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Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes

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Background: In order to provide effective primary care for refugees and to develop interventions tailored to them, we must know their needs. Little is known of the health needs and experiences of recently arrived refugees and other migrants throughout their journey through Europe. We aimed to gain insight into their health needs, barriers in access and wishes regarding primary health care. **Methods**: In the spring of 2016, we conducted a qualitative, comparative case study in seven EU countries in a centre of first arrival, two transit centres, two intermediate-stay centres and two longer-stay centres using a Participatory Learning and Action research methodology. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. Transcripts and sessions reports were coded and thematically analyzed by local researchers using the same format at all sites; data were synthesized and further analyzed by two other researchers independently. **Results**: The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion. **Conclusion**: Health of refugees on the move in Europe is jeopardized by their bad living circumstances and barriers in access to healthcare. To address their needs, healthcare workers have to be trained in providing integrated, compassionate and cultural competent healthcare.

Introduction

In 2015, an unusual high number of migrants from Syria, Afghanistan and Iraq applied for asylum within the EU28.[1] Nearly all European countries were affected and faced the challenge to establish good quality and accessible healthcare for these migrants on the move. Primary Health Care (PHC) is the first point of entry to the healthcare system in most countries. PHC has the potential to respond adequately and at low costs to the health needs of a population, also migrants.[2–4]

In order to be effective, PHC should be informed about the health needs and wishes of the population-under-care.[5,6] Previous research showed a disproportionate burden of physical and mental health problems in refugees.[7,8] As these studies were performed among refugees who had reached their country of destination, or were staying in longer stay refugee centres, they cannot inform us about the health needs and experiences of migrants 'on—the—move' during their journey through Europe. This population has to be involved in the process of determining priorities and content of interventions[9] in order to tailor healthcare to their needs and to address the barriers in accessing PHC. Participatory research methods are needed to establish meaningful involvement of this vulnerable population and ensure their voice is heard.[10]

The EUR-HUMAN project, which ran from January to December 2016, aimed to design and implement interventions to improve PHC delivery for refugees and other migrants during their journey through Europe. This article reports the study undertaken within EUR-HUMAN to gain insight in the health needs, barriers in access and wishes regarding PHC of this population.

Methods

Study design

We conducted a qualitative, comparative case study in seven EU countries using Participatory Learning and Action (PLA) research

methods for data generation and analysis. This methodology enables hard-to-reach groups to share their knowledge.[11] A PLA 'mode of engagement' is the essential attitudinal disposition a researcher adopts to promote participation by diverse stakeholder groups in dialogues that are ideally reciprocal, mutually respectful, co-operative and productive.[12] PLA techniques are inclusive, user-friendly and democratic, generating and combining visual and verbal data. This encourages literate and non-literate stakeholders alike to participate. They are seen as 'local experts' who are uniquely knowledgeable about their own lives.[12]

Setting

The fieldwork was carried out in refugee reception centres between February and March 2016. The local sites (table 1) were chosen because they reflect the journey refugees make through Europe, differing in length of stay of the newly arriving refugees. We identified four types of centres. *Organization of and access to PHC services for the migrants differed between settings (*table 1*).*

(1) 'Hotspot centre' Lesbos, Greece, where the majority of refugees entered Europe by boat from Turkey.
(2) Transit centres, Slavonski Brod in Croatia and Šentilj in Slovenia where refugees stayed at most a few days on their way to final destinations.
(3) Intermediate-stay first reception centres: in Hungary, where, after the closing of the borders end of 2015, refugees were staying for months; and a temporary reception centre for 3000 refugees in the Netherlands.
(4) 'Long-term' reception centres in Italy and Austria where refugees stayed for a long period, after they applied for asylum or because they could not travel further.

