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Attitudes and experiences of asylum seekers and refugees to the COVID-19 vaccination

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Abstract (250 words)

Background: COVID-19 disproportionately affected asylum seeker and refugee (ASR) populations due to language and cultural barriers, lower health literacy, polytraumas and mental health needs, and increased exposure. Despite this, there was vaccine hesitancy and low vaccination rates in ASR populations.

Aim: Explore the attitude to, and experiences of the COVID-19 vaccination among ASRs.

Design and Setting: Qualitative study of 12 diverse purposively recruited ASRs in Bristol.

Methods: Semi-structured interviews transcribed verbatim and analysed thematically to identify emergent themes.

Results: Eight refugees and four asylum seekers were recruited, five of whom were females and seven male, aged between 23 and 48; together representing 7 countries. Six were part of a home office resettlement program, and six had arrived in the United Kingdom by independent means. Analysis showed delayed uptake rather than vaccine refusal due to 3 main themes; fear (secondary to social isolation, misinformation and mental illness), trust (surrounding access to care and community relationships) and systemic asylum issues (repeated relocation, uncertainty, and dependency on the charity sector).

Conclusions
Fear, trauma, and isolation propagated by systemic issues are primary factors impacting healthcare decision-making, and standard approaches to increasing vaccination uptake must be reconsidered in light of this. General practice must appreciate, and invest in providing security in healthcare access for ASR populations. Barriers to practice registration must be overcome to enable ASRs to access care both around vaccination and afterwards. Communication must be clear and accessible to aid individuals in making informed decisions balancing benefits and potential risk of vaccinations.

**Key words x 6**

*Refugees, COVID-19, vaccination hesitancy, vaccination refusal, health services accessibility.*

**How this fits in**

Previous literature anticipated vaccination refusal in and asylum seeker and refugee (ASR) populations due to misinformation and poor practical access to vaccination. This study qualitatively describes hesitancy, rather than refusal contributed to by multiple factors, with minimal refusal. We discovered that though hesitancy was widespread, it was related to systemic asylum issues such as housing instability and asylum case delays, fear contributed to by previous traumas both in the UK and overseas, and trust (or lack thereof) around access to care at community wide rather than individual levels.

**Background**

In 2022, there were over 350,000 asylum seekers and refugees (ASRs) in the United Kingdom (UK)(1). One third were awaiting asylum decisions from the UK Home Office (UKHO). These individuals are “asylum seekers” (AS) who arrived in the UK by independent means; outstaying an existing visa, or entering by undocumented routes (1–3). The remaining two thirds have received positive asylum decisions and are “refugees”. Within this, some are “resettled refugees” (RR), part of a UKHO scheme that selects and transfers vulnerable families from conflict zones to the UK. Assistance with housing, income, employment, healthcare and education is provided by local councils, communities and charitable organisations.(2–4)

The ASR population is diverse, dynamic and non-homogenous with the exception of the asylum system they have in common. There are acute differences between RRs and those who are “independent” ASRs (IASRs). In this paper, we explore the impact of being an ASR on attitudes and experiences of the COVID-19 vaccine, and the difference within this of RRs compared to IASRs.
The COVID-19 pandemic disproportionately affects ASRs due to increased disease prevalence and severity (1). This is exacerbated by frequent relocations, overcrowding and homelessness limiting their ability to lock down effectively (5). Despite this, vaccination hesitancy is common, and vaccination rates are below the national average. (6) There is minimal published data exploring ASRs’ attitudes to, or uptake of the vaccination though literature has forecast contributing factors based upon barriers to primary care, and those impacting other minority populations.(7)

Barriers to primary care for ethnic minority populations include miscommunication caused by language barriers due to inadequate provision of interpreter services, lower health literacy, cultural differences around care-seeking and expectations, and traumatic previous experiences of healthcare (8). In ASRs, this is compounded by poorly understood complex mental health and social needs, a lack of knowledge amongst ASRs and healthcare staff of legal entitlement to healthcare, alongside fears that seeking healthcare may compromise AS asylum case (9,10). In the UK, this is complicated by policies charging refused AS for healthcare (11–13). The pandemic and lockdown curtailed already limited charitable, health and social services, isolating ASRs from face-to-face assistance with medical, legal, housing, financial and social issues and adding significant delays to asylum procedures (11). The COVID-19 vaccination was introduced on this background of heightened perceived and real barriers to healthcare.

