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Interprofessional Approach to Refugee Health

A Practical Guide for Interdisciplinary Health and Social Care Teams

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4. Recognizing the Needs of Refugees: A Healthcare Access Lens

Ganzamungu Zihindula

Introduction

The number of refugees in the world is rising at an alarming rate. At the beginning of 2022, there were 35.3 million refugees, 62.5 million internally displaced people, 5.4 million asylum seekers, and 5.2 million people in need of international protection. In September 2023, it was estimated that more than 114 million individuals were forcibly displaced worldwide (UNHCR 2024: 2). This escalating number means that the challenge of meeting the needs of refugees has also greatly increased. To illustrate this, the UNHCR required a budget of 10,622 billion US dollars to provide life-saving assistance, protection, and solutions for a projected figure of 130.8 million forcibly displaced and stateless people by the end of 2024 (UNHCR 2024). In line with the projected figure, at the end of year 2024 there were 123.2 million FDPs globally. Both the 2024 counting of forcibly displaced and stateless persons (123.2 million) and their projected number (130.8 million) exclude other forms of displaced persons like economic migrants and those who have already naturalized to become citizens of their host countries. This chapter explores the healthcare needs of refugees and discusses best practices for health and social care professionals' recognition and response to these urgent needs. Specific factors that health and social

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care professionals should be aware of to improve the accessibility of the care they provide are highlighted. The chapter also provides details for how health and social care professionals can ensure that they respond effectively to the different needs of people living with refugee experience. The discussion focuses on important issues that health and social care professionals need to recognize and incorporate into their daily practice to improve the quality of care they provide and reduce potential triggers of psychological distress.

Refugee Needs for Consideration by Healthcare Professionals

The needs of refugees can differ from those of citizens in host communities in many ways. The World Health Organisation (WHO) conducted a review of the common health needs and vulnerabilities of refugees and migrants. The impact of migration on physical and mental health, along with low levels of health literacy, experiences of discrimination and restricted access to mainstream health services can mean that refugees' health needs go unmet (WHO 2021). Similarly, children with experiences of forced displacement may have worse health outcomes related to infectious diseases, chronic diseases, and mental health issues compared with local residents or undisplaced children in high-income countries (WHO 2021: 6). In a comparison between refugees and the host population in Uganda, a UNHCR study found that 51% of refugee households were defined as "in need of healthcare services and other basic human right needs", compared to 17% of host households (UNHCR 2022: 3 cited in King et al. 2022). A similar observation was made by the Royal College of Physicians in Ireland, revealing that asylum seekers and refugees had health needs that differed from those of the local Irish population or the citizen thereof, and which should be taken into consideration by healthcare professionals when providing services to the latter. According to the physicians' observations, infectious diseases, including but not limited to Hepatitis B, HIV, and TB, are more common in asylum seekers and refugees following higher background rates of such health conditions in their home countries. This drives the need for screening upon arrival of asylum seekers whose primary needs remain shelter, food, and

healthcare services (UNHCR 2022: 2). The health-seeking behaviours of refugees and asylum seekers mirror their differences in health needs (Zihindula 2015) and are influenced by cultural practices and religious beliefs across communities and countries of origin. These factors need to be recognized by a healthcare professional providing services to forcibly displaced persons.

Refugees can require mental health and psychosocial support due to traumatic experiences endured in their country of origin, during transit to their destination, as well as after arriving in the host country due to re-traumatizing events. These factors mean that refugees should receive a thorough needs assessment and identification of health and social care requirements. Such assessments should take into consideration all the effects of psychological trauma including, but not limited to, changes in relationships, reliving traumatic incidents, anger and frustration, euphoria, isolation, sadness, guilt and shame, helplessness, fear, disbelief, and bewilderment, as well as emotional disconnection and distance. In a study of refugee healthcare needs in New Zealand, readily accessible interpreters (language needs), culturally competent and sensitive health practitioners (cultural sensitivity training), and availability of clear and accurate information were found to help refugees access the healthcare services they required (Bafreen Sherif et al. 2022: 5). Studies in South Africa had previously yielded similar results, yet also found that traumatic experiences, especially for refugees and asylum seekers coming from conflicts zones, fear of disclosing their status due to stigma and discrimination, and refugee perceptions of healthcare professionals, are potential barriers to accessing healthcare (Ganzamungu Zihindula et al. 2015; Alfaro-Velcamp 2017; Meyer-Weitz Asante & Lukobeka 2018). To provide appropriate healthcare services for refugees, healthcare professionals should recognize that many refugees arrive from settings where healthcare facilities have been destroyed by war (such as the Democratic Republic of Congo, Palestinian territories, and South Sudan), and have experienced exacerbated vulnerabilities due to economic instability and discrimination based on cultural and traditional practices (Alfaro-Velpimo 2017; WHO 2021). In such environments, interruption of access to health services for chronic health conditions exists in advance of forced migration patterns, thus leaving individuals predisposed to deteriorating physical health and,

