Physical and mental health profile of vulnerable migrants/refugees in the EU including needs, expectations and capacities of service providers

D4.3: Survey and interview findings

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4	NATIONAL CENTER OF INFECTIOUS AND PARASITIC DISEASES	NCIPD	Bulgaria
5	ETHNIKO KAI KAPODISTRIAKO PANEPISTIMIO ATHINON	UoA	Greece
6	ECOLE DES HAUTES ETUDES EN SANTE PUBLIQUE	EHESP	France
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Table of Contents

The Mig-HealthCare project 4
Part A: Qualitative study by the MigHealth-Care project: Focus group results 6
Summary 7
Introduction 9
Methods 10
Data analysis 12
Results 12
Summary of results 13
Access to health care 14
Specific problems in transit countries 22
Specific health problems and health priorities 22
Suggested solutions and good practices 24
Discussion 28
Conclusions: Balancing ends and means 29
Policy recommendations 29
Part A - References 30
Part A – Appendix 1: Interview Guides 31
..... 39
Part B – Physical and mental health among migrants and refugees in ten European countries: Survey results 39
Background 40
The MigHealth-Care questionnaire 43
Pilot testing 44
Study population 44
Sampling 44
Study sample 45
Demographics 45
Household Characteristics 47
Education and employment 48
General well being 49
Access and interaction with health care services 53
Screening 55
Dental Care 55
Immunization status 56
Skin problems 56
Women's Health 57
Perceptions about health 57
Current situation 59
Conclusions 62
Part B - References 64
Part B – Appendix 1: STATISTICAL APPENDIX 65
Part B – Appendix 2: The MIGHEALTHCARE questionnaire 103
Part B - Appendix 3: MigHealth care Survey Methodology Guidelines 109
Part B – Appendix 4: Consent Cover Letter 113
Part B – Appendix 5: Interview Log Book 114

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The Mig-HealthCare project

Since the Middle East crisis broke in 2011 Europe has seen increased flows of migrants and refugees arriving mainly at the Mediterranean shores. This is not though the first time Europe has experienced the influx of large migrant/refugee flows. Immigration to Europe has a long history; Europe has always been a destination continent for people seeking refuge from war, poverty and natural disasters. Many can argue that in a way most European citizens have a migrant background and migrant origins. Especially Western European countries experienced a high growth in immigration after World War II. In particular MS of the EU-15 have sizeable immigrant populations, both of European and non-European origin. The fall of the Soviet Union in the later part of the past century brought new waves of migrants to Western Europe. This time it also bought waves of migrants to previously traditional emigration countries such as Greece, Italy and Spain.

The current refugee/migrant crisis has once again put Europe in a "reactive mode" as recently stated by Carlos Moedas, the European Commissioner for Research, Science and Innovation during the International Conference on Understanding and Tackling the Migration Challenge (4-5 February 2016, Brussels).

The good news is that Europe does have long experience in the integration of migrants and refugees. Over the last years the European Commission has focused efforts on tackling issues related to migration and has financed a plethora of related programs. The evidence on effectiveness exists – it needs to be assessed under the prism of new developments and put to the test. Action is urgent given also Europe's dark past in anti-migrant negative attitudes which are rising across Europe exacerbated by the adverse economic situation in many MS. European countries have a unique opportunity to put past and current experience to practice promoting the integration of refugees and migrants so as to "live up to European values of democracy, peace and respect of human rights" as put in the words of Carlos Moedas.

Definitions
Migrant and *refugees* are terms that are often used interchangeably, but they are defined by the UN as follows (https://refugeesmigrants.un.org/definitions):

Refugees are "persons who are outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection. The refugee definition can be found in the 1951 Convention and regional refugee instruments, as well as UNHCR's Statute".

Migrants "While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more".

Health and social care for migrants and refugees in Europe

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Migrants, asylum seekers and irregular migrants are, compared to the general population, at a higher risk of poverty and social exclusion. Research has indicated that in many cases these vulnerable groups do not receive appropriate health and social care that best meets their needs (Stanciole & Huber, 2009).

Anderson Stanciole (WHO, Switzerland) during a policy seminar on the barriers to Healthcare Services for Migrants organized by the European Health Management Association highlighted the fact that migrants are not a homogeneous group and face very different barriers when accessing health services. Additionally, it is clear that different MS have very different circumstances when it comes to how health and social care for migrants is organized. Hence the "one size fit all" approach is not going to respond to the very complex and urgent situation.

Nevertheless, there are common barriers among different migrant groups when accessing health and social services which mostly have to do with lack of knowledge about available services; language differences; and varying cultural attitudes to health and health/social care.

Numerous EU projects have been implemented in the last years with the objective of mapping existing health services for migrants and refugees and looking into their improvement through recommendations and action plans. Research and projects point to significant differences between the MS in terms of service provision while recommendations and action plans often oversee country specific circumstances (i.e. the economic recession).

Some areas are widely unknown. For example we will explore what is available for mental health, dental health, services for minor surgical operations and services related to obstetrics and gynecology among migrants/refugees

The contents of this report

This report will discuss the results of the participatory research conducted within the Mig-HealthCare consortium to explore the physical and mental health of migrants and refugees in the consortium countries which include Greece, France, Malta, Germany, Austria, Italy, Cyprus, Spain, Sweden and Bulgaria.

This work is complementary to the literature review report which examined existing information at country and EU level concerning the physical and mental health status of migrants/refugees in Europe.

With this research we aim to cover the gaps concerning less explored health issues (mental health, dental health, gynecological issues, dermatological issues etc) as well as needs and expectations of health care providers.

More specifically we aim to answer the following questions:

- What is the physical and mental health status and the main physical and mental health problems of migrants/refugees in the EU? Some areas are widely unknown. For example we will explore mental health, dental health, obstetrics and gynaecology issues among migrants/refugees
- Which differences are observed between different groups (migrants living in the community, migrants/refugees living in organised facilities, irregular migrants/refugees, vulnerable groups such as women and children) and why?
- Geographically where are the problems in Europe concentrated?
- What are the needs, facilitators and barriers, as viewed from the providers who offer health care and social services to migrants/refugees in Europe?

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Original research included:

1. Three (3) focus groups with health care providers in all the consortium countries
2. A survey using a purpose made questionnaire answered by migrants/refugees in all participating countries

This report is divided into two parts. The first part details the methodology and results of the focus groups while the second part discusses the methodology and results of the survey questionnaire.

Part A: Qualitative study by the MigHealth-Care project: Focus group results

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Summary

Introduction

Existing studies of migrants' access to health care in Europe constitute a fragmented evidence base, which offers neither a basis for understanding the issue across Europe, nor for comparison between different countries. This qualitative study explores the barriers and facilitators to equal health care to migrants in ten European countries to gain a better understanding of migrants' situations. The research was conducted by the Mig-HealthCare project consortium, funded by the European Commission and took place between autumn 2017 and spring 2018.

Methods

Using a common interview guide, each national research team planned to conduct three focus group discussions or, where necessary individual interviews, with health care professionals and service providers; policy makers; and representatives from Non-Governmental Organisations - NGOs. Thematic qualitative analysis was employed to explore how access and provision of health care to migrants and refugees was understood from the perspective of providers, policy makers and NGOs working with health.

Results

The following themes emerged from the analysis

1. Access to health care
2. Specific problems in transit countries
3. Specific health problems and health priorities
4. Suggested solutions and good practice.

These results can be summarized as follows:

- Infrastructural and organizational factors are reported as damaging migrants' mental health (e.g. life in reception camps).

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- A shift from a humanitarian emergency mind-set to focus on integration needs to take place.
- Health care for migrants is considered more or less adequate depending on the actor that is speaking, and the EU country in which they operate.
- Health care providers and NGOs agree that health care for migrants is inadequate and biased in favor of particular conditions and cases (minors, pregnant women and acute conditions).
- Health care providers appear to be generally more critical of the *status quo* of provision for migrants as compared with policy makers.
- Austerity measures following the 2008 financial crisis have negatively affected health care system in general, which in turn has negative affected the provision of health care for migrants.
- Respondents in different countries have different views of how the 2015 refugee crisis affected the provision of health care for migrants.
- Challenges faced in the different countries vary; while in some countries the main issue is legal access, in others basic needs such as sanitation and basic infrastructure were emphasised.
- Health care provision for migrants is uneven throughout the EU and variations exist even within the same country.
- Discrimination linked to socio-economic status and ethnic group is reported as a barrier to equal health.
- Gender may act as a barrier, with women tending to be more marginalised in the host country in terms of language proficiency and health literacy, which impedes health care access.
- Knowledge, language and communication on both the demand and the supply side of health care provision emerge as crucial to ensure equal access for migrants.
- Organisational issues and inadequate cooperation between private and public actors; insufficient training, scarcity of resources and infrastructural deficiencies are highlighted as major barriers to the provision of health care and to equal access to that care.
- Mental health is regarded as a health priority by informants in all countries. Deterioration of mental health is influenced by social stigma and a lack of access to care. Health care systems are ill suited to address mental health issues for migrants and the model of reception in hosting countries exacerbates mental illness through isolation, inactivity, pervasive uncertainty and social deprivation.
- Among the solutions suggested are: training in intercultural communication and conflict management; basic healthcare education for patients in their mother tongue; support in accessing primary care; a stronger community based approach - all identified as necessary across the consortium countries represented in this qualitative study.

