that the consequences are far-reaching, with a

> potential population living without healthcare, education, and suitable shelter, while being vulnerable to exploitation in the informal economy.

> *"The range of issues go wider than health really ... as an undocumented migrant, they're frightened to send the child to school because the school might report the undocumented status of the child ... you know how many people are living without not just healthcare, but education and appropriate shelter? being exploited by the cash-in-hand economy? So, socially, it's probably a much bigger problem than we know"* (Specialist caseworker).

Certain stakeholders perceived the arrest and deportation of irregular immigrants as dehumanizing. According to a refugee project officer, deporting individuals to countries they were forced to flee not only demonstrated a lack of compassion but also disregarded human rights, especially considering the UK's early commitment as a signatory to the 1951 Convention on Refugees' Rights. The officer emphasized the dangers of questioning individuals' right to seek asylum, highlighting that anyone could be at risk and in need of seeking refuge under certain circumstances.

> "*One can say it's dehumanising. There is no compassion, and there is a lack of understanding that seeking asylum is a human right. And what happens now to people who are forced to leave their countries? Questioning the right to seek asylum is very dangerous. Because all of us as humans are at risk and ... the UK has been one of the first signatories of the 1951 Convention on the Rights of Refugees*" (Refugee project officer).

Disclosing/sharing immigrants' personal information

The majority of homeless immigrants held the belief that their personal information, including their immigration status and accommodation details, would be shared with the Home Office by GP practices. This fear stemmed from the concern that the Home Office would track them down, question their eligibility, and potentially arrest and deport those without legal status in the country. This perception created a belief that accessing GP services was a trap for irregular immigrants, leading to arrest and detention. Consequently, convincing other immigrants in need of healthcare to utilize GP services became challenging. This lack of trust further impeded immigrants from seeking necessary healthcare services.

> *"All those places are scary, to be honest, I just feel like they will pick my information and give it to the Home Office. Maybe they are working together, then they will pass you over, and then their staff will start calling and looking for me. I don't give a shit! That is why I never actually went to the GP"* (Female refugee 28).

Contradictions on information sharing

Contrary to the fears expressed by homeless immigrants, all the healthcare providers interviewed adamantly stated that they had never shared immigrants' personal information with the Home Office to facilitate arrests and deportations. An assistant practice manager consistently refuted the notion of encountering any instances where an irregular immigrant was arrested while accessing the GP surgery. He emphasized that the GP surgery was not affiliated with the Home Office or the Border Force and had no involvement in political or immigration matters. The assistant practice manager made it clear that the GP practice did not discourage any immigrants from seeking healthcare services and welcomed every patient who sought assistance, regardless of their immigration status.

> *"I haven`t come across the fact that someone is arrested while he's accessing the service. We're not the Home Office. We're not the Border Force. We are a GP surgery and if someone presents to the GP surgery, we have to take them on. So, the political side of it is not on our doorstep*" (Assistant practice manager).

Concerns about patient confidentiality and the impact on immigrants' access to healthcare were raised by various stakeholders. They emphasized their professional duty to maintain anonymity and confidentiality when providing care, regardless of their patients' immigration status or how they entered the country. One social prescriber suggested that the perception of GP surgeries sharing personal information with the Home Office may have arisen from informal conversations among immigrants and witnessing the deportation of their social networks. They emphasized that their teams' focus is on providing care without questioning how or why individuals arrived in the country. On the other hand, a specialist caseworker noted that in some immigrants' countries of origin, patient confidentiality practices may not be as advanced as in the UK. This experience from their home countries may deter immigrants from accessing formal services due to fears of data being shared with the police or the UK Border Force.

> *"I think it's sort of colloquial evidence between people and maybe seeing friends and family or neighbours being deported. At least in the team that I work with, at least to me, I don't care how you got here, why you're here, or anything. Our job is to provide care and not ask questions about it. There's meant to be anonymity and confidentiality for people, there shouldn't be a worry like that, there must be something going on in the community or people that have come out there before"* (Social prescriber).

> *"So the idea of confidentiality, I mean if you come from a country where perhaps that's not quite as sophisticated as it is in this country, the idea that your data might be shared with the police or the UK Border Agency I think has been a big deterrent for many undocumented migrants not to go anywhere near formal services*" (Specialist caseworker).

While stakeholders claimed to maintain confidentiality and not share immigrants' personal information with the Home Office, there were instances where such information was indeed shared. The assistant practice manager explained that they would disclose patient health diagnoses to third parties such as the benefits system in cases of suspected fraud, for child protection purposes, for criminal investigations, or when an individual was attending prison.

> *"The only time we've been contacted is through the benefits system who wanted to confirm someone`s health diagnosis, for fraudulent purposes, so someone's fraudulently getting maternity pay or benefits through their insurance claims. Sometimes for child protection ... if someone's attending prison, then the Home Office might come asking for their health records in that instance"* (Assistant practice manager).

Although healthcare providers denied sharing data with the Home Office, the concerns expressed by homeless immigrants were not unfounded. In support of this perspective, some homeless immigrants recounted instances where the Home Office requested their medical histories from their GPs. Until recently, the Home Office utilized information from primary care records to locate immigrants, resulting in many potential immigrant patients feeling too afraid to register with a GP (Papageorgiou et al., 2020). While this policy has changed, some immigrants still harbor fears of accessing primary care services due to the apprehension of being traced and targeted.

4.6.3 Lack of awareness of their health status and needs

The lack of awareness regarding their own health status and needs was found to be a barrier to homeless immigrants' access to GP services. Some homeless immigrants often remained unaware of their health conditions until family members or friends pointed them out and supported them in seeking medical consultations. Stakeholders also highlighted situations where immigrants requested specific medications without adequate knowledge or exhibited a limited understanding of certain health conditions. Insufficient knowledge about health conditions among immigrants decreased their likelihood of accessing GP services. This lack of awareness, encompassing both mental health and related healthcare services, contributed to a community that is unfamiliar with the healthcare system, leading to significant delays in receiving necessary healthcare.

> *"They all want Diazepam, believe it or not. They don't want anything else other than Diazepam so we have to educate them to say that it's not the best medication for depression*" (Advanced nurse practitioner).

4.7 Homeless immigrants' mistrust and unmet and diverging expectations

Most of the immigrant and stakeholder respondents reported that immigrants' mistrust and unmet expectations were hindrances to seeking primary care services, especially GP services. The mistrust was reported particularly among new immigrants who were unfamiliar with the healthcare system and afraid of sharing their personal information for fear of being arrested and deported. However, stakeholders suggested that it takes time to allow both immigrants and healthcare providers to familiarize themselves with each other, build up trust, and for immigrants to open up to them. Additionally, some immigrants also had unmet and diverging expectations which entailed the expectation of a directive healthcare approach from GPs, the expectation that the GP surgery is a one-stop shop, and expectations influenced by previous experiences in their home countries.

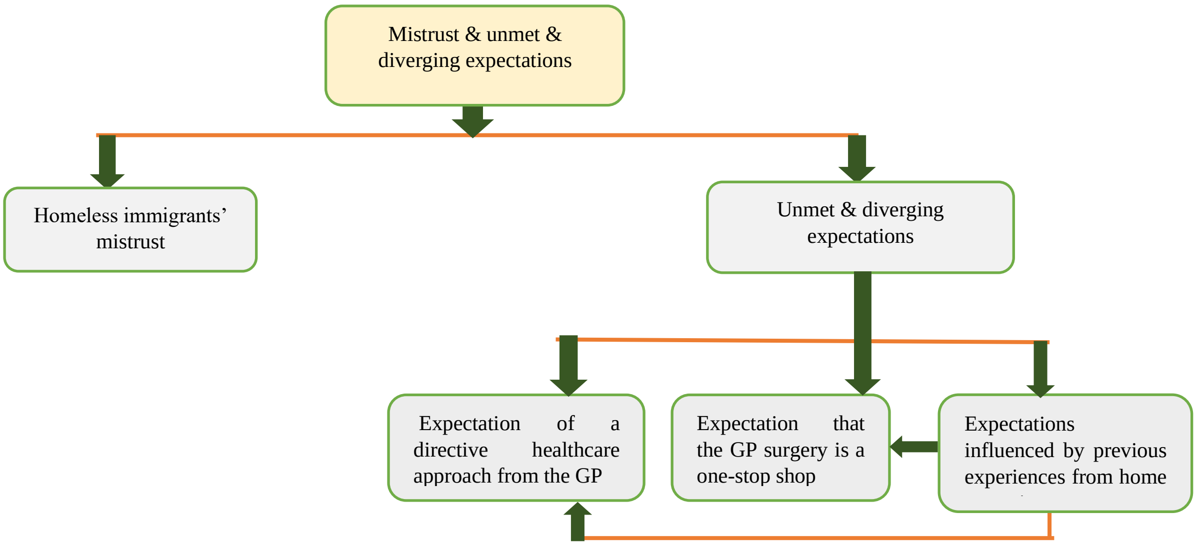


Figure 9 Sub-theme: Homeless immigrants' mistrust & unmet & diverging expectations

4.7.1 Homeless immigrants' mistrust

The reluctance of homeless immigrants to seek primary care services, specifically from GP staff, was influenced by their mistrust of healthcare providers. Many irregular immigrants were unsure of whom to trust and feared being reported to the Home Office if they approached the GP surgery or confided in anyone beyond their immediate social circles. However, healthcare providers claim in Section 4.4.2 that they do not report irregular immigrants, suggesting that the fear of being reported is based on misinformation. Some stakeholders highlighted the need to establish trust with immigrants. As such, some healthcare providers took proactive measures, such as regularly visiting homeless immigrants' temporary accommodations, to familiarize themselves with the community. This was to allow homeless immigrants sufficient time to build trust with healthcare providers, as trust may not be established in a single appointment but rather over a while.

> *"Those initial times I was afraid to go to the GP, to even talk to anybody. I was not talking to any person because I didn't trust anybody, I didn't know whom to trust or tell my story, they might report me. So, I would just talk to myself and the people that I live with who know me, I was afraid to speak to anybody about what I was going through, I didn't know the system, and they might report me so I was just afraid to speak to anybody*" (Female asylum seeker 14).

> *"We have to also allow for people to build up trust with us as well. So sometimes that can take quite a while. So sometimes we won't always get all of the information we need in that initial appointment, but we hope over time, particularly with people who we see*

> *regularly, that they will build and will be able to share that information* (Nurse practitioner).

There were also views among some homeless immigrants that some health practitioners did not trust them. For example, one asylum seeker felt that doctors at the GP surgery did not trust her. Being a stateless and homeless person in the UK, she felt GPs were rude and did not trust her as they thought she was lying about her health condition. She described having back pain and many times when she spoke to her GP, she was ignored. This made her feel like he did not trust her because of her housing and immigration status.

> *"When it comes to the doctors at the GP, am a stateless person, am homeless they don't trust me. They are a bit rude like we are lying about something. They don't trust us. For example, like my back, I have very big pain. Many times, I've asked my GP but he simply ignored me,*" (Female asylum seeker 5).

4.7.2 Unmet and diverging expectations

Unmet and diverging expectations reported by some immigrants were commonly shaped by rumours, anecdotes, and previous experiences from friends. Some homeless immigrants expected a directive healthcare approach from their GPs, and others expected GP surgery to be a one-stop for all healthcare needs. These expectations were influenced by previous experiences in immigrants' home countries. When these expectations were not met, some immigrants were deterred from seeking future GP services as they thought visiting the GP surgery was a time waste as they felt that they did not get the attention and help they deserved. These aspects of unmet and diverging expectations are explained in more detail in the proceeding section.

Expectation of a directive healthcare approach from GPs

Some homeless immigrants had expectations of a directive healthcare approach from their general practitioners (GPs), rather than a non-directive approach that takes into account the patients' views. One female immigrant student shared her experience that left her feeling disappointed and unsupported because of the mismatch between her expectations and the non-directive approach taken at the GP practice. Nevertheless, it is important to recognize that a solely directive approach may neglect individual needs, perpetuate hierarchical dynamics, and pose risks for marginalized groups like homeless immigrants, who may feel blamed or distrustful of authority (Mohr et al., 2020). The preference for a directive approach among some homeless immigrants was influenced by their previous experiences in their home countries, where a medical model was employed. However, some healthcare providers reported how they utilized a non-directive approach that prioritized patient involvement in decision-making.

> *"I went when I had an allergic reaction, I was trying to figure out what I was allergic to. And they were rather asking me questions about what I had recently eaten, stuff like that ... So, I was hoping to find out from them after they did the tests, what exactly I was allergic to ... But they were asking me to tell them the solution ... For me, I've never had a great experience with them"* (Female student 11).

> *"I think they're much more used to doctors telling them what to do rather than, I mean, we've got a way of asking them what they want to do kind of way and I think they can find that very difficult, almost as if we don't know what we're doing because why is the doctor asking me what to do and it's a very different way of working. I think it's very much more a medical model where you go to the doctor if you've got a sore arm or a rash or, you know*" (General practitioner).

The expectation that the GP surgery is a one-stop shop

There was a widespread expectation among homeless immigrant respondents that GP surgeries would serve as a comprehensive one-stop shop for their healthcare needs. They anticipated that a single doctor would address multiple health conditions during a single visit. However, they often faced the reality of being asked to schedule separate appointments for each condition, which they perceived as burdensome. This could be attributed to their unfamiliarity with the UK healthcare system and the roles of GPs. The notion of a one-stop shop was supported by other stakeholders who explained that some immigrants lacked understanding regarding the specialized nature of healthcare providers. For instance, when patients presented with additional health concerns during appointments, they expected the same doctor to address them all.

> *"The problem is with the GP, you cannot tell them two diseases, you tell them one, if you have gone for your back pain, its back pain not knee, they say go and book another appointment, which is a task of work*" (Female indefinite leave 19).

> *"Another issue is lots of people also don't understand that we sort of all have different specialisms and so you may be seeing someone with TB and they'll suddenly complain of struggling with their mental health or something like that, and they don't understand*

> *that it's not a one-stop shop as well. And so in that sense, you then have to get that onward referral into the hospital"* (Specialist caseworker).

Some stakeholders discussed how the expectation of a one-stop shop may have been shaped by previous experiences of receiving assorted healthcare services while staying in Home Office accommodation. A nurse practitioner who provided comprehensive healthcare services for asylum seekers described himself as a one-stop shop for various medical needs, including screening, assessments, treatment, and referrals. However, this differed from the functioning of GP surgeries, and despite efforts to raise awareness about the NHS system, many immigrants only grasped its workings through first-hand experiences. Therefore, the expectation of a one-stop shop among immigrants previously housed in Home Office accommodation may have influenced their belief that GPs would provide all the necessary healthcare services.

> *"Here I'm the one-stop shop. I sort of screen everything, everything comes through me so I can signpost as necessary and assess and treat if needed. So, it's a kind of bubble here in a way, and the fact that it's not like how the rest of the NHS works. And we educate people about how the camp works when they arrive from a medical point of view. And we can give leaflets out about how the NHS works. And until people experience it, perhaps it doesn't go in"* (Nurse practitioner).

Expectations influenced by previous experiences from home countries

The expectations of immigrants were heavily influenced by their previous experiences with healthcare services in their home countries, as highlighted by various perspectives. Stakeholders noted how some immigrants often encountered a culture shock upon arriving in the UK, as the healthcare system differed from what they were accustomed to or expected. This divergence in expectations was evident through comparisons made between the UK system and the healthcare system known to them. Additionally, other stakeholders also explained how in certain immigrant countries, free public health services were not trusted, leading some immigrants to seek private doctors instead. In the UK, where primary care services such as GP services are provided free of charge, some immigrants anticipated a lower standard of care similar to what they had experienced in their home countries. This unfamiliarity with the UK healthcare system played a significant role in shaping their perceptions which in turn influenced their access to PCS.

> *"Some of them have experienced culture shock coming to the UK, it's a different place, certain things are different from what they are used to or what they expected*" (Public health specialist).

> *"In our countries, if we feel sick, you only go to a private GP and you get the treatment. We have this free treatment in our countries, but it is not commonly used by the people because the institutions in our countries are not trusted. And some of them think the same here when they come to the UK, they think, why should I go to the GP or why don`t I just find someone, you know that can treat me"* (Youth ambassador 1).

4.8 Availability of outreach activities, drop-in health clinics, and safe surgeries

The availability of outreach activities, drop-in health clinics, and safe surgeries increased the chances of immigrants being able to approach the services. One way of bringing the services closer to immigrants included establishing outreach clinics in communities that were far away from health facilities and closer to hard-to-find communities. These initiatives offered multiple primary care services including health checks, GP registration, COVID and flu vaccination, dental care, hepatitis screening, and sexual health. These initiatives went a long way to overcome barriers faced by immigrants in accessing GP services including the fear of visiting the GP surgery due to the misconception of getting arrested and deported. They increased the visibility of primary care services and healthcare personnel in the immigrant communities and got immigrants to open up about other challenges including their accommodation issues. Hence blurring the boundaries between health and social care. However, there was still some hesitancy to approach these initiatives for some immigrants as later discussed in detail.

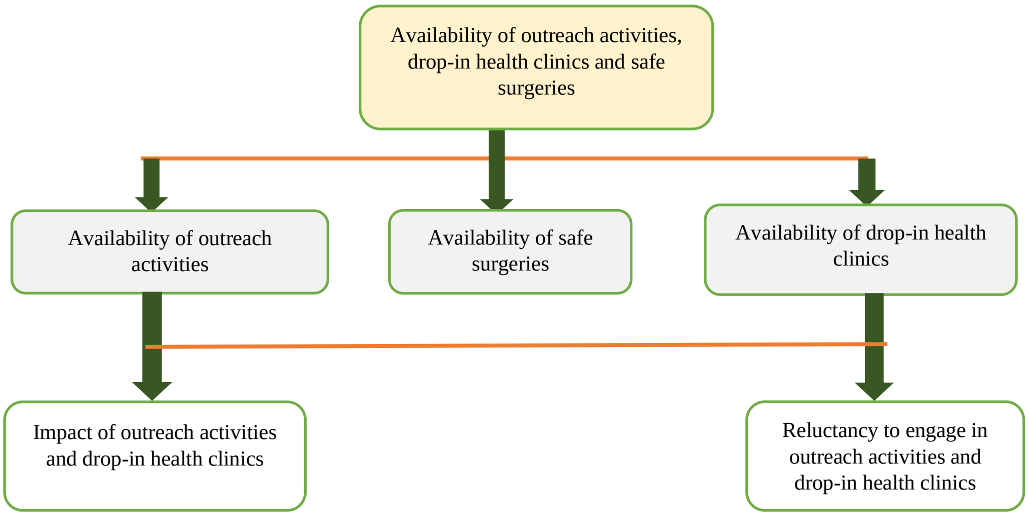


Figure 10 Sub-theme: Availability of outreach activities, drop-in health clinics, and safe surgeries

4.8.1 Availability of outreach activities

The availability of outreach activities played a crucial role in bringing healthcare services closer to immigrants and overcoming barriers to accessing primary care to some extent. These outreaches offered a range of services including COVID-19 vaccinations, screening, check-ups, and prescriptions. These initiatives were crucial in reaching immigrants who were hesitant to approach GP surgeries, including those without legal status. They increased the visibility of healthcare providers among immigrant communities, built trust between immigrants and healthcare personnel, and created a platform to understand their healthcare needs.

> *"We wanted to break down those barriers from being able to access healthcare and understand why they weren't taking up the COVID vaccine. We did a pop-up clinic during the summer … to find out if they had any concerns or if they needed any medical help … We then followed up to try and tackle this cohort and get them vaccinated"* (Social prescriber).

4.8.2 Availability of drop-in health clinics

Drop-in health clinics were established by some healthcare providers at day centres, hospitals, addiction centres, and accommodations for asylum seekers, refugees, and homeless individuals, bringing primary care services closer to vulnerable populations. These clinics also provided primary care services such as COVID vaccinations, health checks, and addressing other health concerns. Similarly, some charity organizations also operated their drop-in clinics, staffed by volunteer doctors, offering healthcare services and medication.

Some homeless immigrants living in temporary accommodations praised the accessibility and efficiency of these clinics, emphasizing their importance in attending to their healthcare needs hence improving their healthcare outcomes.

> *“There is a free clinic at these organisations where they have a nurse, or an assistant, or a doctor that comes in once a week and you can go in and speak of any medical problems you have and you will be given the medication or sent to a hospital where you can be treated. So that was lovely*” (Male asylum seeker 1).

4.8.3 Availability of Safe surgeries

The availability of safe surgeries was found to partially facilitate homeless immigrants’ access to primary care services. Safe surgeries refer to GP practices that declare themselves as accessible to everyone, removing barriers such as lack of identification, proof of address, immigration status, or language (Doctors of the World, 2021). These designated safe surgeries collaborated with outreach teams to raise awareness among immigrants about the availability of GP services and assured them that their immigration status would not hinder their access. Therefore, the existence of safe surgeries has the potential to improve homeless immigrants' access to primary care services.

> *“There are what we call safe surgeries out there where people can register. But it's just about letting them know that. So, we work very closely with the outreach team ... particularly for our asylum seekers and refugee clients, we have what's called safe surgeries, where they can go and register ... we will always work with the outreach workers because they will be aware of clients who aren't accessing day centres or a GP. So, they will be able to alert them of our service ... whereby we can hopefully engage them with their health needs”* (Female Inclusion project lead).

4.8.4 Impact of outreach activities and drop-in health clinics

Outreach activities and drop-in health clinics were implemented to serve vulnerable populations, including immigrants and the homeless, to bridge the gap between communities in need and healthcare services. These initiatives had multiple positive impacts, such as improving health outcomes, empowering individuals to take control of their well-being, promoting healthy living and active lifestyles, establishing and nurturing relationships with communities, and providing support to those affected by domestic violence and homelessness. Outreach activities involved proactive engagement with communities, addressing health concerns beforehand, and breaking cycles of isolation and disconnection.

They fostered improved relationships and reconnected individuals with mainstream care. Overall, these initiatives proved essential in bringing healthcare services closer to vulnerable groups and fostering positive change in healthcare access and community well-being.

> *"For me, the outreach is about building up a relationship, my role is to list patients back into mainstream care, although we are taking everything to them"* (Homeless health nurse).

4.8.5 Reluctancy to engage in outreach activities and drop-in health clinics.

Despite extensive efforts to bring healthcare services closer to hard-to-reach immigrant communities through outreach activities, there were challenges due to immigrants' reluctance to engage in community programs, including with COVID-19 vaccinations. Stakeholders raised concerns about the reasons behind this reluctance, questioning whether it stemmed from a lack of awareness or understanding about the importance of vaccinations. Some immigrants demonstrated hesitancy and were unwilling to participate, possibly due to fear of authority and the potential discovery of their immigration status, which could result in arrest and deportation. This fear was evident when an immigrant family mistook healthcare providers for immigration officers, highlighting how concerns about immigration enforcement might have discouraged individuals from participating in outreach programs.

> *"We've done a lot, in the recent years, with the COVID vaccinations. And again, we've seen a big hesitancy in our immigrant population in having the vaccine ... there's a lack of willingness to engage ... So, I don't know whether it's a knowledgeable thing, whether they don't know why we are doing it"* (Assistant practice manager).

4.9 Availability of supportive social networks on issues of navigating the healthcare system

Immigrants relied on various forms of support from families, friends, communities, and charities to overcome barriers to accessing primary care services. Stakeholders acknowledged the importance of assisting homeless immigrants, including raising awareness about available GP services and accompanying them to appointments. However, there were concerns that new immigrant arrivals were unaware of the support provided by charities, making it challenging for them to navigate the healthcare system independently. While some immigrants had social workers, the frequent changes in their support workers highlighted the need for more stable support systems offered by charity organizations. However, the mistrust within social networks prevented some homeless immigrants from seeking help in navigating the healthcare system, as they feared being reported for lacking legal documentation and thereby hindered from accessing GP services.

> *"It's about making them aware of these systems and how they work. And we will do everything we can to support them to go to the GP. So that might be that we may go ourselves with them*" (Inclusion project lead).

> *"Because I don't have any help, I don't know how to do it [access GP services] because I never asked the friend I was staying with because I don't know her from anywhere, so it's difficult for me to open up, you know, I don't know if she is going to do what. So, I was living with fear, my heart was full of worry and pain"* (Female asylum seeker 15).

Theme 2: Acceptability of primary care services and the homeless immigrants’ ability to seek healthcare

4.10 Introduction

The following section explains both the homeless immigrants’ and stakeholders’ perceptions about the extent to which primary care services are socially and culturally acceptable to homeless immigrants in South East England. It entails the notions of acceptability of primary care services (supply-side factors of health systems) and the ability of homeless immigrants to seek healthcare (demand-side factors of homeless immigrants).

The concept of "acceptability" delves into whether homeless immigrants can embrace healthcare services that align with their individual, social, or cultural beliefs, allowing them to access these services without experiencing feelings of insecurity or discomfort. This, in turn, ensures the provision of appropriate and equitable healthcare services. Based on the findings, it was noted that factors like the lack of culturally sensitive care and the preference for healthcare providers of a specific gender influenced homeless immigrants' access to PCS.

Complementary to the notion of acceptability of primary care services is the ability to seek healthcare. Factors such as partner violence, immigrants’ competing priorities, and their health-related norms and values were reported to impact the homeless immigrants’ ability to seek healthcare services. Immigrants who were hindered from accessing primary care services resorted to alternative healthcare-seeking strategies as discussed in detail in the proceeding section.

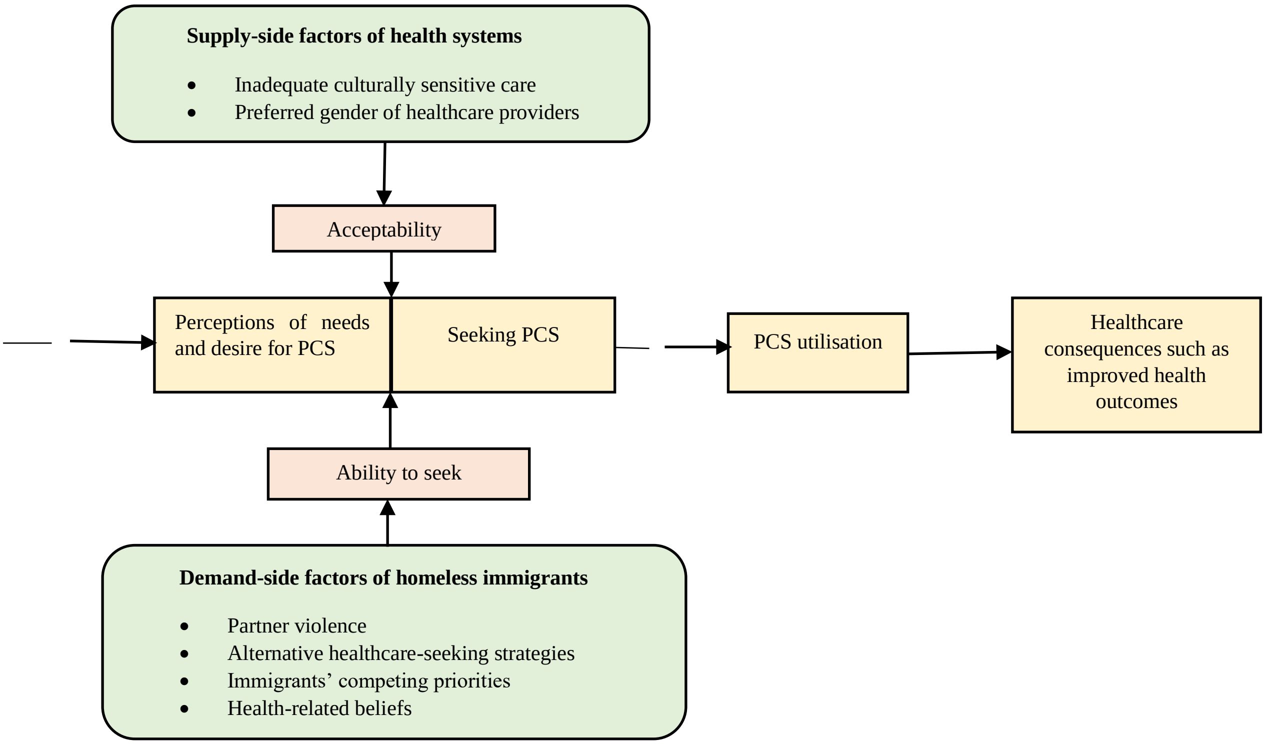


Figure 11 Theme 2: Acceptability of PCS (supply side) and the ability of homeless immigrants to seek healthcare (demand side)

4.11 Partner violence

The intersectionality framework is evident in the analysis of partner violence as a barrier to accessing primary care services for homeless immigrant women. The results demonstrate how factors such as gender, immigration status, and cultural norms intersect to create inequalities that hinder access to PCS. Some homeless immigrant women facing partner violence often experience denial of access to primary care, influenced by their partners' control and their lack of knowledge about the healthcare system. Cultural norms, where women required permission from male family members for medical services, further restricted their access. The stigmatization of divorced women and the unfamiliarity with UK systems exacerbated the challenges faced by these women. Therefore, understanding and addressing these intersecting factors was crucial in developing effective strategies and support systems to overcome the barriers faced by homeless immigrant women in accessing primary care services. These factors will be discussed in detail in the proceeding sections.

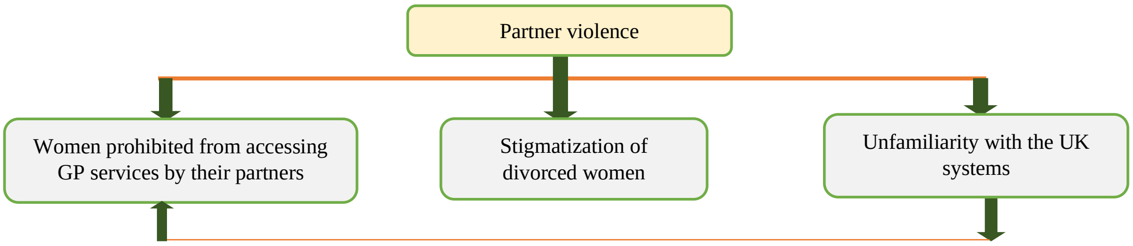


Figure 12 Sub-theme: Partner violence

4.11.1 Women prohibited from accessing GP services by their partners

Several homeless immigrant women shared their experiences of being prevented from accessing GP services by their partners. One woman, an asylum seeker, explained how her partner forbade her from leaving the house after allowing her to go out for only one month upon her arrival in the country. Instead, she was confined to domestic chores and faced food insecurity, leaving her feeling trapped and abused. Another woman, also an asylum seeker, attributed her partner's control to her unfamiliarity with the UK healthcare system. Despite her worsening condition, she was denied access to medical care and relied solely on Ibuprofen. These stories highlight the struggles faced by immigrant women who are isolated and denied essential primary care services.

> *“My ex was so rude to me, I couldn’t go out. The first month he took me out with him to see how it was outside. Then after one month, he put me at home as a maid. To clean his house and make the food he wants … I suffered a lot, sleeping without food, not going out, staying at home, waking up early”* (Female asylum seeker 3).

> *“He told me not to say that I want to go to the doctor because everything the doctor is going to give me, he will buy for me … I didn’t know anywhere … I don’t go anywhere … for almost five years, I did not go to the GP. He would go buy for me Ibuprofen. When I was sick, he would not take me to the GP … I suffered that time. I remember one time, I couldn’t talk, I couldn’t sit down, I couldn’t breathe, I think I got asthma, you know … he went and bought Ibuprofen”* (Female asylum seeker 23).

Some stakeholders highlighted how certain cultural norms hindered primary care access, particularly for women and children. These norms dictated that women and children couldn't seek medical services without the permission of their husbands or fathers. An example was given by a public health specialist who encountered a family refusing COVID tests because the father was absent, preventing healthcare professionals from conducting the tests without his consent. This practice might stem from cultures where men are seen as the sole decision-makers, thereby denying women and children their rights to health and the ability to make informed choices. Other immigrants also voiced similar concerns about this situation.

> *"Cultural norms may affect access because sometimes when the person affected with the illness is the woman or the child, in some cultures it is the man that sanctions the woman from accessing health services, so you cannot just go except when the husband says so. The child cannot just go to the health service without the father's permission. So in that way, it has to be with the permission of the father ... So that's in a way, maybe affecting access. I remember we had to do COVID tests for some family, and the father was not around, they had to wait until their father came before we conducted tests*" (Public health specialist).

4.11.2 Stigmatization of divorced women

Due to cultural norms, some homeless immigrant women face challenges such as enduring abuse to avoid the stigma of divorce. These norms dictated that divorced women were rejected and stigmatized in their cultures. One woman, prohibited from contacting her mother, was threatened with divorce by her abusive husband if she complained about the abuse. She felt compelled to accept the mistreatment to avoid the label of divorcee, knowing her family would not accept it. Additionally, some women were blamed for the abuse they endured, with cultural expectations pressuring them to stay with their abusive partners. Such harmful gendered norms and stereotypes entrenched abuse, exacerbating health and social inequities for women and children. Similarly, some stakeholders reported how reporting abuse was discouraged in some immigrant cultures, as it could bring embarrassment to the husband or the community. Language barriers further hindered reporting, with women who lacked English proficiency less likely to seek help from authorities.

> *"He stopped me from using the phone not to talk to my mother, not to complain. This is life and you have to accept it, otherwise, I will divorce you and you will go back to your uncle's. Because he knows about the mentality of my family, so every time he threatens me ... 'I will divorce you and you will go back to your family as a divorced woman, you will see how they will treat you, what they will do to you' ... And, indeed, my family doesn't accept a divorced woman. We have this mentality that the woman has to support everything, should be a maid to her husband*" (Female asylum seeker 3).

> *"You know, I think if English isn't your first language, you're struggling to talk, say for example, a lady who is being domestically abused, you know, part of her culture is to*

> *accept whatever her husband does as a newly married person. And you shouldn't cause embarrassment to either the husband or the community, so it would be frowned upon, so they're less likely to report abuse to the police"* (Focused care team lead).

4.11.3 Unfamiliarity with the UK systems

The suffering endured by some homeless immigrant women at the hands of their partners was partly due to their lack of familiarity with the systems in the UK. An asylum seeker explained that she was unaware of her rights and the available support systems, including emergency services. Furthermore, she was isolated by her abusive partner, and prohibited from making friends or leaving the house, leaving her without a support network. This level of control extended to her health, as she was not taken to the doctor when she fell ill, compounded by her unfamiliarity with accessing GP services.

> *"I suffered with him. I did not know the law, or my rights in this country because I didn't have any friends at that time. He didn't allow me to make friends. No one came to me, I couldn't go out … To be honest, from 2017 to 2018, I didn't have any idea about this country. I didn't know the number of the police, or the ambulance. I didn't know because when I got sick when I was with him, he never took me to the doctor. If I'm good, I'm good, if I'm not good, I'm at home suffering with my illness*" (Female asylum seeker 3).

Similarly, according to some stakeholders, immigrant women who experienced domestic violence often faced different forms of abuse, including physical, emotional, financial, and sexual abuse, which left them traumatized and affected their self-esteem. These women, being new to the country, were unfamiliar with the UK system, including healthcare services, which contributed to their decision to stay in abusive relationships. Accessing GP services was challenging unless they found someone to support and guide them. The lack of knowledge about their rights in the UK also made immigrant women vulnerable to abuse. Additionally, there was a gap in services as these women lacked safe spaces to discuss their experiences, and although online services were available, they were reported as being complex.

> *"We had a [mentioned nationality] woman, she had no recourse to public funds, she was heavily reliant on her partner who has work legitimately and she was a victim of domestic abuse. Because she was a vulnerable victim, she didn't know her rights in the UK*" (Male Outreach manager WK).

> *"Not knowing which authorities to go to. I do think there is a real gap in the community for people to be introduced into groups, safe for people to talk about domestic abuse, you know, it's still very hidden. But the resources online are quite complex, and so I think they've got lots of different barriers, haven't they?"* (Female Focused care team lead).

4.12 Alternative healthcare-seeking strategies

Immigrants experienced various challenges when accessing primary care services that contributed to the adoption of alternative healthcare-seeking strategies. These challenges were influenced by intersecting factors such as familiarity with the healthcare system, cultural backgrounds, and the fear of legal repercussions related to immigration status. For instance, the fear of legal repercussions discouraged some irregular immigrants from seeking formal medical assistance, leading to self-medication with over-the-counter painkillers, the use of natural remedies, and the consumption of leftover medication from social networks. Additionally, some homeless immigrants resorted to ordering medication from their home countries and utilizing accident and emergency services for healthcare needs. These findings emphasize the importance of considering multiple factors when examining healthcare-seeking behaviors among homeless immigrant populations. Further elaboration on these factors can be found in the subsequent section.

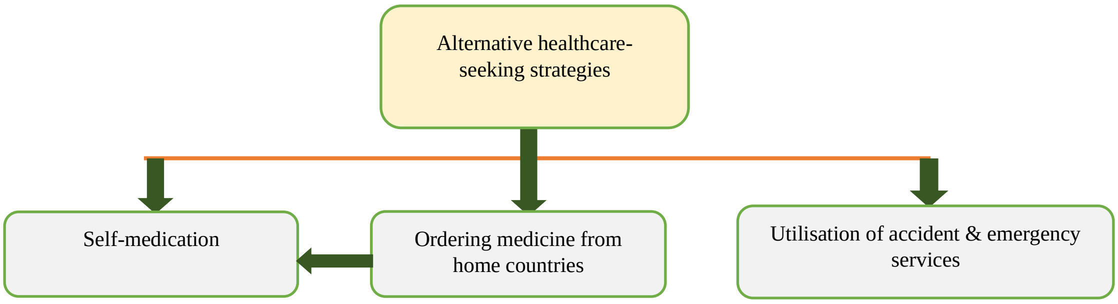


Figure 13 Sub-theme: Alternative healthcare-seeking strategies

4.12.1 Self-medication

Some homeless immigrants, although registered with a GP, chose not to use their services due to infrequent illnesses. Instead, they resorted to self-medication for common ailments like colds, coughs, and migraines. Natural remedies such as lemon, ginger, and lime were commonly used. Others purchased over-the-counter painkillers like paracetamol and ibuprofen from supermarkets. Traditional medicines, including bitter African herbs, were also employed to manage health conditions like diabetes. The lack of legal status in the country may have hindered access to GP services for irregular immigrants, leading them to rely on self-medication. This preference for alternative remedies highlights the use of herbs as treatment options.

> *"Well, I registered a long time ago but I haven't used the GP service because I hardly fall sick, and when I do have let's say, a cold or flu or some sort of migraine, I tend to use local herbs like natural substances like fruits, lemon, lime, ginger, that kind of stuff"* (Male failed asylum seeker 30).

> *"I also suffer from type II diabetes, and I've done a foot operation because of diabetes, and I'm on insulin and my sugar is not controllable even with my diet. So, it always controls when I drink a lot of bitter herbs, especially some African herbs, then it can go down*" (Male failed asylum seeker 13).

4.12.2 Ordering medicine from home countries

When homeless immigrants fell ill, instead of visiting a GP, some opted to order medication from their home countries. Antibiotics were the most commonly ordered medications, obtained through their social networks that had traveled back home. Despite being aware of the risks of self-medication with antibiotics and the development of antimicrobial resistance, one immigrant argued that this was the easiest healthcare-seeking option, particularly for those without legal status in the country. Accessing antibiotics without a prescription was easier in their home countries, and they believed these medications could treat various conditions. Fear of detention and deportation among irregular immigrants prevented them from seeking GP services and led to self-medication. Unmet expectations from GPs may have also influenced the use of alternative healthcare-seeking strategies. Additionally, some immigrants reported using leftover medications prescribed to their social networks, acknowledging the dangers but stating that it was a common practice within their community due to the need for medication and apprehensions about their immigration status.

> *"When I fell sick, I couldn't access any GP or any medication. If you want medication, you have to get it from someone else who comes from the same country, you tell them if it`s possible can you bring it for me. We have antibiotics but they affect our health since they are not good for frequent use. But you find that it's the only thing helping the people here who are not in the system because it is easily accessible and they can almost treat many infections but they increase resistance in the body that you can reach a time when some medications are not effective on you*" (Male refugee 9).

Some stakeholders supported the notion of self-medication among immigrants. According to a social prescriber, immigrants often relied on medication from their home countries, which could be purchased in various shops or markets. These immigrants had different expectations based on their experiences back home, which hindered their utilization of GP services. In certain countries, medication could be obtained directly over the counter without a prescription, unlike in the UK. Consequently, many immigrants preferred visiting these shops instead of going to a GP practice. This preference stemmed from the fear of being identified as an irregular immigrant when interacting with government systems during a medical visit, although healthcare practitioners reassured that such concerns were unfounded (see section 1.2.2).

> *"Access to healthcare services is different from what they may be used to in their country. In some countries in Europe, they'll probably pay directly for their treatment. It's different over here and they don't wanna see a doctor. If they want antibiotics or pain medication there are quite a lot of European markets or food stores ... some of these shops sell pharmaceuticals over the counter that have been brought over from different countries, and none of that is legal. I think there might be more that visit those shops to get what they need rather than come in to see us*" (Social prescriber).

4.12.3 Utilisation of accident & emergency services

Some immigrants chose to use Accident and Emergency (A&E) services instead of visiting the GP practice for medical treatment. While some health conditions require immediate attention at A&E, others that are non-urgent should be addressed at the GP practice. Some healthcare providers considered this utilization of A&E for non-emergency cases as an unintended misuse of the healthcare system. Additionally, some homeless immigrants mentioned that the complexity of their health conditions led them to seek A&E care instead of GP services, as they believed GPs were more suitable for general health concerns rather than their specific and intricate conditions.