Recruitment

Our study population consisted of refugees and other migrants without permanent residence permits, who arrived less than half a year before at the site. Participants were recruited by purposive sampling using network and snowball strategies. All participants received a letter in English, Arab or Farsi explaining purpose and content of the study. If needed, additional oral explanation in their own language was provided for. Every participant filled in an informed consent form. Letter and consent forms were specifically developed for this population: user-friendly with short sentences and clear language. At the start of the fieldwork, considerable time was taken to explain the consent procedure, the scope of the study and the confidentiality with the help of local refugees who acted as cultural mediators–translating and explaining culturally bound opinions and experiences.

The number of fieldwork sessions and participants depended on the type of reception centre and the time available for refugees. At hotspot/transit sites, it was only feasible to hold one session per group, since the refugees stayed there for just a few hours or days. At some other sites 2–3 sessions were feasible. Forty-three groups were held, with approximately five participants each; all but five were single sex groups.

In Croatia refugees in transit could not be accessed, as their train only stopped for a few hours, not allowing travellers to contact others than police or healthcare workers. Instead, sessions were conducted with healthcare workers employed by NGO's or the ministry of health. In Slovenia, interviews were used when there was only a single participant available. table 1 provides an overview of the fieldwork sessions.

Data generation

Before the start of the fieldwork, the local researchers from all sites involved participated in a 2-day training to enhance quality and consistency of data generation and analysis across diverse settings.

Data were gathered through PLA style flexible brainstorm discussions and in-depth interviews. This brainstorming method applies the 'PLA-mode of engagement' and uses materials adapted to the health literacy of participants giving ample opportunity to the participants to come up with their topics instead of using a fixed topic-list. This encourages interactive data generation.[12,14,15] Each fieldwork session took approximately 2 h.

During the sessions, all participants 'posted' (using a picture or in writing on a post-it paper) their thoughts and explained them one at a time; the 'posts' were categorized with the help of the researchers who acted as facilitators, and recorded on PLA charts following a pre-agreed template used by all sites. Topics for the discussion were brought up by the participants. In addition, facilitators could use a pre-defined list of topics (Supplementary appendix S1) to ensure that all relevant aspects of health needs and barriers were covered. All PLA charts were digitalized by making a picture after each session and sessions were audio recorded and transcribed. In one group, refugees refused audio recording. In that case, extensive field notes were taken.

Data analysis

We followed the principles of thematic analysis in qualitative research.[16]

Table 1 Overview of sites and fieldwork

Site and country	Type	PHC General strength of PHC system[a]	PHC available for migrants at the site	PHC Barriers in access[b]	# participants and # sessions
Moira Lesvos, Greece	Hotspot	Weak	yes	2, 4	20–5
Šentilj, Slovenia	Transit	Strong	yes	1, 4	19–14
Slavonski Brod, Croatia	Transit	Unknown	yes	1, 4	25–5
Bicske, Hungary	Intermediate	Weak	yes	4	32–6
Heumensoord Nijmegen, the Netherlands	Intermediate	Strong	yes	4	8–3
Villa Pepi and Villa Immacolata, Italy	Long-term	Medium	yes	1, 3, 4	11–4
Vienna, Austria	Long-term	Weak	no[c]	1, 3, 4	8–6

a: From Kringos D, Boerma W, Bourgueil Y, Cartier T, Dedeu T, Hasvold T, Hutchinson A, Lember M, Oleszczyk M, Pavlic DR, Svab I, Tedeschi P, Wilm S, Wilson A, Windak A, Van der Zee J and Groenewegen P. The strength of primary care in Europe: an international comparative study. British Journal of General Practice 2013; 63:e742–e50. (13).

b: 1 = migrants have limited time to attend services, 2 = access limited by time pressure and lack of manpower, 3 = access hampered by finances and 4 = access hampered by linguistic and cultural differences.

c: In Austria, the refugees usually do not have HC available in the centres (even if there are exceptions, depending on the NGO taking care of the centres); in general they go to the nearest PHC provider or other health facility.