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Introduction

The MighealthCare consortium conducted a qualitative investigation of the health care needs of vulnerable migrants in Europe in the aftermath of the refugee crisis of 2015. The research, conducted between Fall 2017 and Spring 2018, focussed was on the barriers to and facilitators for equal health care access.

Background

The qualitative research project was informed by a review of the literature on health and migration in Europe, conducted between July and November 2017. The review demonstrated a widespread interest in understanding barriers to access and the creation of inequalities among migrants in marginalized situations seeking health care in Europe: this interest was evident across the range of reports and articles reviewed in the various countries represented in the consortium. Despite the evident interest, the review offered a fragmented picture due to a lack of common definitions of key terms, few clearly defined and common goals of health care provision and limited evaluation of outcomes (MigHealthCare, 2018). The findings of the literature review can be summarised as follows:

- The various emphases of studies in different countries make comparison across settings difficult. While some studies compare the health of migrants with the local population, other studies focus on health conditions of children pre-dating their migration (e.g. hepatitis, dental problems) and the disparity of mental health problems between migrants and non-migrants, such that results are context specific and sometimes contradictory.
- The health status of migrant women, children, and middle aged men and older people are often in focus, rather than an investigation of how migrants' own, self-defined health care needs can be met.
- An elevated use of emergency services by migrants (often compared to the local population) and particularly during unsocial hours; together with the higher use of obstetrical and gynaecological services by migrant women compared with non-migrant women.
- A growing interest in the barriers to migrants' use of regular health care services, but little systematic investigation. A few studies have investigated the accessibility of health care for migrants, testing intercultural policies aimed at helping health care providers meet migrants' needs,

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while others have focussed on the conditions discouraging migrant from seeking care (e.g. communication problems, lack of understanding of the system; previous bad experiences).

- Existing literature has identified interventions aimed at improving access to and responsiveness of health care services. For example by providing interpreting services to assist service providers, or by increasing their cultural competence, or again by supplying migrants with information about the health care system. There is no systematic evaluation of the effectiveness of such interventions.

Among the measures identified to cope with the challenge of providing suitable health services to migrants, recent literature emphasizes the following steps (MigHealthCare, 2018).

- To guarantee the same legal entitlement for migrants as for other residents of the country is a fundamental step towards improving migrants' access to health services. This aspect is particularly urgent for undocumented migrants, such as visa or permit 'overstayers', rejected asylum seekers and individuals who have entered a country without documentation. Limitations to health care entitlement are sometimes justified as a measure to discourage 'health tourism'. This concern that migrants travel to access health services and the discriminating rhetoric behind it are not supported by studies with undocumented migrants. Limiting access to emergency services has been proven both ineffective and costly (Mladovsky, Rechel, Ingleby, & McKee, 2012).
- To design health policies that respond to migrants' need. Studies emphasise that migrant health policy is often vulnerable to changing political representation, economic and financial circumstances. In order to justify sustainable migrant health policy, good quality data on the health status, needs, and expectations of migrants with regards to health is required. The literature review confirms the persistent lack of data on perceptions and needs expressed by migrants themselves, with these perceptions and needs all too often described by service providers.
- A call for the systematic inclusion of "migrant background" in official health monitoring is underlined by different sources as one path to make available data more precise, reliable and comparable.
- The crucial role played by primary care in delivering high quality, culturally sensitive and appropriate care for migrants, especially those in vulnerable situations has been underlined by recent studies (de Brún et al., 2015; Kohls, 2011; O'Donnell et al., 2016). Despite the acknowledged role of primary care, much of the scientific production in European countries focuses on the health status of specific groups of migrants defined by country of origin and / or stage of the life course, rather than on assessing when and how the migrants' health needs are met.
- Improving the quality of European comparative work. The lack of a rigorous analytical framework to identify and evaluate migration health policies in the different European countries is apparent. So too is the need to map regional, sub-national, non-governmental initiatives in order to understand how to develop health policies in such diverse political, social and cultural contexts. The need to maintain migrant health as a European priority, despite the adverse climate of economic austerity and anti-migrant political discourses, is also urgent.
- Understanding the mental health and health care needs of migrants is still at a relatively early stage as shown by the inconsistent and sometimes contradictory results of the studies conducted in this field.

Methods

Developing from the literature review, the research question addressed by the current qualitative investigation was:

What are the health care needs of migrants and what factors facilitate or prevent the provision of services to migrants?

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In order to answer the question, each national research team planned to conduct three focus group discussions or, where necessary individual interviews, with:

1. Health care professionals and service providers;
2. Policy makers;
3. Representatives from Non-Governmental Organisations - NGOs.

Thematic qualitative analysis was employed to explore how access and provision of health care to migrants and refugees was understood from the perspective of providers, policy makers and NGOs working with health.

A common interview guide was drafted in English, translated into all the different languages of the consortium and it was used by the partners to conduct the focus group discussion (see below). (See appendix for the interview guide translated into the various consortium languages).

Figure 1: Focus group discussion interview guide

- What has been your involvement with health care provision for migrants/refugees?
- In your experience, what do migrants say that they need most in term of physical, mental and dental care?
- Is it possible for local services to address these needs?
- What sort of tools or services would help you to better assist migrants/refugees to effectively address the issues mentioned above?
- Do you think local communities would assist? Do you think local communities have a role in migrant integration and if they do, can you elaborate on that?
- Is there a need to guide migrants on how to use the health care system?

Data collection

Between November 2017 and April 2018, 20 focus group discussions and 19 individual interviews were conducted with health care providers, policy makers and representatives from NGOs, including volunteer workers in the 10 countries of the consortium.

The table below provides a summary of the number of focus group discussions and interviews and the type of participants in each country.

Table 1: Interviews per country

Country	Focus group	Interviews	Participants
Malta	1	8	NGOs; Policy Makers; Health care professionals

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Austria	2	6	NGOs; Policy Makers; Health care professionals
Italy	3		NGOs; Policy Makers; Health care professionals
Spain	3		NGOs; Policy Makers; Health care professionals
Greece	3		NGOs; Policy Makers; Health care professionals
Germany	2	2	NGOs; Policy Makers; Health care professionals; Social Workers
France	3		NGOs; Policy Makers; Health care professionals
Cyprus	2	2	NGOs; Policy Makers; Health care professionals
Sweden		4	NGOs; Policy Makers; Health care professionals
Bulgaria	1		NGOs; Policy Makers; Health care professionals

Data analysis

Full transcripts or detailed summaries in English of each focus group discussion and interview were provided by the 10 countries of the consortium. The use of summaries rather than full transcripts enabled researchers to access data produced in languages other than English. While fully translated transcripts may have captured more detail and nuance, time and budget constraints required a quicker means of sharing material across languages. This means of translating and summarising material allowed for a thematic analysis, but did not support a narrative or content analysis. Since the analysis was undertaken from summaries (as well as transcripts), the specific terms used in the original discussions and interviews could not always be checked. In particular the lack of specificity around the terminology of types of migrants (refugees, asylum seekers, rejected asylum seekers, forced migrants, undocumented migrants) could not be confirmed. In the text below the term 'migrant' is used as to cover the range of different types of migrants and refugees although we recognise that these terms have specific legal definitions. This lack of specificity and nuance is off-set by the advantage of including material from a range of language groups.

The analysis tried to account for emerging themes, including those that were not covered by the interview guide. It benefitted from the inclusion of a range of actors and service providers, including health care practitioners, NGO workers and policy makers. The heterogeneity of the sample was aimed at gaining a true picture of health care and migration in Europe, by accounting for different perspectives and points of views, triangulating across them to balance both the particular and the general.

Results

The results are presented under four separate categories, as follows:

1. Access to health care
2. Specific problems in transit countries
3. Specific health problems and health priorities
5. Suggested solutions and good practice.