> *"Well, the hospitals are impenetrable unless you've got an appointment. So, for people who come to the hospital, their only access point would be to come in through an accident and emergency. Unless they're acutely unwell, it amounts to an unwitting abuse of a system*" (Specialist caseworker).

> *"I can't contact the GP and generally the GP to me, is one I can contact whenever I have a health condition, not like my kind of health condition. So, the GP will even tell*

> *me, to go to my doctor, the person dealing with me generally, so they are more like general stuff but they don't specify the kind of sickness I have ... I just call 911 emergency straight on if I'm sick*" (Female refugee 21).

4.13 Competing priorities

Competing priorities were identified as a significant barrier to homeless immigrants seeking primary care services. Homeless immigrants confronted various interconnected challenges, such as fulfilling basic needs (food, housing, employment) and dealing with immigration status, which often took precedence over healthcare. The immediate need for survival underscores the complex interplay between socioeconomic factors and health access, resulting in the neglect of physical health needs in favor of immediate survival concerns. Mental health concerns were also overshadowed by immigration issues, leading to a prioritization of legal support over mental health assistance. Recognizing the significance of addressing basic needs first, some voluntary sector providers offered practical support like accommodation and allowances, understanding that such support was essential for homeless immigrants to commit to health treatment. Through the intersectionality lens, it becomes evident that homeless immigrants experienced intricate competing priorities that hindered their access to primary care services, necessitating interventions that address the intersecting challenges they encountered, encompassing both healthcare and basic needs.

> *"So their main health would be physical, you know, the normal check-ups that you'd go to a dentist, if you had a chest infection, getting it treated and not leaving it ... but people have sort of neglected their physical health when they're sleeping rough that's not their immediate concern. It's just to keep warm and get food and drinks*" (Homeless health nurse).

> *"We cannot help them unless sometimes we do offer the right support for them, so when they come they need practical support before the emotional support, someone has to have her bed or roof to sleep and then they can start thinking about what's happened to them*" (Counsellor).

4.14 Health-related beliefs

The intersectionality framework reveals that gender and cultural norms intersect to impact the access to primary care services for homeless immigrants. The cultural and social stigma surrounding mental illness hindered some homeless immigrants from seeking mental health services, particularly for men who adhered to cultural expectations of masculinity and denied their mental health issues. Additionally, some immigrant cultures did not acknowledge mental health, exacerbating hesitancy to seek assistance. Also, some cultural beliefs towards treatment methods influenced access as some homeless immigrants prioritized traditional treatments over modern medical procedures, leading to mistrust in general practitioners and refusal of medical advice. Additionally, cultural differences, such as wearing hijabs, created challenges for some homeless immigrants, as they fear being stereotyped when seeking healthcare services. To address these barriers, healthcare systems must recognize and address the intersection of gender and cultural norms through tailored interventions and culturally sensitive approaches that consider the diverse identities and contexts of homeless immigrants. These factors are discussed in detail in the proceeding section.

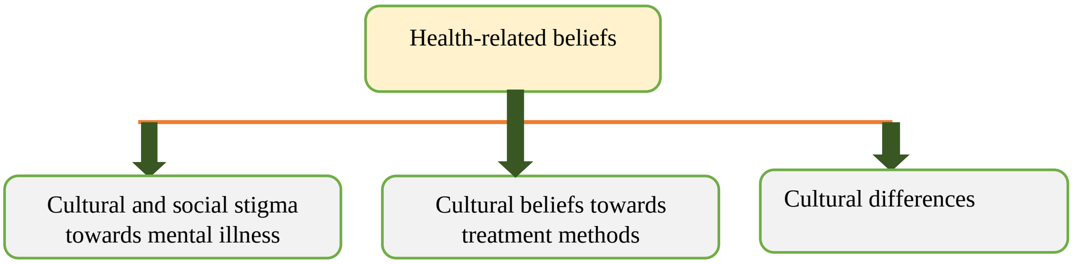


Figure 14 Sub-theme: Health-related beliefs

4.14.1 Cultural and social stigma towards mental illness

Cultural and social stigma surrounding mental illness was identified as a significant barrier to seeking mental health services among immigrants. Mental illness was often viewed as a sign of weakness, being crazy, or being locked up in a mental institution, leading to denial and reluctance to seek help. Immigrant men, in particular, were resistant to acknowledging their mental health issues due to cultural expectations of masculinity. Furthermore, in certain immigrant cultures, mental health was not acknowledged, further hindering help-seeking behavior. In addition to the limited access to mental health services in their home countries, the perception of being locked up in an institution also deterred some immigrants from seeking mental health services.

> *"I work with [mentions ethnicity], especially the men they are very resistant to tell you they have mental problems. They have depression but men cannot have mental problems, it's a cultural thing. They have pride, 'I am a man, I have to be strong even if I live on the street"* (Project worker).

> *"There is a couple of two or three people I am working with from [mentions region], who have been very reluctant to engage because culturally, if you have a mental health issue, you're crazy and you're mad and the stigma attached to that is huge"* (Complex caseworker).

4.14.2 Cultural beliefs towards treatment methods

Some immigrants were hindered from seeking primary care services due to cultural beliefs and mistrust of modern medical procedures. Some stakeholders reported how some immigrants preferred traditional treatment methods over modern ones, leading to a lack of trust in GPs. This was attributed to cultural beliefs that prioritized traditional treatments which resulted in some immigrants rejecting medical advice based on their cultural beliefs. For example, one immigrant couple refused to terminate a pregnancy despite medical recommendations, resulting in the birth of a non-viable child.

> *"Other issues could be like for example not trusting anything the GP himself because some people don't believe in some kind of treatments, you know they only believe in old ways of treatments, the traditional treatments"* (Youth ambassador 1).

> *"They don't believe in termination ... so the baby died at birth, and they knew the child was going to be non-viable but didn't want a termination"* (Advanced nurse practitioner).

4.14.3 Cultural differences

Some stakeholders reported how the cultural differences made it difficult for some immigrants to access health care services. They were afraid that their cultural differences might lead to stereotypes. For example, one youth ambassador explained how some immigrant women who wore hijabs were afraid of being stereotyped by others. As such, they felt unnerved to book GP appointments and access healthcare services.

> "*One of the other issues is about the hijab. For example, some of our females wear hijab and this is something so common in our countries, but here it is not common. So, they feel shy, you know, to book an appointment with the GP because they feel that they*

> *would be stereotyped by others. You know this kind of feeling being ecstatic and shy at the same time, you just don't want to do something because you feel you are different from the others"* (Youth ambassador 1).

4.15 Inadequate culturally sensitive healthcare

The majority of the stakeholders reported how inadequate culturally sensitive healthcare services particularly mental health services played a key role in hindering access to healthcare services. This was exacerbated by the language difficulties that made it difficult for the immigrants to express themselves. There was also an insufficient understanding of the cultural awareness among some healthcare providers which made some of them hesitant to ask some personal questions for fear of offending their immigrant clients. These factors are discussed in detail in the proceeding section.

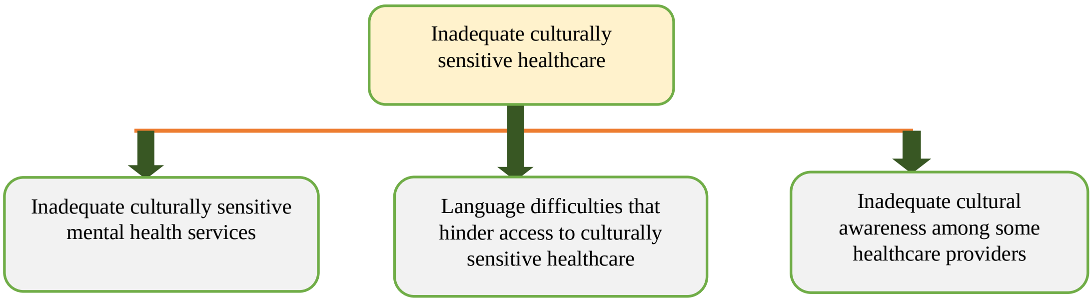


Figure 15 Sub-theme: Inadequate culturally sensitive healthcare

4.15.1 Inadequate culturally sensitive mental health services.

Inadequate culturally sensitive mental health services hindered immigrants from accessing support for mental illnesses, as reported by stakeholders. The lack of cultural sensitivity among mental health services posed a greater challenge for immigrants compared to the general population. Some immigrants refrained from engaging with mental health services that did not cater to their needs which resulted in long delays in diagnosing mental illness which worsened their conditions. Some immigrants found it difficult to access therapies like Cognitive Behavioural Therapy (CBT), as they were deemed unsuitable or unfamiliar. Counselling services were also questioned in terms of their appropriateness for addressing the mental health needs of immigrants, with concerns raised about generic counsellors not being able to address trauma and specific cultural issues. In addition, referrals to specialist counsellors were uncertain, hindering immigrants' access to appropriate mental health services.

> *"You know, being in the UK and not being diagnosed for so long, it allowed the problem to become worse or the issue to be less manageable. Some young people might*

> *not engage with some of the services because the services are not purposed. And then at a crisis point, it's even difficult to monitor and manage. So I think …mental health is lacking"* (Mentoring coordinator).

> *"I think if they wanted to, they can access this counselling. But whether that counselling would then be appropriate to their needs, I think, is the problem because they would just be referred to generic counsellors who are used to dealing with the problems of the local population, which, is mainly depression, anxiety, and that sort of thing … I don't think the counsellors dealing with anxiety and depression would be able to manage the specific problems of trauma within immigrant communities"* (General practitioner).

4.15.2 Language difficulties that hinder access to culturally sensitive care

Language difficulties pose a significant barrier for immigrants to access culturally sensitive healthcare services, especially in the context of mental health services. Stakeholders highlighted concerns about immigrants' inability to effectively communicate their issues, leading to potential misunderstandings and misdiagnoses. This language barrier also prevented mental health professionals from understanding the broader cultural context, including how mental health is perceived, stigmatized, and normalized in immigrants' cultures. While NHS mental health services provide interpreters, there is a recognized gap in tailored services in immigrants' native languages. Moreover, some healthcare providers expressed concerns about involving third-party interpreters during counselling sessions, as it made some immigrants uncomfortable and reluctant to use the services. Instead, the recommendation was made for the provision of same-language therapists who possess an understanding of the immigrants' cultures.

> *"Mental health support I think is a big one. I think it's difficult for them to access mental health support that has cultural sensitivity. Some of our people don't have the language which makes it difficult to communicate those things, but also just to have the context about mental health and what that means to different cultures and how that might be perceived and a stigma that might be around it within their culture"* (Mentoring coordinator).

> *"There is a big gap in providing ethnic minority migrant people with mother tongue therapy. But the NHS mental health approach is completely different. And we had a lot of our clients use NHS counselling services but they are not happy … they will use this*

> *service through an interpreter, but they don't want the interpreter. So there is a big gap there and they need someone to understand them, someone aware of their culture, someone who speaks their language as well"* (Counsellor).

4.15.3 Inadequate cultural awareness among some healthcare providers

Inadequate cultural awareness among certain healthcare professionals posed a hindrance to accessing primary care services, specifically mental health services for homeless immigrants. Stakeholders reported a lack of healthcare providers who understood immigrant cultures, shared a similar cultural background, and spoke the same language. This resulted in some immigrants failing to recognize the value of mental health support that was not tailored to their culture and language. some healthcare providers acknowledged their unfamiliarity with the cultural norms and values of immigrants, leading to discomfort and hesitation in addressing sensitive topics. Some homeless immigrants also expressed dissatisfaction with healthcare professionals who made decisions without understanding their needs or lacked knowledge in handling traumatic experiences. While some providers demonstrated partial cultural understanding, they often lacked awareness of deeper issues related to the immigrant experience. Despite efforts to address cultural sensitivity, some homeless immigrants remained skeptical due to previous experiences where they were not actively involved in decision-making.

> *"There's not enough cultural understanding or enough professionals from similar backgrounds as the young people, and it's around mental health. I think it's hard for people to see how mental health support is effective if it's not tailored towards their culture and their language"* (Mentoring Coordinator).

> *"A lot of people making decisions who don't even know what we need ... people are locked up in poor conditions, some people beat up in police stations, some people have been raped, some people have seen their whole family murdered. That is something you don't read in a book, that is a life-lived experience. So these people don't know how to deal with it and when I told them my problem, I felt that they were talking down on me*" (Male asylum seeker 20).

4.16 Preferred gender of healthcare providers

The preferred gender of healthcare providers had a significant impact on immigrants' utilization of primary care services, as revealed by this study. Cultural and religious beliefs led some immigrants to prefer healthcare professionals of the same gender due to restrictions on body contact and cultural norms surrounding reproductive health and physical examinations. These beliefs strongly influenced immigrants' healthcare-seeking behaviors, often resulting in avoidance of treatment or complete avoidance of GP practices. Cultural differences also contributed to immigrants' discomfort with opposite-gender healthcare providers, as they were unfamiliar with the UK cultural norms that allow patients to be examined by professionals of any gender. Consequently, some immigrants felt culturally constrained from interacting with and confiding in opposite-gender healthcare providers.

> *"I think because of our culture, it's very different and they're not used to it. The boys, some of them are not used to a woman coming and wanting to examine them, they don't feel comfortable with things like that ... we're trying to encourage them to come down here to the surgery but again, it`s a cultural thing, they don't like to mix and the men don't like to talk to women, you know, again it is another example of cultural issues going on there"* (Advanced nurse practitioner).

However, some homeless immigrants reported how some healthcare providers respected their cultural beliefs and allowed them access to doctors of their preferred gender. One female asylum seeker described how, particularly during a private examination like a smear test for cervical cancer screening, she was asked whether she preferred a male or female doctor. She felt respected by being asked and allowed to be treated by a doctor of her preferred gender, which might have facilitated her continued use of GP services.

> *"Now they the GP ask, they show respect, they ask, 'do you want male or female?', and I say, 'female please', they bring female. For example, if I have some smear test because I got a smear twice, they ask me, 'do you want male or female?' and they respect and bring me female. I've noticed that they are good at this point, they show respect. If you say woman please, they bring woman"* (Female asylum seeker 3).

On the contrary, some stakeholders reported how the failure to provide the preferred same-gender doctors complicated communication because some immigrants were reluctant to disclose intimate information like sexual problems to doctors of the opposite gender. One advanced nurse practitioner explained how doubtful she was that some male immigrants would disclose their sexual problems to her. However, they were successful in obtaining urine samples from the immigrants with the help of the male interpreter. This, therefore, highlights how having interpreters of the same gender is crucial in facilitating immigrants' utilisation of GP services.

> *"I was female and we didn't have any male physicians to go in, and of course, they were all male. So that in itself was a barrier in communication because I doubted if they would talk to me about sexual problems if they had them. I'm sure they would not because they didn't say anything about that. I did with the interpreters ask if they could have a urine sample so we can do tests ... but that was with the male interpreter, so we got them to do that*" (Advanced nurse practitioner).

Similarly, other healthcare providers explained how some immigrants did not want interpreters of the opposite gender. However, this resulted in longer waiting times for the GP appointments because the appointments had to be rescheduled to get the appropriate interpreter.

> *"I think I can think of two cases where they didn't want a female interpreter. So I had to explain that to the interpreter and then called back and got a male interpreter*" (Nurse practitioner).

Theme 3: Healthcare availability and the ability to reach health services

4.17 Introduction

The subsequent section provides insights into how both homeless immigrants and stakeholders perceive the accessibility of primary care services, including their physical locations and the availability of healthcare professionals, for homeless immigrants in South East England. This discussion encompasses the concepts of healthcare accessibility, which pertains to the presence of healthcare resources with the capacity to deliver services, and the ability of homeless immigrants to physically access these services promptly. These considerations encompass both the supply-side factors related to the healthcare system and the demand-side factors associated with homeless immigrants (Levesque et al., 2013).

Healthcare availability encompasses the physical presence of healthcare resources equipped with the necessary capacity to provide healthcare services (Levesque, Mark F. Harris and Russell, 2013). From the results of the present study, healthcare availability entailed four main sub-themes. The first sub-theme, *appointments with healthcare providers (HCPs)* entailed long waiting times for appointments, the inadequate number of appointments with healthcare providers, limited consultation time for immigrants, availability of walk-in appointments at health facilities, and availability of supportive social networks that influenced access to primary care services among homeless immigrants. The second sub-theme, *GP registration* entailed a lack of documentation required by GP practices to register clients which resulted in the denial of GP registration, awareness about immigrants' rights to access PCS, and availability of supportive social networks. The third theme was *geographical location* and the fourth theme was the *inadequate number of healthcare providers* which were also reported to impact homeless immigrants' access to primary care services.

Complementary to the notion of healthcare availability, the ability of homeless immigrants to reach primary care services refers to factors that would enable homeless immigrants to physically and timely reach primary care services (Levesque et al., 2013). This was influenced by *digital exclusion*. This comprised inadequate digital devices, phone credit and data, low digital literacy, and the availability of supportive social networks. These factors and more are reported in greater detail in the proceeding section.

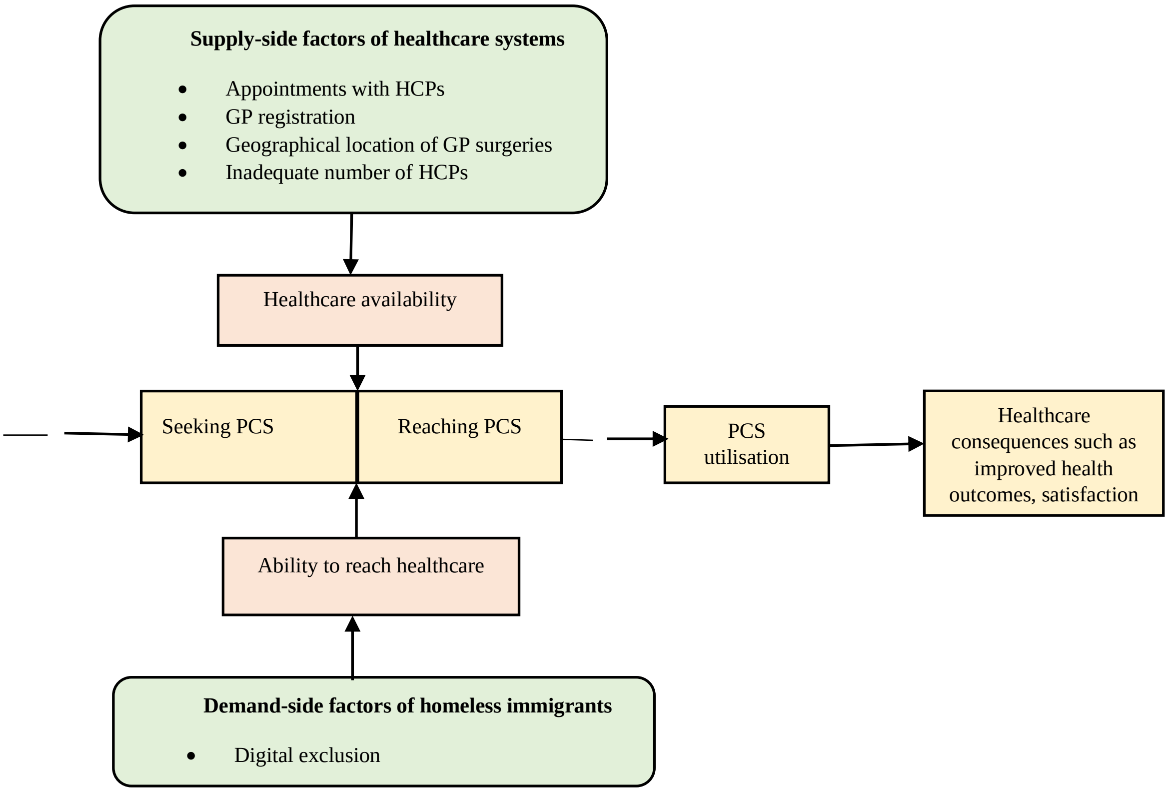


Figure 16 Theme 3: Healthcare availability (supply-side) and the ability to reach health services (demand-side)

4.18 Appointments with healthcare providers

This sub-theme entails various factors that affect homeless immigrants' access to primary care services. These include the long waiting times for appointments with healthcare practitioners, and the inadequate appointments which include insufficient GP and dentist appointments. It further entails the limited consultation time for GP appointments, the availability of optician and walk-in appointments at the GP practice, as well as the availability of supportive social networks. All these factors impact homeless immigrants' access to primary care services as discussed in detail in the proceeding section.

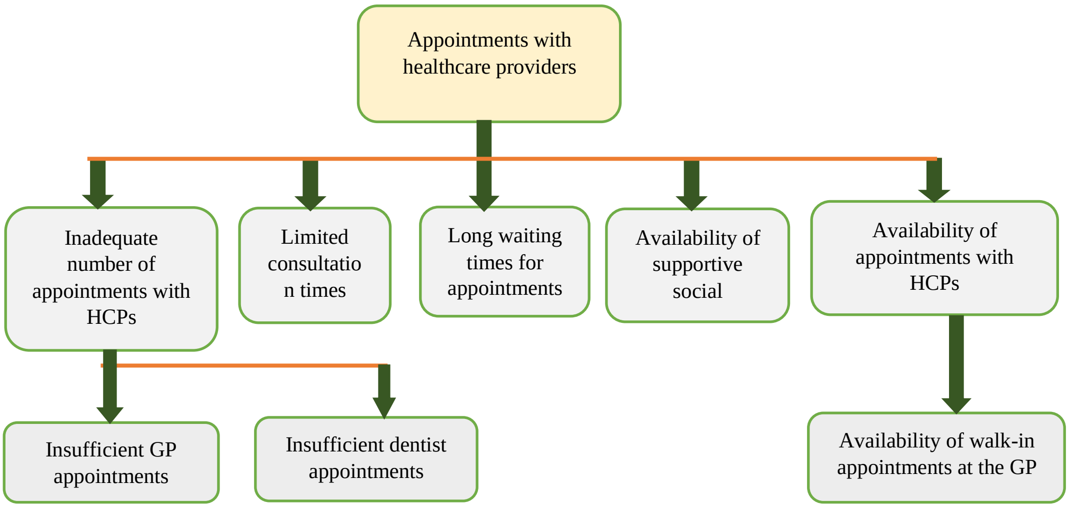


Figure 17 Sub-theme: Appointments with healthcare providers

4.18.1 Long waiting times for appointments

Most homeless immigrants expressed dissatisfaction with the long waiting times for GP appointments, reporting delays of one to two weeks or even cancellations. They felt compelled to wait despite their dissatisfaction, emphasizing their lack of choice. Those residing in Home Office accommodation, particularly asylum seekers in reception or camp centres, faced even longer waiting times as they required referrals from centre-attached health practitioners, making it more challenging for them to access GP services. To improve the appointment process for these asylum seekers, a refugee project officer highlighted the need for additional efforts to streamline the healthcare system.

> *"If you are to wait, you wait. What can you do? You wait, not until your time comes and then they write you a letter and give you a particular date. At times they can even cancel it"* (Female indefinite leave 19).

> *"For people who are asylum seekers in reception centres, it's a bit difficult to be seen by a GP because they need to go through a health practitioner who is in the centre who would then refer them to a GP. So, there is a little bit of work to be done to smooth that process, possibly"* (Refugee project officer).

Other immigrants also expressed dissatisfaction with the long waiting times for specialised care. It was reported that some immigrants had to wait for many months to be seen by a specialist. Some reported being tossed around from one service to the next without being attended to be a specialist. This, therefore, created delays in getting appointments for specialised care such as mental health therapy. This is similar to other studies where some immigrants although recognised that health care might help, found access to mental health care a challenge, experiencing long waits or no care at all (Khanom et al., 2021).

> *"Sometimes it takes time for you to get appointments. That is the main issue I was having ... when I was having mental issues they referred me for mental therapy. But it wasn't coming fast, it was taking time. They just toss you around, go to the GP, they will tell you, they will want you to call the number yourself. And when you call a number like talking therapy, they say they need to assess you, later they will tell you, oh, we can't do this, you need to go somewhere else". It was difficult"* (Female refugee 16).

Some healthcare providers reported that they were perceived by their immigrant clients as being racists because of the delays in getting appointments. However, they argued that the long waiting times for appointments did not apply to just immigrants but to the general population as well. As such, one nurse practitioner recommended waiting patiently for appointments just like everyone else.

> *"And it's not because you're an asylum seeker to wait sixteen weeks to see a physiotherapist. Joe Doe down the road is the same. And although it's not a racist thing, you get this racist thing thrown in your face ... but not a racist, we are in process, you just need to wait patiently*" (Nurse practitioner).

4.18.2 Inadequate number of appointments with HCPs

Inadequate number of GP appointments

Some immigrants expressed frustration over the insufficient number of available GP appointments. They reported the challenges of trying to secure a slot by calling the GP surgery early in the morning, often before 8 am. However, even those who made early calls described being placed on hold for extended periods, only to be informed that all the appointment slots were already filled and asked to try again the next day. This resulted in wasted time and added burdens, as they had other responsibilities, such as work, to attend to. Some immigrants also mentioned how the timing of their calls did not make a difference, as they were occasionally informed that all slots were taken, regardless of the time they contacted the surgery. However, children seemed to have better access to appointments, usually within a day or two, whereas adults struggled to secure appointments. The difficulty in obtaining appointment slots for adults was highlighted, with one female asylum seeker noting the importance of adults being healthy to care for their children.

> *"Sometimes I have to be on call since 8:00 and I'll be on this call till my kids go to school, till like 10. I know sometimes I work … when they eventually pick you up, they tell you all the appointments are gone. And then I'll have to wait for the next morning to call again on time"* (Female refugee 18).

> *"So, I have been trying to book appointments for a long time at 8, sometimes 7:55, 7:59, they will tell me I'm on the queue. So, when they finally get to me, they tell me the appointments are finished. I have been calling for more than a month now … access to the GP is so difficult to even see a GP. For your child, they can give you a day or 2 days after, but for adults, they will tell you, we don't have space. So, if your health is not okay, there is no way you can look after your child"* (Female asylum seeker 27).

Some immigrants got fed up with calling the GP practice and resorted to self-medication. In cases where their children were sick, and parents had failed to get quick appointments for them, they were taken to the accident and emergency services. However, to some immigrants, going to the emergency services also meant spending a day at the hospital waiting to see a doctor. This implies that there was no easy alternative as they still had to wait for a long time to see a doctor.

> *"So, I am just fed up of calling them, just fed up … I just do self-medication, for me, for my son when I see it's too much for him, I just take him to A&E, so we spend almost like a day. The last time we went, we almost spent a day there"* (Female asylum seeker 27).

Other immigrants raised concerns about the GP practice's lack of responsiveness to their calls, prompting them to seek assistance from third-party entities like charity organizations to secure appointment slots more efficiently. This approach was preferred as it expedited the process. One immigrant mentioned their habit of involving a third party when contacting the GP due to the practice's inconsistent response. Stakeholders working with charity organizations echoed these concerns and highlighted instances where immigrants who were unable to secure GP appointments experienced worsening health conditions, necessitating access to emergency services.

> *"If I am feeling unwell, … I will call my GP, but sometimes they don't answer me. So what I always do, I always call a third party, to be honest, am so used for a third party to be involved, it makes it quicker*" (Female refugee 28).

> *"I had an awful young person who came here infected to me, and it was looking quite bad. So he couldn't get any family doctor, so he went into A&E and I think he was given some painkiller and had kind of a small little operation"* (Youth and outreach support worker).

Inadequate number of dentist appointments

Accessing dentist appointments posed significant difficulties for many immigrants, particularly those entitled to free NHS dental treatment. When attempting to book appointments, immigrants on benefits were informed that no slots were available for them, with the only options being slots for individuals who could afford to pay for dental treatment. Immigrants who managed to secure appointments for free NHS dental treatment experienced frequent cancellations, leading to disappointment. This created a barrier for immigrants who couldn't afford dental treatment.

> *"I've been using that dentist for a while now because I know lately if you want a change or transfer to a new NHS dentist, they will tell you, 'Oh we don't have such NHS dentists anywhere' so they are just private. So I decided to stick with my dentist that I have been using ever since I was an asylum seeker because it's going to be hard to find a new one"* (Female refugee 21).

Additionally, some homeless immigrants also reported challenges in obtaining free appointment slots with local dentists. Consequently, immigrants were reluctant to switch dentists who had previously provided them with free NHS dental treatment, as many dental practices prioritized paying clients. Stakeholders confirmed this difficulty, reporting that several dental practices rejected patients entitled to free NHS dental treatment. As a result, immigrants who couldn't afford dental treatment resorted to self-medication, with some seeking advice from pharmacists to alleviate pain.

> *"And the challenges so far are dentists ... I can't seem to register patients locally with a dentist because they're not taking patients"* (Homeless health nurse).

> *"I just have to go to the local pharmacy, and I tell them what I am going through and they tell me, Okay, you take this, you put it on, so that is what I'm using to manage now"* (Female refugee 16).

`4.18.3 Availability of appointments with HCPs

Availability of appointments with opticians

Although the majority of the participants reported how difficult it was to get an appointment with a GP or a dentist, getting an appointment with the optician was however reported as easy because they gave slots to individuals who needed free NHS eye treatment.

> *"Most opticians are easier, you just walk in and say, do you take NHS patients? They will tell you it is fine, they will book an appointment for you. Optician is quite easy to get"* (Female refugee 24).

Availability of walk-in appointments

Insufficient appointment slots prompted some GP surgeries to establish walk-in appointments, enabling vulnerable groups like rough sleepers to access healthcare services without prior booking. These initiatives facilitated homeless immigrants in accessing GP services, including registration and vaccinations. This aligns with the findings discussed in section 1.4.2, where drop-in health clinics at various day centres played a similar role in facilitating immigrant access to GP services. The availability of walk-in appointments also provided an opportunity for stakeholders to address the needs of vulnerable individuals before they left the GP surgery, as their return visits were uncertain. This flexibility allowed homeless immigrants to receive necessary healthcare services.

> *"One of the surgeries where I work, we have every Saturday in the morning between 8:00-12:00, there is just a registration session, so anyone can walk in from the street. So those kinds of tactics are very good to try and attract people to come"* (Focused care team lead).

4.18.4 Limited consultation time

The interviewed healthcare practitioners commonly faced limited consultation time when dealing with immigrants, especially those with language barriers and unmet health needs. The practitioners expressed dissatisfaction with the standard 10-minute slot allocated to immigrants without proper planning. Communicating with these patients became a challenge due to the language barrier, and it was acknowledged that the short time frame was inadequate to address their significant health needs. Therefore, in cases where language was an issue, arranging a follow-up appointment with an interpreter present was deemed important. Prioritizing immediate critical needs was done through the use of basic language skills and understanding the patients' concerns. The reception team played a role in identifying the patients' language, contact details, and background information to facilitate longer and more effective consultations with appropriate interpreters at a later time.

> *"I think it's usually a little bit of a heart sink situation when they turn up because they've usually just been booked into a normal 10-minute slot with no pre-planning whatsoever. So, no one's asked about the need for interpreters. So that they just turn up ... and you realise that you can't communicate with them because you don't speak the language, and you also realise that there's a huge level of unmet need there that you can't even begin to try and meet in a 10-minute appointment when there's a huge language barrier. But I usually think they've done well to even get the appointment ... so, I usually think they've done well to get that far"* (General practitioner).

Some health practitioners expressed dissatisfaction with receiving the same payment for treating immigrants as they did for the general population, arguing that immigrants often required more time to address their health needs. The fixed payment for a 10-minute slot was seen as a disincentive if the practice took on a large number of immigrants, as the additional time required would have to be taken from the general population. In addition, extended waiting times caused disruptions to practitioners' schedules and were perceived as a burden on the healthcare system. To effectively manage the needs of immigrants, some healthcare providers proposed that the government should allocate more financial resources to reflect the additional time required for their care.

4.18.5 Availability of supportive social networks on issues of appointments with healthcare providers

Access to supportive social networks played a crucial role in facilitating immigrants' access to GP services. Immigrants who had connections with family, friends, social workers, and charities were provided with information and assistance in booking GP appointments. For immigrants facing language difficulties, their social networks often contact and schedule appointments on their behalf. Some immigrants preferred having charities reach out to GP practices on their behalf, as they found that the practices were more responsive to charities than to individual immigrants. The effectiveness of social networks was evident when one immigrant, who had struggled to secure an appointment independently, was able to obtain a same-day appointment through the involvement of a charity. This highlights the importance of social networks in successfully securing appointment slots with GP surgeries.

> *"It is just that someone from a charity organisation will call them and are like, my name is so and so, I work in this charity. And once they hear that, the doctor will respond differently, I don't know why, it always happens all the time. Even recently, I was trying to go to my GP for like four days, and they wouldn't answer the phone, if they answered the phone, they wouldn't give me an appointment. But when I got a charity involved and the person called the GP, can you believe that the GP gave me an appointment that same day"* (Female refugee 28).

Stakeholders, particularly those working with charity organizations, played a vital role in assisting immigrants by contacting and booking GP appointments on their behalf. This not only helped build trust between stakeholders and immigrants but also encouraged immigrants to open up about their needs, facilitating their access to appropriate services. Social networks often accompany immigrants to their appointments, providing support and familiarity with the healthcare system. In cases where social workers were unavailable, some immigrants relied on charities for assistance, where mentors not only helped with appointment bookings but also empowered them to access services independently. Accompanying immigrants to appointments also allowed stakeholders to conduct multidisciplinary team meetings to better support individuals with complex health conditions. Overall, the involvement of social networks and stakeholders proved instrumental in facilitating immigrants' access to GP services.

> *"So, I think it's just the way we take care of them, even if it's here in the shelter and then they start to feel a bit more trust in the services and they've got a bit more support around them to access, like the staff here who phone up and book a GP appointment for a patient if they don't have a mobile or they don't feel confident to do it"* (Homeless health nurse).

> *"Sometimes we will accompany them to an appointment as well*" (Youth and outreach support worker).

4.19 GP registration

From the findings of the present study, the majority of the immigrants reported they were denied GP registration due to the lack of documentation, yet some had lost their documentation. Healthcare providers reported various reasons for asking for documentation from immigrants. The section also discusses the consequences of being denied GP registration such as self-medication and access to emergency services. This sub-theme also entails awareness about the rights of immigrants to access GP services and the availability of social networks that support immigrants to register for their GP surgeries.

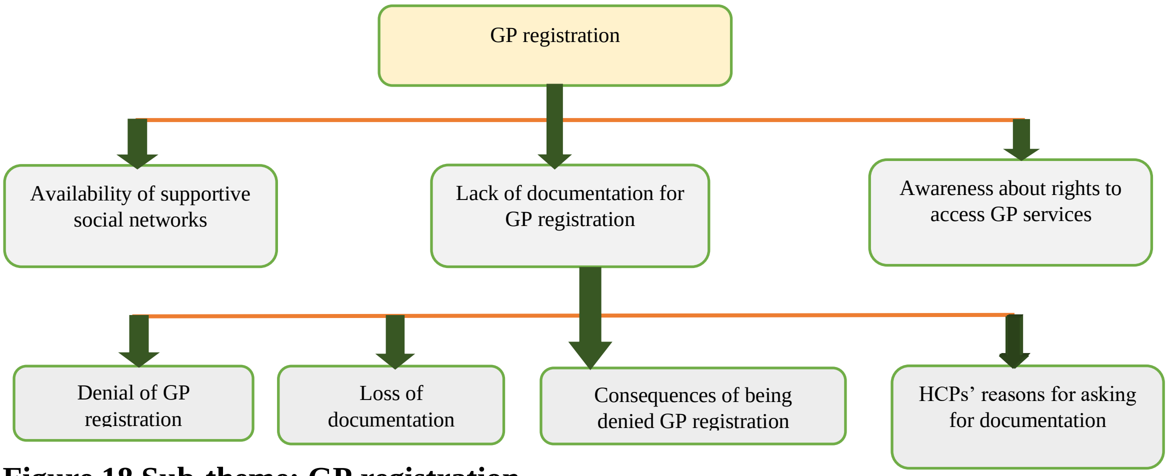


Figure 18 Sub-theme: GP registration

4.19.1 Lack of documentation for GP registration

The majority of the immigrants reported how a lack of documentation such as proof of identification and address hindered them from registering with surgeries. This is because GP surgeries denied registration to those who lacked this documentation. However, there were mixed reactions on this issue among stakeholders. Although some stakeholders, particularly the healthcare providers highlighted how the GP practices registered immigrants regardless of whether they had documentation or not, there were some other stakeholders, particularly those working with charity organisations, who reported how some immigrants were denied registration due to lack of the documentation asked by the GP practices. The following section expounds on this issue.

Denial of GP registration due to lack of documentation

The denial of GP registration based on lack of documentation was a common experience among immigrants. Many were denied registration due to the absence of identification documents like a biometric residence card or passport. Even asylum seekers with legal documentation from the Home Office were sometimes denied registration if they did not possess a passport or biometric card. However, refugees with the required biometric cards found it easier to register. Some immigrants sought assistance from third parties, particularly charity organizations, to navigate the registration process. This led to feelings of unfair treatment and discrimination based on immigration status, despite the right to access primary care services without the necessary documentation. Additionally, some immigrants faced registration challenges due to the lack of proof of address, making it difficult for rough sleepers and those living with friends or family to register. The denial of registration based on documentation and proof of address posed significant barriers for immigrants seeking healthcare access.

> *"They needed an ID card like a biometric card with faces. So, I was like, 'I don't have that', then they needed a passport, 'I don't have a passport this is what I have got'. But because you are an asylum seeker, 'we don't accept this ID card' is what they were saying ... But when you have your biometric, they will accept you. It's not right because whether you are an asylum seeker or refugee, you still have a right, they shouldn't be treating us like that"* (Female refugee 28).

Furthermore, the acceptance of proof of address varied among GP surgeries. Despite some immigrants, especially asylum seekers, presenting documentation from the Home Office as both proof of identification and address, it was still rejected by some surgeries for registration.

> *"When I got there, she is like 'you need a proof of address' and I was with a document saying, this is my proof of address, I'm with the Home Office and this is the letter, ... but she wouldn't open it ... I was like I need to see someone because I'm going through these, my child needs to get his medication, ... but they wouldn't. She was like, 'you know, I can't open a GP because you don't have proof of ID"* (Female refugee 18).

Contrarily, some stakeholders thought that immigrants who lacked proof of ID and address were allowed to register at the GP practice using documentation from the Home Office as it highlighted their personal information. However, as noted above, some immigrants described how they were denied registration even though they had documentation from the Home Office. This highlights the uncertainties about using Home Office documentation for registration.

> *"You and I probably have a BRP, ... we have registered addresses. For them, these things are not in place. So there has to be some form of improvisation when it comes to*

> *this thing. So they don't have a BRP yet, it takes a long while to get the BRP, so they need a letter from the Home Office to say that this is their status. And because the letter is coming from the Home Office, the GPs tend to accept that"* (Public Health Specialist).

Although the majority of the immigrants reported how they had been denied registration due to the lack of documentation, there were mixed reactions from various stakeholders. Some stakeholders expressed that they never denied registration to immigrants who lacked documentation. Instead, it was reported that they used the surgery address as the nominated home address to register homeless immigrants.

> *"When the adults present at the surgery, we try and get as much information as we can from them. But if they don't have any information then we still register them … If they don't have an address, then what we do is we use the surgery address for them, … say someone is homeless, then they have the surgery as their as their nominated address"* (Assistant practice manager).

On the contrary, some healthcare providers reported that the act of asking for documentation was deeply ingrained among the receptionists at the surgeries, that even when they were told to register people who lacked proof of identification or address, they still asked clients for this documentation, were unwelcoming and denied registration to immigrants who lacked the required documentation. Moreover, it was described to be worse for immigrants with language difficulties as they could not understand the requirements asked by receptionists.

> *"I think it's so deeply ingrained in our receptionist. They've asked it for so long that, 'we need proof of address, proof of I.D', that even though we say to them that you don't need that, you can still register someone without that. I sometimes do go walk past reception and I hear them saying to people, 'you need 2 proofs of address'. I'm not sure that they would be welcoming to somebody that said they didn't have proof of address*" (General practitioner).

Loss of documentation

The loss of documentation was identified as a significant challenge faced by some immigrants, including rough sleepers. Homeless immigrants reported instances where their personal belongings, including identification documents, were stolen from them while living on the streets, which posed a barrier to GP registration. Similarly, female immigrants who experienced abuse from their partners shared how their documents were confiscated by their abusive partners.

> *"I got my passport and other things stolen from me whilst on the street ... where we were sleeping"* (Male asylum seeker 1).
>
> *"He took my passport"* (Female asylum seeker 3).

Stakeholders supported these accounts, confirming that some female immigrants had their documents seized by their abusive partners, thereby impeding their ability to register with a GP practice.

> *"Occasionally, you get domestic abuse type survivors who will come out, who come into the country and their partners have all of their documents, and they've got no real remit to be here*" (Outreach service manager 15).

Consequences of being denied GP registration

Being denied GP registration due to a lack of documentation had significant consequences for immigrants. It hindered their access to healthcare services as they feared the possibility of being reported or facing legal repercussions. Additionally, the fear of accessing GP services without the required documentation had a detrimental impact on the mental health of some immigrants. Some homeless immigrants reported experiencing depression and anxiety due to the fear associated with seeking medical care. Additionally, one female asylum seeker shared how she almost suffered a miscarriage because she was afraid to visit a GP and face the requirement of presenting documentation during a period when she lacked legal status in the country.

> *"I was scared to go because anytime I go to the GP, it is not easy, you've got no papers ... I thank God I didn't get a miscarriage because of fear"* (Female asylum seeker 23).