by extension, mental health. It is worth noting the complexities of the health needs of refugees when they present to a healthcare facility for care. The long-term physical and psychological problems experienced by refugees can date back to their pre-immigration experiences and can be later exacerbated by post-migration factors (RACGP 2023), including discrimination, stigmatisation, racism, gender issues, hostility of the host community, and access barriers to socio-economic and basic human rights opportunities like higher education, healthcare services, and documentation.

The context and geographic location within which a person with refugee status is seeking health services will impact their needs. For example, a refugee located in any country or region in sub-Saharan Africa will have different needs compared to a refugee in a high-income country Europe, North America, or Oceania (Emansons Guntars 2023: 4). In the setting of a high-income country, refugees have access to basic health services (which are sometimes covered by national health insurance policies), healthcare settings regulated by sanitation requirements and adequate equipment, and safety, all of which have positive impacts on mental wellbeing, compared to their counterparts in many sub-Saharan African countries where these remain an issue (WHO 2021). While such services may not be without fees in some high-income countries, such as the USA, the vast majority offer the services free even in low- and middle-income countries (LMICS), e.g., South Africa, Uganda, Kenya, and Zimbabwe. Beyond the actual health service given between clinicians and refugees, safety within facilities is an additional aspect to consider that differs from the general security measures of health institutions. Refugees face a heightened risk of stigma and discrimination by healthcare workers and or other patients. Moreover, their emotional and mental safety during the interaction with healthcare workers is of critical importance. Such safety measures are rooted in cultural awareness, a conscious effort to overcome language barriers, and the intentionality to provide a thorough exam to screen, diagnose, manage, and treat the refugee comprehensively and at the earliest engagement with the facility. At present, the likelihood of discrimination raises questions of whether safety is equally distributed.

Recognizing Dynamic Socioeconomic Needs of Refugees

Refugees can face additional social, educational, and economic challenges in their host communities, including rejection, hostility from the host population, and social class acceptability based on perceptions of race, ethnicity, and identity. Scientific evidence suggests that, in Ireland, refugees from Ukraine who present as white are received more hospitably, with positive emotions, compared to refugees who present as people of colour from Asian and African countries such as the Democratic Republic of Congo, Sierra Leone, Somalia, and Syria (Xuereb 2023). Ukrainians have been referred to as 'brothers' by most European Union states, and particularly in Ireland, where the host communities have been mobilized to receive Ukrainian refugees in solidarity. This 'social solidarity cause' has not been the case for other nationalities, irrespective of the dire situations in which they find themselves, thus exacerbating their risk of mental and emotional harm.

This 'selective solidarity' approach applies to service delivery and access to fundamental human rights. There are radical differences among different refugee groups regarding their access to higher education or the financial support they receive in the form of monthly stipends. For example, Ukrainian refugee undergraduate students at any university in Ireland receive a monthly stipend of 1150 Euros, while all other asylum seekers and refugee groups studying toward a similar undergraduate degree within the same institutions receive a rate that is eight times less than that, at 155.2 Euros a month (Irish Universities Association 2023; Irish Refugee Council 2023). Such unequal consideration and resource distribution have negative effects on the mental health and psychological wellbeing of the recipient refugee, leading to potential sadness, a sense of isolation, helplessness, anger, frustration, and all other effects of psychological trauma. Knowledge of the overarching discriminatory approaches applied to refugees across the many private and public institutions within host countries should be essential for healthcare workers. Adopting a sensitive approach to the lived realities of refugees as central to their health and well-being may reduce the risk of re-traumatisation. This knowledge, along with cultural competency

training, are key to providing appropriate healthcare services to asylum seekers and refugees.