Table 2: Results

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1. Access to health care

a. Legal and systemic barriers
b. Austerity
c. Organisational issues and actors dynamics
d. Discrimination
e. The 2015 refugee crisis
f. Knowledge, understanding, language and communication barriers

2. Specific problems in transit countries

3. Specific health problems and health priorities

4. Suggested solutions and good practices

Summary of results

- Health care for migrants is considered more or less adequate depending on the role played by the actors, on their expectations and on the EU country they operate in. Health care providers seem to be more critical than policy makers.
- Most of the health care providers and NGOs agreed that the health care for migrant is inadequate and it tends to focus on certain cases (minors, pregnant women and those in need of acute care). By contrast, policy makers tend to see the provision of health care for migrants as satisfactory. However, even within countries there are variations in the care given to migrants. Different interpretations of the law concerning access to health care account for some of this variation. In Austria, France and Germany, for example, it was reported that some health care providers refuse to treat migrants, while other providers try to ensure optimal treatment at their own expense and report of discrimination and fatigue. In Spain, health providers, NGOs and policy makers noted no difference in the treatment of migrants when compared to that of other categories of patient.
- Informants' named a range of challenges to providing migrants with adequate health care. In some countries the main issue is legal access (e.g. France), while in others basic needs such as sanitation and infrastructure were emphasised as lacking (e.g. In some camps in the boarder islands of Greece).
- Knowledge, understanding, language and communication on both the demand and the supply side of health care provision emerge as crucial to ensure equal access for migrants.
- Organisational issues and inadequate cooperation between private and public actors; insufficient training, scarcity of resources and infrastructural deficiencies are highlighted as major barriers to provision of health care and equal access to care.
- Mental health is regarded as a health priority by informants in all countries. Deterioration of mental health is influenced by social stigma and a lack of access to care. Health care systems are ill suited to address mental health issues for migrants and the model of reception in hosting countries exacerbates mental illness through isolation, inactivity, pervasive uncertainty and social deprivation.
- Among the solution suggested are: training in intercultural communication and conflict management; basic health care education for the patients in their mother tongue; support in accessing primary care;

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a stronger community based approach - all identified as necessary across the consortium countries represented in this qualitative report.

Access to health care

The interviews gave evidence of multiple barriers for migrants and refugees accessing health care. These barriers are described under the following headings: laws and regulations knowledge; language and communication; austerity measures; discrimination; gender and ethnicity and organizational problems.

Legal and systemic barriers

Participants underlined challenges in the application of laws and regulations. For example, formal universal access to health care, which applies to migrants and refugees, does not always translate into actual equal access to care (Austria; Greece; France; Italy; Germany).

> "Some service providers are not sure what the entitlements are when family members present different legal statuses." *(*Community Development Officers, Malta)

> "We should also stress that in terms of legal access we have laws that have liberated many, many things. Today we generally have a better access to health care and everyone has access to the health care system without problems, regardless of their status. Nevertheless, the health care system ails; and the rest of the system hasn't yet adapted to this law. And this happens because the health care system isn't adequately prepared, educated and staffed to properly respond to what the law provides for. We'd be playing with fire, if we complained these days for legal access to the health care system. This right has been granted to migrants/refugees, something that wasn't happening until now. And we fought for it. Let's take for example the government officials who have to ensure that the Law is properly applied. People working at the Citizens' Service Center ignore the way this should be implemented in the case of refugees and foreigners in general. It's not just the health care system, but also a significant part of government authorities that support this Law. All these social services that aren't informed enough to respond to the Law's requirements." (Health-care provider working in an NGO, Greece)

The system of health care provision is described as complicated in general and even more so for migrants.

> "The care pathway is quite complex and from a health point of view for people who do not know that well and [...] and who do not know how to find their way around the system. [...] Well, in France in terms of administrative things we are quite expert in making things complicated [...] There may also be abuses of the system. If you question several different local health insurance funds, CPAM [Caisse Primaire d'Assurance Maladie – Social Security service], they will give you a different list of papers to provide to open the same rights. [...] Not to mention all this work of linking, of mediation that is more than necessary, which nobody recognizes , especially at the NGO level, but which is very necessary." (Voluntary medical doctor in NGO, France)

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Delay in access to health care especially for victims of torture was reported in Cyprus due to delays in the issuance of the medical card, producing medical reports for victims of torture and in referrals. Although the health care system is already burdened in Cyprus even for citizens, issues related to access to health care was especially problematic for vulnerable migrants and refugees as they lack the resources to access the private health care sector.

> "When someone arrives [..] he has to pass through the immigration to get a confirmation letter which means that it may take a few days. If someone is sick – we had an [unaccompanied] minor that does haemodialysis therefore he had to be admitted to the hospital immediately [..] if the confirmation letter doesn't exist none of the medical services accepts him. When the confirmation letter is ready he can only go to the emergency, nowhere else. There is a procedure a bit long afterwards in order to be able to get the medical card and be allowed to free medical care. [..] He undergoes a procedure which takes a few days because he has to go through other medical exams [..]. Until all of this happens 2-3 weeks may pass. Therefore, if someone has a serious health problem he will need to wait. This is our biggest issue." (Social worker, Cyprus)

In some cases (France, Malta) asylum seekers, including minors, have to wait a six-month period to have their status recognised. During this time, they have no access to public health care. French informants underlined the paradox of this long waiting time with the presence of a refugee population that is largely transiting to move to other countries.

> "The administrative steps to open health rights are very long so it does not correspond to a population here that is just passing through." (Coordinator in NGO, France)

Reports of insufficient information being given to refugees regarding their legal status concerning access to health care were made. In some cases undocumented migrants are reported by health care providers to be afraid to access health care so as not to jeopardise their residency (France).

> "(...) They don't want to come to the hospital. They are afraid of being filed, to be picked up by the police." (Health manager from the Hospital, France)

A similar situation is reported in Austria:

> "A black man came to the hospital at 3 am with fever of 40 degrees. He refused to name his country of origin as someone has told him that if he would do otherwise, he would be refused the examination. This was also the reason why he would not say a word during the examination which made the whole procedure very difficult." (Doctor, Austria)

There is a variety of services and the coordination between them is not always effective. If for example migrants go to the wrong clinic, this gives them fewer rights than they would be entitled to elsewhere.

> "There is a lack of a coordination between the STP clinics (Stranieri Temporaneamente Presenti/Foreigners temporarily present) inside the ASL (Local Health Service) and other services provided by the ASL itself, and a bigger lack of coordination between the health area and the social one." (ASL-Local Health Service- doctor, Italy)

Some informants (Italy) underlined the need to train people in legal aspects of the provision of care for refugees. Informants also highlighted that one of the challenges in the provision of care are the internal differences of the Italian system that would be better described as "21 health systems", with one per region.

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Austerity

Subsequent to the 2008 recession, austerity measures were enacted in most European countries, which weakened the capacity of health care system to cope with 2015 refugees' crisis. Although, there is an improvement now, the budget cuts are still a challenge.

In France austerity translated into a lack of volunteers and a lack of funding, but also impacted migrants' living conditions. The problem of lack of funding for the health care sector is reported also by informants from Germany, Italy, Spain, Malta, Cyprus and Greece, in combination with increases in the cost of living. In Germany insufficient medical equipment at hospitals was reported as problem which delayed access to health care for migrants.

> "And there was a huge shortage, especially with regard to the X-ray examinations, because the Celle hospital was completely overwhelmed to carry out the relevant examinations, which- according to the law- were planned." (Representative of Medical Chamber, Germany)

In Greece, informants mentioned the weakening of the health care system in general, due to the financial crisis and austerity, as a central challenge in the provision of health care for migrants and refugees.

> "The economic crisis has weakened the current health care system, which was further weakened due to the refugee crisis and the incapacity of the health care authorities to respond specifically to this population. All these situations acted increasingly and led to what is seen today as deficit resulting from the combination of these situations. Many times it is more essential that we don't have the money to support the public health care system; other times that we don't have the know how; other times that we are in crisis; other times that the staff is insufficient due to cuts; other times that the staff suffers from burn-out. Each factor has a different effect each time." (Health care worker working in an NGO, Greece)

Organisational issues and actor dynamics

The absence of both a programme to promote migrants' health literacy and of cultural mediators is identified as major barriers to equal health care (Germany) and is attributed to the unwillingness of policy makers to put migrants' health on their agenda (Spain). French German, and Greek health providers underlined the crucial role played by cultural mediators in removing barriers to access health care and how this role is jeopardized by short-term employment contract lasting only two to three months.

Policy makers tend to evaluate the access to health care as satisfactory (Cyprus), as long as migrants follow the official procedure. They identify migrants' lack of health literacy, language and communication skills as the main barrier in the provision of health care (Spain). In Spain, policy makers also mentioned social stigma of refugees, their lack of awareness of available resources and difficulties in accessing appropriate drugs, as barriers to equal access to health.

Insufficient collaboration with authorities and policy makers especially during the 2015 movement of refugees was underlined (Austria, France, Italy). The lack of a common system for medical records, especially when migrants move to different places was also noted (Greece).