Healthcare providers' reasons for asking for documentation

Stakeholders, especially the healthcare providers reported various reasons for asking for documentation during GP registration. Some healthcare providers reported asking for documentation, such as identification and proof of address to ensure that there was a record of the immigrants in the system and not for tracking purposes as they feared. It was also done to ensure that there was continuity instead of starting afresh every time they registered. Moreover, some stakeholders considered the lack of documentation as a small barrier for the immigrants to access services. This, however, contradicts the findings from immigrants above that show how the lack of documentation created fear that hindered them from accessing GP services hence highlighting how significant it is as a barrier.

> *"I mean it's a low barrier, but you still have to produce your name, your date of birth, and the address that you're at and that's not really for any kind of tracking purposes by any stretch of the imagination. It's just to create a record on the system"* (GP associate).

Some healthcare providers reported that they asked for documentation, particularly when children were involved, to address safeguarding concerns such as child trafficking. Instances were reported where adults falsely presented children as their own during registration. To prevent such issues, GP surgeries gathered as much information as possible. Additionally, requesting documentation aimed to prevent registration with falsified information. However, healthcare professionals mentioned that they still registered immigrants without documentation, as the GP registration system could be overridden in certain cases. However, this decision was ultimately determined by individual GP practices.

> *"Within [mentions town] there's a history of child trafficking. So certainly, when there are children, we ask for as much information as we can because a lot of the time people have brought their nephews and nieces over, register them as their siblings, as their children ..."* (Assistant Practice Manager).

> *You usually need a passport or a driving licence or a bill ... but when you got a population who don't have ... a passport on them and a bill ... they could make up a name ... we have to just override the system to do that because the system says you need to have this information. But these people don't have that information to do that ... But each practice manager makes that decision"* (Advanced nurse practitioner).

4.19.2 Awareness about rights to access GP services

There existed some level of unawareness among some homeless immigrants about their rights to access GP services regardless of their immigration status, and whether they had the documentation required by surgeries or not. This was also attributed to being new in the country, and as a result, some immigrants were unable to fight for their rights to access GP services. When asked if she was aware of her right to register with a GP practice without documentation, one female refugee mentioned that:

> *"No, I was not aware because I was just new in the country, so I didn't know anything" (Female refugee 16)*

Contrarily, some immigrants reported how they were knowledgeable about their rights to register with the GP regardless of their immigration status and having the documentation required. This awareness facilitated their registration and access to GP services. One female refugee described how she was asked for an ID to register which she didn't have as an asylum seeker. However, she argued that she did not need one as it was her right to register with or without an ID. And as such, she was able to get registered. Hence her awareness about her rights facilitated her access to GP services.

> *"I had to go to a GP to say I need to register, again they wanted an ID. This time around I was aware. So, I said, I don't need an ID, I fought for myself. They opened the GP, they registered me and this is like how many months now like it's like six months or so"* (Female refugee 18).

4.19.3 Availability of supportive social networks

The availability of supportive social networks played a crucial role for some immigrants who faced difficulties in registering with a GP. Social workers and charities assisted those who were previously denied registration. Similarly, immigrants without documentation received treatment and support from charity organizations after being denied registration at hospitals. Stakeholders acknowledged the role of these charities in providing medical consultation and helping immigrants register with local GPs.

> *"I had to call a charity, and they are the ones that helped me register for a GP because nobody else would accept me. And so, they ask you if you're an asylum seeker, if your ID card is valid, it is hard. Until the charity got involved and I got to register for a GP"* (Female refugee 28).

> *"If they are not registered then we refer them to [mentions charity] who will provide relevant medical advice that they may need. And then actually, [mentions charity] will help them to register with a local GP" (Refugee and migrant service worker).*

On the contrary, some social networks particularly family and friends were reluctant to assist immigrants in registering with the GP. They were afraid and worried that if an immigrant who lacked the legal documentation to stay in the country used their home address to register, they would get into trouble and be questioned as to why they were housing them.

Consequently, when these immigrants got ill, they self-medicated using painkillers such as paracetamol, while others used accident and emergency services.

> *"I fell sick but I was afraid to go to the GP because the people I was staying with wouldn't give me their address because I was undocumented. So, when I was sick, I would just keep it to myself … I just asked the lady if I could have Paracetamol, even though I knew there was not something that Paracetamol could do, but I just had to do something to be on my feet. Yes, I know when I was very sick, I asked, they said they can't give me their address, they might be in trouble"* (Female asylum seeker 14).

4.20 Digital exclusion

More than a quarter of the immigrants reported how digital exclusion hindered their access to GP services. Some immigrants lacked access to phones, credit, and internet to contact their local GP. It was also reported that some immigrants had limited digital literacy because they did not know how to access the GP online services hence hindering their access to GP services. However, some stakeholders, particularly those that worked with charity organisations reported how they provided immigrants with access to digital devices, and internet, and drop-in health services to facilitate their access to GP services. These factors are discussed in more detail in the following section.

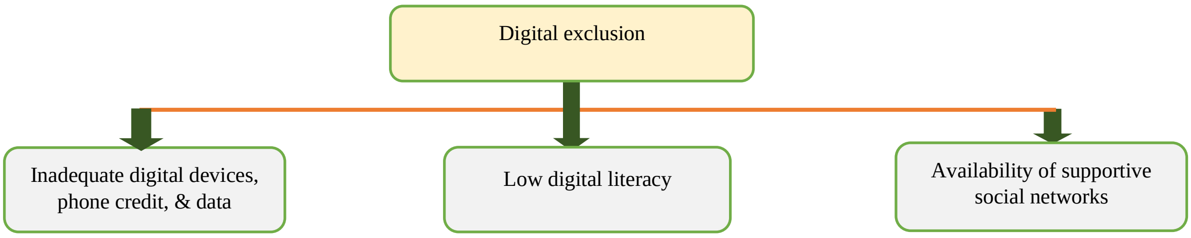


Figure 19 Sub-theme: Digital exclusion

4.20.1 Inadequate digital devices, phone credit, and data

The lack of digital devices, phone credit, and data posed challenges for immigrants in accessing GP services. Some immigrants did not have phones, while others lacked the necessary credit and data to make calls or access the internet. This hindered their ability to contact GPs and book appointments, as phone credit was required for communication. Furthermore, some GP surgeries had an online appointment system, which was advantageous for those unable to secure appointments during working hours. However, it remained unfavourable for homeless immigrants who lacked smartphones and data to access the system.

> *"Last time I used to call, and now they have got a system called patient access. So, I have to book in at 7:00 in the evening for when I want an appointment. Then again, it is good and bad at the same time because one, you need to have a mobile phone, two, you need to have data. So, it's kind of a yes and no at the same time as well …"* (Male asylum seeker 20).

In addition, the allowances provided to immigrants on benefits were insufficient to meet their needs, especially considering their responsibilities towards their children. Asylum seekers mentioned that they couldn't allocate money from their limited allowance of £35 to purchase phone credit and data when they had more pressing basic needs like food to consider. The priority was ensuring an adequate food supply, as it directly impacted their health. Some stakeholders also acknowledged the challenges faced by immigrants without access to phones, credit, and the internet in accessing GP services. Certain services, like E-consult, required digital devices such as smartphones or laptops, which were expensive for immigrants to afford given their meagre allowances.

> *"There is no way I can remove money from the £35 which I am collecting for buying credit when I know that I have to feed my son, I have to eat. The network is not even a priority, food is the priority. Because as long as there is food, there is health. The rest they can provide … That is why there is no way we can squeeze money out of that money to buy internet because that means you are going to fall short in another part of the area where you need food"* (Female asylum seeker 26).

4.20.2 Low digital literacy

Low digital literacy was identified as a significant barrier to accessing GP services for some immigrants. When directed to use online systems at GP surgeries, they struggled due to unfamiliarity with devices like computers. Homeless immigrants reported difficulties in navigating online GP services, emphasizing the challenges of adapting to the digital era. Limited training in their home countries and lack of access to smartphones contributed to their unfamiliarity. Stakeholders confirmed that certain online services, such as E-consults, were particularly challenging for individuals lacking knowledge in filling out online forms or utilizing digital platforms.

> *"And even the E-consults now, … they get turned away and told you need to fill out an E-consult … I'm sure there must be so many people out there as well, they don't know*

> *how to use the E-consults. I've not come across one person yet that knows how to do the E-consults, I think it's complicated"* (Homeless health nurse).

The limited digital literacy among some immigrants was perceived by some stakeholders to widen the gap of health inequalities among immigrants. As such, they recommended the establishment of population health-based interventions to enable access to services among the hard-to-reach communities who might lack a registered address with the GP practice.

> *"There has been a widening gap of health inequalities because obviously in general practice, we've gone to a more digital kind of model of access and people in those groups don't necessarily have the skills or the IT equipment to fill out an E consult and do all those kinds of things. It's a priority of the system to reduce health inequalities to do more population health-based interventions ... because obviously, they're hard to reach groups, they don't necessarily have a registered address*" (GP associate).

4.20.3 Availability of supportive social networks on issues of digital exclusion

The availability of supportive social networks played a crucial role in addressing digital exclusion among immigrants. Those who lacked digital devices and phone credit received assistance from charity organizations within their social networks. They were supported with access to phones or provided with credit to make necessary calls and book GP appointments. Stakeholders, including those working with charities, affirmed their role in providing mobile phones, internet access, and computers to immigrants, particularly during the pandemic when face-to-face services were limited. Community drop-in venues were established to ensure access to the internet and laptops for utilizing online services. Furthermore, healthcare providers operated walk-in health clinics in communities, providing GP services without the need for appointments. These initiatives brought healthcare services closer to individuals who lacked access to phones or credit, addressing the issue of digital exclusion to some extent.

> *"We provide as an organisation as many cell phones as we can and digital exclusion was something that we found affected our cohort, especially during the pandemic when support settings became less of face to face ... we have community drop-in venues as well, where somewhere people can access internet and laptops and do some of that work"* (Outreach operations manager).

4.21 Geographical location of GP surgeries

The geographical location of GP surgeries posed challenges for some homeless immigrants in accessing services. Living far from their registered GPs required them to commute by bus or train, which could result in missed appointments due to delays. Some healthcare practitioners exhibited less understanding towards homeless immigrants who arrived late for their appointments. One immigrant participant shared an instance where he was denied consultation by a nurse for being five minutes late, despite explaining the transportation difficulties he encountered. This prompted some voluntary sector providers to offer transportation assistance for immigrants' appointments.

> *"There was a time when I went, about three weeks I was late for about 5 minutes and I called them, I was on the way, and I said I'm coming. I was coming by train, so the train got stuck in [mentions location]. And then I got off the train, rushed to the bus, then I came, I was 5 minutes late. But the diabetic nurse I was going to see refused to see me"* (Male failed asylum seeker 13).

> *"And so the support worker would drive them to the GP if it's too far away"* (Refugee project officer).

4.22 Inadequate number of healthcare providers

The insufficient number of healthcare providers at GP practices was highlighted by homeless immigrants, leading to a lack of available appointments. As a result, some immigrants sought treatment from charity organizations that had their doctors. These organizations played a vital role in providing medical care to asylum seekers who lacked access to medications. Stakeholders confirmed the involvement of volunteer doctors from charity organizations in treating immigrants, further highlighting the issue of shortage of healthcare providers.

> *"For me when I fell sick, I decided to go to a certain organisation, there are certain organisations that help asylum seekers who don't have access to medications, and the charity where I was taken, that is [mentions charity]. They have done a great job. They give you some treatment since they have doctors around"* (Male refugee 9).

The majority of stakeholders expressed concerns about the overstretched mental health services, leading to limited availability of appointments and long waiting times. These services were often short-term, which posed challenges for individuals with trauma who required long-term support. Consequently, some immigrants turned to charity organizations to access mental health support, which proved beneficial in addressing their traumatic experiences and enhancing their well-being.

> *“Mental health care has a very high threshold at the moment. And though there's a sort of local wellbeing service here, there's a very long waiting list for it, and it can't always support people in trauma, sometimes it is more about shorter-term mental health needs, and the referral system can be very unclear ... So, we've had people that have approached the subject of mental health with their GP and then they've been asked to fill out a form and leave it on the desk. And then with waiting lists of up to six months, they are in limbo and they don't know what they can be offered”* (Generalist advice worker).

Theme 4: Financial support and basic needs from government and organisations; and the ability to pay out of pocket for health-related costs

4.23 Introduction

The following section explains both the homeless immigrants' and stakeholders' perceptions about the extent to which primary care services and related costs are affordable to homeless immigrants in South East England. It entails the notions of financial support and basic needs from the government and organisations (supply-side factors of health systems and organisations) and the homeless immigrants' ability to pay out of pocket for health-related costs (demand-side factors of homeless immigrants) (Levesque et al., 2013).

Financial support and basic needs from the government and organisations entailed three main sub-themes. The first sub-theme, *availability of asylum support from the UK government* included financial support and accommodation, and free prescriptions. The second sub-theme, *lack of recourse to public funds* entailed the ineligibility of some immigrants to a range of benefits and services including housing support, child benefits and allowances, and free prescriptions and secondary care. Such ineligibility negatively impacted immigrants' health with some of those affected reporting depression. The third sub-theme entailed the *availability of financial support from charities* which was an important source of help for some immigrants who were struggling to make ends meet.

The capability of homeless immigrants to cover healthcare expenses through personal financial means involves their ability to generate financial resources from various sources, such as income, savings, borrowing, or loans, to cover health-related costs without facing a severe depletion of resources needed for essential living expenses (Levesque et al., 2013). *Insufficient personal financial resources* were reported to restrict the capacity of homeless immigrants to pay for healthcare and related costs thereby increasing their vulnerability and exposure to labour *exploitation*. There was also *limited knowledge about available benefits and financial supports*, which resulted in eligible immigrants instead paying for prescriptions. These factors are discussed in detail in the greater detail in the subsequent section.

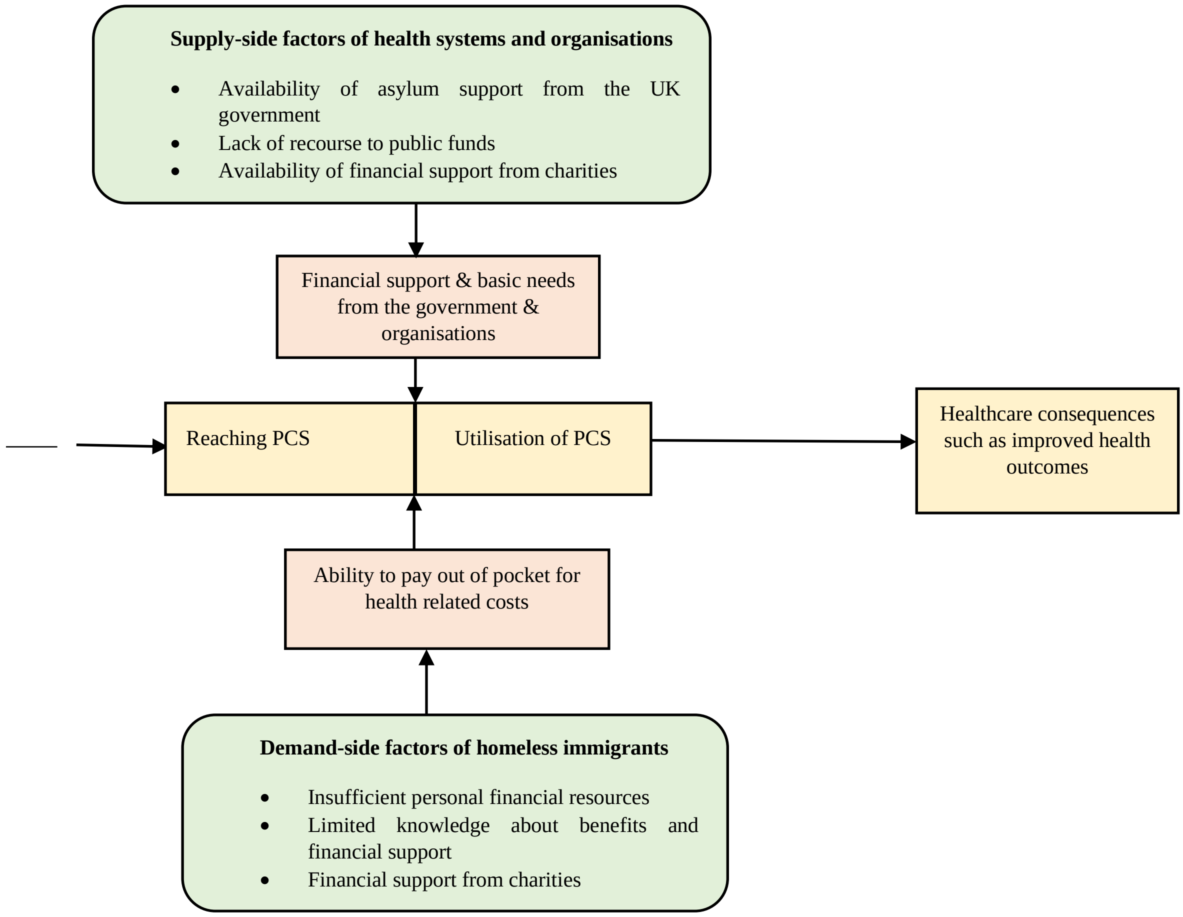


Figure 20 Theme 4: Financial support & basic needs from government and organisations (supply-side) and the ability to pay out of pocket for health-related costs (demand-side)

4.24 Availability of asylum support from the UK government

Certain immigrants, especially asylum seekers, mentioned the existence of government-provided asylum support. Individuals in the process of seeking asylum are typically not eligible for regular welfare benefits and are often restricted from employment. Nonetheless, destitute asylum seekers have the option to request accommodation and/or financial assistance from the Home Office while awaiting a decision on their asylum application (Gower, 2021). Additionally, some asylum seekers noted that they could obtain medications without charge, provided they possessed an HC2 certificate as proof of their eligibility for free prescriptions. These factors will be further explored in the following section.

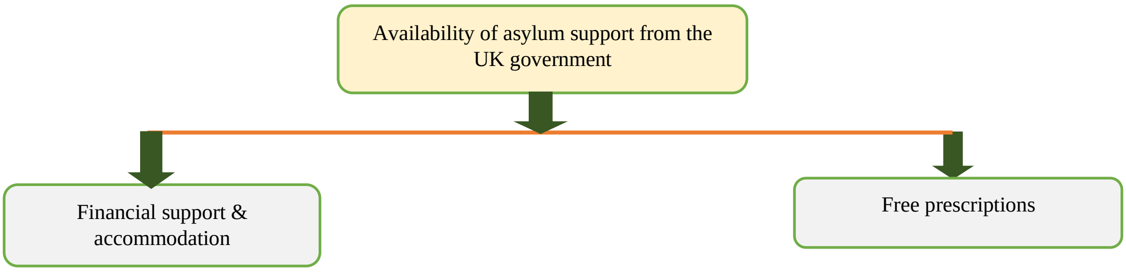


Figure 21 Availability of asylum support from the UK government

4.24.1 Financial support and accommodation

The majority of homeless immigrants, especially asylum seekers, stated that they were prohibited from working by the Home Office and instead received weekly allowances ranging from £30 to £40. However, these allowances were deemed insufficient by some immigrants to meet their basic needs such as food, phone credit, and transportation. Female asylum seekers specifically mentioned additional needs like sanitary products, all of which had to be covered by the weekly allowance. Consequently, some immigrants relied on support from charities to address these unmet needs, as the government's allowances were inadequate. This aligns with the findings of section 3.5.3, where immigrants mentioned receiving extra allowances from charities to cover expenses related to phone credit and internet access.

> *"The allowances they give asylum seekers mostly are not right. They expect you to live on £35 a week. So, I am sorry, that can do nothing. If it wasn't for charities helping us we would have died of starvation. You live on £35 a week, as a woman you have all these needs. That money will not even last you a day. It is not enough to look after yourself, it will buy you nothing. You have transport on that money, you have sanitary products, you have different things, the food is also coming for it."* (Female refugee 28).

4.24.2 Free prescriptions

Several asylum seekers indicated that they were eligible for cost-free prescriptions, dental care, and eye examinations under the low-income scheme, facilitated by the NHS through an HC2 certificate. This HC2 certificate offers comprehensive coverage for their healthcare expenditures (Kang et al., 2019). However, asylum seekers who did not possess the HC2 certificate, even though they were entitled to free healthcare, had to pay for their medical costs themselves.

> *"If I needed dental treatment, I have the HC2 certificate, my case worker gave it to me. So, I use that for dental treatment … If you have your certificate, it should be free. If you don't have that, you have to pay"* (Female asylum seeker 14).

Furthermore, asylum seekers who were denied free prescriptions and had to pay for medication out of pocket expressed their confusion and dissatisfaction with the GP practices. One female asylum seeker shared her negative experience, where she was initially told she was entitled to free medication but was later made to pay for it at the pharmacy. The weekly allowances provided by the government were already insufficient to cover all their needs, exacerbating the issue. This situation highlights the lack of clear guidelines or communication among different primary care services, which ultimately hampers immigrants' access to healthcare. Some asylum seekers also mentioned being denied free prescriptions for certain medications like paracetamol, which were considered cheap and readily available. However, for these individuals, using their limited weekly allowances to purchase such medications posed a financial burden and hindered their access to necessary treatment.

> *"Because we are asylum seekers, we are entitled to free medication and I'm not supposed to pay, but most times I end up paying for my medication … we called the GP and they said they will be giving me free medication. But the other time I went, I had to pay again. So, it's not easy for me because I'm taking off of my weekly allowance"* (Female asylum seeker 27).

4.25 Lack of recourse to public funds

Some immigrants reported how they lacked recourse to public funds. As such they were ineligible for a range of benefits and services including housing support, financial support, free prescriptions, and free secondary care. Such ineligibility negatively impacted immigrants' health with some of those affected reporting depression. These factors are discussed in detail in the proceeding section.

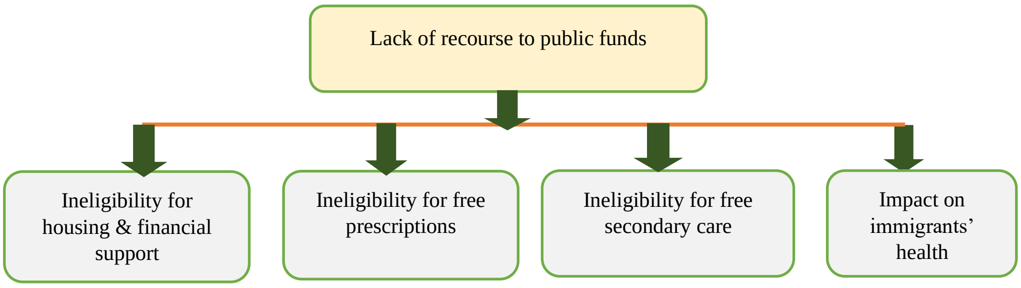


Figure 22 Sub-theme: Lack of recourse to public funds

4.25.1 Ineligibility for housing and financial support

Immigrants without legal status in the UK faced challenges in accessing government financial support, rendering it difficult for them to meet basic needs such as food for themselves and their families. The resulting inability to provide for their families had a detrimental impact on their mental health, leading to feelings of unhappiness and depression. Furthermore, immigrants with no recourse to public funds were ineligible for free accommodation, contributing to their homelessness. This created a cycle where homeless immigrants would become ill, receive treatment, and then return to the streets, raising concerns about the effectiveness of accessing healthcare without addressing the underlying issue of homelessness, which increased the risk of poor health. Such rough sleeping was reported to have a negative impact on their mental health, causing feelings of degradation, trauma, and inhumanity.

> *"So, they would fix you up and you go to the street again, and then you collapse again they fix you up. What's the point? They might as well let you just be there on the street. Because of no recourse to public funds, you can't stay in a hotel, 'we can't give you a house, we can't help you'. It is so degrading, mentally. ... the longer you are street homeless, the more traumatised you get and it's harder for you to recover ... Because I've got no recourse to public funds, I'm not treated as a human being, my mental health deteriorates ..."* (Male asylum seeker 20).

Furthermore, asylum seekers whose claims were rejected and exhausted described how the government discontinued their benefits and required them to leave their accommodation and return to their home countries. Those who did not return, for various reasons, lived in constant fear of deportation, leading to a majority of them becoming homeless. Some sought shelter with family or friends, while others resorted to sleeping on the streets. In addition to the termination of allowances and housing, they were also prohibited from working, making it difficult for them to meet their basic needs. As a result, some immigrants relied on charities for necessities like food and temporary shelter. Stakeholders confirmed this situation, explaining that immigrants without recourse to public funds were not supported by local authorities and would only receive assistance in returning to their home countries unless they applied for asylum.

> *"They sent me a letter that I am no longer eligible to stay in their accommodation and I should be preparing to leave the country. ... that made me homeless because I'm not*

> *receiving any benefits from the government, no recourse to state funds, and I'm not working, I only depend on charities where I am collecting food" (Male failed asylum seeker 13).*

4.25.2 Ineligibility for free prescriptions

Some stakeholders reported how immigrants without recourse to public funds although entitled to healthcare, had to pay for prescriptions.

> *"I think for people that have not got recourse, they have to pay for prescriptions. So, they're entitled to the health care, but they have to pay for prescriptions"* (Outreach service manager).

4.25.3 Ineligibility for free secondary care

Regarding healthcare, while some immigrants faced relatively small charges for prescriptions, the majority of stakeholders highlighted how others were confronted with exorbitant fees amounting to thousands of pounds for hospital admissions, surgeries, and treatments. Stakeholders explained that irregular immigrants, despite being entitled to free primary healthcare services, were not eligible for free secondary care due to their lack of recourse to public funds. This meant that they were denied long-term treatment in hospitals, leading to a deterioration of their health conditions and, in some cases, fatalities. A specialist caseworker shared an example of immigrant patients being denied lung care treatment and being deemed unfit for urgent treatment, ultimately resulting in their death.

> *"We've had patients who've been refused lung cancer treatment and sort of died because they weren't eligible for treatment in hospitals, even though, I mean, there's a category of urgent and immediately necessary. But lung cancer didn't seem to fit in with the urgent and immediately necessary treatment options. And so, he was turned down" (Specialist caseworker).*

Furthermore, stakeholders highlighted the substantial charges imposed by the NHS on irregular immigrants for secondary care. The ineligibility for secondary care also affected access to primary care services. Some stakeholders mentioned instances where GPs ceased further involvement with irregular immigrants due to the high charges imposed by the NHS for secondary care. For instance, one caseworker described how one GP halted secondary care referrals for one irregular immigrant with back pain and instead resorted to prescribing him only pain relief medication. This was described as an example of the hostile environment created by the immigration system.

> *"I dealt with about 18 months ago an example of a hostile environment. A young man, with no access to public funds, and appeals rights exhausted, was hit by a car which gave him significant back pain. He was getting pain relief and other sorts of therapies. But he was starting to get charged for it and the charges built up into tens of thousands of pounds until his GP said they could not engage with him anymore. They refused him any sort of therapy intervention apart from immediate pain relief"* (Complex caseworker).

4.25.4 Impact of lack of recourse to public funds on homeless immigrants' health

Homeless immigrants without recourse to public funds described their inability to obtain free prescriptions, as they were required to pay for medications at the pharmacy. This financial barrier led some individuals to resort to self-medication with natural remedies for conditions like high blood pressure, potentially exacerbating their health conditions. The lack of access to prescribed medication also deterred them from seeking further GP services. Furthermore, immigrants without recourse to public funds relied heavily on friends, family, and charities for basic needs, which resulted in feelings of shame, vulnerability, loss of dignity, and disrespect. This, in turn, harmed their mental health, leading to experiences of depression.

> *"When you are here and you have no recourse to public funds, it means you're dependent on people, and friends, and it's undignified. You have to ask people for certain basic things, in terms of how you dress, shoes, ... you just feel vulnerable in that sense. There is no dignity, no respect, ... So, it is depressing. It's very depressing, you know"* (Male failed asylum seeker 13).

4.26 Insufficient personal financial resources

The majority of immigrants faced a lack of personal financial resources to afford health-related expenses such as prescriptions and transportation to GP surgeries. Many immigrants expressed not having enough money to pay for bus fare, leading them to walk long distances to access various services. This financial struggle was also confirmed by stakeholders, who observed how the cost of travel hindered immigrants from accessing necessary services due to inadequate finances. Despite receiving weekly allowances from the government, these allowances were insufficient to cover the additional expenses of transportation required to access healthcare services.

> *"Access to services could be challenged by travelling costs for asylum seekers because people who are seeking asylum live with less than 6 pounds a day. And that is to cover*

> *their needs … So that could prevent people from accessing services if they need to incur an additional cost because of the bus ride"* (Refugee project officer).

However, contrasting views emerged regarding the ability of immigrants to afford prescriptions. While some healthcare providers acknowledged financial hardships for certain individuals, others argued that most of their clients, who were on benefits, did not struggle with prescription costs. Additionally, some healthcare providers admitted being unaware of the financial barriers faced by immigrants in accessing prescriptions. As their role primarily focused on prescribing medication, discussions regarding the financial aspect of prescriptions were typically between immigrants and pharmacists. Consequently, if immigrants couldn't afford their prescriptions, healthcare providers felt powerless to intervene.

> *"We would issue a prescription, hand it to the patient and they would go to the pharmacy. So, it's only at that point that they would get involved in the cost element of it. So, I'm not sure that I would even know. I suppose some prescriptions can be bought cheaper over the counter, so you would hope the pharmacist would advise them of that. But if their prescription is only medicines, I don't think there is a legal way around it for us to be able to do anything about that"* (General practitioner).

Exploitation of immigrants

Due to limited personal financial resources, some homeless immigrants often find themselves in vulnerable situations, becoming targets for exploitation in various forms, such as labor and sexual exploitation. Additionally, irregular immigrants without recourse to public funds were at an increased risk of falling victim to modern slavery. Their lack of financial resources and self-sufficiency made them desperate and susceptible to manipulation, leading them to accept cash-in-hand jobs. These exploitative situations often involved low wages and poor working conditions, with examples ranging from farm work to living in inadequate caravans.

> *"The reality is that people are prepared to work for in under lesser conditions that is verging on a form of slavery. You pay people low wages, in bad working conditions. A lot of my group workers that come and work on farms live in shitty caravans"* (Mental health specialist).

4.27 Limited knowledge about benefits and financial support

More than a quarter of homeless immigrants lacked knowledge about benefits and financial support, particularly regarding their entitlement to free prescriptions. Some immigrants, unaware of their eligibility, paid for prescriptions related to their health conditions, such as diabetes, until they learned about the availability of free medication. Language barriers contributed to the lack of awareness, with some immigrants unable to effectively communicate with pharmacists and missing out on benefits. This lack of knowledge led to disappointment and frustration among immigrants who realized they were eligible for free prescriptions but had unknowingly paid for them.

> *"Because I'm diabetic, when I came here, at the beginning I paid for my medicine because I didn't know that you cannot pay if you are diabetic. But I didn't know, no one told me then that you don't have to pay for medicine in the pharmacy … So, I used to pay until I understood that I can take free medicine"* (Female indefinite leave 2).

Indeed, some stakeholders noted how some immigrants were unaware of their rights to access benefits. This insufficient knowledge was attributed to the hitches and difficulties of the benefits system.

> *"They don't know their rights … to universal credit benefits and generally, the benefits system is very complicated now. So, for them to understand, it is difficult"* (Counsellor).

4.28 Financial support from charities

The majority of immigrants reported receiving financial support from charities, including monthly allowances, phone credit, and transportation assistance. Charities also provided necessities such as clothes, toothpaste, and food to immigrants. This support improved their livelihoods, especially for those who were ineligible for public funds and faced homelessness. Stakeholders confirmed offering financial assistance, including paying for prescriptions for immigrants who lacked access to public funds and free prescriptions.

> *"That made me homeless because I'm not receiving any benefits from the government, no recourse to state funds, and I'm not working, I only depend on charities where I am collecting food. They sometimes give me vouchers for food or things from the shop"* (Male failed asylum seeker 13).

Theme 5: Appropriateness and homeless immigrants’ ability to engage in healthcare

4.29 Introduction

The next section elucidates the perspectives of both homeless immigrants and stakeholders regarding the suitability of primary care services for homeless immigrants in South East England. This encompasses the concepts of primary care service appropriateness (about the supply-side aspects of healthcare systems) and the capacity of homeless immigrants to engage in healthcare (related to the demand-side factors of homeless immigrants) (Levesque et al., 2013).

Appropriateness pertains to the alignment between primary care services and the specific needs of homeless immigrants. It encompasses the timeliness of care, the thoroughness of health issue assessments and treatment determinations, as well as the technical and interpersonal quality of the services offered (Levesque et al., 2013). It entailed two main sub-themes. The first sub-theme, *interpretation services* entailed mixed views from respondents because although some reported the availability of interpretation services, others reported the low availability of interpretation services at GP surgeries. There were also difficulties with three-way conversations, limited time for consultations, and insufficient knowledge about interpretation services. Respondents also reported the availability of supportive social networks on issues of interpretation and translation. The second sub-theme pertained to the *coordination and continuity of care*, focusing on immigrants' willingness and commitment to participating in healthcare and completing their treatment (Levesque et al., 2013). This sub-theme encompassed aspects such as the availability of referral services, instances of individuals being lost to follow-up, and coordination among different GP practices.

In addition to the concept of appropriateness, the homeless immigrants' ability to engage in healthcare relates to their active participation in decision-making and treatment processes. This dimension is closely tied to their communication skills, which significantly influence their interactions with healthcare providers (Levesque et al., 2013). The study's findings highlighted factors such as *communication difficulties* and the *nature of interactions between immigrants and healthcare providers* as influential elements affecting homeless immigrants' access to primary care services. Further elaboration on these factors is provided in the subsequent section.

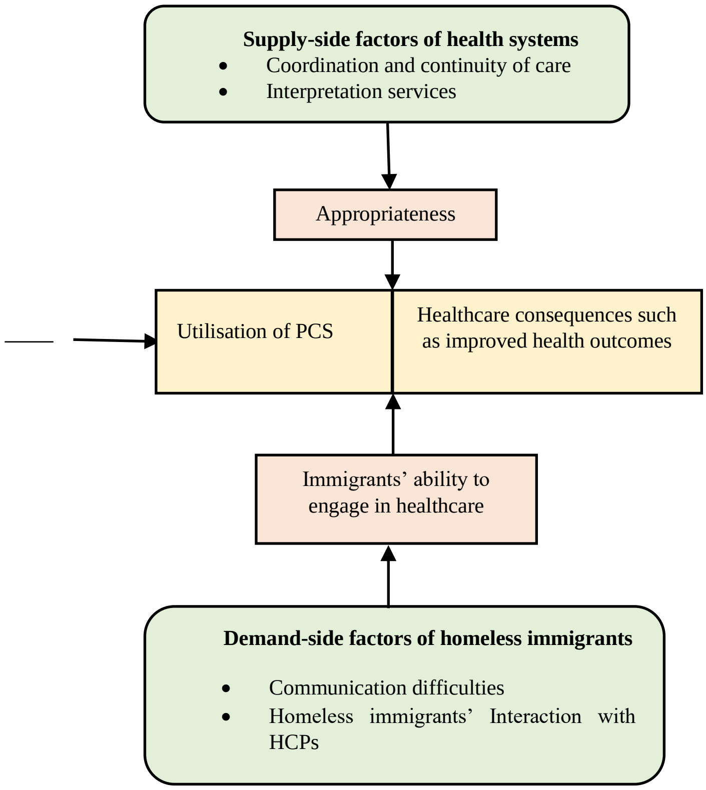


Figure 23 Theme 5: Appropriateness (supply-side) and homeless immigrants' ability to engage in healthcare (demand-side)

4.30 Communication difficulties

The majority of the respondents reported how communication difficulties impacted immigrants' access to primary care services. These difficulties were attributed to language barriers. Some immigrants found it hard to understand what the doctors were saying and vice versa. The inadequate English speaking and reading abilities also created difficulties for immigrants to navigate the healthcare system. Additionally, some immigrants who experienced language difficulties also reported experiencing discrimination from healthcare providers when seeking healthcare services. From the interviews, some stakeholders portrayed negative attitudes towards immigrants with language difficulties. It was also reported by the majority of stakeholders how the language barrier negatively impacted the provision of mental health services to immigrants. These factors are discussed in detail in the proceeding section.

4.30.1 Language barrier

Some homeless immigrants face challenges in communicating with healthcare providers due to language difficulties. They struggled to understand doctors and believed that they couldn't be understood either. To overcome this, some immigrants relied on a third party to speak on their behalf. Healthcare providers confirmed the existence of language barriers, noting that some immigrants had difficulties comprehending written information or instructions due to limited English reading and writing skills. This language barrier hindered effective communication and understanding of medical information.

> *“They don't read and write either. So if you text them or send a letter, they can`t read them or write, so it’s very, very difficult.”* (Advanced nurse practitioner).

Some homeless immigrants faced challenges expressing themselves and being understood by doctors during GP appointments. The limited time slots for appointments were inadequate for immigrants with language difficulties, leading to a perception that GP practices did not prioritize their needs. This affected their interaction with doctors, as some immigrants felt that doctors made assumptions about their illnesses and simply collected their prescriptions without meaningful engagement. Similarly, GP staff reported difficulties in supporting immigrants with language barriers, leading to unpleasant situations. Some staff resorted to communicating through the immigrants' children for interpretation, further highlighting the challenges faced in providing direct support to adult immigrants.

> *“They don’t care … the time they slot, sometimes I can’t even express myself very well, it’s now that I have started speaking English properly … so I can express well. When I first came in, it was difficult for me to express myself and they just assumed what they wanted to assume. Interacting is not interacting as you just go in there and get your medication and go”* (Female refugee 24).

4.30.2 Difficulties in navigating the healthcare system

The language barrier posed challenges for immigrants in navigating the healthcare system, as reported by stakeholders. Immigrants who couldn't understand how the system worked relied on others for translation, which negatively affected their confidence and ability to advocate for themselves. Consequently, these difficulties hindered some homeless immigrants from accessing GP services. Healthcare professionals confirmed that immigrants with limited English skills had a harder time accessing GP services and comprehending medical directions.

> *"And then we have the migrants that are coming over, ... but they come with health issues already, with no, or very little English language. And that makes it a lot more difficult for them to access the health services"* (Assistant practice manager).

4.30.3 Perceived discrimination and negative attitudes towards immigrants

Perceived discrimination

The majority of homeless immigrants with language challenges reported experiencing perceived discrimination at GP practices and other service providers. They felt that their inadequate English-speaking skills led to them being ignored and not listened to. Additionally, they mentioned being treated as stupid because of their limited English proficiency. However, as their English skills improved, they felt less racialized and experienced less discrimination. Stakeholders also confirmed the issue of racism, with some immigrants facing discrimination at GP practices. One social prescriber described how colleagues treated immigrants with language difficulties differently, showing reluctance to help them and being quick to get rid of them if any problems arose. Despite changes in healthcare personnel, the statements from immigrants indicate that discrimination and unfair treatment based on language difficulties persist.

> *"To be honest, racism is a big issue everywhere, I feel it. But the more I speak English, the less I feel racism. But when you do not understand the language, people tend to look down at you like you are stupid or something"* (Female indefinite leave 2).

Negative attitudes towards immigrants

Negative attitudes towards immigrants with language difficulties were evident among some stakeholders, who questioned whether doctors should be expected to speak all languages spoken by immigrants. This skepticism and dismissive attitude may have contributed to a lack of trust in healthcare providers, thus impeding homeless immigrants' access to primary care services. Additionally, some stakeholders questioned why immigrants would choose to move to a country where they couldn't speak the language, expressing their inability to support such individuals due to the communication barrier. These attitudes and statements reflect a lack of empathy and understanding toward the challenges faced by immigrants with limited language proficiency.

> *"If they go where they cannot communicate well, it's tough or do you expect the doctor to speak all the languages in the world?"* (Project worker).

> *"To be honest with you, I don't understand their mentality, I would not move to another country if I could not speak some of their language ... they come in here, 'what do you expect me to do? I've got no way of understanding what you're talking about, why do you expect it to be all on your terms?' ... the fact that people come with no English come here whatsoever confounds me"* (Mental health specialist).

4.30.4 Impact of language barrier on the provision of mental health services

The majority of stakeholders highlighted the impact of language difficulties on the provision of mental health services to immigrants. They observed that immigrants who couldn't speak English faced challenges in discussing their traumatic experiences during talking therapies. Other stakeholders agreed on the negative effect of the language barrier, emphasizing the importance of providing mental health support, especially talking therapies, in the native language of immigrants to facilitate effective communication and address their trauma.

> *"I feel that you probably need to speak to someone in your language to discuss complex trauma ... I think for talking therapies, you need someone that would speak your language ... So now, I agree it would be an impact further on your mental health because you've got no one to talk to about it"* (Outreach service manager EK).

Stakeholders reported difficulties in conducting mental health assessments for immigrants who were not proficient in English, leading them to prioritize support for those who could express themselves clearly in English. They expressed concerns that important information might be missed when immigrants with language difficulties were unable to articulate themselves effectively. Consequently, healthcare providers argued that immigrants with language barriers may not receive adequate mental health support. Referrals were also affected by language difficulties, as some immigrants found it challenging to communicate their mental health concerns to GPs, hindering appropriate referrals to culturally sensitive mental health services and negatively impacting their access to care.

> *"It's very difficult for me to do a full accurate mental health assessment for somebody whose English is not their first language. So, I tend to have less to do with non-English clients because of how people say things and how they say can be completely missed ... some of our clients' English is not very good ... so, I would argue that because of the language barrier, I imagine people from outside of this country do not get as good of a service*" (Mental health specialist).

4.31 Interpretation services

There were mixed views about interpretation services. Although the majority of the immigrants and stakeholders reported the availability of interpretation services, others also reported the low availability of interpretation services. However, very few immigrants reported this. This might be because the non-English speaking immigrants were excluded from the study. There were also difficulties with three-way conversations, limited time for consultations, long waiting times for an interpreter, and the lack of awareness about the availability of interpretation services. However, social networks were reported to offer support in interpretation for the immigrants as discussed below.