Healthcare providers working directly with asylum seekers and refugees must be aware that these populations may have pre-existing perceptions of being structurally and systematically excluded from financial and educational benefits that may have been provided to other forcibly displaced groups. Understanding this dynamic and taking it into consideration when offering healthcare services will prevent the beneficiary from perceiving the healthcare system as a similar institution that applies a 'selective solidarity approach' in the provision of care. Experiences of discrimination can impact the psychological well-being of asylum seekers and refugees, affect their social relationships, increase psychiatric symptoms, lower self-esteem, reduce perceptions of optimism, reduce treatment adherence, and can cause escalating challenges in the work, home, or school environment (Singhal 2024). If not taken into consideration by healthcare providers, pre-existing experiences of discrimination and inequities in social services can lead to reluctance and/or resistance from refugees related to the uptake of health services at healthcare facilities. Not only can this have negative clinical outcomes for patients, but it increases the risks faced by those in their immediate households and communities. In the case of infectious disease, the implications are a cause for concern. Further, poorly managed health conditions will ultimately lead to greater dependence on and cost for the state to manage chronic health conditions and their impact on individuals and families.

Gender, Identity, and Sexual Orientation Care Need Dynamics for Refugees

Women, children, and people who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, or Questioning (LGBTIQ+) are among the most marginalized within refugee communities (Denise Venturi 2023). Age, gender, and sexual identity all have the potential to influence access to healthcare services, and healthcare professionals must recognize that they will experience a vast range of healthcare needs. Sawadogo et al. (2023: 7) conducted a scoping review of barriers and facilitators of access

to sexual and reproductive health services among migrants, internally displaced persons, asylum seekers, and refugee women. Limitations that asylum seekers and refugees regularly report include a lack of autonomy in decision-making, discrimination, stigma, delays due to related administrative factors within the health system, availability of healthcare services, the geographic location of health facilities, and the quality of communication or patient-provider relationship, which ultimately determines the quality of services received. Healthcare providers must recognize that all these barriers could potentially result in determinants of sexual and reproductive health services for women, youth, or members of the LGBTIQ+ community. The Women Refugee Commission (2021: 1) cited in Sawadogo et al. (2023), reports that the limited access to reproductive health services for refugee women and girls results in increased risks of unintended pregnancy, complications of pregnancy, diseases, disability, and deaths that could be prevented. A WHO (2022) report highlights issues of abuse, sexual assaults, and violence which are common in the context of forced displacement. Additionally, instances of torture and trauma during the forced migration process and the impact of the resettlement process have been documented (WHO 2021: 11) and may or may not intersect with other issues related to gender, age, and identity. Women, young people, and members of the LGBTIQ+ community may endure specific challenges in accessing services due to social issues and gender-related stigmatisation, related to their cultural background (Diab et al. 2024). Therefore, for women within the refugee community, 'gender-sensitive' health services are routinely reduced to perinatal care and gender-based violence (GBV) support, often overlooking more comprehensive sexual and reproductive health needs (Keygnaert et al. 2014). Importantly, gender-sensitive health services have fallen short in comprehending the inherent heterogeneity of both women and LGBTIQ+ individuals within the refugee community, at times failing to make important distinctions between the specific healthcare concerns of non-heterosexual and non-cisgender refugees who are confronted with policies, norms, and systems in the host community, and some healthcare providers, as well as other social services providers, who interact with them very differently. National legal and policy frameworks within the host

country have long determined the accessibility of services for refugees, particularly regarding gender-sensitive services. Importantly, the criminalisation of migration, as well as the precarious legal standing host countries impose on refugees with a specific gender identity such as agender, cisgender, genderfluid, non-binary, genderqueer and transgender within their borders, impacts their realisation of their right to access adequate healthcare (Martinez et al. 2015). When providing healthcare services to refugees, it is essential that healthcare personnel acquire a baseline understanding of these dynamics and remain aware that refugee populations are not a homogenous group with the same vulnerabilities and needs.