> "Let's take immunization as an example. Refugees are vaccinated by someone, but we cannot have a full picture of what is actually happening. Right now, there are refugees who have been vaccinated by various bodies three or four times, and we don't know exactly what kind of

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vaccines they received. The situation has recently changed when the Hellenic CDC (Centre for Disease Control) undertook refugee immunization and keeps a record thereof by filling out the WHO yellow books." (Policy maker, Greece)

There is also lack of training for health care professionals concerning how to treat migrants and how to work within a framework of cultural competency. Some informants underlined that under the facade there is a lack of coordination and control, that actors do not cooperate effectively and information is not shared:

> "We are made to feel that in general the Ministry of the Interior has overall control over the issue of migration and that it is extremely difficult for the Regional Health Authority ARS [Agence Régionale de Santé – Regional Health Agency] to succeed in wrestling some control back over its handling, although they are in fact quite aware of the problems that we have mentioned, the need for coordination, the linking of actors, the need for information sharing and vigilance on potentially endemic pathologies." (Volunteer medical doctor, NGO, France)

In Germany, focus group participants spoke of "economization, hierarchization and privatization of the health care system" as processes that make it hard for health care providers to treat patients with different needs. Provider organisations are forced to account for their time and staffing, while trying to meet the needs of patients with mental health issues. In some cases, insurance companies are mainly concerned with saving money and the health care system fails to reach people who need care and to fulfil its obligations. There are cases of people with mental health problems who, as a result of social stigma attached to the condition in their culture, do not make contact with the German health care system.

In countries like Greece and Italy, infrastructural problems are particularly urgent. In Italy, the integration between the public and the private sector that characterized the provision of health care in the Italian regions should be coordinated by a public body to ensure sustainability.

> "The public must govern the private; it is the public who must understand where to intervene" (NGO staff, Italy)

In Greece, informants spoke about burnout in delivering services:

> "You cannot perform triage everyday… burn out rates are alarming in the Greek border islands." (NGO staff, Greece)

French NGOs and hospital health care providers, for example, underlined that professionals providing services, including health care, to migrants need to be supported and trained to deal with the stress and fatigue of their work, to avoid developing inappropriate behaviours towards patients. They also reported of colleagues refusing to take charge of migrants because they see it as a thankless job: they think that "they have no solution for them" (France). They lament discriminating practices that pick and choose certain kind of migrants to treat. An informant described a situation in which the formal policy of universal access does not translate into open, let alone, equal access:

> "We can become a source of maltreatment almost in spite of ourselves [...] When you have the impression that it is through saying no, and through refocusing on petty missions, so that we will have fewer people and so we will feel less overwhelmed [...] We are saturated, we, are unable to manage everyone and the system is totally saturated in fact [...] And then we say, "Ah well, no one can do that, that I will not do, there's no way I'll do that.". And then "we

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consult at such and such an hour and then never again." But we are stuck with doing just that." (Hospital doctor, Health Service Access Point, France).

In Cyprus, however, health care professionals reported a great amount of stress and in some cases fear and insecurity when treating migrants in refugee camps. This is due to some cases of unrest within the camp and among the residents.

Knowledge, understanding, language and communication barriers

Language problems, a lack of interpreters and cultural mediators were reported by participants in most countries (Austria, Greece, Italy, Malta, Spain, Germany, Cyprus).

> "One problem, is the problem of interpreting, but even if interpreters are there, that does not mean that someone who has experienced the most severe trauma, can talk about them. This also means that the soul needs a certain amount of time and certain conditions in order to be able to create contact at all, with others, and therefore also with an expert." (Psychiatrist, Germany)

> "Everyone knows very well that the issue of the management of migrant patients, (unless we do not know all these problems well, or don't have the time to think things through or to think about the system), needs to include the question of interpreting." (Psychologist, hospital, France)

A health provider from Greece underlined that the lack of language and communication skill affects the different levels of the service provision for migrants:

> "At every health facility, whether a hospital or a community health center, there isn't a single government official who can speak English, Arabic or any language needed. He/she must be aware of how the system works and available during working hours to provide assistance to any health or government official unable to successfully communicate and provide solutions to a patient's problem. I'm talking about essential accessibility. I cannot even imagine how a nurse can cope without the presence of an interpreter and work more, in order to provide his/her services to an Afghan refugee. And, of course, then comes the need to be aware of the conditions which this particular population lives under. We should be aware when these people eat, how to interview an Afghan woman, namely of their culture." (Health care provider, Greece)

According to a Swedish informant:

> "… for the assessment of mental health condition the cultural barrier is unbearable." (Nurse, Sweden)

This nurse reported that a migrant woman used the expression "they opened my head" which could be interpreted either as a sign of psychosis or as indicating that a physical assault had taken place. Her point was that she had not means of distinguishing which might be the more appropriate interpretation. The informants also underline that it is not just a matter of knowing the language or having a mediator who knows it and suggest that competence should be integrated to provide the necessary services:

> "Another essential issue is the mediators' lack of education. It doesn't simply suffice for someone to know the language, in order to accompany a refugee to the Hospital… There are smaller NGOs that tend to rush things and, therefore, we come across mediators without the proper education in the field. However, the most essential, of course, is doctors' education.

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> They should be able to understand that it is entirely different to communicate and to diagnose a patient with the assistance of a third party, i.e. the mediator." (Health care provider, Greece)

The inadequacy of the cultural competence of health care providers was underlined in all the countries of the consortium. In Austria, health providers said that they often do not know how to behave in the presence of a translator and that they sometimes talk to the translator and ignore the patients, which is very disconcerting for the patient. An Austrian informants spoke about the doctor-patient encounter as a largely neglected topic, with a new course on the issue only recently added to the medical training programme. Maltese professionals (psychiatrist, psychologists, social workers, nurses) are not adequately sensitized to the needs that migrants may have. Only very recently have university courses begun to include transcultural topics.

Health care providers have also mentioned differences in social conduct of migrant patients, for example concerning punctuality and reliability, which results in doctors being unable to provide the appropriate service when patients are late and in patients' frustration for not being able to see a doctor whenever they arrive. The management of these tricky cases is left to the initiative of the individual health professional; in some cases, the professional is more tolerant of misunderstanding and uncertainty, whereas in other cases they are less forgiving and stick rigidly to the local rules and expectations (Austria, Malta).

> "Migrants often do not comply with appointments, which is a problem." (Doctor, NGO staff, Malta)

The lack of awareness and necessary training to address the needs of the migrants was also emphasised by policy makers (Spain), while some NGOs put more emphasis on the scarcity or lack of financial and human resources (Spain). The divide between what different actors considered most important led to various cultural approaches to health and illness and to health care. The different expectations of interpersonal interactions is underlined by Austrian informants who spoke of patients who want to receive treatment even though there is no appointment, or who overrate or underplay illnesses, in the opinion of the professionals.

Value views and beliefs can severely interfere with the provision of care, in the experience of a Midwife from Malta:

> "Some migrants mentioned they do not need to see antenatal care since God is the one who will provide ..." (Midwife, Malta)

Discrimination

In Spain, being a woman and a migrant is reported as a condition that increases the chances of unequal treatment and unsatisfactory health care provision. According to the Spanish NGOs, health providers and policy makers who were interviewed, women migrants tend to be more marginalised in the host country, with their language proficiency and health literacy often lower compared with migrant men. Their use of health services is more erratic and limited to acute care; they are uncomfortable at being examined by male doctors; they tend to see doctors only accompanied by their husbands, which prevents any confidentiality in the relationship with the doctors.

In 2015 'women's centres' were created to support women in accessing health care (France). Women, according to the French NGOs that took part in the focus group discussion, tend have better access to institutional accommodation because they are considered to be vulnerable subjects.

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In Malta, a main priority is to focus on lone-mother households. In some cases, these families are the product of rape and some women express the desire not to raise their children or, when they do want to raise them, they may need psychological assistance.

Greek informants underlined the special needs of women and unaccompanied minors that face violence while hosted in camps.

> "There was a woman that came in to our social service 5 times because she was raped. 5 times… These were cases that had happened to her in the camps. It is unacceptable to design the living of these people and not to prepare for women's toilets that aren't at an isolated and dark spot." (health-care worker working in an NGO, Greece)

> "The situation is quite dangerous for children as well, and more particularly for unaccompanied ones. In the camps, 3-year-olds live together with teenagers. Another common practice is that several refugees report to be younger than 18 years old, which leads to really young children sharing accommodation with adults." (health care worker working in an NGO, Greece)

Ethnic background and the way it affects conceptions of mental health are an additional barrier to the provision of health care. Informants report that a patient may be seen as a migrant before being seen as a patient.

> "The migrant schizophrenic arrived (at the hospital), in former times schizophrenia is what mattered, but now one considers him to be a migrant, rather than being a schizophrenic. We now end up questioning the fact that he's schizophrenic because they say he's a migrant. This is quite a recent thing, in fact." (Woman, volunteer medical doctor, NGO, France)

The same approaches and practices do not apply to 'normal patients' as compared with migrants. Forced examination of children's genitalia to determine FGC was reported as a practice in Austria. In connection to this, health care providers spoke about having to face ethical dilemmas as an effect of the prescribed procedures that are supposed to apply to migrant.