Table 2 Characteristics respondents

Refugees		**Total (98)**
Gender	Male	65
	Female	33
Age	18–30	66
	31–40	21
	41–50	6
	51–60	3
	60+	2
Country of origin	Syria	39
	Afghanistan	30
	Iraq	12
	Pakistan	6
	Nigeria	4
	Somalia	2
	Gambia	1
	Ghana	1
	Iran	2
	Egypt	1
Healthcare workers		**Total (25)**
Gender	Male	9
	Female	16
Age	18–30	9
	31–40	11
	41–50	4
	51–60	1
Profession	Psychosocial counsellor	7
	Nurses	3
	Interpreter–Cultural mediator	6
	Feeding consultant	1
	Other (emergency unit, organizers, volunteers clothing, protection)	8

Table 3 Overview of mentioned health problems

Main health problem	**Specific health issue**
Disabilities and injuries	*Violence related wounds*
	Burns
	Frostbites
	Broken bones
	Sprained ankles
	Pain in back and legs
	Blisters
	Hypothermia
Mental health problems	*Trauma related distress*
	Depression
	Insomnia
	Fatigue
	Anxiety
	Uncertainty
	Disorientation
Pregnancy related issues	*Dehydration*
	No medical examinations
	Lack of privacy
	Lack of facilities
	Lack of healthy food
Infectious diseases	*Common cold*
	Flu
	Respiratory infections
	Urogenital infections
	Eye infections
	Scabies
Gastro intestinal problems and dehydration	*Diarrhoea*
	Viral gastroenteritis
	Vomiting
	Dehydration
Dental problems	

The local researchers reviewed and coded all charts and transcripts based on the same coding framework, adding new codes if new themes emerged from the data. Each team prepared a detailed narrative report in English using a standardized format. A comparative thematic analysis of these local reports was led by MvdM and TvL in consultation with the local teams.

Ethical approval

All countries acquired ethical approval in accordance with their national legal requirements.

Results

In total, 98 refugees participated in 38 sessions (table 2). Variation in gender, age and country of origin was reached throughout sites. Most were male, between 18 and 30 years. The majority came from Syria (40%) or Afghanistan (31%). In Croatia, 5 PLA sessions were held with 25 healthcare workers or volunteers.

Health needs

The most often mentioned health problems (table 3) were caused by war or violence and accidents during the journey or by unhealthy living circumstances in the often-overcrowded reception centres.

'*. . . most mentioned distress related to shocking events before and during their journey, describing symptoms of depression, insomnia and anxiety.*'(social worker Croatia)

Pregnancy related issues were mentioned often, including the lack of medical examinations, dehydration due to limited fluid intake (to prevent frequent micturition which would delay the journey) and lack of accessible toilet facilities. Many people suffered from common cold, diarrhoea, vomiting and dehydration. At all sites, refugees mentioned dental problems and the lack of dental care.

Barriers in accessing healthcare

In the hotspot and transit centres, refugees and healthcare workers alike mentioned time pressure, lack of trust and lack of information as the biggest barriers. Some refugees mentioned that they did not want to receive care because they wanted to continue their journey as soon as possible.

'*I do not want to go to the doctor now. The only thing I want is to leave the centre and to reach Germany. Then I will go to the doctor.*' (Female, 41, Afghanistan, hotspot, Greece)

The healthcare workers in Croatia explained that the refugees arriving at the centre usually had 3 or 4 h before they were boarded back on the train to continue their journey. Thus, there was no time to build basic trust or to provide necessary care.

'The lack of time is crucial. A crucial point is that we don't have enough time to establish some kind of trust between us and the person we are talking to. They do not have a sense of when the train will depart or will it leave without them. That creates insecurity: should they even ask for help . . .' (Male, 32, consultant, 2.5 months in the centre, transit, Croatia)

Regarding mental health aid, most respondents would prefer not to receive specialized mental health care as long as they were on the move; in short-stay reception centres it would be enough if they could just talk about their situation to ease distress. In some cases, and in the long-term reception centres, they saw a need for expert mental healthcare, which was not always available.