4.31.1 Availability of interpretation services

Both homeless immigrants and stakeholders mentioned the availability of interpretation services provided by GP practices for individuals who could not communicate in English. Homeless immigrants expressed gratitude for the assistance of interpreters, highlighting how it improved their ability to understand and be understood by healthcare professionals. Similarly, stakeholders also acknowledged the use of interpretation services such as the Big Word, Google Translate, and Language Line services, which facilitated communication with immigrants who faced language barriers. These services allowed for three-way conversations over the phone, ensuring privacy and confidentiality. Healthcare providers emphasized the importance of confidentiality, reassuring immigrants that interpreters were not involved with the Home Office, and creating a safe environment for immigrants to discuss their healthcare needs openly.

> *"Now I'm a little bit better than before. Before I couldn't speak, I couldn't understand ... my GP helped me, they got me an interpreter. I was happy when they got an interpreter*" (Female asylum seeker 3).

While translation services played a crucial role in facilitating access to healthcare services, stakeholders noted their limitations during informal visits aimed at fostering relationships and trust within immigrant communities. Stakeholders expressed concerns about the effectiveness of tools like Google Translate, highlighting the need for more nuanced understanding and cultural integration. Additionally, stakeholders mentioned the limitations of available translation services, particularly for languages with various dialects or specific cultural and religious aspects. They stressed the significance of accessing culturally appropriate interpreters who can effectively bridge the linguistic and cultural gaps in healthcare communication.

> *"We have, we have access to translation services. But it's limited in some languages. So, [mentions language] is limited for us* (Assistant practice manager).

4.31.2 Difficulties with three-way conversations

While interpretation services were available to address language barriers, some homeless immigrants expressed concerns about the accuracy of the information being translated, leading to a loss in translation. Similarly, healthcare providers were unsure if all their information and questions were accurately conveyed and if the immigrants received an exact interpretation due to potential differences in word meanings and interpreters' discomfort with certain topics. The authenticity of interpreters, particularly in mental health services, was also questioned by other stakeholders. These issues highlight the complexities and potential limitations of interpretation services in ensuring effective communication and understanding between healthcare providers and immigrants.

> *"As I said, there's a loss in translation sometimes that occurs"* (Male asylum seeker 1).

> *"So, the challenge is, in the past, the challenges have been accessing interpreting services and translation services, so feedback was that when delivering a therapeutic model, sometimes interpreters and translators weren't always authentic in their translation may be"* (Mental health implementation manager)

Healthcare providers expressed concerns about the authenticity of interpreters in delivering mental health services, as they believed that discussing traumatic experiences with a third person present could hinder effective trauma work. They also highlighted the complexities of mental health and the potential for meaning to be lost or altered in translation, making it challenging to assist individuals with trauma and PTSD. Additionally, three-way conversations involving interpreters were reported to make it difficult to discuss intimate health needs, particularly when the interpreter was of the opposite gender. This lack of choice in selecting interpreters based on gender or other preferences created uncomfortable situations for immigrants, impeding open communication. Healthcare providers stressed the importance of accessing appropriate interpreters who consider factors such as age, gender, and cultural background to foster a safe and comfortable environment for immigrants to disclose their health needs.

> *"There's also the problem of what kind of trauma work you can do with an interpreter. Some people might feel that having a third person in that setting can make it difficult to do appropriate trauma work. And of course, part of the issue with suffering from PTSD and things is that often trauma work can be really hard"* (Generalist advice worker).

4.31.3 Low availability of interpretation services

A small number of immigrants expressed concerns about the limited availability of interpretation services, although it should be noted that all the interviewed immigrants in the study were English speakers, potentially excluding non-English speakers. In contrast, a significant portion of stakeholders reported low availability of these services. Healthcare providers admitted that interpreters were not consistently present and were often available for a limited time. This longstanding challenge of insufficient interpretation services led some healthcare providers to resort to alternative communication methods such as drawings, signs, and pointing, but they remained uncertain about the accuracy of the information conveyed. Immigrants who experienced inadequate interpretation services shared instances where they were denied healthcare access due to a lack of interpreters at the surgery, causing them to be sent home without treatment. These difficulties in accessing interpreters also hindered their ability to establish social networks, contributing to their exclusion from healthcare services and negatively impacting their mental health, leading to feelings of depression.

> *"The interpreters are not there all the time. So, it was only at certain times they came in but most of the time it's communication through drawing, through signing, or pointing to things. And you wonder whether you got the true stories as well"* (Advanced nurse practitioner).

Some immigrants who faced a lack of interpretation services shared their experiences of being denied access to healthcare when they couldn't speak English and didn't have anyone to interpret for them at the surgery. This forced them to seek help from friends or rely on their limited English proficiency, leading to frustration and emotional distress. As a result, some immigrants resorted to using emergency services instead of regular healthcare. However, healthcare providers raised concerns that even emergency services might also have limited availability of interpreters, suggesting that this alternative may not effectively address the issue.

> *"They will end up using A&E services. But again, I don't know how they manage in A&E because they won't have interpreters in there either"* (Advanced nurse practitioner).

However, some stakeholders held the view that the limited availability of interpretation services would not directly impact access to GP services for immigrants. Instead, they believed it would primarily affect the communication between healthcare providers and immigrants, potentially leaving immigrants unaware of the details discussed during their appointments. However, they acknowledged that without an interpreter present, it would be challenging to have effective discussions with the GP. This lack of communication could lead to difficulties in understanding and retaining important information. Therefore, healthcare providers emphasized the importance of obtaining informed consent from individuals with language difficulties to ensure that were fully informed about the proposed examinations and procedures before proceeding.

> *"Well, it would not affect access, but it would be a challenge discussing with the GP ... it means that when they don't have an interpreter around, it will be difficult communicating with the GP*" (Public health specialist).

4.31.4 Limited time for consultations

Some healthcare providers expressed their disappointment when immigrants with language difficulties arrived for appointments without prior planning, such as booking interpreters. They highlighted that the standard 10-minute appointment slot was inadequate for addressing the complex and often numerous unmet needs of these immigrants, which were further exacerbated by the language barrier. The healthcare providers found it challenging to communicate with the patients and recognized the significant unmet needs that couldn't be adequately addressed within the limited time frame and language constraints. To address this issue, some healthcare providers arranged for longer consultations with appropriate interpreters to effectively address the immigrants' concerns. However, the scheduling of appointments often did not account for the additional time required for consultations with interpreters, particularly affecting homeless immigrants who faced complex problems and multiple health issues. Some immigrants expressed fear of accessing GP services without an interpreter, as they believed it would waste the doctor's time, considering the standard 10-minute appointment slot given to the general population.

> *“It's usually a little bit of a heart-sink situation when they turn up into a normal 10-minute slot with no preplanning whatsoever. So, no one's asked about the need for interpreters. So, they just turn up and often the first thing you realise is that you can't communicate with them because you don't speak the language, and you also realise that there's a huge level of unmet needs there that you can't even begin to try and meet in 1–10-minute appointment when there's a huge language barrier”* (General practitioner).

4.31.5 Long waiting times for an interpreter

More than a quarter of the stakeholders highlighted long waiting times for interpreters, leading to delays in accessing healthcare services. Healthcare providers reported having to reschedule appointments for at least two more weeks if immigrants with language difficulties arrived without an interpreter. While services like the Big Word and Language Line were deemed useful for some immigrants, accessing these services involved pre-booking, often requiring a wait of two weeks or more. Furthermore, there were instances where interpreters failed to show up for appointments, further prolonging the waiting times and impeding immigrants' access to healthcare. The scarcity of interpreters for certain languages was identified as a contributing factor to the delays.

> *“Some GP surgeries have access to translation services called the Big Word ... So, if someone came in and wanted an appointment, you would have to book them in two weeks because then you knew that the interpreter would come down. So sometimes the interpreter didn't turn up, sometimes they would call in sick and people or patients would be waiting for appointments and wouldn't be able to get anywhere*” (Social prescriber).

4.31.6 Lack of awareness about the availability of interpretation services

Some immigrants expressed their lack of awareness regarding the availability of interpreter services at GP surgeries. They mentioned not being informed about the option of accessing interpreters and recommended that information about these services should be provided at the surgeries. This perception of limited awareness was supported by other stakeholders who observed that immigrants without access to interpreting services were often unaware of their existence and how to access them. Furthermore, it was noted that some receptionists were also uninformed about interpretation services, leading to missed opportunities for healthcare services as immigrants were instructed to bring their interpreters.

> *“Nobody told me I could get an interpreter … If you go to most GPs, you will never see the information that you have an interpreter or a translator there. There should be information for people like me coming in for the GP to know that I can speak to somebody who understands my language there and my problem will be solved”* (Female refugee 24).

4.31.7 Availability of supportive social networks

Relying on charities

Some immigrants, who were unaware of how to access interpretation services, relied on charities to arrange appropriate interpreters for their GP appointments. In addition, other stakeholders mentioned attending appointments with immigrants to serve as interpreters due to the limited availability of interpretation services at the surgeries. These actions were seen as a way to bridge the communication gap and ensure access to healthcare services. Furthermore, some immigrants highlighted their initial reliance on charities to learn English, which empowered them to become independent and act as ambassadors, assisting others in learning English, engaging with the community, and providing interpretation services when needed.

> *“When they go to the hospital or the GP because of the language, they need someone to interpret for them, even though most of the time they provide interpreters, but they don’t always. They call us for support. So, we help them to interpret as well”* (Counsellor).

Relying on family and friends

Some immigrants relied on family and friends for interpretation services. One female immigrant mentioned that she depended on her husband to translate for her during medical appointments due to her limited English speaking skills. Healthcare professionals also acknowledged this practice, noting that some adults sought interpretation assistance from their children. However, there were reservations about relying on children to interpret sensitive health information, particularly when it involved intimate questions. Despite these concerns, consultations had to proceed without alternative options.

> *“Sometimes I've had children as a family member interpreting and having to ask women sort of personal gyno questions which just feel inappropriate, but you know, you just have to do what you can do” (General practitioner).*

Some healthcare providers emphasized the importance of having a professional interpreter provided by the GP surgery rather than relying on family and friends for interpretation. They expressed concerns about the accuracy of interpretation by non-professionals and the potential reluctance of immigrants to share sensitive information in the presence of their loved ones. Additionally, there were worries that family members might withhold or distort information, particularly when delivering bad news. Despite acknowledging the use of family and friends as interpreters, healthcare providers preferred the presence of trained interpreters to ensure accurate and confidential communication during medical consultations.

> *"I think having an interpreter in the room with you is by far the best option. There's all the problems of family interpreters and not knowing whether you're getting the correct translation, whether there's any fear factors, whether they're not wanting to tell the truth with a family member there"* (General practitioner).

Therefore, some healthcare providers were adamant about permitting family and friends to interpret for immigrants. Although it was not unacceptable, they preferred interpreters provided

4.32 Homeless immigrants' interactions with healthcare providers

Similar to other studies (Kang, Farrington and Tomkow, 2019b), participants' experiences of medical consultations were mixed. Although more than a quarter of the homeless immigrants found their interactions with medical professionals to be positive, a larger number experienced negative interactions with their healthcare providers as discussed in the proceeding section.

4.32.1 Positive interactions with healthcare providers

About a quarter of homeless immigrants had positive interactions with healthcare providers, according to their accounts. They praised doctors who were calm, and attentive and took the time to listen to their health concerns. Some doctors even followed up with phone calls if they missed appointments or to check on their well-being. Additionally, some homeless immigrants with mental health issues reported receiving prompt appointments and warm greetings from some doctors who demonstrated genuine concern. These positive practices facilitated their access to primary care services, and these homeless immigrants felt supported by their doctors. Furthermore, some homeless immigrants mentioned that their doctors went the extra mile to assist them in writing referral letters to access mental health support.

However, it is worth noting that some immigrants may not fully understand the role of GPs, as it is part of their responsibility to refer patients to appropriate mental health services.

> *"He was really good and calm. There are a lot of asylum seekers, and he was the favourite of the doctors. He was so calm if you had any problem, he always saw us, listened to what we've got to say, that GP was good… Sometimes he would see us for hours ... If for example, he didn't see me, he couldn't get hold of me for a while, he had to call and check if I was okay, that's how nice he was, you know, of all the doctors I saw"* (Female refugee 28).

Some homeless immigrants expressed that they did not face any discrimination at the surgeries and were treated well regardless of their immigration status. They reported receiving appointments without delays, which contributed to their satisfaction with the services provided. The availability of appointments played a role in fostering positive interactions between healthcare providers and immigrants. The immigrants who experienced smooth appointment scheduling felt that the doctors were kind to them. Additionally, some homeless immigrants highlighted the helpfulness and politeness of some receptionists, who guided and engaged in conversations with them, further facilitating their access to healthcare services. These interactions demonstrated the positive impact of engaging with homeless immigrants and creating a welcoming environment at the GP surgeries.

> *"My experience with the GPs is very good ... very good receptionists, very polite. They go the extra mile of trying to help you, to guide you ... So that's how they have been. And even the receptionist, when you go they want to have a chat with you, I mean, they are friendly anyway. I don't how to put it but they are friendly"* (Male failed asylum seeker 13).

4.32.2 Negative interactions with healthcare professionals

Perception of racial discrimination

Despite some homeless immigrants reporting positive interactions with healthcare providers, a majority of them experienced negative encounters, perceiving racial discrimination. They felt that they were looked down upon and unwelcome by some receptionists due to factors such as their non-British background, migrant status, or language difficulties. They believed that racial discrimination was the reason behind limited doctor appointments, as they had to struggle to secure appointments and often relied on third parties like charities for assistance. Homeless immigrants also expressed disappointment in the surgeries for their perceived inaction in addressing these issues. These accounts highlighted the pervasive nature of racial discrimination in healthcare and its detrimental impact on immigrant access and experiences.

> *"The discrimination is a lot, I am not gonna lie ... I speak English, I don't know how to speak my language, I was like you can understand me, why don't you just give me an appointment, why? They would give their appointment if the charity was involved. I think there's a stigma among doctors to Africans, we people with a refugee or migrant background ... Whether you are an asylum seeker or you have a refugee status, that stigma follows you. I don't think that will ever stop because nobody's talking about it"* (Female refugee 28).

Similarly, some homeless immigrants shared accounts of doctors being rude and disrespectful, asking irrelevant and inappropriate personal questions that negatively affected their mental health and left them feeling stressed. Despite making complaints, no action was taken to address these issues. Stakeholders also highlighted the common occurrence of homeless immigrants being treated differently due to their migrant status, receiving inferior treatment, and having their rights ignored. Many immigrants, unaware of their rights to equal treatment, accepted such differential treatment from surgeries. Furthermore, some homeless immigrants questioned why they were directed to specific doctors who exclusively handled immigrant health concerns, perceiving it as discriminatory and leading to differential treatment, such as medication reduction. These experiences shed light on the disparities and discrimination faced by immigrants within the healthcare system.

> *"She's my doctor but she's very rude, they respect no one, she always says, 'You make me crazy. What do I do with you? Why not get married? Why not find a boyfriend? ... She's very. Too many times I make reports and my caseworker makes a claim to the GP, and my counsellor also sends them a message, 'why make her very stressed? why not help her?"* (Female asylum seeker 4).

Denied GP registration due to immigration status

Homeless immigrants face difficulties in obtaining GP registration due to their immigration status. Similarly, healthcare providers observed instances where immigrants were denied registration by GP surgeries based on their immigration status. Some healthcare providers attempted to justify the denials by highlighting the varying operational practices of GP practices. Additionally, some privately owned GP practices, functioning as businesses, refused to accept immigrant registrations, even training their staff, including receptionists, to deny registration to certain groups such as asylum seekers.

> *"You've got to remember that there are hundreds of GP practices, each one is owned by the doctors or by the partners and run as a business. So, there are no unifying rules regarding anything. There's advice and there's guidance that they're all well-supported for. But ultimately, you know how one practice trains its staff against how another practice trains its staff ... Maybe there's the staff that doesn't agree with the asylum seekers being here"* (Nurse practitioner).

Discrimination due to homelessness

Homeless immigrants faced discrimination based on their homelessness, leading to mistrust and challenges in receiving adequate healthcare. Some homeless immigrants described instances where GP staff doubted the legitimacy of their health concerns, assuming they were exaggerating or being dramatic. This lack of trust and dismissal of their concerns created a sense of being ignored and not taken seriously. One female asylum seeker shared her experience of repeatedly being ignored when seeking help for severe back pain, attributing it to the assumption that being homeless made her less credible. Healthcare providers also observed discrimination within GP waiting rooms, where other patients stigmatized homeless immigrants based on their perceived body odour, creating an unwelcoming environment for them.

> *"Because they probably knew I am a homeless person ... sometimes the management is rude. Most of the time when I go there to ask about my health problems, they think I'm doing some kind of drama ... they think that I'm lying, so they don't take it very seriously ... They don't trust us basically ... For example, I have a very big back pain. Many times, I've asked my GP but he simply ignored me"* (Female asylum seeker 5).

Besides facing discrimination based on their homelessness, some homeless immigrants at GP surgeries were unfairly perceived as thieves by other patients. Some non-migrant patients expressed concerns that immigrants might steal their belongings and opposed their access to GP surgeries. Challenging these misconceptions, stakeholders emphasized the need for awareness campaigns on equality and diversity. However, stakeholders working with charities contradicted these reports, stating that they had not witnessed any discrimination during GP appointments with immigrants and emphasized equal treatment regardless of immigration status. This discrepancy suggests that experiences varied depending on the GP practice. Consequently, the differing operational practices of GP surgeries were identified as both positive and negative aspects of the healthcare system.

> *"When we have the travellers in, immediately people start to say, 'we don't want them here, watch your handbag they will steal everything'. Just because I have travelled doesn't mean to say I am a thief. 'You know if they come in here, they will start to rob, pick pocket people', like really where does this come from? And again, it's time to stop this prejudice and misbeliefs. And I think there needs to be some sort of training on equality and diversity"* (Advanced nurse practitioner).

4.33.3 Hesitant to engage with healthcare providers and services

A significant number of stakeholders highlighted the hesitancy of some immigrants to engage with healthcare providers and services. This reluctance was attributed to experiences of racial discrimination within their communities, which deterred them from participating in community outreach initiatives. Hateful comments and prejudice towards immigrants were reported by some stakeholders, leading to decreased immigrant engagement. In addition, some stakeholders from the voluntary sector emphasized their role in advocating for and assisting immigrants who were willing to engage with their organizations in registering for and accessing GP services. However, immigrants who were hesitant to engage with these services faced challenges in accessing healthcare without the support of these organizations.

> *"I was looking on [mentions name], it's like the online newspaper and I looked at our promotion for the event and the first comment, it's from somebody and he just said stab vests required which is just unnecessary and a bit hateful. I think, because of that, people have been a bit reluctant to engage"* (Social prescriber).

Some stakeholders highlighted that certain immigrants were hesitant to seek healthcare due to their traumatic experiences, leading to self-neglect and isolation. This underscores the importance of establishing trust before immigrants feel comfortable disclosing their traumatic experiences and seeking support. While stakeholders emphasized the need to respect immigrants' decisions about healthcare engagement, they also stressed the importance of providing information about the benefits of seeking care and the potential consequences of not doing so. However, stakeholders from the voluntary sector noted that immigrants' reluctance to engage with healthcare providers resulted from multiple barriers, including long waiting times, language barriers, discrimination, and low self-esteem, such as feelings of shame, which collectively hindered their access to healthcare.

> *"I think accessing those kinds of services is difficult. And it can just go back to so many things that will put off people, it's the bureaucracy, the waiting, the language, the assumptions being made, the self-perceptions of the young people themselves, and the stigma. They feel ashamed, so all those things again coming together to just make that whole issue of trying to access kind of more difficult"* (Complex case worker).

4.33 Coordination and continuity of care

4.33.1 Availability of referral services

The availability of referral services was highlighted by some homeless immigrants who shared their experiences of being referred to hospitals for health care, as well as to charities for basic needs like food and social networking opportunities to combat isolation. Similarly, some stakeholders mentioned referring immigrants to GP surgeries for mental health conditions that exceeded the capacities of their mental health specialists. Overall, these examples demonstrate the collaborative efforts of various organizations in ensuring immigrants receive appropriate care and support.

> *"They have given me a lot of support because, sometimes they referred me to food banks. If I'm a victim of FGM, they will refer me to charities that deal with FGM victims. So, they do referrals like support and wellbeing. They even referred me to another charity where I can go with my baby so I can interact with other women, so I don't feel isolated"* (Female refugee 24).

4.33.2 Lost to follow-up

Healthcare providers highlighted the issue of homeless immigrants, particularly those staying in temporary accommodations like hostels, being lost to follow-up as they frequently moved and didn't return for healthcare services. The problem was compounded by misspelled or misinterpreted names, leading to new GP registrations and the assignment of multiple NHS numbers, disrupting continuity of care. The COVID-19 pandemic further exacerbated the situation, with some immigrants becoming "ghost patients" as healthcare providers struggled to contact them for vaccination invitations and were unsure of their whereabouts. These challenges demonstrate the difficulties in maintaining consistent healthcare access and engagement for immigrants, necessitating improved strategies for follow-up and communication.

> *"The other issue we have is, we have those classed as ghost patients where certainly over the last couple of years with COVID, we don't know if people have gone back to*

> *their own country or have not. They've not registered elsewhere, but we can't get hold of them. And it comes to light during the COVID vaccination programme as you're sending letters, you're trying to ring people and we can't get hold of individuals*" (Assistant practice manager).

However, certain healthcare providers took proactive measures to follow up with hard-to-reach individuals, including those who were not registered with a GP and those who, despite being registered, did not regularly attend specialist appointments after referrals. This approach allowed healthcare providers to gain insights into the reasons behind patients' hesitancy to engage with healthcare services. Additionally, some immigrants reported receiving regular check-ups from their doctors after experiencing a serious health condition, demonstrating the efforts made to ensure their well-being. These initiatives highlight the importance of personalized and persistent outreach to address barriers and enhance patient engagement in healthcare.

> *"So, the remit of my practice was to find those invisible patients, those who aren't registered to GPs, those who are registered with GPs but don't frequently attend or do not attend specialist appointments at the hospital following a referral to look at the reasons for that"* (Focused care team lead).

4.33.3 Coordination among GP practices

The coordination among GP practices was significantly enhanced, according to healthcare providers, due to the integration of digital systems. The linking of different surgeries' digital systems allowed for seamless access to patient records when individuals transferred from one practice to another, ensuring continuity of care. This improvement was exemplified by the consolidation of GP IT systems in certain regions, such as Kent and Medway, which previously operated on different platforms that lacked interoperability. Healthcare providers emphasized the convenience of accessing a patient's records through their NHS number, which facilitated continuity of care within the primary care network. These advancements in digital coordination contribute to more efficient and effective healthcare delivery across multiple GP practices.

> *"The digital systems are now linked up, so for example in Kent and Medway, we are all on one GP system now. They used to be different GP IT systems and they didn't talk to each other. So, every practice now is on one system, which means if someone transfers*

from one practice to another, all that goes with them, … your basic data like your name, address and drugs and your health issues” (GP associate).

Theme 6: Additional factors: Impact of COVID and homeless immigrants' accommodation

4.34 Introduction

Although the Levesque et al. (2013) framework incorporated a majority of the study's findings into its five dimensions and abilities, some themes were however difficult to incorporate into these dimensions. These included the impact of COVID and homeless immigrants' accommodation on access to PCS for homeless immigrants. The *COVID-19 pandemic* contributed to inadequate face-to-face appointments, long waiting times for treatment, and closure of community day centres, thus impacting homeless immigrants' mental health. Additionally, the *immigrants' accommodation* which comprised of unstable accommodation impacted immigrants' livelihoods and health, GP registration, appointments with healthcare providers, and continuity of care. Moreover, immigrants reported how inadequate and unfit accommodation had an impact on their health and how their social networks provided support to address their housing challenges. These factors are discussed in detail in the proceeding section.

4.35 Homeless immigrants' accommodation

This sub-theme involves two main categories. The unstable accommodation was reported by the majority of participants to impact homeless immigrants' livelihoods, GP registration, their appointments with healthcare providers, continuity to healthcare, and their health. Moreover, immigrants reported being moved to inadequate accommodation that was dirty, damp, infested with vectors, and unsafe for occupancy. The inadequate accommodation was reported to impact immigrants' health including their mental health. However, the immigrants' social networks supported some of them who had accommodation issues. These factors are discussed further in the following section.

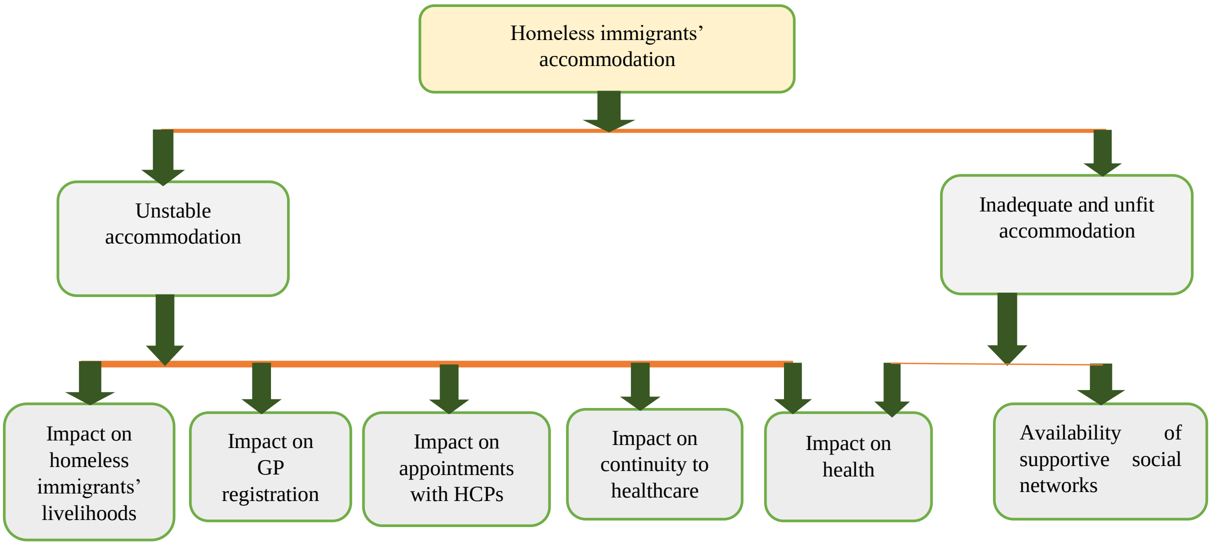


Figure 24 Sub-theme: Homeless immigrants' accommodation

4.35.1 Unstable accommodation

The issue of unstable accommodation was a prevalent concern among homeless immigrants, with a majority experiencing a lack of stable housing. Homeless immigrants, especially asylum seekers, highlighted being constantly relocated to different accommodations by the Home Office. Furthermore, asylum seekers whose claims were rejected were instructed to vacate their Home Office accommodation, leading some to seek temporary shelter with friends and family, stay in night shelters, or even resort to sleeping on the streets. This underscores the vulnerability and challenges faced by homeless immigrants in finding secure and consistent housing.

> *"I asked the Home Office for help. Then they first gave me a place in the hostel which was only for one year. And then when I lost my case, they took it back. Then I came on the road again. And then I was in the night shelter for a few months"* (Female asylum seeker 5).

Impact on immigrants' livelihoods

The lack of stable accommodation had significant repercussions on the livelihoods of homeless immigrants, leading to a lack of stability and hindering their ability to form social connections and build a sense of belonging in communities. Children were particularly affected, as the frequent changes in schools and neighbourhoods disrupted their education and social integration. The demanding commute to reach school on time, combined with the disrupted sleep patterns caused by early mornings, left the children exhausted and unfocused in the classroom. These challenges highlight the detrimental impact of unstable accommodation on the overall well-being and educational prospects of homeless immigrant families.

> *"And then they keep moving you from one place to the other ... So, it's not good for the kids, they're trying to fit in, and you don't want to keep changing their schools. So, if they take you to a far place, you have to travel far making the kids to be waking up early ... And if I don't do that, they will get late to school ... When they get to school, they are tired and always sleepy. Their teacher will be complaining but what can I do?"* (Female refugee 22).

Impact on GP registration

The frequent relocations of homeless immigrants had a notable impact on their GP registration process. Each move required them to register with a new GP, presenting difficulties for those who lacked proof of address, which was often required by GP practices. Consequently, some immigrants were reluctant to register with a GP due to the inconvenience of registering only to be relocated again shortly afterward. The instability of their living situations left them uncertain about the duration of their stay in one place, making it challenging to establish consistent access to healthcare. Additionally, homeless immigrants who did not change their GP after moving faced difficulties in accessing their previous GP, as the distance between their new accommodation and the former GP's location posed obstacles to regular healthcare provision. This highlights the barriers and complexities faced by homeless immigrants in maintaining a stable and accessible GP registration, further exacerbating their healthcare challenges.

> *Because of the instability, and the moving everywhere, you have to think twice before you start registering because when you register, the next day they move you again, so you have to register again. If you register now, they move you again to another place, you get to that place, again they tell you, "Oh, okay, you want to register, you are now living here?", you are not even sure if by the time you resister they are not gonna move you again, you don't know"* (Female refugee 26).

Impact on appointments with healthcare providers

The frequent changes in GP practices for homeless immigrants resulted in extended waiting periods for appointments with healthcare providers. Immigrants who were previously receiving treatment experienced the need to join new waiting lists upon relocation. Consequently, the delays in receiving necessary treatment had a detrimental impact on the health conditions of some immigrants, as their conditions worsened during the waiting period. This highlights the negative consequences of disrupted continuity of care and prolonged waiting times on the health outcomes of homeless immigrants.

> *"I had a Physio before I was moved, and then when they moved me to this place, I'm still on the waiting list to see a Physio. This is affecting me so bad, like sometimes I can't even get up to do my day-to-day routine for my children. That's how bad the pain is and when you tell the GP, you just have to wait ... So, moving people from one place to the other is affecting especially people with medical needs. It will still either not make them get the treatments in time, either will worsen the situation or even die ..."* (Female refugee 18).

Impact on continuity of healthcare

The continuous movements of homeless immigrants had a significant impact on the continuity of their healthcare. Health practitioners expressed frustration with immigrants who accessed GP services but failed to return for follow-up appointments, considering it a waste of their time and effort. This lack of continuity posed challenges in addressing the unmet healthcare needs of immigrants, hindering effective treatment and support. Healthcare providers noted that some homeless immigrants often lacked a health history, including vaccination records, requiring healthcare providers to gather comprehensive information during initial appointments and share it with subsequent surgeries in case of relocation. This approach aimed to build trust and minimize the need for repeated explanations. However, the transient nature of homelessness prevented a thorough understanding of complex health conditions, such as trauma, as individuals did not stay in one place long enough for comprehensive assessments. While some health practitioners considered referring immigrants back to their previous GPs for continued care, the practicality of accessing previous GPs was hindered by long distances and inconveniences faced by homeless immigrants. This highlights the intricate challenges faced in ensuring continuity of care for homeless individuals, with the need for improved coordination and accessibility across healthcare providers.

> *So that's part of the problem with the migrant population, on the whole, is that they tend not to stay anywhere too long, not for any fault of their own, but perhaps that's just their temporary accommodation. So, they'll often come to me and they're in the middle of sessions for X or Y, and I'll assess whether they should go back to where they came*

> *from to continue that care or whether there will be any sort of detriment to their health to be referred into local services*" (Nurse practitioner).

Impact of unstable accommodation on health

The continuous movements were also reported to impact negatively on the health of some homeless immigrants. One female refugee reported how she had a miscarriage as a result of moving up and down from one accommodation to the next. Others also reported how the process was tiresome and exhausting.

> *"I had a miscarriage while I was even running up and down. You know, trying to make sure they do everything that they need to do and I was pregnant at that time. So, I had a miscarriage because of this, rushing, running and these things"* (Female refugee 22).

4.35.2 Inadequate and unfit accommodation

Homeless immigrants faced significant challenges with the accommodations they were placed in. Safety concerns were prevalent, with incidents of theft, alcohol consumption, smoking, and fighting occurring in some accommodations. Female immigrants residing in mixed-gender housing felt particularly unsafe. Additionally, immigrants described living in unfit conditions, including mold, dirt, leaks, and infestations of bedbugs and cockroaches. Landlords were often slow or unwilling to address these issues. Some accommodations provided by the city council were overcrowded, leading to unsanitary conditions and inadequate facilities. Stakeholders confirmed these accounts, noting that immigrants were often given substandard, rundown accommodations due to cost considerations. This treatment was seen as unjust, as immigrants had endured arduous journeys only to be subjected to poor living conditions. Moreover, those given inadequate housing had no choice but to accept it. Furthermore, even after obtaining refugee status, some asylum seekers encountered difficulty in finding private rentals due to landlords' reluctance to accept tenants on a benefits system. The experiences of inadequate and unfit accommodations highlight the urgent need for improved housing options and fair treatment for homeless immigrants.

> *"I was staying in that hostel for 2 months. It was very, very bad. It was too dangerous for me. The people there were drinking, smoking, always fighting … I couldn't stay there, in this mix, I had a 1 room and there was a behind me boy, the room next to me was a boy, around me all boys, am the only girl on the second floor … I can't believe how I stayed in that hostel for 2 months because it was too dangerous for me"* (Female asylum seeker 4).

Impact of inadequate accommodation on health

The impact of inadequate accommodation on the health of homeless immigrants is significant and multifaceted. The cramped living conditions, lack of windows, and infestations of vectors like bedbugs not only contributed to feelings of loneliness and confinement but also triggered traumatic experiences for individuals who had faced persecution in their home countries. The unsafe environment further worsened mental health, leading to depression, anxiety, and stress. Noise pollution in overcrowded accommodations disrupted sleep, while cold and damp conditions caused physical illnesses such as hypothermia. Children were particularly affected, with instances of illness attributed to the unsafe environment. For example, exposure to smoking in the accommodation resulted in severe illness among some children, necessitating frequent visits to emergency services until a change in accommodation was arranged by social services. These accounts underscore the urgent need for suitable and safe housing for homeless immigrants to safeguard their physical and mental well-being.

> *"It did affect my mental health. Because I was suffering already from anxiety, PTSD, depression, and panic attacks. So that just elevated it basically … I remember when they put me in this place which had no windows that reminded me of a prison cell. Because I was put in a prison cell back home for going against the authority. So, I had a panic attack there … it smelled like someone's urine, it had bedbugs … So it's going to affect your mental health"* (Male asylum seeker 20).

Availability of supportive social networks on issues of accommodation

The availability of supportive social networks played a crucial role in assisting homeless immigrants with accommodation issues. Some homeless immigrants found support from their friends who offered them a place to stay after their Home Office accommodation was discontinued. Charities also played a role by providing temporary accommodation, such as night shelters and sleeping bags, particularly during the winter season. However, it's important to note that this support was often temporary, leading to the constant need for immigrants to find new accommodations and highlighting the ongoing challenges they faced in securing stable housing. This highlights the importance of addressing the underlying accommodation difficulties experienced by immigrants to ensure their long-term stability and well-being.

> *"I met some friends who told me to speak to some charity organisation that was able to provide temporary accommodation for me. But giving you this accommodation is only*

> *for a certain amount of time, three months. So, on and off to sleep there. Even now where I am right now, I will be leaving here on Monday, this coming Monday. So, it's been a huge, huge problem for me, being homeless"* (Male failed asylum seeker 30).

4.36 Impact of the COVID-19 pandemic

The COVID-19 pandemic was reported to negatively impact access to GP services among immigrants. It contributed to the lack of face-to-face appointments, and long waiting times for treatment, impacted mental health, and also led to the closure of community day centres.

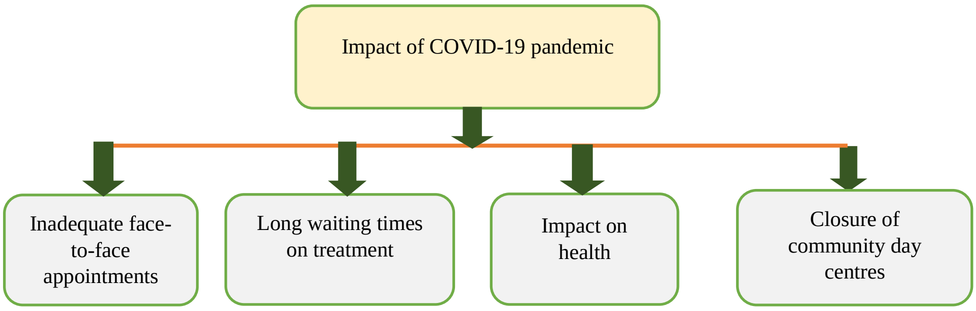


Figure 25 Sub-theme: Impact of the COVID-19 pandemic

4.36.1 Inadequate number of face-to-face appointments

The inadequate number of face-to-face appointments had a significant impact on immigrants' access to healthcare services during the pandemic. Immigrants with health conditions requiring physical check-ups were unable to visit the GP practice and were advised to have telephone appointments instead. However, this posed challenges for homeless immigrants who lacked smartphones and internet access, further exacerbating existing inequalities in healthcare access. Immigrants highlighted the difficulty of making appointments online without the necessary technology. Additionally, stakeholders noted the challenges in booking face-to-face appointments, particularly for immigrants with language barriers who relied on interpreter services, as conducting conversations over the telephone proved to be more challenging. The pandemic's digitalization of healthcare services intensified the barriers faced by homeless immigrant groups, highlighting the need for equitable access and support for marginalized populations.

> *"Ever since COVID came, every time I call, they would tell me that I have to do everything online, and being an asylum seeker then, I don't have internet, I don't have a smartphone. It was just difficult for me to see the doctor"* (Female refugee 24).

4.36.2 Long waiting times for treatment

The COVID-19 pandemic resulted in significant delays in receiving treatment, primarily due to healthcare providers being absent or on sick leave. This led to a backlog of appointments at medical facilities, resulting in long waiting times for patients seeking healthcare services.

> *"Because of COVID, the waiting time for appointments can be further or longer, depending on the size of the GP and the area they cover, depending on the staff they have as well. With COVID, you never can tell, you can wake up this morning and one of your staff who's supposed to be on duty tests positive and will not be available for the next 10 days ... So I think there is nothing anybody can do about COVID"* (Public health specialist).

4.36.3 Impact on mental health

The pandemic had a detrimental effect on the mental health of certain immigrants, leading to feelings of isolation, stress, and frustration. The inability to interact with their social networks due to lockdown measures resulted in depression. Additionally, immigrants faced greater challenges during the lockdown compared to the general population due to language barriers, cultural differences, and unfamiliarity with the UK system, exacerbating the difficulties they experienced during this period.

> *"I know here you are locked in your room and it is very depressing and very stressful. It was stressful and very depressing for all people over the world. But for us, it's more because, first, we lack everything, we don't know the languages, the cultures and we're not familiar with everything, the technologies, and news, it makes it more than 10 times harder for us"* (Male young person 6).

4.36.4 Closure of community day centres

The closure of community day centres during the pandemic limited some homeless immigrants' access to these essential facilities. The lockdown measures led to the closure of many day centres, preventing immigrants, especially rough sleepers, from accessing vital support services that were typically available to them.

"It made it hard during COVID because everything was locked down, you can't go to a centre or use a phone. So that made it even more difficult ... your phone might not be charged because I am street homeless so I couldn't go to [mentions centre] to charge my phone ... And if you lost your phone, who can you call? People don't know whether you exist, alive or

dead, nobody knows. And if you can't charge your phone, you as good as you not having a phone as well” (Male asylum seeker 20).

PHASE TWO: TWO-ROUND DELPHI SURVEY

4.37 Demographic characteristics

A total of 12 participants completed both rounds 1 and 2 of the Delphi survey and their demographic characteristics are presented in **Table 8**. Most respondents provided services in the County of Kent. Most were females (75%) and healthcare providers with nurse practitioners being the majority (33%). The 12 participants constituted a subset of the initial stakeholder sample involved in phase one (qualitative phase) and were invited to take part in phase two of the study.

Table 8. Demographic characteristics of the Delphi panel (N= 12)

Variable	**N (%)**
Sex	
Male	3 (25)
Female	9 (75)
Location	
Kent	9(75)
London	3(25)
Profession	
Healthcare providers	
Nurse practitioners	4 (33.3)
Specialist caseworkers	2 (16.7)
General practitioner	1 (8.3)
Practice manager	1 (8.3)
Voluntary sector providers	
Project workers	2 (16.7)
Mentoring coordinators	2 (16.7)

4.38 Round one of the Delphi survey

In the first round, 49 of the 58 items reached 75% frequency or more in ranking as important or very important (i.e., achieved consensus) by stakeholders (**see Appendix 15)**. The 9 items that did not achieve consensus belonged to the categories of; *improving communication between immigrants and healthcare providers* (n=2); *improving the quality of primary care services* (n=2); *providing culturally sensitive primary care services* (n=1); *improving and* *promoting mental health services among homeless immigrants* (n=1); *raising awareness of immigrants regarding the UK healthcare system* (n=1); *targeted community outreach activities and drop-ins* (n=1); and *empowerment of Immigrants concerning health and social determinants* (n=1). Furthermore, 25 items (51%) of the 49 items achieved mean scores of ≥ 4.5 and were thus included in round two of the Delphi survey (**see Table 9**). Notably, the 2 categories of *targeted community outreach activities and drop-ins* (n=2 items) and *research and epidemiology* (n=2 items) had none of their items achieve a mean score of ≥ 4.5.