Episodes of discrimination and unequal treatment are reported:

> "I opened a letter this morning from a young person who had been taken care of in A&E, and had also been seen by the shrink. It is, at the beginning of the report "Young migrant..." ». [...] Before we used to read in hospital reports, I do not know, "Cameroonian or... "But now it's " young migrant ". This is the new category: "Migrants". It is as if to say they do not really want to take care of them." (Voluntary medical doctor in NGO, France)

In Austria, there is a sense that migrants should be thankful for whatever health care they receive even if it is not the same as the general population. The necessity for the expression of gratitude was attributed to policy makers and it was also mentioned by two policy makers in their focus group. Health care providers also spoke about an increased resentment towards migrants (Austria and France). Episodes of bullying of Muslim children were also reported (Malta). As an informant put it:

> "I fear, the darker the skin the less likely health professionals treat you with respect..." (Member of multidisciplinary team for poverty alleviation and social inclusion, Malta)

However, there are also informants that have not experienced discriminatory or unequal practice towards migrants:

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> "Once the new arrivals are admitted, I have not seen any differentiation or discrimination." (Nurse in a closed psychiatric ward, Sweden)

Providers also underlined the link between health and the employment situation, the ban on employment during the delay for refugee status to be recognised and a residence permit is issued, which increases stress and mental illness (Austria).

Discrimination is in some cases reported as having to do more with financial means than with skin colour (Malta).

The 2015 refugee crisis

Different countries have different views of how the refugee crisis affected the provision of health care for migrants. According to the interviews with service providers in Spain, for examples, NGOs and policy makers all agree that during the 2015 refugee crisis they did not experience additional challenges. By contrast, other countries such as France, for example, it was underlined how the number of migrants living in informal camps skyrocketed in 2015 (from 150-200 to 2,500). To respond to the emergency, Médicins Sans Frontières built camps with sanitary facilities and shelters. To guarantee health care access, volunteers drive patients to the hospital when needed. The Regional Health Agency gave financial support to hospitals to develop the Health Service Access Point. French informants also spoke about the increase in the number of NGOs when the refugee crisis was "mediatised", which then led to a lack of funding. The refugee crisis of 2015 only aggravated the already overloaded public health care system, which has been in deterioration over the last 10-15 years (France).

A German psychiatrist, who had always worked with migrants, underlined that after the new arrivals in 2015, he has met a new wave of patients with a different group of psychiatric disorders such as post-traumatic stress disorders, anxiety concerning their unclear legal status and uncertain life circumstances.

Informants also described the EU-Turkey agreement to restrict migration as keeping newly arrived refugees for long periods in closed camps as a main challenge that negatively affects the health conditions of new arrivals, especially their mental health. The restriction of movement augments the vulnerability of migrants and refugees.

> "Think of a person that travels. We won't begin from his/her homeland and what he/she has been through there. He/she travels, however, to and reaches Turkey, stays hidden and the conditions there are tough. He/she reaches the coast and boards a boat. One major concern is to escape from pirates who sabotage the journey and the boats. That person has already given everything he/she has, or still has something left. Either way, he/she has paid a great amount to travel under the most severe conditions to the other side and arrives there wet, soaked to be transported, where? Nowhere… People coming in even today find a tent waiting for them. Especially now that the geographical restriction has come into force after the agreement between Greece and Turkey, the situation at points of entry has worsened: people that cannot leave due to geographical restrictions and those coming in gather in one place. Although during the summer there was some flexibility for those having medical issues to be transferred to the mainland, this flexibility is now gone and people must remain on islands, despite the fact that they don't have access to services. The vulnerability of these people is multiplied due to living conditions. Their hopes have disappeared. They are pent up, and cannot move on. This is the so-called trauma these people bear anywise coming from a war zone; and this trauma grows bigger during the journey, and when they reach Greece, namely Europe, after the new agreement with Turkey is magnified." (NGO staff, Greece)

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Specific problems in transit countries

This section focuses on transit countries, but some the information here highlighted have already been included in other sections.

In Greece, the providers who were interviewed, downplayed inequalities in health care provision and access. Informants also named sexual assault in the camps; and work pressure and exhaustion of the workforce as pressing difficulties. According to some informants, the main issue is that the provision of health care to migrants is seen as a humanitarian intervention to deal with the emergency. Greek informants also stressed the fact that migrants perceive the country as a transit place and not a country where they would finally stay.

In Cyprus, access to health care varies depending on the route migrants take to Cyprus. Migrants arriving with the boats receive an initial health assessment, get introduced to the system and are informed on access to health care services. However, those arriving individually by land through the north part of Cyprus do not have receive any such information.

In Greece and in Italy according to NGOs, the reception system and the conditions in the camps are reported as damaging for the mental health status of migrants. A policy maker from Greece, on the other hand also talked about the misuse of mental health services by refugees. In their desperate efforts to leave the closed refugee camps in the Greek border islands and to move into the mainland and thereby, into other European countries, they use mental health problems as an excuse. The authorities then are obliged to transfer them to the mainland for the provision of special treatment.

> "If to leave the islands you must appear to be vulnerable, a way to do so is by proving that you have a mental health issue. It is much harder to prove that you are pregnant when you are not, but you can claim that you suffer from mental health problems as an excuse without, in fact, lying, given that you suffer from severe discomfort due to the living conditions in the refugee camps. This is somehow the only way for someone to achieve the prioritization of the refugee's request for the examination of his/her asylum application, his/her transfer to the mainland etc." (Health care worker working in an NGO & policy maker, Greece)

According to the Italian focus group discussions, the problem is not discrimination but scarcity of professionals and the uneven provision of services and health care among different hosting structures. Informants also lament the inability of the health care system to react to changes (Italy). The lack of resources together with the low political commitment emerges also from interviews conducted in Malta.

Specific health problems and health priorities

Health care providers have difficulties in evaluating the physical and mental health status of migrant and refugee patients. Migrant health status is reported to be both overestimated and underestimated (Austria). This is true in particular of mental health. The challenges are linked to the lack of information on the patients' health background (Austria), but also to the difficulties in securing follow-up appointments with migrants who move away (France) and to a limited capacity to evaluate the effects of depression and trauma. The lack of understanding and tolerance of cultural difference is also a problem, but so too is the more general lack of time to spend with migrant patients. Austrian informants emphasised that doctors need more time to listen to the patients' needs.

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Mental health is regarded as a health priority in Germany and Italy as well:

> "I believe it is (mental health) is a very big problem, what we see in the refugee camps, are the people - I do not want to say the word "traumatized" now, but let's just say "[mentally] unstable" and they are pushed from one place to another." (Social worker, Germany)

> "One of the most important health needs of the asylum seekers is linked to mental health." (Health care provider, Italy)

The Italian model of reception is mentioned as one of the possible causes of mental distress, because migrants have to live for long periods in ex-barracks, in a status of uncertainty and social deprivation. The reception system regarding mental health is defined as "totally inappropriate, generic and inadequate compared to reality" (NGO staff, Italy). Also in Greece, the system of closed refugee camps is singled out for worsening mental health.

> "Let's begin with this issue: I would say that if people with the best possible resilience and in the best mental shape lived under the conditions which people on Greek islands live under today, they would lose their mind in just 4 or 5 days. The second issue we have to deal with is not just the conditions in the camps, but also the migrants'/refugees' expectations that are disappointed: the stress, the uncertainty for the next day that no one knows what is going to happen tomorrow, and all these result to unwanted and disturbing behaviors." (Health care worker working in an NGO & policy maker, Greece)

According to the focus group discussions conducted in Malta, mental health problems increase isolation:

> "Migrants suffering from mental illness are often isolated even by their own community." (Office of the Mental health Commissioner, NGO staff, Malta)

A lack of support around mental health concerns emerges as the most urgent need according to informants from Malta. Anxiety, depression, isolation of asylum seekers in the Open Centres (that represent intermediate step between the Reception Centre and subsequent integration into the Maltese community) affects women and men alike. Substance abuse is reported to be mainly a problem among men.

Among the difficulties in addressing specific health issues there is, informants suggest that patients lack the capacity to assess their own health problems. Do to stress, lack of confidence in their body or because of traumatic experiences, but also simply because now they feel safe enough to address the needs that they have long suppressed, patients may overestimate their health issues (Austria). In terms of expressing their needs, participants reported incidents where migrants were vocal about their "anger" while waiting in a public hospital to see a doctor and not being served well. On the other hand, participants mentioned migrants/refugees who were more receptive; they exercised a more polite communication style while expressing their desire to be served.