The UK vaccination roll-out demanded and created hierarchy-flattening strategies and collaborations, and increased community partnership to achieve high uptake at speed (7,11,14–19). Interventions were targeted to ASRs based on predictions that vaccine hesitancy would be associated populations with lower incomes and literacy rates, Muslim religion or minority ethnicity (3,6,16). These primarily aimed to combat vaccine misinformation circulating on social media platforms (WhatsApp and Facebook), utilised by minority groups and particularly impacting those with low literacy (7,11,21–24).

Though interventions were based in evidence and local knowledge, greater understanding of continuing structural and individual barriers to vaccination and accessing healthcare for ASRs is required. We seek to understand the attitudes and experiences of the vaccination in the ASR population.
Methods

Qualitative Branch

Study Design & Research Team

Semi-structured interviews were conducted with 12 ASRs in Bristol attending one of three Non-Governmental Organisations (NGOs) providing education, community support or food. In September 2021 AG volunteered at all NGOs for two weeks and met with potential participants and staff. Recruitment then began, face-to-face using quota and snowball sampling in collaboration with NGO staff to ensure only those appropriate to interview in terms of mental health and age (>18) were approached. Interest individuals were given information sheets in their first language and opportunities to ask questions seven days before their interview. Written consent was documented immediately prior to interviews. No participants dropped out following recruitment. We recruited a highly diverse sample in ethnicity, age, gender and English-speaking ability (24).

Data Collection

Topic guides (written in English) were formulated iteratively, informed by a literature review and previous experience of LM & AG and later by previous interviews. Interviews were face-to-face, lasting approximately 30 minutes and conducted by AG (who is trained in interview technique), introduced as a “researcher from the university, collaborating with the city council to understand their experiences”. Interviews were in English or with an interpreter as chosen by the participant. Six Arabic speaking participants requested an interpreter, for whom a female native Arabic speaker interpreted responses verbatim into English, which was recorded, checked by LM (a native Arabic speaker) for accuracy and transcribed in English. Our interpreter was formally trained, worked regularly with the NGOs and the city council and was familiar to participants. Interviews were conducted in private rooms in NGO buildings, or at participants’ homes with only one researcher (AG), participant, and where requested, an interpreter present.

Interviews began with closed demographic questions followed by broad questions establishing knowledge of the disease and vaccination, access to care and lived experience before more specifically
exploring barriers and facilitators to care. Finally, we asked whether participants had or had not accepted the vaccination and why. Data collection continued to saturation on these key topics.

Interviews were digitally recorded using an encrypted device, transcribed verbatim and screened for accuracy before being made anonymous by AG. Field notes to provide context to interviews and a reflexive diary for self-awareness were maintained throughout data collection and analysis. This enabled analysis of setting, interactions and non-verbal cues during and around interviews.

**Data Analysis**

Data were organized using NVivo 12 and reflexive thematic analysis undertaken with an inductive, semantic and critical approach (25,26). Codes were derived from the data by AG and independently verified by LM with consensus reached regarding themes in regular analysis meetings. Member checking of transcripts was not pragmatic due to low written English literacy for many participants, and privacy as contact details were not collected.

Funding constraints rendered us unable to offer participants financial incentives. Ethical permission was granted by the University of Bristol Research Ethics Committee (FREC 0097).

**Findings**

The 12 ASRs, seven female and five males aged between 23-48 representing seven nationalities, are described in Table 1. Eight were refugees and four AS. Six were RR, and six IASR- one outstaying a student visa, and five entering the country via undocumented routes (Figure 2). Despite only two participants reporting receiving information regarding the vaccination in their own language, ten had received at least one dose of the vaccination.
Eight ASRs were housed in private local council accommodation, two in temporary accommodation and two were informally ‘sofa surfing’. Three described being moved between cities by the UKHO, and seven had lived transiently in other countries prior to entering the UK (Figure 2).

Findings consist of three themes with subthemes (Figure 1). Throughout interviews, though questions focused on vaccination, participants responded by discussing their experiences with healthcare services as a result of the asylum system. Our themes therefore reflect the breadth of interview responses, however a summary of key barriers and factors increasing uptake induced from this can be seen in Table 2.