Table 9: Top-25 ranked strategies following round 1 of the Delphi survey

Item	**25 Strategies**	**Mean (S.D)**	**Important & Very important (frequency)**
Improving and promoting mental health services among homeless immigrants			
1	There is a need to improve the diversity of mental health professionals to enable culturally appropriate interactions and improve communication with homeless immigrants.	4.83 (0.39)	100
2	There is a need to employ more mental health professionals to reduce work overload among mental health professionals.	4.75 (0.45)	100
3	There is a need to provide secure accommodation where homeless immigrants can have safe and quality sleep. This can also positively impact their mental wellbeing.	4.50 (0.67)	91.7
Raising awareness of immigrants regarding the UK healthcare system			
4	There is a need to raise awareness among homeless immigrants on the available primary care services, and how they can be accessed.	4.83 (0.39)	100
5	There is a need to raise awareness among undocumented immigrants about their rights to access primary care services and further reassure them that healthcare providers do not share their information with the Home Office.	4.67 (0.49)	100
6	There is a need to raise awareness among homeless immigrants that they can access GP surgeries even if they don’t share their home addresses with surgeries.	4.5 (0.52)	100
Fight against discrimination and prejudice, and respect differences			
7	There is a need to ensure that GP staff respect, create trust, and treat everybody equally without prejudice regardless of their immigration status or homelessness.	4.83 (0.38)	100
8	There is a need to review and/or develop and enforce policies against all forms of discrimination within the healthcare system.	4.73 (0.47)	100
9	There is a need to ensure that healthcare providers deliver healthcare services without any form of discrimination, such as xenophobia or racism.	4.67 (0.49)	100
10	There is a need to motivate healthcare providers so that they deliver healthcare to homeless immigrants with improved attention to their specific needs and priorities	4.50 (0.52)	100
Addressing the social determinants of health			
11	There is a need to provide suitable accommodation to homeless immigrants, for example, that is in a good	4.73 (0.47)	100

	state, and free of vectors like bedbugs and mice.		
12	There is a need to provide accommodation for homeless immigrants who require medical treatment in accordance with the human rights approach to care. This applies in situations where a homeless immigrant has a serious healthcare need that warrants accommodation during treatment.	4.50 (0.82)	81.8
Improving GP registration services			
13	There is need to raise awareness among the surgery staff on homeless immigrants’ rights to accessing primary care services. For example, they should be informed that every homeless immigrant has a right to access primary care services regardless of their immigration status.	4.72 (0.47)	100
Enabling access to benefits and financial support			
14	There is a need to raise awareness among healthcare providers on who can access free prescriptions and the required paperwork for such eligibility. This ensures that homeless immigrants have access to free prescriptions.	4.67 (0.49)	100
Provision of culturally sensitive primary care services			
15	There is a need for healthcare providers to receive specific training on cultural competencies and communication skills.	4.67 (0.49)	100
16	There is a need to raise awareness among GP surgeries about homeless immigrants. Since being the gatekeepers to the NHS, surgeries need to understand more about the people who present to them as they come from various communities with varying gender and cultural expectations.	4.58 (0.51)	100
17	There is a need to integrate cross-cultural training into professional development and training activities for health care providers.	4.5 (0.67)	91.7
18	There is a need for health education and health promotion messages to take into account cultural diversity.	4.5 (0.52)	100
Empowerment of Immigrants with regard to health and social determinants			
19	There is a need to support homeless immigrants in developing social networks within their communities. For example, through linkages to support groups, organisations, events, community centres, etc.	4.63 (0.50)	100
20	There is a need to raise awareness and educate homeless immigrants about their rights, entitlements, and support (such as benefits) particularly when they are new in the country.	4.5 (0.67)	91.67
Intersectoral collaboration			
21	Increasing the involvement of homeless immigrants and voluntary sector providers in the planning and delivery of primary care services.	4.58 (0.67)	91.7
22	There is a need to put in place measures that ensure that the Integrated Care System (ICS) which addresses both health and social issues, has a meaningful impact at the community level.	4.50 (0.52)	100
Changes in immigration policies			

23	There is a need to increase opportunities for asylum seekers to engage in formal and informal employment. This ensures their safety against exploitation and that they can afford basic needs and health-related costs such as transport costs, and phone credit, among others.	4.58 (0.67)	91.7
Improving the quality of primary care services			
24	There is a need for health service providers to treat homeless immigrants with respect without stereotyping them based on their immigration status or their homelessness.	4.58 (0.67)	91.7
Improving communication between immigrants and healthcare providers			
25	There is a need to provide high-quality interpreter services, either in person or by telephone. There is also a need to make these services easily accessible to homeless immigrants.	4.5 (0.52)	100

4.39 Round two of the Delphi survey

In the second round, 10 items with the highest mean scores were chosen as key priority strategies ranked by stakeholders who participated in the study (**see Table 10**). Four of the top five rated strategies belonged to the two categories of *improving and promoting mental health services among homeless immigrants* and *fighting against discrimination and prejudice, and respecting differences.* Specifically, under *improving and promoting mental health services among homeless immigrants*, the need to improve the diversity of mental health professionals (Mean = 4.58 (S.D = 0.49), 100% consensus) and the need to employ more mental health professionals (Mean = 4.58 (S.D = 0.67), 91.7% consensus) ranked as 3rd and 4th respectively.

The need to ensure that GP staff respect, create trust, and treat everybody equally without prejudice (Mean = 4.75 (S.D = 0.45), 100% consensus) was ranked as 1st and the need to ensure that healthcare providers deliver healthcare services without any form of discrimination (Mean = 4.50 (S.D = 0.52), 100% consensus) was ranked as 5th. Both items belonged to the category of *fighting against discrimination and prejudice and respecting differences.* The remaining item which was ranked as 2nd belonged to the category *of empowerment of Immigrants with regard to health and social determinants.* This item concerned the need to raise awareness and educate homeless immigrants about their rights, entitlements, and support particularly when they are new in the country (Mean = 4.67 (S.D = 0.49), 100% consensus). Among the top 10 items, the least ranked items (i.e., 9th and 10th) were the need to raise awareness among GP surgeries about homeless immigrants (Mean = 4.33 (S.D = 0.65), 91.7% consensus) and the need for healthcare providers to receive specific training on cultural competencies and communication skills (Mean = 4.27 (S.D = 0.79), 81.8% consensus). Both items belonged to the category of *provision of culturally sensitive primary care services.*

Table 10: Top-10 ranked strategies following round 2 of the Delphi survey

Item Rank	Top-ten strategies	Mean (S.D)	Important & Very important (frequency)
Improving and promoting mental health services among homeless immigrants			
4	There is a need to employ more mental health professionals to reduce work overload among mental health professionals.	4.58 (0.67)	91.7
3	There is need to improve diversity of mental health professionals to enable culturally appropriate interactions and improve communication with homeless immigrants.	4.58 (0.49)	100
Raising awareness of immigrants regarding the UK healthcare system			
7	There is a need to raise awareness among homeless immigrants on the available primary care services, and how they can be accessed.	4.42 (0.67)	91.7
8	There is a need to raise awareness among undocumented immigrants about their rights to access primary care services and further reassure them that healthcare providers do not share their information with Home Office.	4.41 (0.51)	100
Fight against discrimination and prejudice, and respect differences			
6	There is a need to motivate healthcare providers so that they deliver healthcare to homeless immigrants with improved attention to their specific needs and priorities	4.42 (0.51)	100
1	There is a need to ensure that GP staff respect, create trust, and treat everybody equally without prejudice regardless of their immigration status or homelessness.	4.75 (0.45)	100
5	There is a need to ensure that healthcare providers deliver healthcare services without any form of discrimination, such as xenophobia or racism.	4.50 (0.52)	100
Empowerment of Immigrants with regard to health and social determinants			
2	There is a need to raise awareness and educate homeless immigrants about their rights, entitlements, and support (such as benefits) particularly when they are new in the country.	4.67 (0.49)	100
Provision of culturally sensitive primary care services			
9	There is a need to raise awareness among GP surgeries about homeless immigrants. Since being the gatekeepers to the NHS, surgeries need to understand more about the people who present to them as they come from various communities with varying gender and cultural expectations.	4.33 (0.65)	91.7
10	There is a need for healthcare providers to receive specific training on cultural competencies and communication skills.	4.27 (0.79)	81.8

Chapter Five: Discussion

5.1 Introduction

This thesis explored in depth the views and experiences of homeless immigrants and a range of stakeholders within the health and social services realm in South East England. The study focused on three primary aspects: firstly, it investigated the factors influencing the provision and accessibility of PCS for immigrants grappling with homelessness; secondly, it analyzed the impact of intersectionality on access to PCS; and thirdly, it identified the top-priority strategies for enhancing access to PCS for this demographic.

Research questions 1 and 2 were explored through a qualitative exploratory research design, utilizing the Levesque framework and an intersectionality lens. This approach facilitated the collection of diverse experiences and viewpoints from participants (Cuthbertson, Robb and Blair, 2020). To tackle research question 3, the Delphi approach was employed, aiming to achieve consensus among stakeholders regarding the most prioritized strategies. To tackle research question 3, the Delphi approach was employed, aiming to achieve consensus among stakeholders regarding the most prioritized strategies. Significantly, the scoping review carried out in chapter two unveiled that this investigation marks the initial qualitative exploration into the views and experiences of homeless immigrants and stakeholders concerning the provision and accessibility of PCS within the UK.

This chapter of discussion (Chapter Five) delves into the comprehensive findings of the thesis and provides insights into the research process. It commences by discussing the four key research contributions in Section 5.2. The chapter then addresses the three initial research questions, which were introduced in Section 5.3. This chapter then delves into a reflection of the methodological framework, presented in section 5.4, and reflects upon conducting research among marginalized groups, as expounded upon in section 5.5. And lastly, a thorough evaluation of the research's strengths and limitations is explored in section 5.6.

5.2 Research contribution

This section highlights four significant research contributions from my present study. Firstly, through an intersectionality lens, the analysis of my results highlights how various forms of inequality are shaped and experienced by homeless immigrants while accessing primary care services. Secondly, the findings bring attention to the complexity and immense impact attributable to the COVID-19 pandemic on homeless immigrants' ability to obtain primary care services. Thirdly, through the application of the Levesque framework of healthcare access, this study uniquely illustrates how the supply factors influence the health systems and demand for primary care services among homeless immigrants, which ultimately affects their access to such services. Lastly, by employing the Delphi approach, this research identifies the top prioritized strategies among stakeholders for the improvement of access to primary care services among homeless immigrants. These research contributions are discussed in detail below.

5.2.1 Applying an intersectionality lens to the findings

These findings from this work highlighted the important role of adopting an intersectionality lens to more comprehensively explicate the complexities surrounding homeless immigrants' access to primary care. The findings underscore the interplay between various socially constructed identities and factors, such as gender, race, poverty, homelessness, and immigration status, and their influence on the utilization of healthcare services. For example, some homeless immigrant women not only faced challenges common in immigrant populations, such as language barriers and discrimination but also experienced additional hardships owing to their identity as women, for example, intimate partner violence, stigmatization, and social isolation. Therefore, the intersection between gender (especially being a woman) and a homeless immigrant further complicated immigrant women’s access to primary care. Homeless immigrant women in my study who experienced partner violence reported that they faced additional difficulties, such as being denied access to the doctor by their abusive partners, which meant that they would often resort to self-medication with painkillers or natural remedies. This, therefore, underscores the urgency of applying an extra lens (i.e. Intersectionality lens) while examining the far-reaching implications of immigration and homelessness, considering that women may experience some unique sources of barriers in accessing healthcare. Race was another important factor that played a significant role in influencing homeless immigrants’ access to PCS. Specifically, my findings revealed how some homeless immigrants faced barriers in accessing PCS owing to the perceptions or experiences of racial discrimination and negative stereotypes from healthcare providers. In my study, some homeless immigrants reported feeling judged and unwelcome by GP receptionists due to their ethnicity, particularly if they were Black. Such racial discrimination contributed to mistrust of healthcare providers, thereby hindering some homeless immigrants from accessing PCS. This implies how race/ethnicity was also in one way or another linked to cultural expectations, beliefs, and practices. Where information and advice were sought, the level of trust in the healthcare providers, among other health-related practices, was partly influenced by the race/ethnicity of some immigrants who took part in my study. This finding accentuates the need for a deeper examination of race/ethnicity and related cultural norms, beliefs, and practices while understanding access to primary care services for homeless immigrants. This can inform the process of planning culturally appropriate healthcare in which the issues of discrimination are addressed thereby promoting equitable access to healthcare.

Moreover, poverty emerged as another significant factor contributing to health disparities and limited access to primary care services among homeless immigrants. Despite the availability of free primary healthcare in the UK, poverty acted as a secondary barrier to access, as evidenced by the experiences shared by the study participants. Financial hardship impacted some homeless immigrants' ability to fulfill basic needs such as food, broadband, travel expenses, and prescription medications. As a result of poverty, some of the homeless immigrants could not readily access some healthcare services owing to direct barriers like travel expenses, whereas some homeless immigrants resorted to prioritizing other immediate basic needs like food and daily upkeep instead of access to primary care services. Consequently, some homeless immigrants resorted to alternative healthcare strategies, including natural remedies, due to financial constraints. Furthermore, these financial difficulties compelled certain immigrant women to remain in abusive relationships due to their economic dependence on their partners.

Homeless immigrants without legal status were also more likely to experience challenges in accessing PCS compared to those with legal status. Those without legal status harbored concerns about data-sharing between healthcare providers and the Home Office, fearing detention or deportation. Despite healthcare providers denying data sharing for immigration enforcement, irregular homeless immigrants remained apprehensive about accessing PCS, partly due to the documentation requirements imposed by GP receptionists. Their concerns about data-sharing and potential consequences indicated a lack of trust in the healthcare system, which is meant to provide care and support to all individuals, regardless of their immigration status. This privacy concern or fear-driven barrier created an unjust situation where irregular homeless immigrants who were already marginalized faced an extra source of marginalization which negatively impacted their access to PCS.

In my study, I found that the intersection of immigration status and homelessness created inequalities that hindered homeless immigrants from accessing primary care services. While being an immigrant had its challenges, being an immigrant and homeless further exacerbated the situation. Those with irregular immigration status lacked access to public funds, resulting in poverty and the inability to afford medical expenses such as prescriptions, transportation to healthcare facilities, and communication with general practitioners. Limited access to social housing and homelessness assistance led to overcrowded and substandard living conditions, exploitative landlords, and precarious tenancies. Consequently, homeless immigrant families faced ongoing risks of eviction, frequent relocations, and reliance on temporary night shelters. Moreover, frequent moves posed additional barriers to primary care, including disruptions in continuity of care and challenges with safe hospital discharge due to the absence of entitlements to housing or social security benefits. The findings of this study underscore the importance of adopting an intersectionality lens to fully understand the complexities surrounding homeless immigrants' access to primary care. These findings emphasize the need for culturally appropriate healthcare provision, addressing discrimination, and promoting equitable access to healthcare services for homeless immigrants.

5.2.2 Impact of COVID-19 pandemic

The findings of this study showed how the COVID-19 pandemic further intensified the barriers faced by homeless immigrants in accessing primary care services, particularly with the shift from in-person to predominantly virtual interventions during the pandemic. The increased digitalization of healthcare delivery, while advantageous in some ways, excluded marginalized groups, including homeless immigrants, from accessing various services. Limited access to technology, unaffordability issues, and low digital literacy further hindered some homeless immigrants from accessing primary care services. My study highlights the risk of digital exclusion and the need for targeted additional support to ensure access to services for homeless immigrants and other marginalized groups. The findings relating to

COVID-19’s influence on PCS further emphasize the need for conducting needs assessments and possibly adapting co-design approaches to adequately plan for well-targeted and contextually relevant approaches when addressing access to PCS in homeless immigrants.

5.2.3 Delphi follow-up survey

Findings from the previous sections illustrate the complexity of various barriers faced by homeless immigrants in accessing PCS, for example, fear of detention and deportation, low health literacy, language barriers, financial hardships, discrimination, lack of stable accommodation, and digital exclusion. Moreover, these were likely exacerbated by the COVID-19 pandemic. Given such complexity, identifying priority strategies to counter these barriers may require a consultative and systemized research approach. In my study, the Delphi follow-up survey was the approach of choice and was crucial in the identification of the most prioritized strategies for improving access to primary care services for homeless immigrants. The Delphi survey allowed for the input of multiple stakeholders, including healthcare providers and voluntary sector providers, to reach a consensus on the most effective and feasible strategies. By employing multiple rounds of surveying and feedback, the Delphi method prioritized interventions that addressed the specific barriers identified in this study.

The Delphi follow-up survey provided valuable insights on the strategies that were considered as being most important and feasible in overcoming the identified barriers in my study setting. It helped to identify targeted approaches that were deemed as most appropriate for addressing discrimination and prejudice, and the various social determinants of health, including the provision of suitable accommodation. The identified priority strategies further sought to improve and promote mental health services for homeless immigrants, raise awareness of immigrants regarding the UK healthcare system, improve GP registration services, enable access to benefits and financial support, provide culturally sensitive PCS, empower immigrants concerning the health and social determinants, and improve communication between immigrants and healthcare providers. Using a Delphi follow-up survey, I was able to identify the most prioritized strategies needed to improve access to primary care services for homeless immigrants may be useful shortly for developing targeted evidence-based interventions to address specific needs in this sub-population. It enabled the involvement of key stakeholders, provided a structured approach to consensus-building, and ensured that interventions/strategies identified were deemed feasible for addressing the diverse and complex barriers faced by homeless immigrants in accessing primary care services. The findings of the Delphi follow-up survey are discussed in detail in the subsequent chapters.

5.2.4 Applying the Levesque framework

This research adopted the Levesque Framework to steer the examination of the elements influencing homeless immigrants' access to primary care services. This approach facilitated an impartial evaluation of the access challenges encountered by homeless immigrants, addressing both supply and demand aspects (Levesque, Harris and Russell, 2013). On the healthcare provider (supply) side, it encompassed five dimensions: approachability, acceptability, availability, affordability, and appropriateness. Likewise, it delineated five corresponding abilities on the demand side: the ability to perceive, seek, reach, pay, and engage with healthcare services. Employing this framework allowed for a comprehensive exploration of the multifaceted components influencing homeless immigrants' access to primary care and pinpointed specific areas necessitating enhancement. Nonetheless, certain factors, such as homeless immigrants' housing situations and the impact of the COVID-19 pandemic on primary care access, extended beyond the current scope of the Levesque framework's domains. Tables 6 and 7 offer summaries of the study's themes.

5.3 Research questions

5.3.1 Research question 1: Understanding factors that impact access to PCS

Levesque et al.’s (2013) conceptual framework served as a valuable perspective for comprehending the determinants affecting the accessibility of PCS for immigrants grappling with homelessness. Virtually all the factors uncovered in my study aligned closely with the five dimensions of healthcare access outlined in the Levesque framework: approachability, acceptability, availability, affordability, and appropriateness. This framework proved instrumental in structuring and analyzing the multifaceted aspects influencing access to primary care services in the context of homeless immigrants.

From my research, there were some additional factors, such as the impact of the natural environment and disasters like the COVID-19 pandemic, and immigrants’ accommodation which do not fit within any of the Levesque framework’s five dimensions. This may represent one of the limitations of using the Levesque framework because it does not explicitly consider the role of the natural environment, e.g. disasters or individuals' accommodation on access, as discussed later in this section. Nevertheless, similar to my investigation, this framework effectively facilitated the organization of data and the identification of key factors shaping the accessibility of primary healthcare services for this particular demographic (Khanom *et al.*, 2021). It is noteworthy that some of the experiences and barriers to primary care reported by my study participants are also sometimes experienced by the general population in the UK although to a lesser extent, for example, long waiting times for appointments and the inadequate number of available appointments with healthcare providers (Paisi et al., 2022). In the following sections, I discuss in more detail the identified factors in my research using the Levesque framework's dimensions.

Significant gaps in the healthcare knowledge and comprehension of homeless immigrants regarding the UK healthcare system became apparent. This deficiency in health literacy emerged as a prominent theme during the thematic analysis conducted using Levesque et al.'s (2013) framework of access to healthcare. Remarkably, a recent qualitative study delving into the experiences of asylum seekers and refugees while accessing primary healthcare services in the UK echoes the findings observed in the current investigation (Kang et al., 2019). Homeless immigrants recounted their unfamiliarity with the roles of general practitioners, which they attributed to a lack of adequate information about the healthcare system. This issue of insufficient comprehension of the healthcare system, as noted in other literature concerning healthcare access among refugees in the UK, was further compounded by language barriers, impeding homeless immigrants' access to PCS (Mudyarabikwa et al., 2022). In some cases, the insufficient information and understanding of the procedures on how to schedule appointments with healthcare providers resulted in using alternative healthcare-seeking strategies such as self-medication with non-prescribed medicines or with natural remedies like ginger, and the use of emergency services. The projection of homeless immigrants' limited grasp of the healthcare system, as revealed in my findings, prompts inquiries into who is responsible for imparting knowledge about healthcare access to newcomers in the UK. Notably, this concern has also surfaced in the work of other researchers (Kang et al., 2019). To address the issue of inadequate understanding of the UK healthcare system, a recent scoping review on access to healthcare for people experiencing homelessness in the UK and Ireland suggested the need for raising awareness of healthcare providers through routine training to ensure that staff are better educated on how to effectively communicate with people experiencing homelessness and to get important information about primary care services across (McNeill et al., 2022). These solutions were also raised by my study participants during the Delphi component of this study and are discussed in more detail at a later stage of this discussion.

My findings highlight that the homeless immigrants' expectations of the UK's healthcare system were shaped by their experiences in their home countries. This is consistent with the approachability dimension outlined in Levesque's framework, which emphasizes the influence of prior experiences on an individual's perception of the healthcare system (Levesque, Harris and Russell, 2013). Frequently, high expectations can lead to a sense of disconnect and, consequently, dissatisfaction. It's essential to consider how individuals' past encounters shape their attitudes and beliefs regarding healthcare services. In this present study, a mismatch in expectations of homeless immigrants was highlighted for example by their common expectations of a directive healthcare approach from the GPs yet sometimes GPs engaged/asked the client how they would deal with their issues. Another homeless immigrant's unmet expectation was that GP surgery would be a one-stop shop where all health needs were addressed. The results from my research are consistent with previous findings showing that unmet expectations generated mistrust of GPs which hindered homeless immigrants from accessing GP services (Khanom et al., 2021).

Besides unmet expectations, homeless immigrants' mistrust of healthcare providers was also founded in previous experiences including discrimination, and the perception that healthcare providers would share homeless immigrants' data with the Home Office. The connection between mistrust of healthcare providers and concerns about confidentiality and discrimination are also reported in other studies conducted among homeless people and immigrants (Chang, 2019; Masson et al., 2020). In my research, homeless immigrants expressed concerns about the sharing of their information between healthcare providers and the Home Office, as they were apprehensive about potential detention or deportation. This fear of being deported and the unknowns about making formal contact with service providers among immigrants, especially those without legal status has been reported in a recent report on homelessness among Black and Minority ethnic communities in the UK (Bramley et al., 2022). Although healthcare providers in my study denied sharing homeless immigrants' data for purposes of getting detained or deported, homeless immigrants without legal status were still afraid of accessing these services hence creating mistrust in the healthcare providers. This situation can also be linked to the requirements imposed on them by GP receptionists.

Consequently, the insecurity stemming from having an unstable immigration status and the associated legal obstacles contribute to poorer health outcomes among immigrants (Smith et al., 2016).

Additional research has posited that immigrants who have overstayed their visas, entered the country without legal authorization, or had their asylum claims rejected may ultimately slip through the cracks in healthcare service provision after being deemed ineligible for PCS (Yong and Germain, 2022). This argument aligns with my study's findings, which revealed instances where certain homeless immigrants were denied GP registration by receptionists due to their lack of documentation, such as proof of address and identification (e.g., a passport). This occurred despite the government's assertion that everyone in the UK is eligible for PCS (Yong and Germain, 2022). Scholars argue that such statements, asserting universal eligibility, fail to account for the complexities of precarious immigration statuses and those who fall into the gaps, including individuals with denied asylum claims and overstayers. The hostile environment policy plays a significant role in the challenges faced by immigrants when attempting to access PCS (Parker, 2015).

To address the issue of mistrust, this present study found that some healthcare providers conducted community outreaches to improve community engagement while providing primary care services such as vaccinations. These outreaches were meant to increase the visibility of healthcare providers among immigrant communities with the expectation of building trust and reaching hard-to-reach homeless immigrants who were afraid of accessing primary care services, particularly GP services. To ensure the effective engagement of migrant communities in these primary care outreach initiatives, scholars recommend the comprehensive involvement of these communities in the planning and execution of tailored and targeted approaches to encourage the widespread participation of migrants in these outreach activities (Berrocal-Almanza et al., 2019). This is vital in building partnerships and trust among public health teams and healthcare professionals with migrant communities (Crawshaw et al., 2021).

The availability of supportive social networks played a critical role in improving homeless immigrants' access to primary care services. These results are corroborated by findings from previous studies in the US where social capital was found to serve as a facilitator for improved access to healthcare services (Sanchez *et al.*, 2019). As anticipated, participants who reported the availability of social support also reported more knowledge about the availability of healthcare services that helped them to navigate the healthcare system more easily. In some cases, social networks referred homeless immigrants to healthcare providers. They also interpreted for them to help them understand healthcare information, while others provided homeless immigrants with food, shelter, transport, mobile phone data, or phone credit to make GP appointments and other basic needs that can impact their health. These results align with prior research that has demonstrated positive connections between social support and individuals' overall well-being, encompassing aspects like physical health, emotional well-being, and behavioral outcomes (Sanchez *et al.*, 2019). The present findings provide further insights into the growing body of literature, highlighting that marginalized and disadvantaged groups, such as irregular homeless immigrants without legal status in the UK, may place greater reliance on their social networks. This reliance is often a result of their marginalized status, stemming from immigration-related issues, especially given the limited support they receive from formal institutions, including housing assistance (Sanchez et al., 2019). These findings are in line with previous research indicating positive associations between social support and overall health (i.e., physical, emotional, and behavioral) (Sanchez et al., 2019). These current findings contribute to the existing body of research suggesting that vulnerable and disenfranchised populations such as irregular homeless immigrants without legal status in the UK may rely more on their social networks as they are often marginalised due to their immigration status by formal institutions that provide support like housing (Sanchez *et al.*, 2019). Therefore, the availability of supportive social networks can assist homeless immigrants, particularly those without legal status in increasing their access to primary care services.

My research identified significant cultural beliefs and misconceptions, particularly related to mental health, which served as substantial barriers, dissuading homeless immigrants from seeking mental health support. Within some homeless immigrant communities, there was a notable stigma surrounding poor mental health. It is worth noting that while some were willing to visit their GP for general health concerns, they hesitated to access specialist mental health services. This stigma associated with mental illness aligns with existing literature on immigrant populations from diverse cultural and linguistic backgrounds (Salami et al., 2019). For instance, a study that explored cultural factors affecting access to mental health services among Nepali and Iranian migrant communities in the UK highlighted how misconceptions about mental health issues and the accompanying stigma within these immigrant communities were linked to delays in seeking or reluctance to seek mental health support

(Simkhada et al., 2021). This highlights the pervasive stigma surrounding mental health within immigrant communities. Furthermore, there is evidence indicating that immigrants are more likely to discontinue mental health treatment prematurely, which subsequently increases their risk of re-admission to in-patient services for those grappling with mental health issues (Yaghoubi et al., 2008). These findings emphasize the importance of raising awareness about mental health issues among vulnerable populations and advocating for initiatives that provide support for both initiating and maintaining mental health treatment among individuals facing vulnerability (Simkhada et al., 2021).

My research also identified gender differences among homeless immigrants, which had an impact on their access to and utilization of PCS, particularly mental health services. Notably, the stigma surrounding mental illness appeared to be more prevalent among men within this population. This observation may be attributed to the influence of hegemonic masculinity, a concept that plays a significant role in shaping gender disparities in seeking mental health support (McKenzie et al., 2018). Hegemonic masculinity is characterized by its social privilege and cultural dominance, which reinforces a hierarchy in gender relations among men. In my study, cultural and patriarchal norms were observed to influence the behavior of male homeless immigrants concerning their mental health. Having a mental health issue was often perceived as a sign of weakness and shame among this group of men. This aligns with a global concern regarding masculinity and men's health-seeking behavior, which can lead to delays in seeking help when facing health challenges (Simkhada et al., 2021). Understanding the nuances of gender-related issues concerning engagement with mental health services among homeless immigrants, particularly among males, is crucial. Some male homeless immigrants in my study did not recognize the need for mental health support, emphasizing the importance of addressing gender-specific barriers to mental health care access (Amato and MacDonald, 2011).

My findings revealed that inadequate cultural competency was a considerable barrier to accessing primary care services, particularly mental health services among homeless immigrants. Cultural competence pertains to the capacity of healthcare systems to deliver care that aligns with the diverse values, beliefs, and behaviors of patients, while also customizing the delivery to address their social, cultural, and linguistic requirements (Paisi et al., 2020). Despite recognizing the significance of culturally sensitive healthcare in improving access to healthcare services for marginalized populations, its full integration into practice remains incomplete or insufficiently implemented (Paisi et al., 2019). My study found that the mental health support such as the generic counselling provided to the general population was not appropriate to address the mental health needs of homeless immigrants. Because of their traumatic experiences, some homeless immigrants needed specialised mental health services such as traumatic counselling. Therefore, the participants in my study held a strong perception that the current healthcare system lacked the requisite friendliness and inclusivity, primarily because it had not been tailored to accommodate their cultural needs or address their concerns. My findings align with previous studies conducted in the UK (Khanom *et al.*, 2021) and Canada (Salami *et al.*, 2021) that inadequate cultural competency was associated with insufficient cultural awareness of healthcare providers.

Researchers argue that the absence of cultural awareness among some healthcare professionals can have repercussions on patient care and may contribute to feelings of resentment, erecting a psychological barrier that dissuades immigrant communities from seeking medical assistance (Yong & Germain, 2022). The inability of healthcare providers to respond in a culturally sensitive manner can result in unmet needs, consequently driving homeless immigrants, as observed in my study, toward alternative avenues for seeking healthcare. Despite the growing recognition of the importance of cultural sensitivity, recent research indicates that medical doctors continue to lack preparedness, largely due to insufficient training and evaluation of cultural competence within medical education programs (Khanom et al., 2021). To provide effective care that caters to the diverse needs of the community, healthcare professionals must exhibit consciousness and respect for different cultural practices and beliefs (Simkhada et al., 2021). Researchers recommend the implementation of additional awareness training programs for healthcare providers concerning cultural customs and beliefs, with a particular focus on understanding the repercussions of previous torture and trauma experiences on healthcare-seeking behavior. This is especially crucial for delivering trauma-informed care and offering enhanced support to victims of trauma and torture to foster a positive healthcare experience (Salami et al., 2021; Paisi et al., 2022). Further research could also explore the integrative collaborative models of care such as incorporating community or religious leaders in mental health service provision to address the issues of inadequate cultural competency (Simkhada et al., 2021).

Adverse experiences, including instances of discrimination and suspicions that GPs may share homeless immigrants' personal information with the Home Office, exacerbated the existing mistrust and dissatisfaction regarding PCS in the UK, particularly GP services. These findings align with prior research conducted in the UK. For instance, a systematic scoping review examining the perceptions of general practice among Central and Eastern European immigrants in the UK revealed that their distrust and dissatisfaction with general practice facilities prompted alternative healthcare-seeking behaviors, such as self-medication, importing medications from their home countries, and resorting to emergency services (Poppleton et al., 2022). Moreover, a systematic review exploring self-medication with antibiotics in European and Anglo-Saxon countries demonstrated that self-medication practices were prevalent among immigrants in other nations, including the US (Lescure et al., 2018). In the US, self-medication was linked to a lack of knowledge regarding appropriate antibiotic usage. However, these findings on the lack of knowledge about proper medication usage (Lescure *et al.*, 2018) are contradicted by my findings which revealed that some homeless immigrants who self-medicated with antibiotics were aware of the problem of antibiotic resistance. My findings also showed that the eagerness to use alternative health-seeking strategies was more impelled by some homeless immigrants' lack of legal status in the UK which made them afraid of accessing primary care services. To address this issue, researchers suggest the need for co-designing outreach activities with immigrant communities alongside providing out-of-hours drop-in options to improve access to primary care services (Poppleton et al., 2022).

The literature on homelessness and deprivation has documented instances of marginalized groups grappling with conflicting demands in their daily lives, a phenomenon similar to what my research has uncovered (O'Donnell et al., 2016). This concept has also emerged in studies involving immigrants. For instance, research conducted among homeless individuals in the UK highlighted that while the homeless population recognizes their health issues, the urgency for intervention doesn't always take precedence (Rae and Rees, 2015). In my study, some homeless immigrants expressed that their primary concern was improving their sub-standard living conditions before addressing their access to PCS. This illustrates how a stable home environment can serve as a foundational step toward accessing healthcare services (O'Donnell et al., 2016). Furthermore, certain participants in my study identified immigration-related matters, such as completing immigration applications, as significant challenges impacting their health. These instances provide concrete examples of how social determinants of health are at play and underscore that improving health often necessitates addressing a broader spectrum of social factors (McNeil et al., 2013). To address the issue of competing priorities, researchers recommend employing suitable approaches, such as cooperative and participatory initiatives. For instance, in Ireland, a participatory learning and action research study engaged marginalized groups, including homeless individuals and immigrants, in shaping local primary care services by incorporating their perspectives on priority areas for improvement (O’Donnell et al., 2016). This approach can inform the development of more patient-centered PCS tailored to the specific needs of homeless immigrants.

Similar to my study, other research has highlighted the distress experienced by immigrants due to the limited time they spend with healthcare providers during consultations, often finding that professionals are rushed to attend to other patients (Mbanya et al., 2019). However, contrasting findings have emerged, with some studies revealing that patients who had longer consultation times did not necessarily perceive their visits as longer or express higher satisfaction with the services received compared to those with shorter consultation times (Xie and Or, 2017). Consequently, researchers suggest that the effectiveness of healthcare services and the attitudes of healthcare professionals might play a more pivotal role than the duration of treatment (Xie & Or, 2017). Furthermore, my study identified other factors, such as extended waiting times for appointments, which align with findings from existing research demonstrating that patients who experience prolonged wait times tend to view healthcare services as less accessible and their wait times as less acceptable (Mbanya et al., 2019). While these challenges are not exclusive to immigrant populations and may affect the general populace (Khanom et al., 2021), when coupled with the unique hurdles faced by homeless immigrants related to housing instability, underemployment, lack of transportation, these factors can collectively act as significant barriers to accessing PCS (Salami et al., 2019). Therefore, reducing patient waiting times is crucial for enhancing health outcomes and should be a priority within the UK healthcare system (Mbanya et al., 2019). However, it's important to acknowledge that achieving this goal may not always be feasible due to resource constraints and an inadequate number of healthcare providers, a situation further exacerbated by the COVID-19 pandemic (Flynn *et al.*, 2020). In light of these challenges, researchers recommend managing patient perceptions of waiting times through various patient-centered strategies. These strategies include providing patients with informative details about the healthcare services they are about to receive and introducing them to the healthcare professionals who will be providing those services. Healthcare providers can also be encouraged to demonstrate respect, empathy, and friendliness toward patients and their accompanying family members or friends (Xie & Or, 2017).

My findings are consistent with prior studies that have identified barriers to healthcare access experienced by immigrants without recourse to public funds. These barriers include factors such as the immigration health surcharge, prescription costs, and the absence of UK-recognized identification, all of which serve immigration control purposes (Mbanya et al., 2019). In my research, some homeless immigrants lacking access to public funds expressed frustration with the recurring cycle of seeking healthcare only to return to sleeping on the streets afterward. Earlier studies have also documented challenges related to the safe discharge of homeless individuals from hospitals back into the community, particularly for patients without recourse to public funds. This difficulty arises from their lack of entitlement to housing or social security benefits (Mbanya et al., 2019). Researchers have further highlighted the detrimental implications of lacking recourse to public funds among immigrants from lower socioeconomic backgrounds, emphasizing its adverse effects on health and its contribution to homelessness. It has been noted that limited access to primary healthcare services can have repercussions on morbidity, mortality rates, and the utilization of emergency healthcare services (Jagpal et al., 2020). The impact of recourse to public funds on homeless immigrants' access to primary care services is cross-cutting among various issues like housing, and GP registration as discussed in the results section .

Apart from the pre-existing challenges that homeless immigrants encounter before accessing the healthcare system, their experiences within the healthcare system itself have also been explored in this study. Consistent with existing literature, language has emerged as a prevalent barrier hindering homeless immigrants' access to PCS (Paisi et al., 2019). This language barrier has created difficulties for homeless immigrants when trying to communicate with healthcare providers once they are within the healthcare system (Mbanya *et al.*, 2019). The language barrier identified in my research aligns with the findings of previous studies conducted among various minority populations worldwide (De Moissac and Bowen, 2019) and other local studies focused on immigrants in the UK (Kang et al., 2019). A systematic review has underscored how language barriers lead to multifaceted challenges in accessing services and expressing an understanding of issues for community members (Satinsky *et al.*, 2019). Additionally, a recent study involving Nepali and Iranian migrant communities in the UK highlighted that language barriers were among the reasons for not accessing mental health services (Simkhada *et al.*, 2021). Likewise, a review that assessed the impact of migration on the health of Iranian migrants in Western countries, including Australia, Canada, and the US, demonstrated that language insufficiency was associated with poor mental health among Iranian migrants (Shishehgar et al., 2015). These findings emphasize the fundamental role of communication in the successful implementation of patient-centered care and its significance in ensuring the continuity of care.

Despite the existence of NHS policies that advocate for access to free primary care services for all (Public Health England, 2021), the communication difficulties between healthcare providers and some immigrants limit the uptake of healthcare services and impact two-way and open communication during care (Shibli et al., 2021). These challenges can potentially undermine the quality of healthcare in several ways, including discouraging homeless immigrants from utilizing primary care services. Moreover, these language barriers can hinder their ability to articulate symptoms and communicate their requirements, particularly in terms of mental health needs. Consequently, this leads to dissatisfaction among homeless immigrants regarding the healthcare services they receive (Khanom et al., 2021). The findings of my study stress the necessity for the provision of simplified information about the UK healthcare system, available in both English and other frequently requested languages, to address this issue effectively. Indeed, other literature also advocates for the need for culturally sensitive and translated messages, especially on how to access primary care services as well as the need for an adequate presence of culturally sensitive interpreters (Gerrish et al., 2004).

My findings align with prior research that also identified the insufficiency of interpretation services as a barrier to accessing primary care services. To illustrate, Khanom and colleagues conducted a study on asylum seekers and refugees' healthcare experiences in the UK, revealing that the initial interactions of some immigrants with frontline staff like GP receptionists, emergency paramedics, and pharmacists were often compromised due to the lack of effective interpretation services (Khanom et al., 2021). The experiences of participants in my study stress the repercussions of inadequate interpretation services, emphasizing the fundamental importance of effective communication during medical consultations. Additionally, the broader impacts of this issue have been highlighted, including its adverse effects on patients' self-esteem (Kang, Farrington and Tomkow, 2019). This emphasizes the critical need for improved access to interpretation services within the healthcare system to enhance the overall quality of care and patient experiences. On the other hand, some interviewees in my study, particularly, the healthcare providers reported the availability of interpretation services at health facilities. However, in alignment with previous research, my study found difficulties with third-party conversations including the loss of some information during translation (Gerrish *et al.*, 2004). Employing interpretation services and cultural intermediaries, while considered essential, can pose difficulties due to the limited training available for these roles, insufficient funding to support full-time positions, client apprehensions regarding confidentiality, and the potential imposition of personal values and beliefs held by these mediators during client interactions (Salami et al., 2019).

In my research, I found that certain homeless immigrants faced challenges when seeking medical care, particularly in the context of language barriers. Some of these individuals relied on their social networks, such as family and friends, to interpret for them during medical consultations. However, it's worth noting that some healthcare professionals expressed concerns about this practice, citing confidentiality issues. This situation seems to conflict with the current guidelines set forth by the NHS, which strictly permit trained professionals to act as interpreters, as pointed out by Paisi et al. (2019). Consequently, there is a need for a reevaluation of interpretation protocols or, at the very least, an exploration of alternative approaches to providing language support that aligns with cultural sensitivity and a patient-centered approach, as suggested by Lehane and Campion (2018). Additionally, the literature also suggests considering the utilization of bilingual healthcare providers as a potential solution to this challenge. Future research endeavors should focus on identifying the most effective strategies for ensuring access to culturally appropriate interpretation services, including the feasibility and effectiveness of employing bilingual providers within primary care settings (Lehane and Campion, 2018). Furthermore, future research must delve into the impact of relational dynamics in interpreter interactions on patient care and overall health outcomes. This inquiry should also investigate whether these experiences are influenced by the mode of consultation, whether in-person or remote (Paisi et al., 2022). Such investigations can significantly contribute to improving the quality of healthcare services for homeless immigrants.