Mental health is seen an urgent and yet neglected problem in France:

> "Mental health...Speaking of volunteers and professionals who are "feeling the brunt of mental health issues as well." They feel completely helpless in the face of the psychological suffering of the refugees before them. One must understand while there are few answers in terms of mental health [here], or even one could say there is a huge lack [of provision] that the issue of interpreting is essential. Because if you can't understand someone (and their problem), you can't

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understand anything. They have made efforts at the level of the PASS [Health Service Access Point] treatment center … an interpreter is made available." (Coordinator, Migrant Support Association, France)

French health care providers underlined skin problems and trauma as the two main problems. Other health conditions common in migrant patients come under gastroenterology, respiratory pathologies and post-traumatic stress (Austria). Other health conditions needing treatment among migrants include chronic diseases (diabetes, hypertension) and infectious diseases like TB and scabies.

Dental health is also a neglected concern that needs to be addressed. Most refugees have very bad dental health, which was partly attributed to the lack in basic dental care education (Spain, Austria). Access to treatment beyond acute care is not easy:

> "With respect to dental care, locally we have the dental center that treats patients who do not have health insurance. There is a lot of waiting to do, but overall, in the emergency department, people can be cared for. [...] As for further care and rehabilitation, it is extremely complicated, if they do not have health insurance, it is not possible." (Hospital doctor, France)

Early diagnosis of chronic diseases and relevant treatment should be a priority according to Greek informants, especially in the case of women with HIV. Other forms of special need, in terms of sexual orientation (LGBT) should also be addressed (Greece).

Alcohol and drug abuse, especially among young men and adolescents is reported to be a particularly sensitive issue because it is often related to refugees' traumatic experience, and to the uncertainty of their current life (Austria).

In Malta, the provision of ongoing health services became harder after 2015, when new arrivals stopped being placed in detention open centres.

As underlined in some focus group discussions conducted in France, migrants in some cases are more concerned with subsistence needs rather than addressing specific health needs (France).

Suggested solutions and good practices

Patient-centred care

Most of the solutions suggested to reach migrant and refugees and effectively meet their health needs, focused on avoiding segregating and discriminating practices. As a French informant put it, it is not that complicated to meet the basic needs of a people who have gone through such hardship:

> "They need a consultation to feel reassured." They need a stethoscope. They need us to ask them three questions. And it's hyper important. They generally have had a terrible migratory journey. They sometimes have never seen a doctor in their lives. They need, at some point, to settle down, for us to do a very simple examination. And then a psychological evaluation. And I personally think this seems rather uncomplicated "(Doctor, hospital, France)

While the doctor quoted felt that a consultation was a straight-forward means of meeting migrants' needs, other professionals emphasized other aspects of the health care process. For instance, **special patient cards** which are issued to allow migrants to access services without providing their names and yet also allow for follow up treatment (France) were underlined as important. In order to facilitate

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migrants' access to drugs, special permission to provide a dispensing pharmacy in close proximity to hospital consultation rooms, and with mediators available to explain how to administer the drug was outlined as key (France).

For the following NGO worker (Greece), a professionally-centred system would never be able to meet the health care needs of migrants. Rather a coordinated cooperative system is required.

> "We must understand that, when we speak of health services for migrants/refugees, the pure doctor-centered model, i.e. hiring a doctor, does not work. An interdisciplinary cooperation is required, meaning cooperation between social services, legal services, field epidemiologists, who shall keep records and systematically register and inform the authorities of epidemiologic data, doctor, nurses and mediators. To make myself clear, a hospital cannot proceed to making an appointment with a refugee woman before first contacting legal services to check whether this woman already has an appointment in the asylum service." (NGO staff, Greece)

Various ways in which this might be achieved were suggested in our interviews and focus groups, which we outline below.

Community-based services

A stronger community based approach would benefit migrants, according to informants in all countries. Migrant communities should be activated to facilitate the access to health care of migrants and refugees. Supporting migrants in accessing primary care and general practitioners is suggested as a way to reduce the flow of patients who do not need emergency treatment into hospital-based acute clinics and wards (Austria).

Informants suggest that training members of the communities as cultural mediators is a way to go, but they also underline how the internal rules and distinct practices of the communities may create tensions and conflicts and how using a cultural mediator from inside the community may threaten confidentiality (Austria). Migrant women can play a key role in raising awareness about health and health care, since by addressing women specifically, according to health providers in Austria, it is possible to reach the whole family. Special support through a health centre for women was underlined and in general, participants pointed out that local, decentralised services should be strengthened to meet the needs of migrants and refugees (Austria).

Health professionals in Austria mentioned the good results achieved by some health education projects that were supported by key figures in the migrant community (e.g. a representative from the mosque). Informants also underlined the key role members of the migrant community could play in community-based services and outreach activities including the reduction of stigma around mental illness, citing a case of Imams encouraging people to take their medication during Ramadan (Malta). Participatory community initiatives which use existing migrant networks, were highlighted as a means of promoting access. Other examples of community supported activities focus on engaging children and youth through sports events, music, theatre and reach other family members.

The identification of migrants and refugees who have a medical or social service background in case their qualification can be recognised, so they can be hired as health care providers or to support to service provision (Malta; Germany), potentially in a mediation role.

Education and training for professionals, migrants and mediators

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Health care providers suggest training in intercultural communication and conflict management as well as tailored interventions specifically targeting migrants (also certain groups of migrants such as Muslim women). Training was recommended, not just to target health care needs but also discriminatory practices and segregation (Austria, Greece, Italy, Malta, Spain).

Emphasis was put on training health care staff at different levels with respect to laws and regulations, epidemiology, main infectious diseases, but also anthropology and ethno-psychiatrics (Italy).

Basic health care education in the refugees' mother tongue should be provided through interactive workshops as well as though brochures and leaflets (Austria). Social workers and health care providers should support asylum seeker and refugee patient in developing a better relationship with their bodies (Austria).

For some informants, migrant education should start with standardized welcome training package for new arrivals would help to establish a better understanding on where they are (Malta).

Communication and cooperation across professions and between actors

The need for the education of mediators and physicians on medical treatment as part of a "three-way communication'' between migrant/refugee patients, physicians, and mediators. The widest group of health care workers (social workers, physicians, nurses, epidemiologists) need to be trained with regard to the provision of culturally competent health care for migrants and refugees (Greece).

Cooperation among the different actors involved in the delivery of health care should be improved. In particular, politics should play a more active role (Austria, Greece, Italy, Malta, France).

> "I am a public health physician in the hospital, in a prevention service dealing with tuberculosis control, vaccination and screening for sexually transmitted infections and others." [...] What we have tried to do here, beyond taking care of them and detecting disease, is to coordinate ourselves, as actors within the city and the department territory with others [...] We try not to be redundant in what we do and [...] so that we don't miss screening people. Because it's our job to do screening. But that's what's missing - coordination between different actors in the locality, each in fact, with their own unique field experience." (Hospital doctor, France).

> "For something to bring results there must be an interdisciplinary cooperation, which shall be achieved through a political initiative, just like in the case of refugees' mass immunization that happened thanks to the collaboration among all stakeholders. In particular, the Hellenic Ministry of Health began the political initiative and there was eventually collaboration between the Hellenic CDC, local authorities, NGOs etc." (Policy maker, Greece)

For some informants better collaboration and communication among the actors involved meant a more robust presence of EU on the issue of migration and health and for speeding up the EU decision-making process.

For others (Greece) it implied a shift from the humanitarian emergency mind set to that of migrant integration:

"There is a tendency today that originates from Europe: managing a crisis situation. However, there needs to be a change to this, given that refugees keep coming to Greece and most of them remain here. Therefore, there needs to be a shift into integration policies and actions in the field. We're not talking

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about integration policies that will have an effect on the access to health care, e.g. Greek language classes and many more." (Policy maker, Greece)

> "It is necessary to systematize not only mediators' education on mediation but also doctors' education, because diagnosing and receiving the medical history of a migrant/refugee isn't the same as in the case of the natives. Moreover, it's not the same because this process is conducted through a mediator. It is also very important that all people involved in migrants'/refugees' health, not only doctors but also social workers, nurses, field epidemiologists, should receive the necessary education when it comes to these populations' different culture." (NGO staff, Greece)

Coordination across regions

Reinforcing coordination at the regional level across all the stakeholders involved in the provision and access of health care for refugees (Italy). Learning from the good practice of particular regions: for instance, the Tuscan region promoted the drafting of a White Book on the reception system that was published through a participatory process. The Friuli Venezia Giulia region established a Regional Technical Health Roundtable in charge of coordinating the stakeholders to highlight problems and solutions. Immunization books (yellow book from the WHO) provided by authorities of the hosting country to newcomers is an example of good coordination and communication (Greece).

The public sector needs to be leading the collaboration with the private sector in order to ensure the sustainability of the efforts (Italy).