Systemic Asylum Issues

Accommodation and Delayed Processing

There was a stark divide between the six RRs, and six IASRs (22). Compared to all six RR, none of the IASRs had a key-worker, 1 in 3 were living in accommodation that was ‘permanent’, and 2 in 3 were registered with a GP (Figure 2). One IASR described his 25 years in England saying

“from 1995 by myself or with some friends, no family members or anything here, which is a big problem. Sometimes with my friends here living here or there, sometimes house sitting… sometimes I’m a little bit down, it’s very difficult for me.” (Interview 2, AS)

The UKHO fails to provide secure and acceptable accommodation for some ASRs. Examples included long periods in temporary hotels, forced relocation between cities, inadequate housing and voluntary homelessness to remain geographically near support networks (family / friends) over guaranteed shelter at locations further afield. During the pandemic, slower processing of asylum claims lengthened stays in temporary accommodation and numbers of ASRs housed there. One participant said “...there are a lot of people now in the hotels. My friend is living around more than 14 months in a hotel... with an 11-year-old son... waiting in a little room.... After these fourteen months he’s so nervous and he has anxiety and both of them nowadays are so depressed.” (Interview 3, Asylum Seeker (AS)). Participants reported that
“Every time when you called the UKHO, they said in this Coronavirus period. You must wait. We know you have a problem, but you must tolerate it.” (Participant 4, AS).

Family and Children

Seven participants described additional strain of supporting children with a lack of practical and psychosocial support. This was heightened for families resettled due to the illness of a child. One mother described feeling like “...it will destroy us... all the time we’re at home... we feel scared because a lot of people they said to us, you have a responsibility, your child is sick, and you want him to get sick?” (Interview 9, RR).

NGO Input

IASRs described the positive impact of NGOs, and RRs, their resettlement program key workers in supporting them. Key workers “… made it more easy for us. They was with us step by step. If we need any information, they explain it, so that’s what made it more easy for us.” (Interview 7, RR). Key workers and NGOs helped with accessing, translating and interpreting information, transportation and registering with General Practitioners (GPs). IASRs were often dependent upon NGOs for financial, social, and emotional support, alongside signposting to housing, healthcare, and legal services.

Fear

Previous Trauma & Bereavement

Participants described fear provoked by traumas prior to claiming asylum. Nine participants described losing family members and friends to COVID-19 both in the UK and overseas. Participants described awareness that “a lot of community members they lost their life... a big number.” (Interview 6, independent refugee (IR)). In addition, participants described traumas seeking healthcare in other crises or warzones, saying “...you know like in Iraq if someone gets sick and he goes to hospital, he will not come back. He will die” (Interview 10, RR).
These traumas and resultant fears, alongside the national and international news and social media were overwhelming; with participants saying they “can’t stand anymore to just stay with these things. I couldn’t travel outside, couldn’t go anywhere, I lost some of the relatives in Iraq they died of the disease and here friends they died so all this affected me.” (Interview 9, RR).

Mental Health

This contributed to diagnosed mental illness detailed by 9 participants, 4 of whom disclosed that they were taking medication or had sought specialist help, despite multiple participants commenting that “we don’t really want to tell people, ‘(I) have a mental health issue’” (Interview 5, IR).

Social Isolation

In some families, fear manifested as remaining in self-imposed lockdown for up to 18 months longer than national policy required. One participant said “We just stayed in our tiny flat. Nothing more than. Three months we didn’t go out.” (Interview 9, IR).

UKHO accommodation far from support networks also contributed to isolation, often for prolonged periods with dual threats of the pandemic, and prolonged uncertainty regarding their future due to delayed asylum case processing times.

Misinformation

Social isolation due to fear, lockdowns and isolating accommodation alongside reduced health literacy; language and cultural barriers left participants vulnerable to misinformation. All participants accessed information online through national news outlets, social media, or by word-of-mouth (including WhatsApp groups). Participants reported reading that COVID vaccinations were “poison… from China” (Interview 9, RR), “make diseases” (Interview 8, RR), “kill you... or (that) you can’t have a baby in the future” (Interview 4, AS), or
Despite this, eleven participants were able to identify misinformation that they had seen as untrue, stating that it was “fake news” (Interview 4, AS) from “people who are less educated... just gossip, they don’t know what they are talking about” (Interview 9, RR). Participants cited BBC, and British formal media outlets as reputable information, over outlets from their countries of origin, or community social media groups, and ten had already had their first dose of vaccination. One participant refused vaccination due to online misinformation. He also denied the existence or severity of the pandemic, saying that he had “heard about a lot of people died and big numbers... they’re lying. It’s not true” (Interview 12, RR). As such he did believe that vaccination was necessary, and vaccines were made by “the mafia, they just want to get money from the people” (Interview 12, RR). This individual had complex social and medical needs rendering him housebound. His wife was not housebound, and had received the first dose of the vaccine. All participants reported “the majority of (their community) has got at least one jab” (Interview 9, RR).