Homeless immigrants encounter significant obstacles when accessing PCS, which can have detrimental effects on their overall health, as has been discussed about various contributing factors. Particularly, my research revealed that these barriers became even more pronounced during the pandemic when many healthcare institutions shifted from in-person consultations to virtual interventions. The increased digitalization of primary care delivery, a trend likely to persist, brings with it several advantages, but it also raises concerns about its potential negative impact on marginalized groups, as noted by (Knights et al., 2021). Notably, my study uncovered that homeless immigrants, who were already grappling with obstacles to accessing primary care, are at heightened risk of digital exclusion. Consequently, there is a pressing need to provide them with additional support to bridge this digital divide, a finding that may have implications for other marginalized communities facing similar challenges. Furthermore, homeless migrants face an elevated risk of receiving misinformation related to COVID-19 and encounter barriers to vaccination, as also identified by (Knights et al., 2021). To address these issues, healthcare providers interviewed in my study detailed their efforts to conduct outreach and community engagement activities, particularly targeting immigrant communities with low COVID-19 vaccine uptake. They aimed to disseminate clear and concise information about COVID-19 and facilitate vaccine uptake among these populations. In the broader context of the evolving primary care landscape during the COVID-19 pandemic, these findings hold significant importance. They offer valuable insights into the specific strategies needed to support migrant groups in accessing primary care, combating misinformation, and promoting vaccine uptake (Knights et al., 2021).

A recent study examining the impact of remote consulting in the UK has echoed concerns raised by GPs (Murphy *et al.*, 2021). These concerns center around the heightened significance of non-verbal cues in communication, particularly within migrant and other marginalized groups. The study suggests that the shift towards e-consultations and video appointments may inadvertently widen the healthcare gap, primarily benefiting individuals with advanced IT skills while exacerbating pre-existing health disparities among homeless immigrants. These concerns are substantiated by Doctors of the World UK, who have also pointed out that various marginalized populations face substantial barriers in terms of technology access and proficiency. These individuals often struggle to afford broadband or mobile data services (Doctors of the World, 2020). Importantly, these issues formed a central theme in my research. When combined with other factors, such as the fear of arrest or deportation, language barriers, and inadequate interpretation services, homeless immigrants encounter formidable obstacles that severely impede their ability to access PCS (Knights et al., 2021). This multifaceted challenge highlights the pressing need for comprehensive and equitable solutions to ensure that healthcare services are accessible to all, regardless of their socio-economic or immigration status.

5.3.2 Research question 2: Understanding homeless immigrants' access through the intersectionality lens

My results revealed the need for an additional lens of intersectionality to properly understand how various socially constructed identities or factors of homeless immigrants have implications for their access and utilization of primary care. In line with previous research, I interpreted the results as an expression of how social identities including gender, race, poverty, homelessness, and immigration status interact and impact homeless immigrants' access to primary care services (Gottlieb et al., 2020; Shibli et al., 2021). My finding that homeless immigrants with two or more vulnerabilities are more likely to experience greater challenges in accessing primary care services echoes what has been reported in the literature. An intervention study conducted in two high-income countries, Canada and Australia also found reports of greater disparity in access among socially vulnerable persons which was associated with multiple vulnerabilities such as low educational level, immigrant status, and financial poverty (Haggerty *et al.*, 2020). Using an intersectionality approach (Shields, 2008) may be instrumental in understanding how intersecting social identities impact access to healthcare services and finding culturally sound ways to resolve these issues (Shibli et al., 2021). I discuss the aspects of intersectionality relating to my research in the following sections.

The perspective of intersectionality plays a crucial role in acknowledging the distinctive challenges faced by homeless immigrant individuals, both women and men. It enables a comprehensive analysis of the intertwining factors such as race, immigration status, cultural background, poverty, and homelessness, all of which may converge to impede the access of homeless immigrant women and men to PCS (O'Doherty, Pillinger and Bowen, 2018). My research featured a notable finding: among homeless immigrants, women were more likely to encounter heightened disadvantages and risks, such as experiencing partner violence within their relationships, compared to their male counterparts. This disparity in experiences creates inequalities when it comes to accessing PCS. Homeless immigrant women who experienced partner violence were hindered from making contact with a GP practice or other services which resulted in self-medication with painkillers. Besides, whereas experiences of such violence increased their risk of mental illness, the control and restriction from their partners meant that these women were at increased risk of aggravated mental and related implications of stigma. Furthermore, the pre-existing instances of partner violence may have been intensified by the COVID-19 pandemic. Donà (2021) highlighted the plight of women whose immigration status is linked to their partners, emphasizing the added apprehension of compromising immigration status due to Hostile Environment policies, which further constrained their capacity to escape unsafe environments.

Certain studies have identified a strong connection between homelessness or housing instability and intimate partner violence. Additionally, this link has been associated with worsened maternal mental health and the well-being of children within homeless women's families (Gilroy et al., 2016). Conversely, within the context of homeless immigrant men, some were fortunate enough to receive support from their spouses when it came to accessing primary care services. This discrepancy in support for homeless immigrant women reflects a broader patriarchal framework, which can be observed in various communities, including African and Asian cultures, where men are often assigned the role of the family's head, while women are expected to manage household affairs (Hunt *et al.*, 2018). My research aligns with previous studies that have shown how immigrant women who experience partner violence often find themselves trapped in abusive relationships due to the immensely challenging choice between enduring abuse or risking their legal status and potential homelessness (Erez and Harper, 2018). In the United States, a study exploring the experiences of battered immigrant women also revealed that factors such as unemployment and undocumented immigration status could contribute to the initiation or escalation of domestic violence in immigrant communities (Erez, Adelman and Gregory, 2009). However, my study also uncovered that, to some extent, male homeless immigrants were more prone to exhibit suboptimal health-seeking behavior, particularly in the context of mental health services. This observation aligns with existing literature that addresses the global issue of masculinity and its impact on men's reluctance to seek medical help promptly (Amato and MacDonald, 2011). This phenomenon may contribute to delays in seeking assistance when facing health issues (Simkhada et al., 2021).

Similar to other research (Erez and Harper, 2018), my study found homeless immigrant women to experience both problems commonly experienced by immigrants such as language barrier, discrimination, and unfamiliarity with the healthcare system, as well as additional hardships related to partner violence, like stigmatization and social isolation, all of which may increase the complexity surrounding their access to primary care services. Furthermore, researchers have uncovered that immigrant women who have endured partner violence often internalize the belief that such violence is a normal and acceptable aspect of marital and family life (Erez, Adelman and Gregory, 2009). Within the context of my study, female participants shared their experiences of how their families and communities stigmatized divorced women, creating a significant barrier to leaving abusive relationships due to the fear of being branded as divorcees. It's important to note that while engagement with support services in the UK may gradually reshape immigrant women's perceptions of domestic violence, some abusive men within immigrant communities persist in viewing abuse as a prerogative reserved for men (Erez and Harper, 2018). The intersection of immigration and partner violence in the lives of immigrant women is a complex and multifaceted issue with far-reaching implications for their well-being and health. Consequently, researchers advocate for ongoing monitoring of this area, particularly in an era characterized by growing anti-immigration sentiments and stringent immigration control measures (Erez and Harper, 2018). This vigilance is crucial to ensure the safety and protection of immigrant women in the face of these evolving challenges.

Similar to the findings of my study, race is an important determinant of health and well-being among immigrants (Bacong and Menjívar, 2021) A recent report on homelessness among Black and Minority ethnic communities in the UK found that there were stark ethnic disparities within the Statutory Homeless system. As an illustration, when examining homelessness in England, it becomes evident that Black households face a significantly higher likelihood of experiencing homelessness compared to White households. Specifically, Black households are 3.6 times more prone to homelessness, and this disparity becomes even more pronounced in London, where Black households are 5.2 times more likely to be affected by homelessness (Bramley et al., 2022). The perspectives of homeless immigrants regarding racial discrimination and the presence of negative stereotypes held by healthcare providers have emerged as significant impediments to their access to PCS. These findings align with prior research, highlighting that the experience of racial discrimination interacts with immigration status and homelessness, creating a compounding effect on the obstacles faced by homeless immigrants in their pursuit of accessing PCS within the UK (Bramley et al., 2022).

My study also found that some homeless immigrants felt that the health professionals were judgmental because of the immigrants' ethnicity (i.e. being Black). They felt unwelcome and looked down on by GP receptionists because they were not White. Additionally, some homeless immigrants shared instances where certain healthcare providers made disparaging remarks, such as suggesting they should return to their countries of origin if they found it challenging to adapt to life in the UK. My study also found how some homeless immigrants received negative stereotypes such as being perceived as thieves and dirty because they were homeless. This highlights how the intersecting identities of race, immigration status, and homelessness may interact and thereby exacerbate the difficulties of the immigration system for some racial groups such as Black homeless immigrants. The challenges mentioned are closely associated with adverse outcomes, including reduced levels of trust and subpar interactions with healthcare providers. These experiences can have enduring repercussions on individuals' health-seeking behaviors, as underscored by the findings of Mbanya et al. (2019). An examination of access to the Norwegian healthcare system for African immigrants further sheds light on this issue. This research highlights that discrimination, negative stereotypes, and a lack of cultural awareness among healthcare providers inadvertently contribute to disparities in the quality of care received by African immigrants compared to the wider population (Mbanya et al., 2019). Importantly, the impact of racial discrimination experienced within the healthcare context extends beyond immediate experiences. It also negatively influences how immigrants perceive the healthcare system and their overall engagement with health services and care providers (Kang, Farrington and Tomkow, 2019).

Other research has echoed concerns about institutional racism within the healthcare system, along with anxieties regarding the stigma associated with immigration status (Holroyd, 2015). Prior investigations have emphasized how the NHS in England, as an organization, struggles to provide equitable access to care for all, primarily due to resource constraints. This failure not only reflects an inability to fulfill its mission of ensuring equal healthcare access but also implies the presence of institutional racism that is implicitly ingrained within the organization itself (Germain and Yong, 2020). Disturbingly, one of the most profound consequences of this overarching discrimination is the erosion of trust that immigrants harbor toward healthcare providers. This erosion of trust can significantly impede immigrants' willingness to seek out healthcare services (Yong & Germain, 2022). Consequently, this mistrust may contribute to a cycle of negative experiences, ultimately rendering healthcare services less suitable or appropriate, as elucidated in the final stage of Levesque's framework for assessing healthcare access, namely, appropriateness (Levesque, Harris and Russell, 2013). These findings emphasize the pressing need for the implementation of culturally sensitive healthcare solutions to address the issues associated with discrimination (Mbanya et al., 2019). It is crucial to rectify these disparities and foster a healthcare environment where individuals of all backgrounds can access appropriate and equitable care.

It is crucial to recognize and appreciate the diversity within our study sample and the intricate nature of the data collected. The homeless immigrant population we studied exhibited a wide spectrum of cultural backgrounds, varied migration journeys, and distinct health requirements. This complexity interacted with the pervasive challenges presented by the immigration system, affecting multiple aspects within the Levesque framework of healthcare access (Levesque, Harris and Russell, 2013). To illustrate, my findings emphasized how economic barriers and poverty played significant roles in creating health disparities and constraining the ability of homeless immigrants to access essential primary care services. These economic challenges emerged as influential factors, further emphasizing the multifaceted nature of the obstacles faced by this population in their pursuit of adequate healthcare.

In the UK, where primary healthcare is provided free of charge, the narratives shared by homeless immigrants in my study illustrate how poverty can serve as a secondary obstacle to accessing healthcare services. This observation aligns with findings from two separate studies conducted in the UK (Kang, Farrington and Tomkow, 2019) and Canada (Etowa et al., 2021) that have highlighted the impracticality of using public transport for appointments due to the associated costs. Additionally, other research conducted in the UK has elucidated that the weekly allowances of £39 provided to asylum seekers are insufficient and exacerbate their financial hardships. These collective findings underscore the significant impact of economic challenges on the ability of immigrants, including homeless individuals, to access essential healthcare services, despite the ostensibly free nature of primary healthcare in the UK (Kang, Farrington and Tomkow, 2019). Due to such financial hardship, asylum seekers were often unable to buy essential items, including basic needs such as food (Kang, Farrington and Tomkow, 2019). It is important to note that access to basic needs like food can significantly influence immigrants' health-seeking behaviour in such a way that accessing primary care services becomes a lesser priority for homeless asylum seekers when basic needs are not satisfied (Philip, King and Durham, 2022). Out-of-pocket expenditure on healthcare can become a daunting experience for the immigrant population (Kik et al., 2009). Similar to other studies (Kang, Farrington and Tomkow, 2019), my research revealed that extended waiting periods for the issuance of eligibility certificates, which are required for obtaining free prescriptions, resulted in some immigrants being unable to access necessary medications. Even when they possessed the necessary documentation to prove their eligibility, certain primary care services, especially dental services, exhibited a preference for accepting private patients rather than homeless immigrants who qualified for free dental treatment (Etowa et al., 2021).

Although my study showed that both male and female homeless immigrants had issues related to poverty, women were more disadvantaged. Some homeless immigrants who were women with children to look after were at an increased risk of sexual and labour exploitation due to the additional costs of taking care of a child, yet, they received insufficient weekly allowances for asylum support. My research outcomes corroborate the conclusions drawn by Jolly et al. (2022), who emphasized that enduring destitution could result in various financial challenges. These challenges extend to issues such as the affordability of formula milk for immigrant mothers facing social vulnerability. Additionally, in line with existing scholarly work, my study identified how destitution can create obstacles for some immigrant women in extricating themselves from abusive relationships due to their financial reliance, as elucidated by Jolly (2018).

Another potential underlying factor contributing to poverty among immigrant homeless individuals in my study is their restricted legal capacity to engage in formal employment. This limitation substantially curtails their disposable income, making it challenging to meet basic needs and access healthcare services effectively. For irregular immigrants in the UK, paid employment is generally prohibited. Moreover, even among those with legal work authorization, the requirement to periodically report to the Home Office creates hurdles in maintaining stable employment. Additionally, some employers may not be accommodating when it comes to granting time off work for these reporting obligations, as noted by Jolly et al. (2022). Consequently, the inability to secure regular employment elevates the vulnerability of homeless immigrants, potentially exposing them to exploitation. In alignment with findings from other research, such as the work of Mbanya et al. (2019), my study also revealed that the lack of adequate financial resources or income compelled homeless immigrants to seek alternative or self-administered treatments. Furthermore, some homeless immigrants who lacked access to public funds were unable to make payments for secondary healthcare services, particularly those involving high-cost procedures. These financial constraints exacerbate their challenges in obtaining essential medical care. Taken together, poverty intersects with homelessness and migration status to further worsen access and uptake of healthcare among homeless immigrants with extreme financial and economic hardship (Philip, King and Durham, 2022).

My study highlighted how immigration status intersected with homelessness to create inequalities that hindered homeless immigrants from accessing primary care services. Immigrants who experienced homelessness and had an irregular immigration status lacked recourse to public funds. As a result, they were exposed to poverty, and could not afford health-related costs like medical prescriptions, transport to health facilities, and phone credit to contact GPs, unlike the immigrants who had recourse to public funds and were eligible for suitable housing, and free medical prescriptions. Similar to my study, Boobis, Jacob and Sanders (2019) also observed a rising trend in migrant homelessness, with the most rapid growth occurring among individuals lacking access to public funds and/or possessing irregular migration status. This surge can be attributed to limitations on accessing social housing and homelessness assistance, as documented by Guentner et al. (2016). Consequently, accommodation options for this demographic frequently involved overcrowded and substandard living conditions, with exploitative landlords and precarious tenancy agreements (Lombard, 2023). Such circumstances left families grappling with the constant threat of eviction, frequently necessitating repeated relocations or resorting to temporary night shelters (Jolly, Singh and Lobo, 2022). For homeless immigrants who moved repeatedly, my study found that they experienced additional barriers to accessing primary care services such as difficulties with continuity of care including loss of follow-up. Also, consistent with my findings, Potter et al. (2020) similarly observed challenges associated with the safe transition of homeless immigrants, particularly those lacking access to public funds, from hospital settings to the community. Furthermore, the government's Test, Track, and Trace program, which relied on individuals' self-isolation during the COVID-19 pandemic, presented difficulties for asylum seekers and migrants in precarious conditions living in overcrowded accommodations, as highlighted by Donà (2021). Despite their willingness to adhere to guidelines, the impracticality of self-isolation and social distancing in such living conditions posed a significant challenge. These difficulties arose due to their limited entitlements to housing or social security benefits.

Much like the findings in my study, existing literature from the UK highlights a common pattern wherein certain immigrants are referred to local authorities in hopes of receiving support for housing and subsistence, as a preventive measure against destitution. However, a significant portion of those with no recourse to public funds often finds themselves denied assistance (Jolly, Singh and Lobo, 2022), placing them at an elevated risk of destitution due to the impact of the Hostile Environment (Donà, 2021). Scholars advocate for the development of initiatives that can seamlessly integrate with other social services accessible to immigrants. Strategies such as employing case managers and community navigators, who function as liaisons within the community, have shown promise in addressing these challenges (Yong and Germain, 2022). In my study, I identified outreach programs as an effective approach to meet the care needs of homeless immigrants who are particularly hard to reach due to the complex barriers they face when attempting to access primary care services. While it is crucial to gather evidence regarding the adverse outcomes associated with the lack of recourse to public funds among homeless immigrants, this research must be undertaken with consideration of its potential to depoliticize the issue of No Recourse to Public Funds. Such depoliticization may inadvertently separate it from the broader political context surrounding the hostile environment, everyday bordering practices, and the mounting anti-migrant racism (Jolly, Singh and Lobo, 2022).

5.3.3 Research question 3: Top ten priority strategies in improving access to PCS

Using a Delphi consensus method, I was able to identify and rank the top ten priority strategies from an initial list of 58 strategies suggested by homeless immigrants and stakeholders for improving access to PCS for homeless immigrants in England. Based on the list of the top five priority strategies, my study highlights that fighting against discrimination and prejudice and respecting differences; improving and promoting mental health services; and empowering homeless immigrants regarding their health and social determinants were the three most outstanding intervention areas identified to improve access to PCS for homeless immigrants in Kent and London.

My study identified the top priority strategy (out of a total of 10) as the need for healthcare providers to demonstrate respect, build trust, and treat everyone equally, regardless of their immigration status or homelessness. This finding is well corroborated by previous studies from England, which showed that segregation and racism extensively undermined confidence in public institutions including the NHS, and this increased barriers to accessing PCS

(Karlsen and Nelson, 2021; Paul, Fancourt and Razai, 2022). In addition, COVID-19-related racial discrimination has been reported in other parts of the world (Addo, 2020). This potentially demonstrates the high level of recognition, readiness, and commitment among stakeholders to counter the issue of discrimination. Based on my research, it is evident that public health initiatives must involve PCS stakeholders in developing culturally appropriate solutions to address discrimination, instead of adopting a one-size-fits-all approach (Hinkel, 2011a). The involvement of PCS stakeholders is important because they have a comprehensive understanding of its enormous existence. One of the top ten recommendations was the provision of culturally appropriate healthcare, which is a crucial factor in addressing discrimination, despite being ranked last. This reinforces the recognition that discrimination is a significant issue that needs to be addressed. These efforts are crucial for promoting equitable access to healthcare services for marginalized groups, as recommended by other researchers (Skosireva *et al.*, 2014). Overall, curbing discrimination against immigrants and marginalized populations contributes to the preservation and well-being of their health, aligning with the broader objective of enhancing overall health outcomes and reducing disparities in healthcare access (Szaflarski and Bauldry, 2019).

My findings reveal that the need to improve and promote mental health services for homeless immigrants was of high priority for PCS stakeholders. Related to mental health, we find that the suggested solutions are both applicable to improving the mental health of homeless immigrants, as well as that of the healthcare providers. For instance, stakeholders prioritized the need to address the work overload among mental health professionals by employing more professionals and enhancing diversity within the workforce to facilitate culturally appropriate interactions and improve communication with homeless immigrants. First of all, mental health problems are reported as highly prevalent in homeless (Hossain *et al.,* 2020) and immigrant (Blackmore *et al.,* 2020) populations in the UK, and elsewhere (Gil-Salmeron *et al.,* 2021b), and yet, mental health services continue to experience overwhelming health staff turnover, underfunding and excessive workloads (Bergman *et al.*, 2021). Research shows that mental health problems among immigrants in the UK have been exacerbated by the strain on healthcare professionals (Pollard and Howard, 2021b). Additionally, the COVID-19 pandemic has been shown to have exacerbated the pre-existing mental health inadequacies among health systems, and at the same time increased the burden of mental health across populations (Gillard *et al.*, 2021). Healthcare workers also experienced work overload, burnout, anxiety, and other mental health issues arising from COVID-19, for example, rapid transition to online service delivery, and fear of contagion, among others (San Juan *et al.*, 2021). A report by the UK's Health and Social Care Committee highlighted chronic excessive workload as a significant contributor to burnout and staff shortages within the NHS, with existing shortages even before the full impact of the pandemic (Health and Social Care Committee, 2021). Indeed, the suggestions on mental health raised by our study participants align with findings from other studies that emphasize the importance of increased human and physical resource investment in mental health services, as well as the need for evaluation of existing strategies to improve access and quality of mental healthcare for immigrants (Giacco, Matanov and Priebe, 2014). Also consistent with my findings, previous research emphasizes the need for the enhancement of diversity among mental health professionals as a crucial step toward the provision of culturally sensitive care to immigrants (Gopalkrishnan and Babacan, 2015). In line with my findings, the NHS mental health implementation plan for 2019/20- 2023/24 recognizes the need to provide mental health support for the homeless population, through the establishment of a mechanism to assess their needs and provide trauma-informed care with the involvement of multiple delivery partners, as well as targeting the provision of specialist mental health services in the areas where they are most needed (NHS England, 2019).

I found that the need for strategies to empower homeless immigrants about their health and social determinants emerged as one of the top three intervention areas. Specifically, the key strategy identified within this intervention area was the need to raise awareness of the rights to receive support and access PCS among homeless immigrants. Indeed, various studies identify the lack of awareness of rights, and differing interpretations and implementation of rights at regional, institutional, and individual levels as some key barriers to access to PCS among immigrants and homeless people (Woodward, Howard and Wolffers, 2014; Neves-Silva, Martins and Heller, 2018). This finding emphasizes the key role of adopting a rights-based approach in PCS delivery. Similar to my findings, the increased recognition of the urgency for a rights-based approach to tackling homelessness in many parts of the developed world has been documented (Fitzpatrick and Pleace, 2012; Kenna and Fernandez Evangelista, 2013). The rights-based approach was created as a means to operationalise and expand human rights, based on the notion that it’s a first step towards the empowerment of excluded groups by acknowledging that those individuals have rights (Kenna and Fernandez Evangelista, 2013).

In my study, the 4 lowest ranked among the 10 strategies belonged to the intervention areas of raising awareness of immigrants regarding the UK healthcare system and the provision of culturally sensitive primary care services. Although not top-ranked, these intervention areas and strategies remain crucial for enhancing access to PCS for homeless immigrants. In line with these two broad intervention areas, the co-design of health interventions has been coined as one of the effective participatory approaches for empowering vulnerable sub-populations to take charge of their health and livelihood (Cheng *et al.*, 2021). There is research demonstrating improvement in health and livelihood through having healthcare professionals or social workers working alongside immigrants or homeless people to co-design well-tailored and culturally appropriate health interventions and informational materials addressing important topics, for example on the operation of the healthcare system, on targeted services and offers (e.g. legal privileges, financial aid, subsidies, food and medical items) and available community level resources or supports (Keygnaert *et al.*, 2013; William C W Wong *et al.*, 2014). Previous research has underscored the significant barriers created by the absence of culturally competent services in immigrants' access to healthcare, particularly when seeking assistance for healthcare issues where cultural variations make it challenging for providers to comprehend the causes and experiences of illness (Wood and Newbold, 2012). Researchers have emphasized the significance of understanding the cultural needs of individuals seeking treatment and advocating for policies that ensure inclusivity based on specific cultural affiliations (Giacco, Matanov and Priebe, 2014; Sarkar and Punnoose, 2017). A prior systematic review has furnished evidence indicating that cultural competence training represents an efficacious intervention capable of equipping healthcare providers with the skills necessary to deliver culturally sensitive care. This, in turn, leads to increased patient satisfaction among minority groups (Govere and Govere, 2016). Furthermore, research underscores the significance of assembling a healthcare workforce comprised of inter-professional teams. These teams contribute by leveraging their diverse skill sets, training backgrounds, and prior patient interactions to effectively address a wide array of individual needs and expectations, ultimately enhancing the quality of PCS (McGregor *et al.*, 2019).

5.4 Reflections on the methodological framework

5.4.1 Strengths of the methodological framework

Utilizing the Levesque Framework of access to healthcare access to guide my analysis of the factors influencing homeless immigrants' access to primary care services has enabled an impartial evaluation of the access challenges encountered by homeless immigrants, considering both the supply and demand aspects (Levesque, Harris and Russell, 2013). This choice represents a notable strength, which has also been acknowledged in the existing literature (Philip et al., 2022). This approach holds promise in facilitating a more comprehensive understanding of intervention opportunities and areas, adopting a systemic perspective. Additionally, the incorporation of an intersectional lens within this framework serves to further enhance the exploration of access issues from various angles. This demonstrates the framework's adaptability and its capacity to seamlessly integrate with other analytical approaches, such as the intersectionality approach (Philip et al., 2022). Furthermore, this framework is increasingly applied in studies from around the world, and therefore this provides an opportunity for improved comparability of my research findings with other similar studies from around the world (Cu et al., 2021).

5.4.2 Limitations of the methodological framework

As noted by Cu et al. (2021), certain difficulties arose when attempting to delineate specific aspects of access. In some instances, the Levesque framework of access did not seamlessly align with the data, as certain subthemes transcended multiple overarching themes. One example is the language barrier. Although this has been discussed about the appropriateness and ability of homeless immigrants to engage with health services and providers, it also impairs access through; approachability (as the language barrier makes it difficult to navigate the healthcare system); acceptability (as homeless immigrants with language barrier were unable to access culturally sensitive care particularly for mental health services, because some individuals were at risk of being misunderstood or misdiagnosed); healthcare availability (as the presence of an interpreter shortens consultation time); and through affordability (as those with language difficulties paid even though they were eligible for free prescriptions because they found it difficult to communicate with the pharmacists). Consequently, the subthemes proved challenging to neatly compartmentalize, resulting in an interconnected web within the analysis. This highlights the intricate and intersecting socioeconomic obstacles confronted by homeless immigrants. Given this complexity, it may be worthwhile to consider further academic exploration employing intersectionality as a theoretical framework (Kang et al., 2019). Building upon the insights of Levesque, Harris and Russell (2013), who emphasized the significance of taking structural factors, including social environments, into account when assessing access, I advocate for an extension of their model. This extension would involve recognizing the influence of natural environmental factors, such as natural disasters and disease pandemics, as well as individuals' living conditions, in shaping access to and utilization of healthcare services. Furthermore, there is a need for the framework to acknowledge the intersectionality of social identities and how they create inequalities that impact access to healthcare services (Lovejoy et al., 2023).

5.5 Reflections on research with homeless immigrants

Engaging in fieldwork with homeless immigrants presented a myriad of challenges that manifested at various stages of the research process, concurrently raising a range of ethical inquiries. In this context, I aim to contemplate the intricacies associated with conducting research within marginalized communities, with a specific emphasis on i) the intricacies of recruitment, ii) the utilization of gatekeepers, iii) my positionality as an immigrant researcher, and iv) adhering to ethical practices while managing expectations and remuneration for homeless immigrants.

5.5.1 Recruitment challenges

Several challenges did indeed emerge during the recruitment process. While I ultimately succeeded in enlisting 30 homeless immigrants, it was not without its hurdles. Some participants were reluctant to participate in this research or be audio-recorded for fear of sharing their data with the Home Office which they thought might jeopardize their immigration status. I maintained transparency regarding the research's objectives and provided participants with assurances regarding the confidentiality and anonymity of any identifiable information. Also, because I conducted this study during the COVID-19 pandemic, I used video and telephone interviews. However, this might have unintentionally excluded those who lacked phone credit/data and those who didn’t know how to use digital services or both. Coordinating data collection schedules posed a challenge in certain instances, primarily due to the demanding lifestyles of some participants. For instance, the constant change of accommodation delayed some interviews. Also, because of the COVID-

19 pandemic, some interested participants reported having COVID-19 which delayed some interviews.

Whilst all the participants I interviewed spoke English, a few of them had insufficient English-speaking skills which resulted in shorter interviews compared to their counterparts who were fluent in English. Although excluding participants who did not speak English might have impacted my results to a certain extent, when analysing my data, I triangulated information from stakeholder interviews. This was undertaken with the dual purpose of mitigating or diminishing biases, thereby enhancing the study's reliability and validity. Furthermore, it aimed to augment the study's comprehensiveness, thereby imbuing it with a qualitatively derived depth that contributes to a more comprehensive understanding of the phenomenon being examined. Thirdly, triangulation helped to increase the confidence about the validity of the results (Jonsen and Jehn, 2009) Although I interviewed only English-speaking immigrants, I feel the majority of my conversations were in-depth because participants were able to talk about personal/sensitive issues without worrying about third-party dynamics involving an interpreter.

5.5.2 Using gatekeepers

I used gatekeepers, mostly voluntary sector providers to recruit homeless immigrants. They provided a physical and social bridge for me to recruit research participants that I might not have recruited otherwise. An example of such participants is the homeless immigrant women who had experienced partner violence (Clark, 2011). The gatekeepers provided the necessary information for homeless immigrants to make contact with me. Nevertheless, I harbored reservations regarding the potential impact of the gatekeepers' close association with the participants, as they served as integral components of their support networks. I recognized that this proximity could potentially influence or bias the responses provided by participants within my study. For instance, some homeless immigrants explicitly requested that I refrain from sharing their information with voluntary sector providers. In response, I offered reassurance that their data would be handled and reported in a manner that preserved their anonymity. This assurance was upheld by employing techniques such as coding personal data to safeguard participants' identities, securely storing data within a password-protected university account, and diligently removing any identifying details to minimize the risk of breaching confidentiality (Dempsey et al., 2016). I also emphasized that they should be honest and not feel pressured to provide particular responses because they would be anonymous. Although the use of voluntary sector providers to recruit participants was helpful, I was concerned about not reaching participants without any connections to voluntary sector providers. To address this, I used snowball sampling where some homeless immigrants were recruited through their acquaintances. Scholars highlight that this approach tends to be particularly efficacious when the individuals within the study population are not readily reachable, as is often the case with homeless immigrants (Naderifar, Goli and Ghaljaie, 2017).

5.5.3 My positionality as an immigrant researcher

My status as an immigrant in the UK may have had a positive impact on the rapport I was able to build with homeless immigrants and the trust they had in me, which may have made them feel more comfortable opening up to me. Establishing trust and cultivating rapport have been recognized by researchers as essential elements for fostering productive research relationships (Clark, 2011). However, it is essential to acknowledge that my own experiences and perspectives as an immigrant researcher may have exerted some influence on the interpretation of my data, potentially introducing biases into my research. These biases could manifest as overlooking certain issues that may not be universally shared by all immigrants. To counteract this potential bias, it was imperative to maintain a keen awareness of my positionality throughout the research process. This involved actively seeking out diverse perspectives from participants to ensure a well-rounded and balanced exploration of the subject matter. This included asking open-ended questions, avoiding leading questions, audio recording and verbatim transcription, and actively listening to participants' experiences and perspectives (Onwuegbuzie and Leech, 2007).

In my capacity as a student immigrant, it's important to recognize that I may possess certain privileges that surpass those of some participants in my study. Specifically, I have legal status and access to certain resources that they may lack. This distinction in status could potentially have significant implications for my relationship with the homeless immigrant participants. Moreover, this distinction may have inadvertently given rise to a sense of inequality, wherein the researcher wields greater power and influence than the participants. Such a power dynamic can pose challenges as it may hinder participants from feeling entirely at ease when sharing their experiences, opinions, and perspectives with the researcher. However, having experienced the challenges that immigrants face in the UK including unfamiliarity with the healthcare system, and being at risk of homelessness, enabled me to understand their experiences. I was able to actively listen, ask open-ended questions, and refrain from interrupting or invalidating participants’ experiences. The way I interacted and spoke around the homeless immigrants was therefore heavily guided by my common racial identity, which might have been different for a non-immigrant researcher who might not have known what it meant to be an immigrant (Jacobson and Mustafa, 2019).

5.5.4 Ethics in Practice: Meeting Expectations

Engaging in research with a population categorized as 'vulnerable' or, at the very least, situated in a marginalized societal position, introduces a multitude of ethical and methodological dilemmas concerning the extent of one's responsibility toward research participants. On multiple occasions throughout my fieldwork, I harbored concerns that potential participants might mistakenly assume that my involvement could substantially ameliorate their circumstances, thus prompting their participation in these expectations. Despite my concerted efforts to convey that my research did not possess such transformative capabilities, some participants inquired if there was any way I could potentially aid their situations. However, beyond guiding them toward available voluntary sector resources and providing a £20 voucher, my capacity to effect meaningful change in their immediate circumstances was inherently limited. While striving for tangible, long-term improvements is an overarching research objective, this pursuit may offer little solace to individuals whose focus extends only as far as their next night's lodging, their evening meal, or the status of their pending applications (O’Donnell et al., 2016).

5.5.5 Ethics in Practice: paying participants

Delving into the ethics of offering monetary compensation to research participants is a nuanced endeavor. This practice is far from ethically straightforward, as it raises questions concerning the nature of free consent and the potential for participants to provide responses that align with expected outcomes rather than expressing their genuine sentiments (Head, 2009). Additionally, there is the concern that financial incentives might incentivize individuals to provide inaccurate information to qualify for a study. To address these apprehensions, I opted to recruit participants through voluntary sector providers who have a history of working closely with homeless immigrants. Given the extensive nature of the interviews I conducted, I have reason to believe that participants did not falsify information to become eligible for my study. It's worth noting that in discussions about the ethics of research involving homeless individuals, scholars contend that offering monetary compensation for participation could potentially serve as an inducement and be regarded as exploitative of interviewees (Head, 2009). While I may not possess certainty regarding the extent to which this factor influenced their willingness to participate, it's important to recognize that for those subsisting on limited asylum budgets, a £20 voucher can indeed carry substantial significance. In light of this, I deemed it appropriate to provide this token as a gesture of gratitude, acknowledging their invaluable contribution of time and energy to the study. Moreover, this amount was agreed upon based on some institutional guidance and a review of my research ethics by the University ethics panel.

5.6 Strengths and limitations of the study

The research undertaken for this thesis exhibits a range of strengths as well as a few limitations, which I will briefly delineate in this section.

5.6.1 Strengths of the study

The research conducted in this study boasts several noteworthy strengths. Despite the challenges elaborated upon in section 7.4.1, I successfully engaged with a broad spectrum of individuals, including those occupying particularly vulnerable positions. Many of these individuals had previously had limited opportunities to have their voices heard. The utilization of qualitative data collection methods facilitated an in-depth exploration and comprehension of the various factors influencing the provision of and access to primary care services, considering both the demand (i.e., homeless immigrants) and supply-side (i.e., healthcare providers) aspects. The substantial scale of this study, coupled with its multiple phases and the inclusion of diverse voices and perspectives, effectively captured the inherent diversity among homeless immigrants. This approach significantly bolstered the validity of the study (Zuurmond et al., 2019). Furthermore, the research acknowledged the roles played by voluntary sector providers and local council professionals in shaping homeless immigrants' access to PCS. As a result, I was able to enhance the depth of the study by conducting interviews with both professionals and homeless immigrant participants, thus providing a more comprehensive and nuanced understanding of the subject matter.

Also, through the Delphi surveys, this study identified strategies for improving access to PCS from stakeholders. This engagement of a wide range of stakeholders has been found to enhance the perceived relevance and adoption of research findings by health systems

(Concannon et al., 2012). Additionally, the utilization of an online survey during the Delphi rounds enabled participants to provide evaluations regardless of their geographical location and to address barriers in communication and research posed by the COVID-19 pandemic. Another strength is that this work was conducted during the pandemic. The pandemic period was an opportune period (unique) in that some of the greatest barriers to accessing PCS were being experienced, and the experiences learned are unique for post-pandemic recovery and for planning for future disasters. In conclusion, the fusion of two theoretical frameworks—namely, the Levesque framework and the intersectionality perspective—enabled me to gather valuable insights. These insights extended beyond the realm of conducting research within diverse vulnerable groups; they also illuminated the intricate interplay of social identities, which converge to form disparities that have ramifications on healthcare service access for these vulnerable populations.

5.6.2 Limitations of the study

The study does have certain limitations worth acknowledging. To begin with, I was unable to secure a completely representative sample of homeless immigrants hailing from the UK. Furthermore, the adoption of telephone interviews in place of face-to-face interactions may have led to a diminished capacity for capturing non-verbal communication cues. Conversely, the use of telephone interviews did afford greater anonymity to study participants as suggested by Khanom et al. (2021). It is also important to consider that the majority of the homeless immigrants included in this research were clients of gatekeeper organizations, signifying that they had some history of engagement and interaction aimed at enhancing their quality of life and access to services. Consequently, these participants may be viewed as possessing a greater degree of knowledge and resources for accessing primary care services in comparison to other members of the same marginalized groups who lack such engagement with gatekeepers. However, owing to snowball sampling, I was able to recruit some participants without connections to these gatekeeper organisations. Whilst my study excluded non-English speaking homeless immigrants, triangulation through interviewing various stakeholders provided an insight into the challenges faced by non-English speaking individuals in accessing PCS. Additionally, it's worth noting that individuals with intellectual impairments or mental health conditions were not encompassed within the scope of this study. This presents an avenue for exploration by future research endeavors (Zuurmond et al., 2019).

The study was conducted within the South East region of England (mainly Kent) and London and therefore, the issues arising need to be interpreted with caution and may not be fully representative of the entire homeless immigrant sub-population in the UK. As data informing this study was collected late into the pandemic, it is plausible that some of the COVID-19 pandemic-related factors may have impacted accessibility differently during different phases of the pandemic. Therefore, this not being a longitudinal study may imply that some factors or issues changed throughout the pandemic and were therefore not fully brought out. Some important social identities, such as LGBTQ were not well represented or fully explored while examining intersectionality. Sexual orientation/identity is a highly important area for understanding social determinants of health and therefore this is an area that needs future research.

Another limitation is the exclusion of homeless immigrants from the Delphi study due to challenges related to digital connectivity, which might have resulted in low or no responses. Yet, incorporating the perspectives of homeless immigrants would have provided valuable insights into the topic under investigation. Additionally, although the Delphi technique lacks universally agreed-upon criteria or a specific number for expert selection, in this study, the limited participation of only two voluntary sector providers and the absence of local council professionals may have impacted the comprehensiveness and diversity of the collected results (Keeney, Hasson and McKenna, 2006). Nonetheless, we prioritized representativeness by including a diverse range of healthcare providers in our panel composition. Lastly, due to the small sample sizes within specific subgroups, such as voluntary sector providers, we were unable to conduct a subgroup analysis of item rankings. Furthermore, policy makers although essential, were not included in the study as part of the stakeholders. However, policymakers possess a wealth of knowledge that can offer valuable perspectives regarding the viability, pertinence, and practicability of research findings when applied to real-world scenarios. Their contributions serve to bridge the divide between research and the actual implementation of policy, thereby ensuring that the study's outcomes ultimately strive to enhance the health and well-being of homeless immigrants (Erismann et al., 2021).

Chapter six: Recommendations and conclusion

6.1 Introduction

In this chapter, I highlight the significant implications emerging for both research and practical applications. Additionally, I pinpoint potential avenues for further research. Finally, I address policy and public health practice recommendations, concluding with a comprehensive summary of the thesis.

6.2 Implications for research and practice

The outcomes of this research could hold significant implications across multiple tiers, encompassing UK immigration policy, the NHS, primary care practices, and immigrant or community perspectives.

6.2.1 Implications for UK immigration policy

My thesis has effectively illustrated how the immigration system plays a pivotal role in both generating and intensifying the impediments that obstruct homeless immigrants' access to primary care services within the UK. Consequently, it contributes further empirical substantiation to the body of previous research, underscoring how inhospitable policies, including the No Recourse to Public Funds regime, operate to effectively ostracize immigrants, particularly those without formal immigration status, from the protective embrace of the state's safety net. This exclusion results in a cascading series of adverse consequences, including diminished access to suitable employment conditions, secure housing, and financial stability. As a result, many find themselves ensnared in a cycle of poverty, unsustainable debt, destitution, homelessness, and residing in inadequate, overcrowded living arrangements (Fotheringham and Boswell, 2022). Due to their precarious circumstances, homeless immigrants encountered significant challenges in obtaining the PCS that was essential, even though a substantial number of them had additional healthcare requirements (Blane and Ciftci, 2022). Furthermore, my thesis has emphasized how susceptibility to homelessness can be intensified by specific policies and immigration regulations that affect immigrants. This aligns with Netto’s (2006) contention that it is crucial to take into account the influence of structural factors that contribute to homelessness, rendering certain individuals and groups more exposed to this phenomenon than others. It also emphasizes the individual strategies adopted in response to their circumstances, albeit within the confines of limited choices.

Although the UK government's influence over individuals before they reach UK borders is somewhat limited, it does possess substantial authority when it comes to their treatment once they are within the UK. Rather than dismantling the hostile environment policies and ending the practice of inhumane immigration detention and removals as highlighted by Fotheringham and Boswell (2022), the UK government has introduced a new Nationality and Immigration Bill. This proposed legislation seeks to penalize irregular entry into the UK asylum protection system, a move that is likely to exacerbate the existing barriers to accessing PCS (Blane and Ciftci, 2022). While it may be true that the structural organization of the immigration system falls largely outside the purview of public health and primary care disciplines, these fields need to shoulder the responsibility of demonstrating how structural inequalities and policy decisions can have a discernible and detrimental impact on the health of specific segments of the population. In this context, this thesis serves as a valuable addition to a growing body of evidence, equipping these disciplines with the insights and data needed to advocate for positive change.