'*There is no psychological care here. It is very important, more than medication.Especially for the children. The longer there is no*

psychological care, the problems become even bigger' (Male, 50, Syria, intermediate, Netherlands).

However, fear of stigmatization played an important role.

'Maybe it can be different, if I go to psychologist now, the Somali people who lives there saw me, they will say ?Ooooh [Name]., she is crazy.' (. . .) Because of the culture, we don't have this . . . (Female, 29, Somalia; long-term, Austria).

All participants mentioned they received insufficient information about the rules and procedures in the centres and about the organization and location of healthcare services. They had difficulties finding a doctor at busy border crossings, but also in long-term reception centres and difficulties in finding their way through the local customs of the healthcare system and administrative problems hampered accessibility.

'When we got the E-Card I didn't check if it is active or not. But the other camp residents–when they went to the doctors–they refused to give them medicine. They said: They need to go somewhere to activate it.' (Male, 26, Iraq, long-term, Austria).

Lack of continuity of care was a crucial issue. This is related to the lack of information on previous treatment (no personal health record, or only in local language), difficulties in obtaining medication during the journey and lack of knowledge among healthcare workers about care available in the 'next' country.

'We have people here who come with reports written in Greek. That's a big problem. Even medical reports are written in Greek letters.' (Male, 24, organizer/logistic, 5 months in the centre, transit, Croatia).

'. . . we did not get any documentation of the treatment we received . . .' (Male, 26, Syria, intermediate, Hungary).

Language differences were problematic in all settings for both healthcare professionals and refugees.

'The doctor did not speak English, did not understand, then at some point spoke in Italian and gave us a sheet to be signed and goodbye.' (Female, 23, Ghana, long-term, Italy).

Sometimes interpreters were available but this would not always solve the problem especially if it concerned mental health.

'You know that psychological or psychosocial support should be conducted in a very careful way in order not to increase the psychological stress. So the lack of experience in the interpreter with a clinical interview . . . It is not easy to have an interpreter between the counsellor and the person.' (Male, 26, psychosocial counsellor, 3 months in the centre, transit, Croatia).

Less frequently cultural barriers in accessing healthcare were mentioned predominantly by female participants preferring female doctors and if possible, from the same geographical/cultural background. However, in cases of emergencies, the gender of the doctor was considered less important.

Wishes

Most important for all refugees was a friendly and respectful attitude of the healthcare workers. The feeling of being accepted was a prerequisite for building trust.

'A doctor should be humane and open minded.' (Male, 38, Iraq, intermediate, Hungary).

In addition, there was a clear wish for formal interpreters and cultural competence in healthcare to overcome the cultural and language barriers mentioned earlier.

Other important wishes included the availability of cultural competent interpreters, and the provision of information about the local healthcare system, regulations and procedures, like how to access a general practitioner or what to do in case of an emergency.

Discussion

Main findings

This first study on health needs of refugees on the move throughout Europe, in different places and stages of their journey, revealed their main health needs were related to their reasons for flight and to their journey, aggravated by unhealthy living conditions in the reception centres: injuries, common infections, pregnancy related problems and mental distress. All participants mentioned lack of continuity of care and barriers in accessing healthcare due to lack of information, time pressure and language barriers All participants expressed the wish for compassionate, cultural competent healthcare workers, in whom they can find trust, who involve interpreters when necessary.