Cultural Misunderstandings and Communication Breakdown

There is a pervasive assumption that if a patient, in this case, a refugee patient, is quiet, uncomplaining, and compliant, this means that they are okay. Yet, it is equally possible that this refugee patient has been silenced, rejected, and feels unable or unempowered to communicate their needs. In some cultures, around the world, communities have a wide range of social healing practices, which refugees may be unable to practice or access in host countries. Additionally, they may feel silenced due to unequal treatment or feelings of non-belonging or being unwelcome in the host community. Additionally, there exists the risk of assumptions around the level of awareness and knowledge migrants have about the health systems of the host country, their own health status, and their willingness to adopt prescribed clinical approaches readily. The knowledge, attitudes, and practices of individuals and how they respond to care pathways is rooted in their cultural practices, and in familiarity with health systems in their home countries which are context-specific, inclusive, and responsive to socio-cultural norms. In the absence of practices to create an inclusive and safe environment, there remain ongoing risks of avoidable barriers to access care, non-compliance with prescribed treatment plans, and refugees dropping out of the system.

A Case Study on Refugee Social Integration

As a person with lived experience of forced migration, living in Ireland at the time of writing this chapter, I have worked with refugee populations in both direct provision centres and as a facilitator in English language classes. In these volunteer-led classes, hosted at the Centre of Forced Migration Studies at Trinity College Dublin (TCD), small groups of learners practice every-day English speaking and literacy skills, while also experiencing an informal and welcoming opportunity for intercultural exchange. In my conversations with participants, I gathered personal stories and information about the dynamic needs expressed by the community.

I can further witness that refugees' knowledge and information regarding health systems in their host country is limited. Sometimes the information is made available but in languages unknown to refugees, or other times, it is provided through platforms that are not accessible to a vulnerable group. For example, information provided through electronic devices that many refugees in the global south cannot afford, will not serve them. Some information on Sexual and Reproductive Health (SRH) is provided through social media links, yet many of the refugee groups do not necessarily have access to them, for example older persons, children, and those who were less privileged in terms of basic education. In my case, and for my host country, the language in which information was provided and how this reached the refugee community were the two main issues.

Another aspect of misinformation is linked to refugees not being briefed about the model of the health system in a particular country. Usually, asylum seekers and refugees rely on their fellow migrants who arrived in the host country before them to provide necessary information about the functionality of the health system, and access barriers or facilitators. Being new in the host country, my attention was focused on lived experiences shared by fellow forced migrants. It did not come to my attention at any point that their experiences were individual cases that could differ from one person to another. Furthermore, most of their information was also something that they had heard from a fellow forced migrant. Almost none used trusted sources such as an information document from the government or private sector like a

Non-Governmental Organisation (NGO) working in the healthcare service in the country. The same issue of miscommunication and limited access to credible information applies to a forced migrant living in the Global North: if they remain uninformed, they may miss a treatment opportunity due to misinformation. For example, in Ireland, an asylum seeker or refugee must consult their general practitioner/family doctor before going to the hospital for treatment, whereas in South Africa, for instance, the public healthcare system is structured in a different way.