6.2.2 Implications for the NHS policy

As previously discussed, my thesis highlights the impact of the government's hostile environment policies in obstructing access to primary care services. Given the instrumental role of the NHS within these policies (Kang, Farrington and Tomkow, 2019), the NHS holds a critical position in alleviating some of the resulting harm. The findings from the study suggest that homeless immigrants harbor mistrust and fear towards the UK government, potentially endangering both their own safety and broader public health (Papageorgiou et al., 2020). Therefore, it is imperative to firmly commit to and vocally advocate for a complete separation between the NHS and the Home Office. This separation is particularly vital for homeless immigrants, especially those lacking legal status, as it would enable them to seek care without apprehension. Fearing detention or deportation by health authorities, among irregular immigrants often hinders them from accessing primary care services and hence resort to alternative health-seeking strategies, while others depend on services provided by voluntary sector providers (Spitzer et al., 2019). Through the provision of information in suitable formats that take into account literacy levels in various languages, and by involving individuals with lived experiences in the co-production process, the NHS can enhance the awareness of newly arrived immigrants on how to effectively navigate and engage with the healthcare system (Tomkow *et al.*, 2020). This highlights the importance of collaborating with immigrant community organizations to educate both newly arrived and existing immigrants about their rights and entitlements to healthcare and other services. This education can be disseminated through multiple channels, including community groups, to ensure that individuals are well-informed about what they can and cannot expect (O'Doherty, Pillinger and Bowen, 2018).

6.2.3 Implications for primary care services delivery

My thesis has shed light on the influence of both effective and suboptimal primary care practices across all aspects of access. While some homeless immigrants reported positive encounters during medical consultations, they frequently expressed the need for longer appointments, especially those requiring interpreters (Kang, Farrington and Tomkow, 2019). However, they also shared instances of negative experiences, including discrimination and being denied registration. In certain cases, these actions are in contradiction to established guidelines. For example, primary care policies in England, Scotland, and Wales explicitly state that immigration status should not impact one's entitlement to register for and receive primary care services. The NHS England Primary Medical Care Policy and Guidance Manual unequivocally indicate that a lack of proof of identity or address should not serve as reasonable grounds for refusing patient registration (Patel and Corbett, 2015). While these policies are promising, further measures are necessary to ensure their effective implementation (Blane and Ciftci, 2022). To address these issues, primary care practices should take proactive steps to identify homeless immigrants, gain a deep understanding of their unique needs through active engagement, and provide language-specific information about available services and changes in service delivery through various communication methods, including text messages, emails, letters, and posters in local community hubs) (Knights et al., 2021). Another significant implication, particularly relevant for prevention efforts, is the increased emphasis on social prescribing for non-clinical services that can significantly impact health and well-being.

One of the central findings emerging from my study highlights the imperative need to enhance the comprehension and awareness of frontline professionals and service providers regarding the intricacies of intersectionality. This understanding must be actively applied when engaging with homeless immigrants across various sectors. My thesis has effectively illustrated how elements such as race, gender, poverty, immigration status, and homelessness intertwine to form disparities that directly affect the accessibility of primary care services. The positioning of homeless immigrant women at the intersection of these multifaceted identities engenders a distinct and nuanced experience of partner violence compared to that of white or native-born women. The compounded effects of multiple forms of subordination not only shape but also constrain opportunities for meaningful interventions on their behalf. Therefore, it is not only imperative for those collaborating with homeless immigrant individuals across sectors to deepen their comprehension of intersectionality, but service providers must also equip their staff with cultural competence and the confidence to challenge detrimental community norms. Moreover, access to trained interpreters must be readily available, and immigrant women should have the autonomy to request female interpreters during medical consultations, ensuring a more culturally sensitive and accommodating environment. Additionally, the adoption of trauma-informed practices should extend across all contexts in which homeless immigrant individuals, particularly women, seek assistance. This comprehensive approach is essential for addressing the intricate challenges posed by intersectionality and promoting the well-being of this vulnerable population (Bartelson and Sutherland, 2018). It is only by weaving these threads into policies, practical interventions, and research efforts aimed at assisting homeless immigrants that we can initiate the process of tackling the harmful and enduring combination of marginalization and violence that impacts the lives of numerous individuals (O'Doherty, Pillinger and Bowen, 2018).

Using the Delphi technique, I identified the highest-priority strategies for enhancing access to PCS for homeless immigrants. The implementation of these strategies has the potential to improve healthcare access and ultimately enhance the health outcomes of homeless immigrants (Parker *et al.*, 2021). These identified priorities reflect the valuable perspectives of healthcare providers on how to address the issue of improving access to PCS for homeless immigrants. Consequently, the prioritized list serves as recommendations to enhance the healthcare system in the UK by integrating these strategies into primary care practices. The current findings on the prioritized strategies for improving access to primary care services (PCS) for homeless immigrants are highly relevant for post-COVID recovery in terms of improving their healthcare. The pandemic exacerbated existing health inequalities, including access to healthcare for marginalized populations. By implementing the identified strategies for improving access to PCS, healthcare providers can better serve homeless immigrants and improve their health outcomes. Therefore, policymakers and healthcare organizations should consider the study's recommendations to develop interventions and initiatives aimed at improving access to PCS for homeless immigrants, particularly in the context of post-pandemic recovery efforts. Additionally, the identified areas for intervention provide a platform for advocacy and lobbying, especially by healthcare providers of marginalized populations like homeless immigrants.

6.3 Future research questions

While this research primarily delved into the unique experiences of homeless immigrants, it's evident that there are shared experiences not only within other ethnic minority communities but also among socioeconomically disadvantaged white populations, such as homeless individuals and those grappling with extreme poverty. Further research that investigates both the commonalities and distinctions among these marginalized groups could prove invaluable in shaping policies and practices that foster health equity and bolster the evidence base regarding the impact of inequalities on health. Moreover, even though homeless immigrants in the UK may encounter similar challenges when seeking secondary care services, there is a pressing need for additional research that offers a nuanced understanding of the experiences and viewpoints of both homeless immigrants and healthcare providers as they navigate access to secondary care. This can contribute to a more comprehensive comprehension of the intricacies involved in this aspect of healthcare access. This will generate evidence on the impact of hostile environment policies on access to secondary care and contribute to more evidence-based and compassionate policies that prioritize the health and well-being of all individuals, regardless of their immigration status. Additionally, future research could involve policy makers to discuss potential policy implications. Collaborating with policymakers can facilitate the integration of research into policy decisions and enhance the real-world impact of the study.

Whilst this thesis employed a Delphi approach to understanding the most prioritized strategies in enhancing access to primary care services for homeless immigrants, only stakeholder groups participated in the surveys. Further research should incorporate both stakeholder groups and homeless immigrants in the Delphi research aimed to identify the most prioritised strategies in improving access to primary care services. Incorporating homeless immigrants into the Delphi surveys can offer a more comprehensive insight into the strategies that hold the utmost significance for them, aligning with their distinct needs and lived experiences. It also serves the purpose of identifying strategies that might have been inadvertently omitted or undervalued by other stakeholders involved in the process.

Additionally, forthcoming research endeavors should emphasize the assessment of the effectiveness of these prioritized strategies in enhancing access to PCS for homeless immigrants. Longitudinal studies could be conducted to gauge whether the implementation of the recommended interventions results in sustained improvements in health outcomes within this population. Furthermore, this study's findings underscore the potential hindrance posed by the current service delivery model to homeless individuals' access to mainstream primary healthcare services. This observation is consistent with existing literature, which suggests that rigid appointment systems may prove challenging for homeless patients due to the unpredictable and unstable nature of their lives (Gunner et al., 2019). Therefore, there is a need for research that assesses different service delivery models, such as outreach programs and non-medical prescribing, with a focus on their effects on the health and quality of life of homeless individuals (Gunner et al., 2019). Since this research was limited to Kent and London, future research may be relevant for focus on comparative work considering geographical dynamics within the UK.

6.4 Recommendations and conclusion

My thesis contributes significantly to the discourse on public health and primary care in several ways. First and foremost, it sheds light on the experiences and perspectives of homeless immigrants and various stakeholder groups, offering valuable insights into the complexities of accessing PCS for immigrants facing homelessness in the UK. It has uncovered a multitude of factors that affect access, including language barriers, discrimination, low health literacy, distrust of healthcare providers, and prevailing health-related beliefs. These findings highlight the importance of flexible, affordable, accessible, and culturally and linguistically appropriate healthcare services. Enhancements in this regard, such as expanding the pool of service providers, cultural brokers, and interpreters, hold promise for improving the delivery of PCS.

Moreover, my thesis adopts an intersectionality perspective to deepen our understanding of access issues, recognizing how multiple forms of exclusion intersect and compound health inequalities. It also examines the impact of the COVID-19 pandemic on access, highlighting the challenges posed by the digitalization of healthcare services and the shift away from face-to-face appointments, particularly for vulnerable populations like homeless immigrants. Lastly, my study identifies and prioritizes strategies for enhancing access to PCS, offering a roadmap for addressing the unique needs and barriers faced by homeless immigrants and similar socially vulnerable groups, such as homeless individuals. Additionally, healthcare providers should be encouraged to receive training and education on cultural competence, mental health support, and addressing discrimination to effectively implement these strategies in their daily practice. By incorporating these strategies into policy and practice, we can work towards creating a more inclusive and accessible healthcare system for homeless immigrants in England.

The immigration system exerted the most profound influence, shaping the perceptions of public health and primary care professionals toward homeless immigrants. By positioning homeless immigrants in circumstances that hindered their engagement in preventive care and elevated their susceptibility to communicable and chronic health conditions often associated with "lifestyle" factors, these systemic structures effectively enacted a hostile environment towards this vulnerable population. It's important to recognize that difficulties in accessing PCS can result in undesirable outcomes, including delays in seeking and receiving necessary treatment (Etowa et al., 2021). This persistent challenge is, in part, because health policies and interventions tend to target specific barriers or elements of the issue without adequately considering the interconnected and intersecting factors that contribute to the current state of affairs (Venkatachalam et al., 2020). For instance, a comprehensive understanding of how the intersectionality of being a homeless immigrant from an ethnocultural minority background and residing in a lower socioeconomic status interact to affect access can fundamentally reshape the way policies and services are conceptualized and implemented to address these access barriers (Salami et al., 2021).

Considering the diversity within immigrant populations, it is imperative to adopt a more nuanced approach when planning inclusive health services. This approach should depart from the notion of a uniform, one-size-fits-all strategy and instead tailor healthcare services to accommodate the unique needs and characteristics of different immigrant groups. This thesis has highlighted the importance of intersectionality in recognizing that individuals may face multiple and intersecting forms of social identities which can all create inequalities that impact homeless immigrants' access to healthcare services (Zuurmond *et al.*, 2019). Also, research and routine data collection should employ the approach of collecting disaggregated data (for example by gender, race, and immigration status) and not just a broad category of “homeless people” as this would go a long way in identifying and prioritizing social determinants of health in this group. Thus, researchers emphasize that an approach that assumes that "one size fits all" targeting a vulnerable population is insufficient (Hinkel, 2011). To narrow the disparities and enhance accessibility, healthcare services should prioritize cultural sensitivity and customization to address the distinct requirements of various subgroups within immigrant populations. For example, homeless immigrant women experiencing partner violence may require specific services that address their unique needs and experiences. Delivering such tailored services can contribute to enhancing their access to healthcare and ultimately lead to improved health outcomes (Shibli, Aharonson-Daniel and Feder-Bubis, 2021).

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Appendices

Appendix 1: Information form for homeless immigrants

Provision and Accessibility of Primary Care Services among Immigrants experiencing Homelessness in South East England.

INFORMATION SHEET FOR IMMIGRANTS

My name is Carol Namata. I am a PhD student at the Faculty of Medicine, Health and Social Care, Canterbury Christ Church University (CCCU).

What is the study about?

I am doing this study to understand the factors that affect immigrants when they try to get help for their health conditions. In particular, immigrants who are experiencing homelessness. Information obtained from this research study will be used to understand the factors that influence provision and accessibility to primary care services among immigrants experiencing homelessness in South East England.

Why are you invited to participate in this study?

You are invited to participate in this study because you are 18 years or above, you are a non-British citizen, and you are experiencing one or more of the following categories of homelessness.

- Rooflessness (you have no shelter of any kind, you sleep rough on the streets)
- Houselessness (you have a place to sleep but temporary, in institutions or a shelter)
- Living in insecure housing (you are threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or you stay with family and friends)

- Living in inadequate housing (you live in unfit housing, in extreme overcrowding)

What will you be required to do?

You will be required to give your consent after you have read through this document. After agreeing to take part in this study, I will arrange for us an interview to take place at a time and place most convenient for both of us. I will author some suggestions to you for a suitable meeting place.

During the interview, I would like to ask some questions about your experiences after you came to the UK in relation to your health and wellbeing and the kind of support you have been receiving. I am particularly interested in your experiences when accessing primary care services such as services provided by General Practitioners (GPs).

Interviews will be audio recorded for analysis purposes. I am expecting that our discussion could last for about 45 minutes. If you decide to take part in this study, it will be up to you to answer the questions I will be asking.

How will my personal information be used?

I will use your information for purposes of this study only. I will be responsible for looking after your information and using it properly. All audio tapes and transcripts will be anonymised and pseudonymised. Data will be anonymised by deleting any information that might identify you. Data will also be pseudonymised by replacing any identifiers such as names with fake names or codes. I will retain your data until 2024 when I complete my Ph.D. studies.

Data will only be accessed by the student, the supervisors, and examiners. You can find out more about how I will use your information by contacting me (cn239@canterbury.ac.uk). You can also contact the University Data Protection Officer (dp.officer@canterbury.ac.uk). If you want further information about how your personal data will be processed, you can read further information regarding how the University processes your personal data for research purposes at the following link: Research Privacy Notice - https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx

Ethical approval

Ethical approval will be obtained from Canterbury Christ Church University Research Ethics Committee.

Potential risks

There are no potential risks foreseen in taking part in the interview. However, you are free not to answer any questions that you don't wish to or stop the interview at any time. There will be breaks in case the interview takes a long time. In case of any safeguarding issues, I will have to discuss with my supervisor on a way forward.

Potential benefits to the participant

The researcher will offer you a leaflet with details of support services that may be beneficial to you. Your participation in this study will enable stakeholders understand your experiences and perspectives when accessing primary care services.

The researcher will offer you a token of appreciation for your participation in this research study. The token of appreciation will be a £20 supermarket voucher.

Confidentiality and data protection

All information received from you will remain confidential at all times. Hard copies such as consent forms will be kept in a locked cabinet in the supervisor's office. Soft copies will be kept on the researcher's CCCU password protected account.

All data will be kept by the researcher until completion of their PhD studies. Once I have completed my PhD studies, I will destroy all your data. Hard copies will be destroyed in an appropriate manner using university approaches of destroying sensitive data. Soft copies will entirely be deleted from my university account.

Participation and withdraw

Should you decide to participate, you will be free to withdraw your agreement at any time without having to give a reason. You may also refuse to answer any questions you don't want to answer and still remain in the study. If you want to withdrawal from this study, you will send an email to the researcher Carol Namata (cn239@canterbury.ac.uk) or contact her through the telephone number (**01227 767700 3596**) stating that you would like to withdraw your consent to participate in this research project.

Dissemination of the results

The findings of the study will be disseminated to relevant stakeholders, such as healthcare professionals, voluntary sector providers, and local authority professionals. The report will also be available through the CCCU institutional library. Results of the study will also be presented elsewhere as appropriate, such as in academic journal articles and relevant conference presentations. A report will also be available at your request. Results will also be disseminated through my PhD thesis.

Any questions

If you have any questions or concerns about study, please do not hesitate to contact me.

Carol Namata- student/researcher- cn239@canterbury.ac.uk

You can also contact my supervisor

Eleni Hatzidimitriadou - eleni.hatzidimitriadou@canterbury.ac.uk / 01227 923596

Alternatively, the postal address for any queries is:

Faculty of Health, Medicine and Social Care

Canterbury Christ Church University

North Holmes Road

Canterbury

Kent CT1 1QU

Appendix 2: Information form for stakeholders

Provision and Accessibility of Primary Care Services among Immigrants experiencing Homelessness in South East England.

KEY INFORMANT FORMATION SHEET

My name is Carol Namata. I am a PhD student at the Faculty of Medicine, Health and Social Care, Canterbury Christ Church University (CCCU).

What is the study about?

I am doing this study to gain an understanding of the factors that influence provision and accessibility of primary care services among immigrants experiencing homelessness in South East England. Research has shown this population is more likely to use emergency services compared with the general population. However, little is known about their accessibility to primary care services such as general practitioner (GP) services. I am interested in your views, perspectives and experiences about factors that influence provision and accessibility to primary care services among immigrants experiencing homelessness.

In this study, immigrants will be the ones without British citizenship.

According to Public Health England, homelessness includes the following categories.

- Rooflessness (without a shelter of any kind, sleeping rough)
- Houselessness (with a place to sleep but temporary, in institutions or a shelter)
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as ‘sofa surfing’)
- Living in inadequate housing (in unfit housing, in extreme overcrowding)

Why are you invited to participate in this study?

You are invited to participate in this study because you are 18 years or above, and you are a key stakeholder regarding provision and accessibility to primary care services among immigrants experiencing homelessness.

What will you be required to do?

You will be required to give your consent after reading through this document. After agreeing to take part in this study, I will arrange for us an interview to take place at a time and place most convenient for both of us. I will author some suggestions to you for a suitable meeting place.

During the interview, I would like to ask some questions about your experiences, views and perspectives regarding factors that influence provision and accessibility of primary care services among immigrants experiencing homelessness.

Interviews will be audio recorded for analysis purposes. I am expecting that our discussion will last for about an hour. If you decide to take part in this study, it will be up to you to answer the questions I will be asking.

How will my personal information be used?

I will use your information for purposes of this study only. I will be responsible for looking after your information and using it properly. All audio tapes and transcripts will be anonymised and pseudonymised. Data will be anonymised by deleting any information that might identify you. Data will also be pseudonymised by replacing any identifiers such as names with fake names or codes. I will retain your data until 2024 when I complete my Ph.D. studies.

Data will only be accessed by the student, the supervisors, and examiners. You can find out more about how I will use your information by contacting me (cn239@canterbury.ac.uk). You can also contact the University Data Protection Officer (dp.officer@canterbury.ac.uk). If you want further information about how your personal data will be processed, you can read further information regarding how the University processes your personal data for research purposes at the following link: Research Privacy Notice - https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx

Ethical approval

Ethical approval will be obtained from the Canterbury Christ Church University Research Ethics Committee.

Potential risks

There are no potential risks foreseen in taking part in this interview. However, you are free not to answer any questions that you don't wish to or stop the interview at any time. There will be breaks in case you feel tired. In case of any safeguarding issues, I will have to discuss with my supervisor on a way forward.

Potential benefits to the participant

Your participation in this study will contribute to the understanding of the factors that influence provision and accessibility of primary care services among homeless immigrants.

Confidentiality and data protection

All information received from you will remain confidential at all times. Hard copies such as consent forms will be kept in a locked cabinet in the supervisor's office. Soft copies will be kept on the researcher's CCCU password protected account.

All data will be kept by the researcher until completion of their PhD studies. Once I have completed my PhD studies, I will destroy all your data. Hard copies will be destroyed in an appropriate manner using university approaches of destroying sensitive data. Soft copies will entirely be deleted from my university account.

Participation and withdraw

Should you decide to participate, you will be free to withdraw your agreement at any time without having to give a reason. You may also refuse to answer any questions you don't want to answer and still remain in the study. If you want to withdrawal from this study, you will either send an email to the researcher Carol Namata (cn239@canterbury.ac.uk) or contact her through a telephone number (**07862799483**) stating that you would like to withdraw your consent to participate in this research project.

Dissemination of the results

The findings of the study will be disseminated to relevant stakeholders, such as healthcare professionals, voluntary sector providers, and local authority professionals. The report will also be available through the CCCU institutional library. Results of the study will also be presented elsewhere as appropriate, such as in academic journal articles and relevant conference presentations. Results will also be disseminated through my PhD thesis.

Any questions

If you have any questions or concerns about study, please do not hesitate to contact me.

Carol Namata- student/researcher- cn239@canterbury.ac.uk / 07862799483

You can also contact my supervisor

Eleni Hatzidimitriadou - eleni.hatzidimitriadou@canterbury.ac.uk / 01227 923596

Alternatively, the postal address for any queries is:

Faculty of Health, Medicine and Social Care

Canterbury Christ Church University

North Holmes Road

Canterbury

Kent CT1 1QU

Appendix 3: Consent form

CONSENT FORM

Title of Project: **Provision and accessibility of primary care services among immigrants experiencing homelessness in South East England**

Name of Researcher: Carol Namata

Contact details:

Address:	Faculty of Medicine, Health and Social Care Canterbury Christ Church University North Holmes Road Canterbury Kent CT1 1QU
Tel:	01227 767700 3596
Email:	cn293@canterbury.ac.uk

Please initial box

1. I confirm that I have read and understood the participant information for the above study and have had the opportunity to ask questions. ☐
2. I confirm that I agree to have my interview audio recorded. ☐
3. I understand that any personal information that I provide to the researcher will be kept strictly confidential and in line with the University Research Privacy Notice ☐
4. I understand that my participation in this study is voluntary and that I am free to withdraw my participation at any time, without giving a reason. ☐
5. I agree to take part in the above study. ☐

Name of Participant: Date: Signature:

Name of Researcher: Date: Signature:

Appendix 4: Ethical approval from the University

Canterbury Christ Church University

Miss Carol Namata
Graduate College
Faculty of Medicine, Health and Social Care
22nd October 2021
Dear Carol

Confirmation of ethics approval: Experiences of homeless immigrants when accessing Primary Care Services (PCS) in London, United Kingdom.

Your ethics application complies fully with the requirements for ethical and governance review, as set out in this University's Research Ethics and Governance Procedures, and has been approved. Your proposal has been approved on condition that you contact the Faculty Ethics Chair (FHWB.FEPassistant@canterbury.ac.uk) prior to starting the project to confirm which voluntary sector shelters (PorchLight, Catching Lives, Kent Refugee Action Network) will be used to support recruitment of participants. This is to ensure that the third party organisations have confirmed they will assist in advertising the project.

You are reminded that it is your responsibility to follow, as appropriate, the policies and procedures set out in the Research Governance Framework and any relevant academic or professional guidelines. The panel would also like to recommend that personal professional indemnity insurance is seriously considered for when you engage in interviews off campus, as CCCU institutional and employer insurance primarily aims to cover the employer and/or institution.

We look forward to receiving a confirmation on completion of the research, in order to complete our file. The report should be the same one that is provided to your participants. Please note that any changes of substance to the research will need to be notified to us so that we can ensure continued appropriate ethical process.

Any significant change in the question, design or conduct of the study over its course will require an amendment application, and may require a new application for ethics approval. It is a condition of approval that you **must** inform ethics@canterbury.ac.uk once your research has
completed.

Wishing you every success with your research.

On behalf of Faculty of Medicine, Health and Social Care Ethics Panel

FHWB.FEPassistant@canterbury.ac.uk

Appendix 5: Interview schedule for homeless immigrants

Interview schedule for immigrants

Introduction

Thank you for agreeing to participate in this study. Once again, my name is Carol Namata. I am a PhD student at Canterbury Christ Church University. I am studying factors that affect immigrants when accessing primary care services such as General Practitioner (GP) services, optician, pharmacists, or dentistry services in the UK. In particular, immigrants who experience homelessness. In this study, an immigrant is described as one without British citizenship, while a homeless individual is one who falls under one or more of the following categories.

- Rooflessness (without a shelter of any kind, sleeping rough)
- Houselessness (with a place to sleep but temporary, in institutions or a shelter)
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as ‘sofa surfing’)
- Living in inadequate housing (in unfit housing, in extreme overcrowding)

As we have discussed, you identify yourself as an immigrant who falls under one or more of the categories above. I would therefore like to ask you again for your permission to audio record our conversation. As I have explained when you gave consent, feel free to let me know if you want to take a break.

Before we start discussing questions about your experiences, I would like to know more about yourself.

Background information

1. Can you tell me about yourself?

- Prompt: age, ethnicity

Migration history

I am interested to know about your journey and experiences coming to the UK

2. When did you arrive and for how long have you lived in the UK?
3. Can you tell me about your experiences coming to the UK?

- Prompt: reasons for coming to the UK
- Prompt: experiences finding accommodation? Employment? Accessing health care services?

Current living arrangements

I am interested to know more about your living arrangements.

4. Can you talk to me about your current living arrangements?
    - Prompt: living arrangements during day and night
    - Prompt: other areas you have lived at
5. Can you tell me about your experiences since living in temporary accommodation?
    - Prompt: challenges faced; support received
6. Can you tell me how your current living arrangement has affected your access to services?
    - Prompt: health care services, employment

Accessibility to Primary Care Services

I am interested to know about how your accessibility to health care services.

7. What do you do when you are not feeling well?
8. Can you tell me more about your experiences when accessing primary care services (such as GP services, pharmacy, optician and dentistry services)?
    - Prompt: challenges faced; support received to access these services
9. What else do you think can be done to improve your access to these services?
10. Is there anything else you would like to add?

Thank you very much for your time

Appendix 6: Interview guide for stakeholders

Interview schedule for key informants

Introduction

Thank you for agreeing to participate in this study. Once again, my name is Carol Namata. I am a PhD student at Canterbury Christ Church University. I am studying factors that influence immigrants' access to and provision of primary care services. In particular, immigrants who experience homelessness. You have been chosen to participate in this study due to your involvement in:

(These statements will change according to the stakeholder being interviewed)

In this study, immigrants will be the ones without British citizenship.

Homeless individuals will fall under the following categories as defined by Public Health England.

- Rooflessness (without a shelter of any kind, sleeping rough)
- Houselessness (with a place to sleep but temporary, in institutions or a shelter)
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as 'sofa surfing')
- Living in inadequate housing (in unfit housing, in extreme overcrowding)

I would therefore like to ask once again for your permission to audio record our conversation. As I have explained when you gave consent, feel free to let me know if you want to take a break.

Before we start discussing questions about your experiences, I would like to know more about yourself.

Background information

1. Can you tell me about yourself?
- Prompt: what is your role in your organization?
- Prompt: how long have you worked in that area?

Let us talk about your experiences working with immigrants experiencing homelessness

2. Can you tell me about your experiences working with this population group?
- Prompt: can you tell me about any challenges you have encountered while working with this population group?

<u>Health and wellbeing</u>

Let us talk about the health and wellbeing of immigrants experiencing homelessness

3. From your point of view, what are the health care needs of this population?
4. What kind of support does your organization provide to improve the health and wellbeing of this group?

<u>Living arrangements</u>

Let us talk about the living arrangements of immigrants experiencing homelessness

5. Can you tell me about the living arrangements of this population group?
- prompt: what do you think contributes to immigrants becoming homeless?
6. What kind of support does your organization provide to improve the living conditions of this population group?

<u>Access to primary care services</u>

Let us talk about accessibility to primary care services among immigrants experiencing homelessness. These services include General Practitioner (GP) services, pharmacy, optician, and dentistry services. In this country, usually for one to access these services, they have to be registered with a GP.

7. Research shows that some immigrants are denied GP registration due to the lack of documentation such as proof of address. Can you tell me about your experiences and views regarding this issue?
- Prompt: can you tell me about other challenges that affect immigrants and homeless groups from accessing primary care services?
8. What is your organization doing to improve this group's access to primary care services?

9. What else do you think can be done to improve access to services among immigrants experiencing homelessness?
10. Is there anything else that you would like to add?

Thank you very much for your time

Appendix 7: Flyer for homeless immigrants

Canterbury
Christ Church
University

Are you an adult migrant aged 18 years old or above?

Would you like to share your experiences?

Carol Namata, a Ph.D student at Canterbury Christ Church University is looking for migrants experiencing homelessness to participate in her research study.

What is the study about?

This research study seeks to understand the experiences of migrants faced with homelessness when accessing primary care services such as the GP services, dental services, eye services, and pharmacy services.

Participation will involve:

- Sharing your experiences when accessing primary care services in the UK.

As a token for your participation, you will receive a £20 gift voucher

Who can participate?

- Adults aged 18 years old or above who are migrants experiencing homelessness (such as those staying with family and friends, those sleeping on the streets, in cars, shelters, and hostels)
- Migrants living in South East England (such as Kent, Surrey, and Sussex) and London

Interested in participating?

Please contact Carol Namata at cn239@canterbury.ac.uk or call/text her on 07862799483

All responses will be kept secure and confidential. This study has received ethics clearance from Canterbury Christ Church University Ethics Board

Appendix 8: Ethical approval for Delphi surveys

Miss Carol Namata

School of Allied and Public Health Professions

Faculty of Medicine, Health and Social Care

29th November 2022

Dear Carol

Confirmation of ethics approval: Experiences of homeless immigrants when accessing Primary Care Services (PCS) in London, United Kingdom.

Your ethics application complies fully with the requirements for ethical and governance review, as set out in this University's Research Ethics and Governance Procedures, and has been approved.

You are reminded that it is your responsibility to follow, as appropriate, the policies and procedures set out in the Research Governance Framework and any relevant academic or professional guidelines.

Any significant change in the question, design or conduct of the study over its course will require an amendment application, and may require a new application for ethics approval.

It is a condition of approval that you must inform ethics@canterbury.ac.uk once your research has completed.

Wishing you every success with your research.

On behalf of

Faculty of Medicine, Health and Social Care Ethics Panel

FHWB.FEPassistant@canterbury.ac.uk

Appendix 9: Invitation to participate in the two-round Delphi survey

Sent via E-Mail

To: [Insert Email of participant]
From: Carol Namata

Subject: Invitation to participate in a Delphi study

Dear [First name of participant]

I am contacting you to request you to participate in a 2-round Delphi survey aimed at determining the relative importance and ranking priority of each of the suggestions/strategies identified from the initial homeless immigrants' and stakeholders' interviews in which you were a participant on improving access to primary care services (PCS) for homeless immigrants.

I will conduct two online survey rounds aimed at achieving consensus on the relative importance/significance of the identified suggestions/strategies and ranking the priority of these items.

You are being contacted because you initially participated in the stakeholder semi-structured interviews to explore factors that impact the provision and accessibility to primary care services for homeless immigrants. The transcripts were reviewed, coded, and analysed when suggestions/actions to improve access to PCS among homeless immigrants were identified. Suggestions generated were grounded in the thematic analysis of the collected data and will inform the Delphi questionnaire.

You were identified as a stakeholder because of your knowledge and experience in homeless immigrants' health and/or social issues and their access to primary care services.

Your perspectives and viewpoints will be useful in creating a wide base of knowledge on improving access to primary care services for homeless immigrants in the UK.

The data collection for this survey will involve two **online survey rounds**. The **first round** will involve rating the importance of the initially identified suggestions from the homeless immigrants' and stakeholders' interviews via an online questionnaire which will last for approximately 20-**30 minutes.**

The **second round** will involve ranking the priority of the important suggestions that achieved consensus in the first round. I will contact you again when the second round begins which should be within the next **3 weeks** after the due date of the first online survey. A thank you letter for participating in the first round, and brief instructions for the completion of the second questionnaire will be sent to you via email.

The Canterbury Christ Church Ethics Review Panel approved this study. You do not have to answer any questions that you do not want to answer, and you may withdraw your participation at any time.

If you are willing to participate, please see attached a document containing more information about the study and a link to the online questionnaire.

https://canterbury.onlinesurveys.ac.uk/strategies-for-improving-access-to-primary-care-services-f

You have been given a **unique code "1"** to use in the questionnaire for identification by the researcher.

The deadline for completion of the survey is **Friday 23rd December 2022 at 11.59 pm.**

If you have any questions please contact me via email **[cn239@canterbury.ac.uk]**

Thank you again for your participation in this study.

Best Regards,

Carol Namata

Ph.D. Candidate

Canterbury Christ Church University

Appendix 10: Participant information for round one of the Delphi survey

Canterbury
Christ Church
University

Strategies for Improving Access to Primary Care Service for Homeless Immigrants in the UK: A Modified Delphi survey

Participant information

My name is Carol Namata. I am a PhD student at the Faculty of Medicine, Health and Social Care, Canterbury Christ Church University (CCCU).

What is this study about?

This is a two-round modified Delphi follow-up survey involving two subsequent online questionnaires.

This Delphi is a follow-up on the study titled *"Access and provision of primary care services (PCS) for immigrants experiencing homelessness in the UK*". Initially, semi-structured interviews were conducted with homeless immigrants and various stakeholders in which you took part to identify the factors that impact access to PCS for homeless immigrants. The interviews were audio-recorded and transcribed verbatim. The transcripts were reviewed, coded, and analysed when suggestions/actions to improve access to PCS among homeless immigrants were identified. Suggestions generated were grounded in the thematic analysis of the collected data and informed the Delphi questionnaire. The Delphi questionnaire will be subsequently distributed to the expert panel, in order to gain consensus on the importance of various items/suggestions.

Purpose of the Study: The purpose of this survey is to determine the relative importance and rank the priority of the suggestions/strategies identified from the initial homeless immigrants' and stakeholders' interviews. This will contribute to a wide knowledge base on improving access to primary care services for homeless immigrants. The study is aimed at achieving consensus among the panel experts on the various strategies and ranking priority of these strategies in improving access to primary care services.

Why are you invited to participate in this study?

You are invited to participate in this study because you participated in the initial semi-structured interviews where numerous suggestions to improve access to primary care services for homeless immigrants were identified.

You are also a key stakeholder with knowledge, insight, experience and/or expertise in homeless immigrants' health and/or social issues and their access to primary care services.

What will you be required to do?

Round 1

You will be required to give your consent after reading through this information on the study.

In order to determine the relative importance of each suggestion, you will be presented with suggestions from the initial interviews of homeless immigrants and stakeholders and asked to rate them on the basis of their significance. You will be asked how important each item is on a five-point Likert scale (1=Not important at all, 2=Not very important, 3=Moderately important, 4=Important, 5=Very important). You will optionally add comments or suggestions in a free text format. This round has 58 questions and is estimated to take 20-30 minutes to complete.

You will have a 3-week period at your disposal to complete the online questionnaire. A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection. The first Delphi round will conclude when your responses have been returned within the time frame. The results of the first round will be analysed with the purpose of creating the second round questionnaire.

Round two

If you completed the first round, you will be invited to participate in the second round of the Delphi survey which will take place three weeks after the due date of the first round. A thank you letter for participating in the first round, a summary of results from the first round, and brief instructions for the completion of the second questionnaire will be sent to you via email.

After the first survey round, obtained data for each item will be analyzed. Suggestions/items that do not reach consensus after the first round will be dropped for the second round. Items that reach consensus will be presented to you in the second round to rank their priority in improving access to primary care services for homeless immigrants. A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection.

How will my personal information be used?

I will use your information for purposes of this study only. I will be responsible for looking after your information and using it properly. All information will be anonymised and pseudonymised. Data will be anonymised by deleting any information that might identify you. Data will also be pseudonymised by replacing any identifiers such as names with fake names or codes. I will retain your data until 2024 when I complete my Ph.D. studies.

Data will only be accessed by the student, the supervisors, and examiners. You can find out more about how I will use your information by contacting me (cn239@canterbury.ac.uk). You can also contact the University Data Protection Officer (dp.officer@canterbury.ac.uk). If you want further information about how your personal data will be processed, you can read further information regarding how the University processes your personal data for research purposes at the following link: Research Privacy Notice -

https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx

Ethical approval

Ethical approval will be obtained from the Canterbury Christ Church University Research Ethics Committee.

Potential risks

There are no potential risks foreseen in taking part in this study. However, in case of issues such as stress, fatigue, overload, emotional response, and eyesight problems and headaches due to screen time, you are advised to take a break and complete the online questionnaire later. You are reminded to save your responses before taking a break to prevent data loss.

You are also free not to answer any questions that you don't wish to or withdraw from the study at any time. In case of any safeguarding issues, I will have to discuss with my supervisor a way forward.

Potential benefits to the participant

Aside from adding to the body of knowledge about the topic, you will have the opportunity of expressing your own opinions as well as the opportunity to potentially contribute to strategies for improving access to primary care services for homeless immigrants.

Confidentiality and data protection

All information received from you will remain confidential at all times. Hard copies such as consent forms will be kept in a locked cabinet in the supervisor's office. Soft copies will be kept on the researcher's CCCU password protected account.

All data will be kept by the researcher until completion of their PhD studies. Once I have completed my PhD studies, I will destroy all your data. Hard copies will be destroyed in an appropriate manner using university approaches of destroying sensitive data. Soft copies will entirely be deleted from my university account.

Participation and withdraw

Should you decide to participate, you will be free to withdraw your consent without having to give a reason. After the 3-week round 1 survey, you will have a deadline of one week to withdraw from the study before data analysis. After the 3-week round 2 survey, you will also have a deadline of one week to withdraw from the study before data analysis.

You may also refuse to answer any questions you don't want to answer and still remain in the study. If you want to withdrawal from this study, you will send an email to the researcher Carol Namata (cn239@canterbury.ac.uk) stating that you would like to withdraw your consent to participate in this research project.

Dissemination of the results

The findings of the study will be disseminated to relevant stakeholders, such as healthcare professionals, voluntary sector providers, and local authority professionals. The report will also be available through the CCCU institutional library. Results of the study will also be presented elsewhere as appropriate, such as in academic journal articles and relevant conference presentations. Results will also be disseminated through my Ph.D. thesis.

Any questions

If you have any questions or concerns about study, please do not hesitate to contact me.
Carol Namata- student/researcher- cn239@canterbury.ac.uk
You can also contact my supervisor
Eleni Hatzidimitriadou - eleni.hatzidimitriadou@canterbury.ac.uk / 01227 923596
Alternatively, the postal address for any queries is:
Faculty of Health, Medicine and Social Care
Canterbury Christ Church University
North Holmes Road
Canterbury
Kent CT1 1QU

Appendix 11: Round one online Delphi survey

Canterbury Christ Church University

Strategies for Improving Access to Primary Care Service for Homeless Immigrants in the UK: A Modified Delphi survey

Participant information and Consent form

My name is Carol Namata. I am a Ph.D. student at the Faculty of Medicine, Health and Social Care, Canterbury Christ Church University (CCCU).

What is this study about?

This is a two-round modified Delphi follow-up survey involving two subsequent online questionnaires.

This Delphi is a follow-up on the study titled *"Access and provision of primary care services (PCS) for immigrants experiencing homelessness in the UK*". Initially, semi-structured interviews were conducted with homeless immigrants and various stakeholders in which you took part to identify the factors that impact access to PCS for homeless immigrants. The interviews were audio-recorded and transcribed verbatim. The transcripts were reviewed, coded, and analysed when suggestions/actions to improve access to PCS among homeless immigrants were identified. Suggestions generated were grounded in the thematic analysis of the collected data and informed the Delphi questionnaire. The Delphi questionnaire will be subsequently distributed to the expert panel, in order to gain consensus on the importance of various items/suggestions.

Purpose of the Study: The purpose of this survey is to determine the relative importance and rank the priority of the suggestions/strategies identified from the initial homeless immigrants' and stakeholders' interviews. This will contribute to a wide knowledge base on improving access to primary care services for homeless immigrants. The study is aimed at achieving consensus among the panel experts on the various strategies and ranking priority of these strategies in improving access to primary care services.

Why are you invited to participate in this study?

You are invited to participate in this study because you participated in the initial semi-structured interviews where numerous suggestions to improve access to primary care services for homeless immigrants were identified.

You are also a key stakeholder with knowledge, insight, experience and/or expertise in homeless immigrants' health and/or social issues and their access to primary care services.

What will you be required to do?

Round 1

You will be required to give your consent after reading through this information on the study.

In order to determine the relative importance of each suggestion, you will be presented with suggestions from the initial interviews of homeless immigrants and stakeholders and asked to rate them on the basis of their significance. You will be asked how important each item is on a five-point Likert scale (1=Not important at all, 2=Not very important, 3=Moderately important, 4=Important, 5=Very important). You will optionally add comments or suggestions in a free text format. This round has 58 questions and is estimated to last for 30 minutes.

You will have a 3-week period at your disposal to complete the online questionnaire. A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection. The first Delphi round will conclude when your responses have been returned within the time frame. The results of the first round will be analysed with the purpose of creating the second round questionnaire.

Round two

If you completed the first round, you will be invited to participate in the second round of the Delphi survey which will take place three weeks after the due date of the first round. A thank you letter for participating in the first round, and brief instructions for the completion of the second questionnaire will be sent to you via email.

After the first survey round, obtained data for each item will be analyzed. Suggestions/items that do not reach consensus after the first round will be dropped for the second round. The second round aims at ranking the 10 most important or priority suggestions/items. Only items that achieved a consensus of ≥75% as being important/very important will be re-rated in the second round. The top 10 items with the highest mean scores will be the most important suggestions identified to improve access to primary care services among homeless immigrants.

A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection.

How will my personal information be used?

I will use your information for purposes of this study only. I will be responsible for looking after your information and using it properly. All information will be anonymised and pseudonymised. Data will be anonymised by deleting any information that might identify you. Data will also be pseudonymised by replacing any identifiers such as names with fake names or codes. I will retain your data until 2024 when I complete my Ph.D. studies.

Data will only be accessed by the student, the supervisors, and examiners. You can find out more about how I will use your information by contacting me (cn239@canterbury.ac.uk). You can also contact the University Data Protection Officer (dp.officer@canterbury.ac.uk). If you want further information about how your personal data will be processed, you can read further information regarding how the University processes your personal data for research purposes at the following link: Research Privacy Notice - https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx

Ethical approval

Ethical approval will be obtained from the Canterbury Christ Church University Research Ethics Committee.

Potential risks

There are no potential risks foreseen in taking part in this study. However, in case of issues such as stress, fatigue, overload, emotional response, and eyesight problems and headaches due to screen time, you are advised to take a break and complete the online questionnaire later. You are reminded to save your responses before taking a break to prevent data loss.