Informants underline that as long as the organised reception camps existed, better coordination between the different actors, including institutions and government at the local level (Prefecture, Regional Health Agency) (France).

The role of NGOs

For other informants, the role of NGOs was extremely important for ongoing work in reaching migrants and for developing the potential of that work. NGOs often provided the context for multi-professional service provision in appropriate community settings.

In France, NGOs describe how volunteers drive migrants to hospitals when needed. The ongoing work of NGOs reaching migrants was supported by the provision of accommodation, including organised camps (France).

NGOs in focus group discussions pointed to the good work done by the Centre for Intercultural Psychotherapy ANKYRA in Innsbruck in addressing the mental health needs of migrants. However, this centre has very long waiting lists and cannot fulfil the demand for psychotherapeutic assistance. The LEAP centres in Malta (the Social Welfare branch of the government) are mentioned as a good example of multiple services provision that is closer to the population and able to respond to emerging needs in a professional and timely fashion.

Structured co-operation between NGOs and public hospitals has been successful in avoiding delays in and misunderstandings of official procedures and supporting the issuing of the correct documents

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needed by patients. Such co-operation meant that interpreters and social workers from NGOs worked together with personnel of a large obstetrics public hospital (Greece). More general initiatives that get beyond the traditional medical approach to health are to be encouraged:

> "What would be quite efficient would be if in all public hospitals in Greece and community health centers on the islands and in the mainland, where refugees/migrants are accommodated, there where info points. Mediators and social workers would then work there in collaboration with the hospital's staff. This way, these incidents would be quickly dealt with and no time and energy would be lost, since wherever such service is unavailable the refugee may be waiting in the wrong line or outside the wrong office, may be meeting a doctor the refugee cannot communicate with, etc." (Health care worker, Greece)

Discussion

The focus group discussions and the qualitative interviews that were conducted between November 2017 and April 2018 confirm the picture that emerged from the review of the literature on migration and health care in Europe (MigHealthCare, 2018). The present qualitative investigation shed light on the wide range of aspects of care provision that need to be considered, including both the supply and the demand side. The evidence collected shows the wide range of issues affecting health care services for migrants, from the legislation regulating provision and entitlement to services, through the availability of services tailored to the needs of patients, to the political, socio-economic, organizational and cultural contexts in which migrants, service providers and policy makers operate.

The main results of the qualitative analysis show that:

- Health care provision for migrants is uneven throughout the EU and variations exist even within the same country.
- Health care providers and NGOs agree that health care for migrants is inadequate and biased in favour of particular conditions and cases (minors, pregnant women and acute conditions).
- Health care providers appear to be generally more critical of the *status quo* of provision for migrants as compared with policy makers.
- Challenges faced by the different countries vary; while in some countries the main issue is legal access, in others basic needs such as sanitation and basic infrastructure were emphasised.
- Austerity measures following the 2008 financial crisis have negatively affected health care system in general, which in turn has negative affected the provision health care for migrants.
- Different countries have different views of how the 2015 refugee crisis affected the provision of health care for migrants.
- Discrimination linked to socio-economic and ethnic conditions is reported as a barrier to equal health care access.
- Gender may act as a barrier with women tending to be more marginalised in the host country, in terms of language proficiency and health literacy, lowering health care access.
- Knowledge, language and communication on both the demand and the supply side of health care provision emerge as crucial to ensure equal access for migrants.
- Organisational issues and inadequate cooperation between private and public actors; insufficient training, scarcity of resources and infrastructural deficiencies are highlighted as major barriers to provision of health care and equal access to care.
- Mental health is regarded as a health priority by informants in all countries. Infrastructural, organizational and cultural factors can worsen the mental health conditions of the migrants (e.g. the life in reception camps; lack of coordination between different providers; language and communication barriers; inability to contrast the social stigma attached to mental health that discourages people from seeking support).

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- Among the solutions suggested were: training in intercultural communication and conflict management; basic health care education for the patients in their mother tongue; support in accessing primary care; a stronger community based approach - identified has essential across all the consortium countries.

These results were drawn together using summaries and translations into English of the focus groups and interviews conducted by the partners to make the data collected in different languages accessible. In some cases the original aim to perform focus groups discussion was modified and interviews were conducted instead; in other cases bureaucratic procedure resulted in unredeemable delays and a consequent inability to conduct the planned interviews (e.g. the administrative time of the ethical approval process conflicted with the tight project deadlines in the case of Sweden). These limitations of this study may affect the scientific soundness and generalizability of its results but should not prevent the appreciation of the value of being able to access, compare and interpret such original and rich material to the purpose of understanding the complex, challenging and still underexplored topic of the provision of health care services for migrants in Europe.

Conclusions: Balancing ends and means

One of the main challenges for providing equal health care access for migrants has to do with the ability to balance a universal end (health care is a basic right and should be available for all, independent of contingencies and life circumstances) with the particular means of achieving it (health care measures should meet different, individual requests and needs). The evidence collected here shows how this tension between end and means is at work in different moments of the provision of health care for migrants.

Policy recommendations

Based on this qualitative study, a number of policy recommendations can be suggested. The policy recommendations are divided into general and more specific ones and are listed in table 3 below:

Table 3: Policy recommendations

Patient-centred care. Health care services should be demand driven; they should be tailored to the individual patient's needs. Instead of a one-size-fits-all approach, health care services should anticipate and adapt to the actual needs of patients to ensure access to health care in terms of accessibility, availability and approachability.

Increasing investments in health care and moving beyond austerity measures. Investing in human resources, infrastructure, training and education on both the supply and demand side (e.g. education on legal entitlements for patients and providers; training in intercultural communication and conflict management; basic health care education for the patients in their mother tongue).

Adopting a more bottom-up approach to face change. Adopting a bottom-up, more decentralized and less bureaucratic approach to health care in general to make it better equipped to face change and crisis.

Specific policy recommendations

- Increase health care providers' awareness of mental and dental health issues
- Ensure that provision of health care is gender sensitive
- Increasing training for health care providers on cultural sensitivity
- Ensure the availability of interpreters and cultural mediators
- Ensuring that migrants receive adequate information on how and when to access health care
- Ensuring that health care providers receive information on legal rights of migrants concerning access and provision of health care
- Improve coordination between various EU countries and different agencies dealing with health care within EU countries

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Part A – Appendix 1: Interview Guides

Interview guide in Swedish

Guide till fokusgruppsdiskussionen (Frågeformulär)

1. Kan ni beskriva huruvida ni har jobbat med frågor som har med migranters eller flyktings hälso-och sjukvård?

   a) Beskriv alla verksamheter som ni känner till som är involverade i hälso-och sjukvården till migranter eller flyktingar
   b) Vad anser ni är en optimal/adekvat hälso-och sjukvård för migranter och flyktingar?
   c) Vilka svårigheter finns det för att uppnå en sådan optimal tjänst?
   d) Påverkade antalet nya anlända flyktingar år 2015 de utmaningar som redan existerade?
   e) Anser ni att de nya anlända behandlas annorlunda än andra patienter/klienter? Få de bättre kvalitet/tillgänglig hälso-och sjukvård? Får de sämre kvalitet vård? Är hälso-och sjukvården tillgänglig för ny anlända?
   f) Finns det tjänster som nyanlända sårbara migranter inte kan komma åt alls? Kan du ge exempel på sådana tjänster?
   g) Vilka skulle du säga är de största problem som migranter/flyktingar står inför när det gäller hälso-och sjukvård?
   h) Har du märkt några könsskillnader när det gäller tillhandahållande av hälso-och sjukvårdstjänster?
   i) Känner du till några inkluderande och uteslutande praxis gällande tillgång till eller tillhandahållande av hälso-och sjukvård till migranter eller flyktingar? Kan du beskriva dem kortfattat?

2. Vad säger invandrare/flyktingar enligt din erfarenhet om deras behov gällande fysisk, psykisk vård samt tandvård?

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a) Anser du att det finns brådskande ouppfyllda behov vilka invandrare inte uttrycker? Om så varför?

3. Kan de lokala tjänsterna som redan finns tillgodose dessa behov?

Utforska orsakerna beroende på svaret

4. Vilka slags verktyg eller tjänster skulle kunna hjälpa er med att stödja migranter/flyktingar för att effektivt kunna lösa de problem som finns?
5. Tror ni att lokala samhällen/befolkningen (community) skulle kunna hjälpa till? Tror du att lokala samhällen har en roll i integrationsarbetet? Om de har en roll hur kan denna roll utvecklas?

Utforska orsakerna beroende på svaret

6. Finns det ett behov att stödja migranter/flyktingar i navigeringen av hälso-och sjukvården om hur man använder hälsovårdssystemet?
   a) Om så är fallet har du varit inblandad i denna typ av arbete? (t.ex. utbildning, folkbildning, socialisering, översättning etc.).
   b) Hur uppstod detta arbete? Hur var dagordningen inställd? Vad det evidensbaserad? Politiskt initiativ? Utifrån behov? Efterfrågan från migranternas sida?
   c) Vilka är de bästa/sämsta aspekterna av detta arbete? Kan det förbättras?