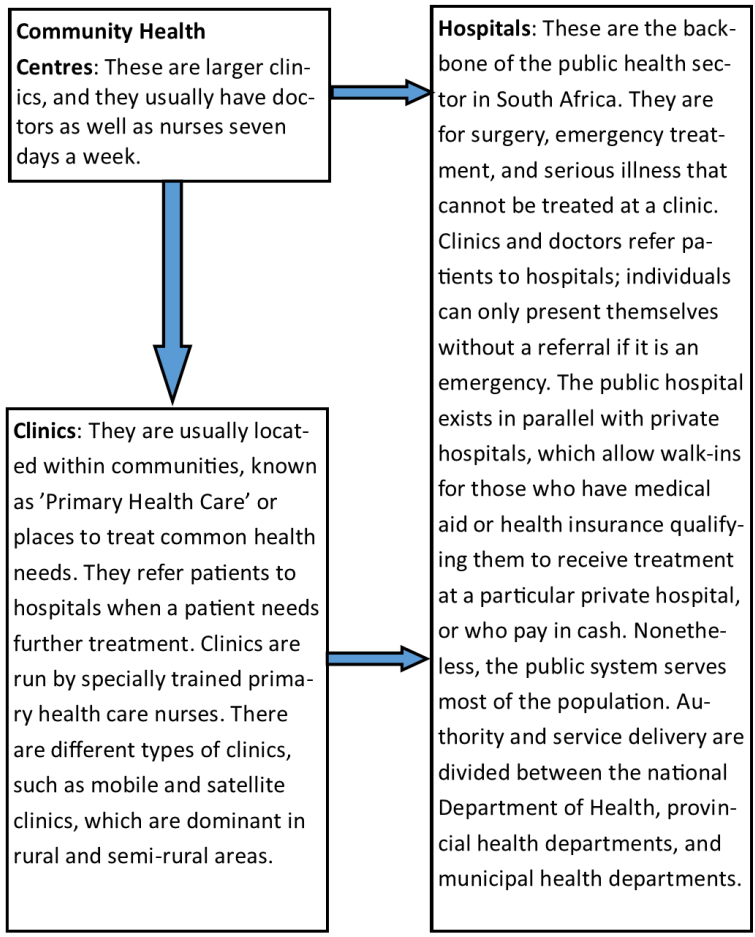

Fig. 4.1 Structure of health service provision in South Africa.

Different countries hosting refugees have different healthcare models and operating systems. It is imperative for refugees to have an orientation session upon their arrival, to inform them about how a particular country's health system operates. This assists in timely access to preventative care and reduces the risks of missing an opportunity for treatment. This system (see Figure 4.1) is different for a country in the Global South such as Malawi, Kenya, DRC, Zimbabwe, or Chad, where refugees live in camps and receive their individualized health services there.

In addition to this summary in Figure 4.1, healthcare professionals ought to recognize that refugees have issues specific to their country of origin and their migration and settlement experiences, making it necessary to understand everyone's unique migration journey and the systemic barriers they have experienced in accessing care (RACGP 2023). A quote from a private correspondent with a lived experience of forced migration and who is currently a medical manager at a hospital providing care to refugees advises that: "Health providers involved in offering healthcare to the refugees must be intentional in addressing the health needs of the refugees and avoid retraumatizing experience" (Dr Lwabanya).

In many contexts, stereotyping is the factor that most hinders both sides in achieving better health outcomes for refugee patients and in building trust between healthcare professionals (HCPs) and patients from refugee groups. Dr Lwabanya reports that HCPs can perceive that patient with refugee experience complain a lot, a perception that does not help them to dig deep and better understand the patient's problems. Thus, they may miss the opportunity to provide better treatment. On the other hand, patients from refugee groups can perceive that they are undervalued in the host country. Consequently, when they visit health facilities, they are in an alert mode, and scrutinize the health provider's attitude to them, e.g., the words used, the tone of the words, how promptly they respond to their requests. Each action taken toward the refugee can positively or negatively affect their relationship with HCPs and ultimately result in a positive or negative impact on the patient's healthcare outcome(s). My experience of training in trauma-informed care (TIC) in the fragile context of the Eastern Democratic Republic of Congo (DRC) has highlighted the need for health providers

to complete this training and recommend it to their colleagues to help them improve health outcomes for their patients, especially those with refugee experience, internally displaced people, and victims of sexual violence or rape.

Key Messages that Need to Be Recognised

Differences in culture and expectations: Cultural competence is central to proper healthcare provision in regular settings. However, its significance becomes even more obvious and compelling when healthcare is targeted at refugee populations in which beneficiaries mostly share no cultural background and understanding with service providers. Lack of cultural competence may lead to frustration on the side of the provider and inability to access healthcare on the side of the refugees. Hence, **cultural competence** is certainly a key goal as it takes a lot of time and experience with a particular cultural group. Nevertheless, cultural humility and openness can be keys to the initiation of proper **communication** with culturally diverse groups (WHO 2021). Rapport building and active listening prove to be effective ways to gain trust and ensure the appropriateness of services for refugees. Also, an increase in the ethnic diversity of healthcare providers whenever possible, providing services through healthcare providers who share the same ethnic background as refugee groups, appears to help ensure cultural competence with less time and in a more efficient way.