Misinformation was unanimously a significant “reason (participants) felt scared” (Interview 8, RR) of vaccination, particularly regarding side-effects or medical vaccination complications. This was the predominant reason for vaccine hesitancy, not barriers to practical access. One participant said, “I was worried before, I was hesitant before I take the vaccine so I was waiting if I can see somebody who had the vaccine and is still alive” (Interview 6, IR).

Information & Trust

Health Literacy

Three Individuals who worked in healthcare or had attended university actively researched, and identified misinformation based on their health literacy. One said “...when I first I heard (about the vaccine) I had no idea about that, but I did some research and... thought yeah, that's necessary, we should do that because we can protect ourselves and others” (Interview 4, AS).
Eight other participants based these decisions on the viewpoints and actions of trusted individuals felt to be educated and informed. These were “good friends... they study here PhD, so they took the vaccine- so when I saw that I was like OK” (Interview 10, RR) or medical professionals. Participants unanimously trusted medical practitioners, saying “...we heard different opinions from different places, but we are not better than the doctors. All the doctors in general they understand better than the rest of us. And a lot of people they took it and they are ok. Then that’s enough” (Interview 9, RR).

All participants described relative ease in overcoming language barriers to information online, saying it was “...easy, so easy, because even if you cannot understand English, you can use Google translator. So yeah, not perfect, but at least it’s an idea of what’s going on” (Interview 4, AS). Specific terminology was often not understood however, and participants varied in the depth of research they attempted to conduct.

Sense of community

Regardless of approach to decision-making, ten participants referred to vaccination uptake decisions in terms of “we” in reference to their community, and not as an individual. Eleven participants discussed being hesitant, rather than refusing to be vaccinated as this enabled them to “wait for somebody to see, and see if they can take and not have side effects or whatever” (Interview 6, RR). Individuals described sharing vaccination status with communities saying, “I ask you, you’ve got the jab, you said yes, of course I’ve got twice, so I ask another one, “Have you got the jab? ” “Yeah, yes, I’ve had it once, so it kind of encourages (me that) everyone has got, why I didn’t?” (Interview 4, AS).

Social Media

More isolated participants communicated through social media with a virtual community of ASRs in the UK and overseas. Participants described large WhatsApp groups spanning multiple countries, which enabled them to “compare what’s different, why they have different opinions” (Interview 5, IR).
One RR described information posted (in Arabic) by a local councilor on a large community Whatsapp group as “very clear about how many people they could host at home, when they meet all this stuff, how to look after yourself to not get sick from Corona…” (Interview 10, RR). This group was also a place they were encouraged to use “if you need anything... any help and support... go there and ask. You will find a lot of people.” (Interview 10, RR). This direct communication with the council enabled the sharing of accurate, relevant information in an accessible format and language.

Social Responsibility

The heightened sense of community extended to the widely cited rhetoric “stay home, (to) save lives” (Interview 6, IR). Participants expressed pride in efforts to protect their communities saying, “we want the society become better be better. Back to normal. So all of us, finally, we decided to have a vaccination” (Interview 5, IR).

Access to Healthcare

Access to care was a crucial determinant of vaccination. Though the motives or ability of healthcare staff were unquestioned, participants felt that they “don’t understand the system, so we not don’t trust the NHS” (Interview 5, IR). Participants felt rebuffed by the ‘111’ service and emergency departments and said “(GP) receptionist(s) always want to hang up your phone... so that’s why some of us we are very afraid to get a vaccination because the if we can't sort out the side effect, maybe we just stay home and extend the lockdown time” (Interview 5, IR).

Despite this, 60% of participants registered with a GP cited their first choice source of vaccination information as the practice, while unregistered participants cited a receptionist saying, “It is a pandemic we couldn’t register you.... this time we need the doctor especially” (Interview 3, AS).

Five RRs expressed confidence in the government saying, “I feel that the government cares about the people... If something happened to my family, we will get support. And to prove that, the vaccine in
Jordan, we refused to take it until we arrived here. Then I said I’m going to take it” (Interview 7, RR). In contrast, no IASRs expressed this confidence, though they trusted individual practitioners.

Finally, participants struggled to communicate remotely with healthcare services, saying “if I got anything in a post, it means I cannot reply. I find it hard to write and read this and again to post it” (Interview 8, RR). Others said they “didn’t know anything about how to use the email ... but WhatsApp I will just do it easily” (Interview 7, RR).