This importance of bridging linguistic and cultural differences is also described in previous research.[17,18] It supports the call for training in providing cultural sensitive healthcare.[19] Information on local healthcare and procedures should be tailored to the often low levels of literacy found in refugees.[20–22]

In addition to the known barriers for migrants in accessing healthcare,[7,8] our study revealed lack of continuity of care and time pressure as a huge barrier, related to the specific setting in hotspots and transit centres. This jeopardized the building of trust, necessary to address the health care needs, especially concerning mental health.[23] Unfortunately, lack of continuity of care also occurs in asylum seekers who are frequently moved.[24] PHC is well placed to provide this trustful, person centred relationship over time.[25,26] For refugees dealing with traumatic experiences and cultural and linguistic differences, gaining trust requires more than basic care. It requires the provider to listen attentively and the desire to understand the patients' context so as to be able to adjust their responses to the patient's needs.[27] Compassionate care that couples an awareness of the suffering of another with the wish to relieve it,[28] might increase trust in doctor-patient relationship.[29]

To be able to deliver good primary healthcare, adequate finances and manpower are a pre-requisite, which are unfortunately not always available in countries like Greece that receive most migrants while still carrying the burden of economic crisis.[30] Besides the policy context in most European countries at this moment is not much in favour of welcoming migrants limiting the attention for adequate service planning and delivery.

The overcrowded situations in hotspot and transit centres, the large numbers of ill people and the lack of sufficient medical staff emphasize the need for guidelines and instruments for screening and rapid health assessment in newly arriving refugees and other migrants.[31]

Strengths and limitations

The involvement of so many different refugees in so many countries over the same period of time is strength of this study. The views of healthcare workers in Croatia helped to complete the picture. We are not aware of any other study documenting the experiences of refugees undertaken in the difficult circumstances at the hotspots and the transit centres. This approach clearly has its limitations as well: due to time pressure, it was not possible to speak at length with most refugees and it was not feasible to involve professional interpreters, which led to a high number of English-speaking participants. Although migrant flows have since changed, our results provide a coherent overview of needs and health-related problems of this vulnerable population under extremely difficult conditions.

Impact of the study

This study underpins the need for provision of good quality cultural competent PHC, recognizing different migrant groups with different needs and entitlements. Integrated PHC requires more attention in certain European settings and lack of resources, time and training hampers well-intentioned current PHC provision. The needs and problems reported in this study help to prioritize issues in the structure and delivery of healthcare. The barriers identified also inform the development and implementation of health related interventions. These implementation factors are amply understood in a refugee and PHC context, but local circumstances will influence the extent to which ideal PHC can be implemented. Therefore, insights in how to implement PHC initiatives in such often chaotic circumstances are of the utmost importance. On-line available guidance and tools, e.g. for assessment and managing mental health issues in refugees as well as training in working with interpreters could support PHC professionals in their delivery of comprehensive, integrated compassionate care to refugees.

This study revealed also the need for safe and feasible ways to establish informational continuity of care. The provision of a paper-based personal health record is not suitable for migrants in transit because of risk of loss and damage and because of their fear other migrants could read the confidential content.[32] Mobile electronic personal health records, using international agreed upon coding like ICD or ICPC seem promising.

Conclusions

Refugees and migrants newly arriving in Europe face multiple health needs related to their journey and unhealthy living circumstances in the reception centres. Their access to healthcare is hampered. Comprehensive, integrated and compassionate PHC could effectively respond to their needs. Guidance and training of healthcare professionals are needed to optimize PHC in refugee reception centres throughout Europe. The challenge is to ensure that healthcare provision for vulnerable groups, travelling through countries under difficult circumstances, is coherent, need-centred and sustainable.

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Supplementary data

Supplementary data are available at *EURPUB* online.

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Key points

- Refugees on the move in seven European countries suffer mainly from health problems related to their journey and bad living circumstances, from pregnancy related problems and from mental health problems.
- They also face important barriers in accessing good quality healthcare due to time pressure, linguistic and cultural differences and lack of continuity of care.
- They wish for more information on legal procedures and on the organization of healthcare, for better continuity of care and above all for compassionate, cultural competent health care providers.
- In order to achieve health equity and secure the access to good quality healthcare for refugees and other migrants on the move through Europe joint efforts from policy and practice are needed. Policy makers in the countries involved should guarantee the availability of sufficient manpower and services; healthcare professionals need to provide compassionate, cultural sensitive care tailored to the needs of the migrants at stake. The development and implementation of guidances and training can support them in this.

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