Patient-provider relationship: In the implementation of trauma-informed care intervention, a series of simulation workshops is conducted using a translational/ transformational simulation approach. Healthcare providers report fewer challenges with socially excluded persons (homeless persons, refugees, asylum seekers, and undocumented persons) when they start building rapport through active listening, connecting before correcting, and offering options, to strengthen such relationships (Vallières et al. 2023). This relates to the importance of communication and interpretation services and the provision of culturally appropriate and respectful care, facilitating the refugee patients to receive appropriately tailored information and health promotion, illness prevention, and preventive care (RACGP 2023: 3). In brief, the patient-provider relationship is nurtured by communication,

which permits HCPs to learn more about the refugee patient's history before their migration to the current host country, building a rapport and clearly recognizing the refugee patient's expectations.

Time constraints: Health visits and consultations create an extremely important opportunity for providers to respond to the healthcare of refugees, especially in terms of mental health. Since these vulnerable groups have an additional disease burden compared to regular patients (WHO 2021; UNHCR 2022; Vallières et al. 2023), they require specific attention to "past experience of healthcare, exposure to traumatic experiences, languages, and cultural differences" before and during appointments. Adopting an approach in which some important steps are incorporated into healthcare delivery necessitates more effort and time allotted to appointments with refugee populations. A study conducted with refugees and asylum seekers in Canada to explore the experiences of immigrants who are new mothers with symptoms of depression reported that patients could not share the feelings of depression with their doctors as they were always rushed, and yet, their emotional issues were not covered in the check-up or at the health facility's reception (Ahmed et al. 2008). Healthcare providers need to invest time in building trust with refugee populations to be able to cover all their health-related needs. Also, it is important for them to take time to achieve cultural understanding, and to explain medical concepts and services that are made available to refugees in a way that is culturally sensitive. To improve communication during medical visits, providers must make sure that they employ appropriate strategies to inform refugees clearly about various topics of health, although they are certainly time-consuming.

Lack of knowledge and skills: The importance of informing refugees about the health system and their right to health in the receiving country is extremely important. Support through training and guidance for providers is usually neglected; the need for more training for healthcare providers who are ill-equipped to deal with the difficulties of refugees in service provision is equally crucial. Regarding the health coverage of refugees, providers can totally be unaware of the refugee entitlement for health in the receiving country. With limited time to prepare for medical encounters with culturally diverse groups and inadequate training

opportunities, healthcare providers usually lack enough knowledge of refugee culture and good communication skills. Consequently, they worry that in their encounters, they may be misunderstood and offend refugee patients in certain ways that are unknown to them. This can even go as far as fearing accusations of racism due to miscommunication and lack of cultural, religious, and general background understanding.

System-related obstacles: The health systems determine the ways in which internal and external factors can strongly interfere with proper service provision. When the systems fall short of responding to the uniqueness of refugee and asylum seekers needs, this reflects a providers' avoidance of cases and eventually leads to poor health outcomes. Limited financial resources for refugee health support programs, which hinders any attempts to improve care, is an added challenge to the health system. Other obstacles include limited flexibility, despite the heterogeneity of refugee groups. The difficulty of refugees in navigating the health system results in compromised care and increased costs, which affect both health seekers and providers in an unfavourable way.

Policy Implications for Refugee Health

The goal of policies in general is to ensure a structured and orderly approach to managing the complex needs of the population, aligned with key national goals and values. The value of human life, and the need for good life outcomes central to human rights, inform how governments design and implement programmes. The intersection between health outcomes and service delivery are both interdependent and unavoidable. While migration remains a global phenomenon, irrespective of its root cause, the case of refugees and persons exposed to violent and harsh realities in countries experiencing war and extreme poverty warrant that context-specific interventions be adopted. This would ensure inclusive approaches that are respectful of human rights, and considerate to the intersections between physical and mental health, and their impact on the individual, their households, and communities. The United Nations Higher Commission of Refugees (UNHCR), the International Organization for Migration (IOM), and other relevant branches of the UN, in collaboration with governments hosting refugees,

can support programmes to improve the quality of care for HCPs and refugees.