**Discussion**

**Summary**

We conducted in-depth interviews exploring experiences and attitudes to vaccination. Responses, on analysis illustrate how decisions around vaccination uptake are a holistic reflection of perceived and real access to healthcare, and the impact of an asylum system that often fails to provide safety or security to this vulnerable and isolated population. Factors that may increase uptake of the vaccination must also be holistic; including an awareness of the true impact of the asylum system on individuals within it amongst practitioners and commissioners, a focus on improving access to primary care, and efforts to enable individual ASRs to connect with members of their natural communities by ethnicity, rather than simply targeting specific interventions focussed only on vaccination.

Findings were disseminated with local policy makers, commissioners and practitioners through verbal presentations, meetings and a lay report. During this process we discovered that framing our key themes and sub-themes alongside Maslow’s Hierarchy of Need enabled us to best present holistic responses in a format well understood by practitioners (Figure 3)(27). The premise of this is that each ‘need’ can only be addressed once the one below it has been fulfilled.

At base ‘Physiological Needs’ level (5); all participants could prioritise healthcare or vaccination while their accommodation and physiological needs remained under threat due to systemic asylum issues. At the ‘Safety Needs’ level (4) participants were unwilling to accept a vaccination, which could risk their
health, and the side effects for which they could not access healthcare to address. Access to a key worker for RRs, or a good relationship with their GP for IASRs was the largest factor in participants feeling that this need was met. At the ‘Love and Belonging’ level (3), participants described the fear bred by isolation, amplified by the pressures of protecting children, and discussed their vaccination status in terms of their whole community. Until there was group consensus that vaccination was safe, and participants felt supported in risk-taking by this group mentality, they were unlikely to accept vaccination (including those with university education, employed in healthcare, or healthcare workers’ support). Mental health issues expressed by nine participants added barriers at the ‘Esteem’ level (2), as participants stated that they could not process information under pressure or have the confidence to make decisions involving risk.

In summary, unless participants felt secure in accommodation, their access to healthcare, sense of community supporting the decision and were secure in their mental health, they delayed vaccination. Eleven participants were able to identify and cite misinformation that they found frightening but this was less significant a causing of vaccination hesitancy than factors described in Figure 3.

**Strengths and Limitations**

This study is the first to explore in-depth the experiences of this population group surrounding the COVID vaccination. The small study population, though non-homogenous demographically, has the impact of the asylum system in common. Key themes therefore have ‘transferability’ to other resettled and IASR populations in the UK moving through the asylum system. Interview setting created a supportive and safe an environment, enabling in-depth, personal explorations, and interviews continued until there were almost no new viewpoints expressed, and data saturation was reached on content from the topic guide.

Recruitment was, however, limited to individuals engaging with NGOs and therefore more likely to be aided in collaborate with healthcare services, which may impact the experiences, and uptake rate reported. Secondly, we have focussed on holistic approaches with a small, non-homogenous sample. Further exploration of specific factors impacting uptake and suggested interventions in each ethnic group is necessary. Finally, member-checking was impossible to triangulate findings with participants,
but data were self-consciously analysed to ensure credibility and dependability, with independent verification of themes, and interpretative challenge in analysis meetings (24).

Comparison with existing literature

High prevalence of vaccine hesitancy, defined as “delay in acceptance or refusal of vaccination despite availability of vaccination” was forecasted in qualitative studies of ASR populations prior to vaccination roll-out (23). Hesitancy has been described in terms of “confidence”, “convenience” and “complacency” (23). “Confidence” was predicted to be eroded by inaccessibility of information due to language barriers, misinformation, and negative healthcare experiences (6, 22, 23). Perceived or real practical barriers (including cost), uncertainty around vaccination entitlement, and disrupted NGO services were predicted to decrease “convenience” (6, 7). Finally “complacency”, was predicted influenced by slow vaccine uptake amongst healthcare staff from ethnic minority groups (2, 3, 29).

Though findings support predicted hesitancy, barriers surrounding “confidence” and “convenience” reflected the far-reaching impact of the asylum system, and ASRs underlying traumas. We found no evidence of “complacency”. We suggest these labels seem inappropriate when applied to a fearful and clinically vulnerable population with limited access to healthcare. Vaccine hesitancy was not due to lack of information, misinformation, or practical access, but these factors compounded by social isolation, trauma and an asylum system which often fails to provide adequate shelter or safety.