You are also free not to answer any questions that you don’t wish to or withdraw from the study at any time. In case of any safeguarding issues, I will have to discuss with my supervisor a way forward.

Potential benefits to the participant

Aside from adding to the body of knowledge about the topic, you will have the opportunity of expressing your own opinions as well as the opportunity to potentially contribute to strategies for improving access to primary care services for homeless immigrants.

Confidentiality and data protection

All information received from you will remain confidential at all times. Hard copies such as consent forms will be kept in a locked cabinet in the supervisor’s office. Soft copies will be kept on the researcher’s CCCU password protected account.

All data will be kept by the researcher until completion of their PhD studies. Once I have completed my PhD studies, I will destroy all your data. Hard copies will be destroyed in an appropriate manner using university approaches of destroying sensitive data. Soft copies will entirely be deleted from my university account.

Participation and withdraw

Should you decide to participate, you will be free to withdraw your consent without having to give a reason. After the 3-week round 1 survey, you will have a deadline of one week to withdraw from the study before data analysis. After the 3-week round 2 survey, you will also have a deadline of one week to withdraw from the study before data analysis.

You may also refuse to answer any questions you don't want to answer and still remain in the study. If you want to withdrawal from this study, you will send an email to the researcher Carol Namata (cn239@canterbury.ac.uk) stating that you would like to withdraw your consent to participate in this research project.

Dissemination of the results

The findings of the study will be disseminated to relevant stakeholders, such as healthcare professionals, voluntary sector providers, and local authority professionals. The report will also be available through the CCCU institutional library. Results of the study will also be presented elsewhere as appropriate, such as in academic journal articles and relevant conference presentations. Results will also be disseminated through my Ph.D. thesis.

Any questions

If you have any questions or concerns about study, please do not hesitate to contact me.
Carol Namata- student/researcher- cn239@canterbury.ac.uk / 07862799483
You can also contact my supervisor
Eleni Hatzidimitriadou - eleni.hatzidimitriadou@canterbury.ac.uk / 01227 923596
Alternatively, the postal address for any queries is:
Faculty of Health, Medicine and Social Care
Canterbury Christ Church University
North Holmes Road
Canterbury
Kent CT1 1QU

Consent to Participate:

I confirm that I have read and understood the participant information for the above study and have had the opportunity to ask questions. I understand that any personal information that I provide to the researcher will be kept strictly confidential and in line with the University Research Privacy Notice. I understand that my participation in this study is voluntary and that I am free to withdraw my participation at any time, without giving a reason.

1. I agree to take part in the above study. *Required*

Yes

No

2. Participant unique ID……………………….. *Required*

Survey

Instructions

When completing this questionnaire, please place a tick in the boxes or write in the spaces provided. If you think a question doesn’t apply to you, or you don’t wish to answer it, just leave it blank. You can skip back and forwards between questions. You don't have to do them in any order. You are free to answer or skip over these questions, however you see best.

Relative importance of suggestions/strategies in improving access to primary care services for homeless immigrants

In this section please answer based on the importance of these suggestions in helping homeless immigrants access primary care services.

Access is defined as the possibility to identify healthcare needs, to seek healthcare services, reach healthcare resources, obtain or use healthcare services, and be offered services appropriate to the needs for care.

Please use the following definitions to answer the questions:
Importance: indicates value or significance; has serious or considerable meaning or worth; deserving or requiring serious attention.

- **Not important at all:** Would not have any value or significance in any way in helping homeless immigrants to access primary care services and therefore does not deserve or require attention.
- **Not very important:** Would have limited value or significance in helping homeless immigrants to access primary care services and therefore deserves only limited attention.
- **Moderately important:** Would have some value or significance in helping homeless immigrants to access primary care services but would still leave many homeless immigrants unaffected and therefore deserves only moderate attention.
- **Important:** Would have value or significance in helping a large number of homeless immigrants access primary care services and therefore deserves serious attention.
- **Very important:** Will definitely have value or significance in helping a large number of homeless immigrants to access primary care services made and therefore must receive serious attention.

How important are the following suggestions/strategies in improving access to primary care services for homeless immigrants?

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving communication between immigrants and health care providers		**1**	**2**	**3**	**4**	**5**
1.	Training the GP administration and reception staff to clearly inform immigrants what kind of interpretation and translation services they can access and how they can access them.					
2.	Awareness raising for GP staff on the entitlements of immigrants to access interpreters.					
3.	Provision of high-quality interpreter services, either in person or by telephone, and should be easily accessible.					
4.	Translation of leaflets giving basic information about health services in some of the languages of the immigrants.					

Additional suggestions/comments

…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Enabling access to benefits and financial support		1	2	3	4	5
5.	Raising awareness of health care providers on who can access free prescriptions and what paperwork they need so that people don't leave the surgery with a prescription and then not take that medicine because they cannot afford it.					

Additional suggestions/comments
…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Provision of culturally sensitive primary care services		1	2	3	4	5
6.	Raising awareness among surgeries about homeless immigrants since being the gatekeepers to the NHS, surgeries need to understand more about the people who present to them as they come from various communities with varying gender and cultural expectations.					
7.	Co-design services with homeless immigrants to ensure the services provided are tailored to respond to the healthcare needs of this population group.					
8.	Healthcare providers should receive specific training on cultural competencies and communication skills.					
9.	Employ cultural mediators or healthcare providers of migrant descent.					
10.	Health education and health promotion messages should take into account cultural diversity.					
11.	Integrating cross-cultural training into professional development and training activities for health care providers.					

Additional suggestions/comments
…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving and promoting mental health services among homeless immigrants		1	2	3	4	5
12.	Establishing Bespoke services based around social activities such as football groups rather than the formal Bespoke Cognitive Behavioural Therapy (CBT) and ensuring that homeless immigrants have access to information about these services through their social workers.					
13.	Offering mental health assessment and support to the newly arrived immigrants in the country to support them to process the trauma that they might have experienced.					
14.	Establishing music as a therapeutic service for homeless immigrants with language difficulties to enable them to express themselves without having the need to have proficient language skills.					
15.	Providing secure accommodation where homeless immigrants can unwind and get better sleep to prevent being kept awake for several nights in bad accommodation hence preventing the negative impacts this might have on their mental well-being.					
16.	Provision of more mental health professionals to reduce work overload for the available professionals.					

17.	Provision of more diverse mental health professionals to enable connections with immigrants in terms of culture and to open up more to them.					

Additional suggestions/comments

……………………………………………………………………………………………………….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving GP registration services		1	2	3	4	5
18.	Raising awareness among the surgery staff on homeless immigrants’ rights to access primary care services without documentation such as proof of address or ID as it is a legal requirement to offer free primary care services to everyone regardless of their immigration status.					
19.	The surgery receptionists should work in hand with the social prescribers to support homeless immigrants without an address to register.					
20.	Social prescribers in surgeries should guide homeless immigrants to register with the GP surgery.					

Additional suggestions/comments

……………………………………………………………………………………………………….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Addressing the social determinants of health		1	2	3	4	5
21.	Social prescribers should follow up on individuals who are socially isolated by speaking to them on phone now and again.					
22.	Social prescribers should support homeless immigrants with difficulties in accessing housing and other benefits to fill out forms and apply for benefits, and/or signpost them to organizations that can help them fill out these forms and navigate the system.					
23.	Ensuring a wide coverage of social prescribers across Kent and Medway.					
24.	Provision of mobile transportation, to and from surgeries, to support homeless immigrants who cannot afford transport costs to access surgeries.					
25.	Provision of accommodation for homeless immigrants that require treatment should be looked at it from the human rights perspective, as it doesn't matter if they don’t have documents or haven’t been in the country long enough. If they've got a healthcare need that would put them in priority hence they should be assessed upon that.					
26.	Provision of suitable accommodation that is not infested with mice or bedbugs to homeless immigrants.					

Additional suggestions/comments

……………………………………………………………………………………………………….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Intersectoral collaboration		1	2	3	4	5
27.	Coordinated actions between the health and social sectors so that services wrap around the person rather than the person having to navigate their way around different services because often, if homeless immigrants haven't got permanent housing, it’s hard to access a GP surgery.					

28.	Ensuring that the Integrated Care System (ICS) that brings together the health and social issues has an impact on a local level in communities.					
29.	Involvement of homeless immigrants and non-governmental organisations (NGOs) dealing with homeless migrants in the organisation of health care services.					

Additional suggestions/comments
…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Raising awareness of immigrants regarding the UK healthcare system		1	2	3	4	5
30.	Raising awareness of immigrants about the available primary care services, how they can be accessed and support them to access them.					
31.	Raising awareness of immigrants about waiting times for appointments because it might not be a racist thing to be on the waiting list.					
32.	Raising awareness among undocumented immigrants that it's safe to access primary care services and reassuring them that healthcare professionals are not going to share their information with Home Office.					
33.	Provision of special consultation the first-time homeless immigrants access primary care services.					
34.	Homeless immigrants should be informed that they can access GP surgeries even if they don’t give surgeries their addresses.					

Additional suggestions/comments
…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Changes in immigration policies		**1**	**2**	**3**	**4**	**5**
35.	Allowing asylum seekers to have the right to work because being unable to enter the formal and safer job market puts them in a very vulnerable position where they are exposed to some sort of exploitation. With the right to work, they would be able to afford some costs such as transport costs and phone credit to enable them access services.					
36.	Provision of accommodation to homeless immigrants without recourse to public funds.					
37.	NHS charges for secondary care should be reduced for immigrants who cannot make ends meet.					

Additional suggestions/comments
…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Targeted community outreach activities and drop-ins		**1**	**2**	**3**	**4**	**5**
38.	Carrying out more community outreaches to create visibility of healthcare workers in areas with high migrant populations to enable homeless immigrants who might find it challenging to ask for help to know that healthcare workers are available on the ground and can support them.					
39.	Establishment of drop-ins for homeless immigrants at the surgeries outside the normal days of Mon-Fri and hours of 9-5pm to ensure flexibility of healthcare					

	services so that homeless immigrants can access these services.					

Additional suggestions/comments
……….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving the quality of primary care services		**1**	**2**	**3**	**4**	**5**
40.	Provision of reception services for homeless immigrants who might experience digital exclusion to be able to walk into surgeries and access services like registration and booking appointments. So those who can use digital can do so, as others who can't are helped via the reception.					
41.	Services should consider the patient as an individual and not stereotype them with their immigration status or accommodation status.					
42.	Surgeries should consider the individuals' specific medical history and social background and give individualised psychological support and empathy.					
43.	Healthcare professionals should take the time to listen to homeless immigrants and check that both parties have understood each other.					
44.	Provision of extra consultation time when dealing with homeless immigrant patients to allow for interpretation and to gain an understanding of a new culture.					
45.	Allocation of GP slots to homeless immigrants because at the moment, homeless immigrants are not considered vulnerable and not given priority hence they have got the same treatment as everyone else such as making long queues that hinders some from registering with surgeries.					
46.	Developing protocols on how to provide person-centred care to homeless immigrants and ensuring that surgeries have access to these protocols and that they know what to do especially in surgeries that might not have many immigrant populations coming in frequently.					
47.	Surgeries should shorten the waiting times for GP appointments.					
48.	Government should provide additional payments to health practitioners at surgeries to reflect the additional time given to immigrants so that they're more likely to get the health care that they need. Otherwise, it's altruistic on the part of the GPs to take on people yet they're not going to get paid for the amount of work that they have to put in.					

Additional suggestions/comments

………………………………………………………………………………………

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Empowerment of Immigrants with regard to health and social determinants		**1**	**2**	**3**	**4**	**5**
49.	Provision of information for migrants in their own language about their rights and the functioning of the UK health care system and social care system.					
50.	Provision of opportunities to learn English to facilitate integration into the UK system and consequently facilitate access to health care.					
51.	Supporting migrants to develop their social networks.					
52.	Raising awareness of immigrants' understanding of their rights, and entitlements particularly when they are new to the immigration system.					

Additional suggestions/comments

………………………………………………………………………………………………

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Fight against discrimination and prejudice, and respect differences		**1**	**2**	**3**	**4**	**5**
53.	GP staff should show respect, create trust, treat everybody equally, be interested and address patients without prejudice and with an open mind.					
54.	Healthcare services should be delivered without xenophobia or any sign of racism.					
55.	Healthcare providers should be motivated to deliver care for immigrants with attention to their specific needs and priorities.					
56.	A policy against acts of discrimination in healthcare facilities should be established and implemented.					

Additional suggestions/comments

………………………………………………………………………………………………

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Research and epidemiology		**1**	**2**	**3**	**4**	**5**
57.	Health care services should be provided with relevant knowledge on health and risk factors concerning the populations they are dealing with.					
58.	Healthcare registries should record and monitor migrant health to facilitate migrant health research.					

Additional suggestions/comments

………………………………………………………………………………………………

Are there any other comments that you would like to provide regarding this study?
………………………………………………………………………………………………………
……………………………………………………………………………………………………….

SUBMIT

Thank you for your participation! I greatly appreciate your support and dedication to the topic

Carol Namata

Appendix 12: Invitation to participate in round two of the Delphi survey

Sent via E-Mail

To: [Insert Email of participant]
From: Carol Namata

Subject: Invitation to participate in a Delphi study

Dear [First name of participant]

Thank you for participating in round 1 of the Delphi survey. You are invited to participate in round 2 of the Delphi survey.

This second round of the Delphi survey comprises only the top-ranked 50% (25 items) selected from the 58 items which achieved adequate consensus on level of importance. **The aim of round two of the Delphi survey is to identify the top 10 most important/prioritized items/suggestions**.

In round two, you will be asked to rate each of the 25 suggestions based on their importance. You will be asked how important each item is on a five-point Likert scale (1=Not important at all, 2=Not very important, 3=Moderately important, 4=Important, 5=Very Important). The top 10 prioritized items will be chosen based on having the highest mean scores on the Likert scale. In cases where items share the same mean score, the one with the highest level of consensus will be selected.

A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection. This round has 25 suggestions/items and is estimated to last for about 15 minutes.

The Canterbury Christ Church Ethics Review Panel approved this study. You do not have to answer any questions that you do not want to answer, and you may withdraw your participation at any time.

If you are willing to participate, please see attached a document containing more information about the study and a link to the online questionnaire.

https://canterbury.onlinesurveys.ac.uk/delphi-round-2-strategies-for-improving-access-to-primary

You have been given a **unique code "1"** to use in the questionnaire for identification by the researcher.

The deadline for completion of the survey is **Wednesday 1st March 2023 at 11.59 pm.**

If you have any questions, please contact me via email **[cn239@canterbury.ac.uk]**

Thank you again for your participation in this study.

Best Regards,

Carol Namata
Ph.D. Candidate
Canterbury Christ Church University

Appendix 13: Participant information for round two of the Delphi survey

Strategies for Improving Access to Primary Care Service for Homeless Immigrants in the UK: A Modified Delphi survey

Participant information and Consent form

My name is Carol Namata. I am a Ph.D. student at the Faculty of Medicine, Health and Social Care, Canterbury Christ Church University (CCCU).

What is this study about?

This is a two-round modified Delphi follow-up survey involving two subsequent online questionnaires.

This Delphi is a follow-up on the study titled *"Access and provision of primary care services (PCS) for immigrants experiencing homelessness in the UK*". Initially, semi-structured interviews were conducted with homeless immigrants and various stakeholders in which you took part to identify the factors that impact access to PCS for homeless immigrants. The interviews were audio-recorded and transcribed verbatim. The transcripts were reviewed, coded, and analysed when suggestions/actions to improve access to PCS among homeless immigrants were identified. Suggestions generated were grounded in the thematic analysis of the collected data and informed the Delphi questionnaire. The Delphi questionnaire will be subsequently distributed to the expert panel, in order to gain consensus on the importance of various items/suggestions.

Purpose of the Study: The purpose of this survey is to determine the relative importance and rank the priority of the suggestions/strategies identified from the initial homeless immigrants' and stakeholders' interviews. This will contribute to a wide knowledge base on improving access to primary care services for homeless immigrants. The study is aimed at achieving consensus among the panel experts on the various strategies and ranking priority of these strategies in improving access to primary care services.

Why are you invited to participate in this study?

You are invited to participate in this study because you participated in the initial semi-structured interviews where numerous suggestions to improve access to primary care services for homeless immigrants were identified.

You are also a key stakeholder with knowledge, insight, experience and/or expertise in homeless immigrants' health and/or social issues and their access to primary care services.

What will you be required to do?

Round two

Thank you for participating in round 1 of the Delphi survey. You are invited to participate in round 2 of the Delphi survey. This second round of the Delphi survey comprises only the top-ranked 50% (25 items) selected from the 58 items which achieved adequate consensus on level of importance. The aim of round two of the Delphi survey is to identify the top 10 most important/prioritized items/suggestions.

You are asked to rate each of the 25 suggestions based on their importance. You will be asked how important each item is on a five-point Likert scale (1=Not important at all, 2=Not very important, 3=Moderately important, 4=Important, 5=Very Important). The top 10 prioritized items will be chosen based on having the highest mean scores on the Likert scale. In cases where items share the same mean score, the one with the highest level of consensus will be selected.

A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection. This round has 25 suggestions/items and is estimated to last for about 15 minutes.

How will my personal information be used?

I will use your information for purposes of this study only. I will be responsible for looking after your information and using it properly. All information will be anonymised and pseudonymised. Data will be anonymised by deleting any information that might identify you. Data will also be pseudonymised by replacing any identifiers with numbers. I will retain your data for five years from completion of this study (as per the university policy).

Data will only be accessed by the student, the supervisors, and examiners. You can find out more about how I will use your information by contacting me (cn239@canterbury.ac.uk). You can also contact the University Data Protection Officer (dp.officer@canterbury.ac.uk). If you want further information about how your personal data will be processed, you can read further information regarding how the University processes your personal data for research purposes at the following link: Research Privacy Notice - https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx

Ethical approval

Ethical approval will be obtained from the Canterbury Christ Church University Research Ethics Committee.

Potential risks

There are no potential risks foreseen in taking part in this study. You are reminded to save your responses before taking a break to prevent data loss.

Potential benefits to the participant

Aside from adding to the body of knowledge about the topic, you will have the opportunity of expressing your own opinions as well as the opportunity to potentially contribute to strategies for improving access to primary care services for homeless immigrants.

Confidentiality and data protection

All information received from you will remain confidential at all times. Hard copies such as consent forms will be kept in a locked cabinet in the supervisor's office. The electronic copies will be kept on the researcher's CCCU password protected account.

All data will be kept by the researcher and discarded after five years from the completion of this study (as per the university policy). Hard copies will be destroyed in an appropriate manner using university approaches of destroying sensitive data. Soft copies will entirely be deleted from my university account.

Participation and withdraw

Should you decide to participate, you will be free to withdraw your consent without having to give a reason. After the 3-week round 1 survey, you will have a deadline of one week to withdraw from the study before data analysis. After the 3-week round 2 survey, you will also have a deadline of one week to withdraw from the study before data analysis.

You may also refuse to answer any questions you don't want to answer and still remain in the study. If you want to withdrawal from this study, you will send an email to the researcher Carol Namata (cn239@canterbury.ac.uk) stating that you would like to withdraw your consent to participate in this research project.

Dissemination of the results

The findings of the study will be disseminated to relevant stakeholders, such as healthcare professionals, voluntary sector providers, and local authority professionals. The report will also be available through the CCCU institutional library. Results of the study will also be presented elsewhere as appropriate, such as in academic journal articles and relevant conference presentations. Results will also be disseminated through my Ph.D. thesis.

Any questions

If you have any questions or concerns about study, please do not hesitate to contact me.
Carol Namata- student/researcher- cn239@canterbury.ac.uk / 07862799483
You can also contact my supervisor
Eleni Hatzidimitriadou - eleni.hatzidimitriadou@canterbury.ac.uk / 01227 923596
Alternatively, the postal address for any queries is:
Faculty of Health, Medicine and Social Care
Canterbury Christ Church University
North Holmes Road
Canterbury
Kent CT1 1QU

Appendix 14: Round two online Delphi survey

Strategies for Improving Access to Primary Care Service for Homeless Immigrants in the UK: A Modified Delphi survey

Participant information and Consent form

My name is Carol Namata. I am a Ph.D. student at the Faculty of Medicine, Health and Social Care, Canterbury Christ Church University (CCCU).

What is this study about?

This is a two-round modified Delphi follow-up survey involving two subsequent online questionnaires.

This Delphi is a follow-up on the study titled *"Access and provision of primary care services (PCS) for immigrants experiencing homelessness in the UK*". Initially, semi-structured interviews were conducted with homeless immigrants and various stakeholders in which you took part to identify the factors that impact access to PCS for homeless immigrants. The interviews were audio-recorded and transcribed verbatim. The transcripts were reviewed, coded, and analysed when suggestions/actions to improve access to PCS among homeless immigrants were identified. Suggestions generated were grounded in the thematic analysis of the collected data and informed the Delphi questionnaire. The Delphi questionnaire will be subsequently distributed to the expert panel, in order to gain consensus on the importance of various items/suggestions.

Purpose of the Study: The purpose of this survey is to determine the relative importance and rank the priority of the suggestions/strategies identified from the initial homeless immigrants' and stakeholders' interviews. This will contribute to a wide knowledge base on improving access to primary care services for homeless immigrants. The study is aimed at achieving consensus among the panel experts on the various strategies and ranking priority of these strategies in improving access to primary care services.

Why are you invited to participate in this study?

You are invited to participate in this study because you participated in the initial semi-structured interviews where numerous suggestions to improve access to primary care services for homeless immigrants were identified.

You are also a key stakeholder with knowledge, insight, experience and/or expertise in homeless immigrants' health and/or social issues and their access to primary care services.

<u>What will you be required to do?</u>

Round two

Thank you for participating in round 1 of the Delphi survey. You are invited to participate in round 2 of the Delphi survey. This second round of the Delphi survey comprises 25 suggestions/items which you are going to rate on a Likert Scale, and the whole exercise is estimated to last for about 15 minutes.

This second round of the Delphi survey comprises only the top-ranked 50% (25 items) selected from the 58 items which achieved adequate consensus on level of importance. The aim of round two of the Delphi survey is to identify the top 10 most important/prioritized items/suggestions.

In round two, you will be asked to rate each of the 25 suggestions based on their importance. You will be asked how important each item is on a five-point Likert scale (1=Not important at all, 2=Not very important, 3=Moderately important, 4=Important, 5=Very Important). The top 10 prioritized items will be chosen based on having the highest mean scores on the Likert scale. In cases where items share the same mean score, the one with the highest level of consensus will be selected.

A reminder will be sent two days before the due date and a final reminder will be sent on the last day of data collection. This round has 25 suggestions/items and is estimated to last for about 15 minutes.

Consent to Participate:

I confirm that I have read and understood the participant information for the above study and have had the opportunity to ask questions. I understand that any personal information that I provide to the researcher will be kept strictly confidential and in line with the University <u>Research Privacy Notice</u>. I understand that my participation in this study is voluntary and that I am free to withdraw my participation at any time, without giving a reason.

3. I agree to take part in the above study. *Required*

Yes

No

4. Participant unique ID………………………. *Required*

<u>Round 2 Survey</u>

Instructions

When completing this questionnaire, please place a tick in the boxes or write in the spaces provided. Please select/tick only one response option per item/question. If you think a question doesn’t apply to you, or you don’t wish to answer it, just leave it blank. You can skip back and forwards between questions. You don't have to do them in any order. You are free to answer or skip over these questions, however you see best.

The aim of round two of the Delphi survey is to identify the top 10 most important/prioritized items/suggestions. Of the remaining 49 items that achieved a consensus, only the top-ranked 50% (25 items) were included in the second round of the survey.

Relative importance of suggestions/strategies in improving access to primary care services for homeless immigrants

In this section please answer based on the importance of these suggestions in helping homeless immigrants access primary care services.

Access is defined as the possibility to identify healthcare needs, to seek healthcare services, reach healthcare resources, obtain or use healthcare services, and be offered services appropriate to the needs for care.

Please use the following definitions to answer the questions:
Importance: indicates value or significance; has serious or considerable meaning or worth; deserving or requiring serious attention.

- **Not important at all:** Would not have any value or significance in any way in helping homeless immigrants to access primary care services and therefore does not deserve or require attention.
- **Not very important:** Would have limited value or significance in helping homeless immigrants to access primary care services and therefore deserves only limited attention.
- **Moderately important:** Would have some value or significance in helping homeless immigrants to access primary care services but would still leave many homeless immigrants unaffected and therefore deserves only moderate attention.
- **Important:** Would have value or significance in helping a large number of homeless immigrants access primary care services and therefore deserves serious attention.
- **Very important:** Will definitely have value or significance in helping a large number of homeless immigrants to access primary care services made and therefore must receive serious attention.

How important are the following suggestions/strategies in improving access to primary care services for homeless immigrants?

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving communication between immigrants and healthcare providers		**1**	**2**	**3**	**3**	**5**
1.	There is a need to provide high-quality interpreter services, either in person or by telephone. There is also a need to make these services easily accessible to homeless immigrants.					

Additional suggestions/comments
……….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Enabling access to benefits and financial support		1	2	3	4	5
2.	There is a need to raise awareness among healthcare providers on who can access free prescriptions and the required paperwork for such eligibility. This ensures that homeless immigrants have access to free prescriptions.					

Additional suggestions/comments

…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Provision of culturally sensitive primary care services		1	2	3	4	5
3.	There is a need to raise awareness among GP surgeries about homeless immigrants. Since being the gatekeepers to the NHS, surgeries need to understand more about the people who present to them as they come from various communities with varying gender and cultural expectations.					
4	There is a need for healthcare providers to receive specific training on cultural competencies and communication skills.					
5	There is a need for health education and health promotion messages to take into account cultural diversity.					
6	There is a need to integrate cross-cultural training into professional development and training activities for health care providers.					

Additional suggestions/comments

…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving and promoting mental health services among homeless immigrants		1	2	3	4	5
7	There is need to provide secure accommodation where homeless immigrants can have safe and quality sleep. This can also positively impact their mental wellbeing.					
8	There is need to employ more mental health professionals so as to reduce work overload among mental health professionals.					
9	There is need to improve diversity of mental health professionals to enable culturally appropriate interactions and improve communication with homeless immigrants.					

Additional suggestions/comments

…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving GP registration services		1	2	3	4	5
10	There is need to raise awareness among the surgery staff on homeless immigrants' rights to accessing primary care services. For example, they should be informed that every homeless immigrant has a right to access primary care services regardless of their immigration status.					

Additional suggestions/comments

…….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Addressing the social determinants of health		1	2	3	4	5
11	There is need to provide accommodation for homeless immigrants that require medical treatment in accordance to the human rights approach to care. This applies in situations where a homeless immigrant has a serious healthcare need that warrants accommodation during the course of treatment.					
12	There is need to provide suitable accommodation to homeless immigrants, for example, that is in a good state, and free of vectors like bedbugs and mice.					

Additional suggestions/comments

……….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Intersectoral collaboration		1	2	3	4	5
13	There is a need to put in place measures that ensure that the Integrated Care System (ICS) which addresses both health and social issues, has a meaningful impact at the community level.					
14	Increasing the involvement of homeless immigrants and voluntary sector providers in the planning and delivery of primary care services.					

Additional suggestions/comments

……….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Raising awareness of immigrants regarding the UK healthcare system		1	2	3	4	5
15	There is need to raise awareness among homeless immigrants on the available primary care services, and how they can be accessed.					
16	There is need to raise awareness among undocumented immigrants about their rights to access primary care services and further reassure them that healthcare providers do not share their information with Home Office.					
17	There is need to raise awareness among homeless immigrants that they can access GP surgeries even if they don’t share their home addresses with surgeries.					

Additional suggestions/comments

……….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Changes in immigration policies		**1**	**2**	**3**	**4**	**5**
18	There is a need to increase opportunities for asylum seekers to engage in formal and informal employment. This ensures their safety against exploitation and that they can afford basic needs and health-related costs such as transport costs, and phone credit, among others.					

Additional suggestions/comments

……….

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Improving the quality of primary care services		**1**	**2**	**3**	**4**	**5**
19	There is need for health service providers to treat homeless immigrants with respect without stereotyping them basing on their immigration status or their homelessness.					

Additional suggestions/comments

………………………………………………………………………………………………

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Empowerment of Immigrants with regard to health and social determinants		**1**	**2**	**3**	**4**	**5**
20	There is need to support homeless immigrants in developing social networks within their communities. For example, through linkages to support groups, organisations, events, community centres, etc.					
21	There is need to raise awareness and educate homeless immigrants about their rights, entitlements and support (such as benefits) particularly when they are new in the country.					

Additional suggestions/comments

………………………………………………………………………………………………

1= Not important at all, 2= Not very important, 3= Moderately important, 4= Important, 5= Very important

Fight against discrimination and prejudice, and respect differences		**1**	**2**	**3**	**4**	**5**
22	There is need to ensure that GP staff respect, create trust, and treat everybody equally without prejudice regardless of their immigration status or homelessness.					
23	There is need to ensure that healthcare providers deliver healthcare services without any form of discrimination, such as xenophobia or racism.					
24	There is need to motivate healthcare providers so that they deliver healthcare to homeless immigrants with improved attention to their specific needs and priorities.					
25	There is need to review and/or develop and enforce policies against all forms of discrimination within the healthcare system.					

Additional suggestions/comments

………………………………………………………………………………………………

Are there any other comments that you would like to provide regarding this study?
……………………………………………………………………………………………………
…………………………………………………………………………………………………….

SUBMIT

Thank you for your participation! I greatly appreciate your support and dedication to the survey.

Appendix 15: Mean scores and frequencies of 58 strategies of round 1 of the Delphi survey

Item	**Strategies**	**Mean scores (Standard deviation)**	**Important & Very Important (%)**	**Consensus achieved ≥75% (Yes/No)**
Improving communication between immigrants and healthcare providers				
01	Training the GP administration and reception staff to clearly inform immigrants what kind of interpretation and translation services they can access and how they can access them.	4.08 (0.90)	66.7	No
02	Awareness raising for GP staff on the entitlements of immigrants to access interpreters.	4.25 (0.97)	83.3	Yes

03	There is a need to provide high-quality interpreter services, either in person or by telephone. There is also a need to make these services easily accessible to homeless immigrants.	4.5 (0.52)	100.0	Yes
04	Translation of leaflets giving basic information about health services in some of the languages of the immigrants.	4 (1.04)	66.7	No
Enabling access to benefits and financial support				
05	There is need to raising awareness of healthcare providers on who can access free prescriptions and the required paperwork for such eligibility. This ensures that homeless immigrants have access to free prescriptions.	4.67 (0.49)	100.0	Yes
Provision of culturally sensitive primary care services				
06	There is a need to raise awareness among GP surgeries about homeless immigrants. Since being the gatekeepers to the NHS, surgeries need to understand more about the people who present to them as they come from various communities with varying gender and cultural expectations.	4.58 (0.51)	100.0	Yes
07	Co-design services with homeless immigrants to ensure the services provided are tailored to respond to the healthcare needs of this population group.	4.42 (0.79)	83.3	Yes
08	There is a need for healthcare providers to receive specific training on cultural competencies and communication skills.	4.67 (0.49)	100.0	Yes
09	Employ cultural mediators or healthcare providers of migrant descent.	3.5 (0.67)	41.7	No
10	There is a need for health education and health promotion messages to take into account cultural diversity.	4.5 (0.52)	100.0	Yes
11	There is a need to integrate cross-cultural training into professional development and training activities for health care providers.	4.5 (0.67)	91.7	Yes
Improving and promoting mental health services among homeless immigrants				
12	Establishing Bespoke services based around social activities such as football groups rather than the formal Bespoke Cognitive Behavioural Therapy (CBT) and ensuring that homeless immigrants have access to information about these services through their social workers.	4.25 (0.96)	83.3	Yes
13	Offering mental health assessment and support to the newly arrived immigrants in the country to support them to process the trauma that they might have experienced.	4.25 (0.96)	91.7	Yes
14	Establishing music as a therapeutic service for homeless immigrants with language difficulties to enable them to express themselves without having the need to have proficient language skills.	3.42 (1.16)	41.7	No
15	There is need to provide secure accommodation where homeless immigrants can have safe and quality sleep. This can also positively impact their mental wellbeing.	4.50 (0.67)	91.7	Yes
16	There is need to employ more mental health professionals so as to reduce work overload among mental health professionals.	4.75 (0.45)	100.0	Yes
17	There is need to improve diversity of mental health professionals to enable culturally appropriate interactions and improve communication with homeless immigrants	4.83 (0.39)	100.0	Yes
Improving GP registration services				
18	There is need to raise awareness among the surgery staff on homeless immigrants' rights to accessing primary care services. For example, they should be informed that every homeless immigrant has a right to access primary care services regardless of their immigration status.	4.72 (0.47)	100.0	Yes
19	The surgery receptionists should work in hand with the social prescribers to support homeless immigrants without an address to register.	4.33 (0.89)	100.0	Yes
20	Social prescribers in surgeries should guide homeless immigrants to register with the GP surgery.	3.91 (1.04)	100.0	Yes
Addressing the social determinants of health				
21	Social prescribers should follow up on individuals who are socially isolated by speaking to them on phone now and again.	4.42 (0.67)	100.0	Yes
22	Social prescribers should support homeless immigrants with difficulties in accessing housing and other benefits to fill out forms and apply for benefits, and/or signpost them to organizations that can help them fill out these forms and navigate the system.	4.08 (0.99)	75.0	Yes
23	Ensuring a wide coverage of social prescribers across Kent and Medway.	4.42 (0.67)	100.0	Yes
24	Provision of mobile transportation, to and from surgeries, to support homeless immigrants who cannot afford transport costs to access surgeries.	4.08 (0.67)	83.3	Yes
25	There is need to provide accommodation for homeless immigrants that require medical treatment in accordance to the human rights approach to care. This applies in situations where a homeless immigrant has a serious healthcare need that warrants accommodation during the course of treatment.	4.50 (0.82)	81.8	Yes
26	There is need to provide suitable accommodation to homeless immigrants, for example, that is in a good state, and free of vectors like bedbugs and mice.	4.73 (0.47)	100.0	Yes

Intersectoral collaboration				
27	Coordinated actions between the health and social sectors so that services wrap around the person rather than the person having to navigate their way around different services because often, if homeless immigrants haven't got permanent housing, it’s hard to access a GP surgery.	4.42 (0.79)	83.3	Yes
28	There is a need to put in place measures that ensure that the Integrated Care System (ICS) which addresses both health and social issues, has a meaningful impact at the community level.	4.50 (0.52)	100.0	Yes
29	Increasing the involvement of homeless immigrants and voluntary sector providers in the planning and delivery of primary care services.	4.58 (0.67)	91.7	Yes
Raising awareness of immigrants regarding the UK healthcare system				
30	There is a need to raise awareness among homeless immigrants on the available primary care services, and how they can be accessed	4.83 (0.39)	100.0	Yes
31	Raising awareness of immigrants about waiting times for appointments because it might not be a racist thing to be on the waiting list.	3.83 (1.03)	58.3	No
32	There is a need to raise awareness among undocumented immigrants about their rights to access primary care services and further reassure them that healthcare providers do not share their information with Home Office.	4.67 (0.49)	100.0	Yes
33	Provision of special consultation the first-time homeless immigrants access primary care services.	3.83 (0.94)	100.0	Yes
34	There is a need to raise awareness among homeless immigrants that they can access GP surgeries even if they don’t share their home addresses with surgeries.	4.5 (0.52)	100.0	Yes
Changes in immigration policies				
35	There is a need to increase opportunities for asylum seekers to engage in formal and informal employment. This ensures their safety against exploitation and that they can afford basic needs and health-related costs such as transport costs, and phone credit, among others.	4.58 (0.67)	91.7	Yes
36	Provision of accommodation to homeless immigrants without recourse to public funds.	4.0 (0.85)	100.0	Yes
37	NHS charges for secondary care should be reduced for immigrants who cannot make ends meet.	4.25 (0.75)	83.3	Yes
Targeted community outreach activities and drop-ins				
38	Carrying out more community outreaches to create visibility of healthcare workers in areas with high migrant populations to enable homeless immigrants who might find it challenging to ask for help to know that healthcare workers are available on the ground and can support them.	4.42 (0.51)	100.0	Yes
39	Establishment of drop-ins for homeless immigrants at the surgeries outside the normal days of Mon-Fri and hours of 9-5pm to ensure flexibility of healthcare services so that homeless immigrants can access these services.	4.0 (1.18)	72.7	No
Improving the quality of primary care services				
40	Provision of reception services for homeless immigrants who might experience digital exclusion to be able to walk into surgeries and access services like registration and booking appointments. So those who can use digital can do so, as others who can’t are helped via the reception.	4.17 (0.83)	75.0	Yes
41	There is a need for health service providers to treat homeless immigrants with respect without stereotyping them based on their immigration status or their homelessness.	4.58 (0.67)	91.7	Yes
42	Surgeries should consider the individuals’ specific medical history and social background and give individualised psychological support and empathy.	4.42 (0.79)	83.3	Yes
43	Healthcare professionals should take the time to listen to homeless immigrants and check that both parties have understood each other.	4.45 (0.69)	90.9	Yes
44	Provision of extra consultation time when dealing with homeless immigrant patients to allow for interpretation and to gain an understanding of a new culture.	4.36 (0.81)	81.8	Yes
45	Allocation of GP slots to homeless immigrants because at the moment, homeless immigrants are not considered vulnerable and not given priority hence they have got the same treatment as everyone else such as making long queues that hinders some from registering with surgeries.	3.67 (1.07)	58.3	No
46	Developing protocols on how to provide person-centred care to homeless immigrants and ensuring that surgeries have access to these protocols and that they know what to do especially in surgeries that might not have many immigrant populations coming in frequently.	4.45 (0.69)	90.9	Yes
47	Surgeries should shorten the waiting times for GP appointments.	3.92 (0.90)	58.3	No
48	Government should provide additional payments to health practitioners at surgeries to reflect the additional time given to immigrants so that they're more likely to get the health care that they need. Otherwise, it's altruistic on the part of the GPs to take on people yet they're not going to get paid for the amount of work that they have to put in.	4.17 (0.83)	75.0	Yes

Empowerment of Immigrants with regard to health and social determinants				
49	Provision of information for migrants in their own language about their rights and the functioning of the UK health care system and social care system.	4.25 (0.87)	75.0	Yes
50	Provision of opportunities to learn English to facilitate integration into the UK system and consequently facilitate access to health care.	4.25 (0.97)	66.7	No
51	There is a need to support homeless immigrants in developing social networks within their communities. For example, through linkages to support groups, organisations, events, community centres, etc.	4.63 (0.50)	100.0	Yes
52	There is a need to raise awareness and educate homeless immigrants about their rights, entitlements, and support (such as benefits) particularly when they are new in the country.	4.5 (0.67)	91.67	Yes
Fight against discrimination and prejudice, and respect differences				
53	There is a need to ensure that GP staff respect, create trust, and treat everybody equally without prejudice regardless of their immigration status or homelessness.	4.83 (0.38)	100.0	Yes
54	There is a need to ensure that healthcare providers deliver healthcare services without any form of discrimination, such as xenophobia or racism.	4.67 (0.49)	100.0	Yes
55	There is a need to motivate healthcare providers so that they deliver healthcare to homeless immigrants with improved attention to their specific needs and priorities.	4.50 (0.52)	100.0	Yes
56	There is a need to review and/or develop and enforce policies against all forms of discrimination within the healthcare system.	4.73 (0.47)	100.0	Yes
Research and epidemiology				
57	Health care services should be provided with relevant knowledge on health and risk factors concerning the populations they are dealing with.	4.25 (0.75)	83.3	Yes
58	Healthcare registries should record and monitor migrant health to facilitate migrant health research.	4.33 (0.65)	91.7	Yes

Appendix 16: Work plan

ACADEMIC YEARS	*YR 1- 2020/2021*										*YR 2- 2021/2022*													*YR 3- 2022/2023*												
MONTHS	*OCT*	*MAR*	*APR*	*MAY*	*JUN*	*JUL*	*AUG*	*SEP*	*OCT*		*NOV*	*DEC*	*JAN*	*FEB*	*MAR*	*APR*	*MAY*	*JUN*	*JUL*	*AUG*	*SEP*	*OCT*		*NOV*	*DEC*	*JAN*	*FEB*	*MAR*	*APR*	*MAY*	*JUN*	*JUL*	*AUG*	*SEP*	*OCT*	
Phase 1 Research Proposal																																				
Write Literature Review	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥		🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥		🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	
Submit first draft of Literature Review to the supervisor	🟥	🟥																																		
Improve literature review and other sections	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥		🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥		🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	
Submit the first draft of the research proposal	🟥	🟥																																		
Submit final draft of research proposal	🟥	🟥																																		
First review meeting		🟥																																		
Address comments from review meeting			🟥																																	
Phase 2 Ethical Approval																																				
Develop interview questions and schedules			🟥																																	
Submit research proposal for Independent peer review				🟥	🟥																															
Address comments from peer review					🟥	🟥																														
Apply for HRA approval					🟥	🟥	🟥																													
Apply for university ethical approval							🟥	🟥	🟥																											
Phase 3 Data Collection																																				
Prepare for data collection (recruitment)									🟥		🟥	🟥	🟥																							
Data collection														🟥	🟥	🟥	🟥	🟥																		
Data transcription														🟥	🟥	🟥	🟥	🟥																		
Data analysis																		🟥	🟥	🟥	🟥															
Writing findings																						🟥		🟥	🟥	🟥	🟥									
Phase 4 Thesis Compilation																																				
Submit findings for review, and make revisions																												🟥	🟥							
Compile thesis and submit the first draft for review																													🟥	🟥	🟥					
Submit the second draft after revisions																															🟥	🟥				
Submit final draft of the thesis and manuscript																																	🟥	🟥	🟥	