Forming this public-private partnership (PPP) and including refugee representatives in the design and implementation of health promotion interventions can positively improve the health and well-being of refugees and their communities. It also makes the health service delivery process safer and more manageable for healthcare workers. Capable public-private partnerships offer an opportunity for the co-creation of approaches that reflect the national mandate, its values and intentions, as well as the voices of refugees to shape systems that are responsive to all stakeholders. Community-led approaches have showed promise in achieving sustainable outcomes across different spheres of governance-related actions. Buy-in from affected persons, and consideration for their needs and expectations, allows for flexible and adaptive systems to be designed that have long-term benefits, reduce risk, and allow for accountability.

Given the diverse social, cultural, and educational needs, and other varied complexities of refugee populations, creating a safe and interactive approach will allow for opportunities for refugee communities to establish and implement behavioural approaches that are conducive to more effective engagement with the healthcare system. This could also improve how healthcare workers and refugees engage during consultations, with positive impact on how data is captured and reported, thus surfacing more information that allows for better understanding of trends and patterns. It could also serve as an opportunity for better collaboration between home and host countries regarding public health approaches and pave the way for improved understanding at regional and global levels about the impact of forced migration on health systems and refugees as independent and interdependent elements. This will ultimately promote integrated actions to accelerate progress for migration health by working across the United Nations system, including the United Nations Network on Migration and other intergovernmental mechanisms (WHO 2021). Lastly, a well-founded health response rooted in the health matters raised in this chapter urges collective efforts to encourage proper policymaking, capacity building, and resource mobilization through a country's own means and that of its partners. This chapter aligns

with the WHO (2021) call on policymakers' involvement and support in building the healthcare capacity for service provision, affordable and non-discriminatory access to health with reduced communication barriers, and training of the healthcare workforce in culturally sensitive service delivery for refugees and asylum seekers, particularly those with different forms of disabilities.

Best Practices in Healthcare Delivery for Refugee Populations

Globally, some countries have made progress toward removing healthcare access barriers for asylum seekers and refugees, and, where known, these can be used as benchmarks. To avoid disease complications among refugee patients, a comprehensive post-arrival health assessment is recommended, to be offered to all newly arrived asylum seekers and refugees, preferably within one month of arrival. In places like Australia, such assessment commonly takes place in general practice and involves a comprehensive history and physical examination, pathology screening, catch up immunisation, further management, and referrals as appropriate (Australian Society for Infectious Diseases, and Refugee Health Network of Australia 2016). Comprehensive primary care that is responsive to the diversity of backgrounds and experiences people have had in their refugee journeys offers an essential first step to address many immediate and long-term healthcare needs (RACGP 2023).

Conclusion

For healthcare professionals to respond promptly and effectively to the healthcare needs of refugees, there are a range of individual and systemic improvements that can potentially have a significant impact on people, or, when implemented collectively, have the potential to greatly impact positive health outcomes. Such improvements are: cultural competency training within a trauma-informed care package for healthcare providers serving refugee populations' embedding translators within the care environment; and embracing diversity in the workplace to promote inclusive health to achieve an improved quality of care for both staff and refugees. The healthcare system must diversify

its human resource for health staffing to include people from refugee backgrounds who should form part of healthcare service delivery. The latter are likely to be aware of the specific needs of refugees, and are thus able to respond to them, and to consider the cultural sensitivity and religious ethos of their colleagues, all of which matter in health services provision. This chapter calls for refugee host countries and their health systems to develop mechanisms that can adjust their healthcare systems to the needs of refugees and asylum seekers, or any other person from a socially excluded background. This will contribute positively towards improving the health status of refugees in different forms and contexts. These mechanisms and models or approaches should include a variety of public health interventions, including capacity building through ongoing training of healthcare workers and the employment of trained and well-equipped interpreters, as well as the hiring of professionals from different cultural and racial backgrounds, and ultimately to establish a refugee-friendly health service provision.

Dr Lwabanya and I both have lived experiences of forced migration, and we are Global Atlantic Fellows for Health Equity, based at Oxford University, UK. Together with other Atlantic Fellows based in the USA, the Philippines, and the UK, we are conducting Trauma Informed Care TIC training using a translational simulation approach, with HCPs who provide services to refugees and forcibly displaced persons FDPs in the Eastern Democratic Republic of Congo (DRC). The team is aiming to generate a toolkit adaptable to the DRC context and which each of the trainees can use to train fellows in other hospitals located in the war-torn zone in the sub-Saharan Africa region.

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