Population health is dependent upon equitable access to healthcare. This pandemic highlighted systemic health inequalities affecting minoritized and marginalised communities. Infrastructures and systems must be rooted in the hierarchy of needs, and priorities of individuals and those targeting ASRs must be designed specifically in light of asylum system within which they dwell.

Implications for practice and further research

Findings have three implications for clinical practice. Firstly, general practice and policy makers must provide perceived, and true equitable access to care for vulnerable populations. This enables them to
take the perceived ‘risk’ of accepting vaccinations with confidence they can access care for side effects. Barriers to practice registration must be eradicated.

Secondly, fear, trauma, and isolation determine ASR healthcare decision-making. Increased communication can overcome this, including resolving issues with remote communication. Utilising “WhatsApp” or text messaging rather than postal communication enables online translation, if communicating in individuals first language is not possible.

Finally, research is needed with homogenous groups of ASRs exploring specific experiences of the ethnic community groups to which these individuals identify as belonging.

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Ethical Approval: University of Bristol Research Ethics Committee (FREC 0097)

Competing Interests: None

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References


Tables & Figures

Figure 1: Themes and Sub-Themes

<table>
<thead>
<tr>
<th>Systemic Asylum Issues</th>
<th>Fear</th>
<th>Trust</th>
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<tbody>
<tr>
<td>• Mobile population</td>
<td>• Social isolation</td>
<td>• Health literacy</td>
</tr>
<tr>
<td>• Accommodation and delayed processing</td>
<td>• Previous trauma</td>
<td>• Community</td>
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<tr>
<td>• Family and children</td>
<td>• Bereavement</td>
<td>• Access to healthcare</td>
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<td>• Mental health</td>
<td>• Social media</td>
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<td>• Misinformation</td>
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Table 1: Demographics of participants

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Figure 2: Resettled and Independent refugees key indicators

<table>
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<th>Independent (n=6)</th>
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<td>Key worker</td>
<td>🧙‍♂️ 🧙‍♂️ 🧙‍♂️ 🧙‍♂️ 🧙‍♂️</td>
<td>🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥</td>
</tr>
<tr>
<td>Information in mother tongue</td>
<td>🌍 🌍 🟥 🟥 🟥 🟥</td>
<td>🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥</td>
</tr>
<tr>
<td>Vaccination 1st dose</td>
<td>🟦 🟦 🟥 🟥 🟥</td>
<td>🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥</td>
</tr>
<tr>
<td>Vaccination 2nd dose</td>
<td>🟥 🟥 🟥 🟥 🟥</td>
<td>🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥</td>
</tr>
<tr>
<td>Vaccination booked</td>
<td>🟥 🟥 🟥 🟥 🟥 🟥</td>
<td>🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥 🟥</td>
</tr>
</tbody>
</table>

Table 2: Factors affecting uptake of vaccination

<table>
<thead>
<tr>
<th>FACTORS INCREASING UPTAKE</th>
<th>BARRIERS TO VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of social responsibility in community</td>
<td>Systemic Asylum System Issues</td>
</tr>
<tr>
<td>Good, accessible information</td>
<td>Misinformation</td>
</tr>
<tr>
<td>Desperation to escape lockdown</td>
<td>Poor mental health</td>
</tr>
<tr>
<td>Trusting relationships with GP</td>
<td>Trauma and bereavement overseas</td>
</tr>
<tr>
<td>NGOs assisting access to healthcare</td>
<td>Perceived poor access to care</td>
</tr>
<tr>
<td>Sense of community</td>
<td>Social Isolation</td>
</tr>
<tr>
<td>Fear of COVID &gt; Vaccination</td>
<td>Fear of vaccination &gt; COVID</td>
</tr>
</tbody>
</table>
Figure 3: Maslow's Hierarchy of Need & interview thematic analysis

KEY THEMES

TRUST & INFORMATION
- Social Responsibility, Health Literacy
MENTAL HEALTH
- Access to healthcare
COMMUNITY
- Social Isolation, Family & NGO Assistance
FEAR
- Bereavement, Other Trauma, Misinformation
SYSTEMIC ASYLUM ISSUES
- Delayed Processing & Accommodation, Mobile Population

MASLOW'S HIERARCHY OF NEED

1. SELF ACTUALISATION
   - Achieving One's Full Potential
2. ESTEEM
   - Respect, Self Confidence, Status
3. LOVE AND BELONGING
   - Family, Friends, Community
4. SAFETY NEEDS
   - Personal security, Health, Employment
5. PHYSIOLOGICAL NEEDS
   - Water, Food, Shelter, Sleep.