7. Hur skulle du tänka dig en integrerad, kooperativ vårdmodell skulle se ut?
   a) Hur är samarbetsnivån mellan olika aktörer involverade i migrationshälsovård? [Denna fråga kan behöva omformuleras beroende på hur diskussionen går]
   b) Hur är samarbetsnivån på nationell nivå?
   c) Hur är samarbetsnivån på kommunal eller regional nivå?
   d) Hur är samarbetsnivån på EU-nivå?
   e) Vilka är dina tankar om samarbetet mellan olika nivåer? Vad är redan bra, vad saknas och vad kan förbättras?

8. Finns det något du vill lägga till, som inte redan har täckts?

Interview guide in Greek

Οδηγός για συζήτηση με τις ομάδες εστιασμένης συζήτησης

1. Με ποιον τρόπο συμμετείχατε στην παροχή υγειονομικής περίθαλψης στους μετανάστες/πρόσφυγες;

Ερωτήσεις:
Περιγράψτε όλους τους φορείς που εμπλέκονται στην παροχή υγειονομικής περίθαλψης στους μετανάστες/πρόσφυγες.

a) Ποιες υπηρεσίες υγειονομικής περίθαλψης θεωρείτε εσείς βέλτιστες/επαρκείς για τους μετανάστες/πρόσφυγες;

b) Ποιες είναι οι δυσκολίες στην επίτευξη παροχής τέτοιων υπηρεσιών;

c) Επηρέασε ο αριθμός των νεοαφιχθέντων του 2015 τις προκλήσεις που ήδη υπήρχαν;

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d) Οι νεοαφιχθέντες αντιμετωπίζονται διαφορετικά από άλλους ασθενείς/πελάτες; Απολαμβάνουν καλύτερης ποιότητας/ευκολότερης πρόσβασης/μεγαλύτερης ανταπόκρισης, υπηρεσίες;

e) Λαμβάνουν χειρότερης ποιότητας/δυσκολότερης πρόσβασης/μικρότερης ανταπόκρισης, υπηρεσίες;

f) Υπάρχουν υπηρεσίες, στις οποίες οι νεοαφιχθέντες/ευάλωτοι μετανάστες να μην έχουν καθόλου πρόσβαση; Μπορείτε να δώσετε παραδείγματα τέτοιων υπηρεσιών;

g) Έχετε παρατηρήσει τυχόν διαφορές/αλλαγές από τις νέες αφίξεις του 2015;

h) Ποια, κατά τη γνώμη σας, είναι τα κύρια προβλήματα που αντιμετωπίζουν οι μετανάστες/πρόσφυγες όσον αφορά στην παροχή υπηρεσιών υγείας;

i) Έχετε παρατηρήσει διαφορετική μεταχείριση ανάλογα με το φύλο, όσον αφορά στην παροχή υγειονομικής περίθαλψης;

j) Γνωρίζετε πρακτικές συμπερίληψης ή αποκλεισμού μεταναστών, από τις παροχές υγειονομικής περίθαλψης; Μπορείτε να τις περιγράψετε περιεκτικά;

2. Κατά την εμπειρία σας, τι δηλώνουν οι μετανάστες ότι χρειάζονται περισσότερο από πλευράς σωματικής, ψυχικής και οδοντιατρικής περίθαλψης;

Ερωτήσεις:

a) Πιστεύετε ότι υπάρχουν επείγουσες ανεκπλήρωτες ανάγκες, τις οποίες οι μετανάστες δεν εκφράζουν; Αν ναι, γιατί;

3. Είναι δυνατόν οι τοπικές υπηρεσίες να αντιμετωπίσουν αυτές τις ανάγκες;

Ανάλογα με την απάντηση, εξερευνήστε τους λόγους

4. Ποια εργαλεία ή υπηρεσίες θα σας διευκόλυναν να βοηθήσετε καλύτερα τους μετανάστες/πρόσφυγες, ώστε να αντιμετωπιστούν αποτελεσματικά τα θέματα που αναφέρονται παραπάνω;

5. Πιστεύετε ότι οι τοπικές κοινότητες θα βοηθούσαν; Πιστεύετε ότι οι τοπικές κοινότητες έχουν ρόλο στην ενσωμάτωση των μεταναστών και αν ναι, μπορείτε να αναπτύξετε περαιτέρω το συλλογισμό σας;

Ανάλογα με την απάντηση, εξερευνήστε τους λόγους

6. Υπάρχει ανάγκη καθοδήγησης των μεταναστών, σχετικά με τη λειτουργία και αξιοποίηση του συστήματος Υγείας;

Ερωτήσεις:

a) Αν ναι, έχετε εμπλακεί σε αυτό το είδος εργασίας; (Διερευνήστε την υπεράσπιση, την εκπαίδευση, την πληροφόρηση, την κοινωνικοποίηση, τη μετάφραση)
b) Πώς προέκυψε αυτό το είδος εργασίας; Πώς καθορίστηκε η ημερήσια διάταξη; Με ερευνητικά στοιχεία; Πρωτοβουλία πολιτικής παρέμβασης; Έντονη ανάγκη; Απαίτηση των μεταναστών;

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c) Ποιες είναι οι καλύτερες/χειρότερες πτυχές αυτού του είδους εργασίας; Μπορεί να βελτιωθεί;

7. Πώς θα οραματιζόσασταν ένα ολοκληρωμένο, συνεργατικό μοντέλο υπηρεσιών υγειονομικής περίθαλψης, στο περιβάλλον σας;

Ερωτήσεις:

a) Πώς είναι το επίπεδο ένταξης/συνεργασίας μεταξύ διαφόρων φορέων που εμπλέκονται στην παροχή υπηρεσιών υγείας στους μετανάστες/πρόσφυγες;

[Αυτή η ερώτηση θα πρέπει να αναδιατυπωθεί ανάλογα με τον τρόπο διεξαγωγής της συζήτησης]

b) Πώς είναι το επίπεδο συνεργασίας σε εθνικό επίπεδο;
c) Πώς είναι το επίπεδο συνεργασίας σε επίπεδο δήμων ή περιφερειών;
d) Πώς είναι το επίπεδο συνεργασίας σε επίπεδο ΕΕ;
e) Ποιες είναι οι σκέψεις σας όσον αφορά στη συνεργασία μεταξύ των διαφόρων επιπέδων; Τι είναι ήδη καλό, τι λείπει και τι μπορεί να βελτιωθεί;

8. Κλείνοντας, υπάρχει κάτι που θα θέλατε να προσθέσετε και δεν έχει ήδη αναφερθεί;

Interview guide in French

1. Quelles sont vos activités en lien avec la prise en charge santé/social des migrants et réfugiés ?

À sonder :

a) Décrivez toutes les structures impliquées dans ce service
b) Qu'est-ce que vous considérez comme optimal, adéquate en termes de services de santé et soins ?
c) Quelles sont les difficultés pour réaliser ce service ?
d) Est-ce que le nombre d'arrivées en 2015 augmente les difficultés qui existaient déjà ?
e) Est-ce que les primo-arrivants sont pris en charge différemment que les autres patients?

Est-ce qu'ils bénéficient d'une meilleure prise en charge ?

f) Est-ce qu'ils bénéficient d'une moins bonne prise en charge ?
g) Est-ce qu'il y a des services qui ne sont pas accessibles aux primo-arrivants ou migrants vulnérables ? Est-ce que vous pouvez donner des exemples de services ?
h) Est-ce que vous avez notez des différences, des changements depuis les arrivées de 2015 ?
i) Quels sont selon vous les principaux problèmes que rencontrent les réfugiés/migrants en termes de services de santé/sociaux ?
j) Est-ce que vous connaissez des pratiques d'inclusion, d'exclusion de migrants dans les services de santé ? est-ce que vous pouvez les décrire ?

2. D'après votre expérience, qu'est-ce que les migrants disent avoir le plus besoin en termes de santé physique, mentale et dentaire ?

à sonder :

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a) Considérez-vous qu'il y ait des besoins urgents non satisfaits, que les migrants n'expriment pas ?

3. Est-ce possible pour les services locaux de répondre à ces besoins ?

Selon les réponses, explorer les raisons

4. Quelle sorte d'outils ou services vous aiderez pour mieux assister les migrants face aux problèmes mentionnés auparavant ?
5. Pensez-vous que l'approche locale/communautaire peut aider ? Est-ce que vous pensez que les communautés locales ont un rôle à jouer dans l'intégration des migrants ? Pouvez-vous développer ?

Selon les réponses, explorer les raisons

6. Est-ce qu'il y a besoin de guider les migrants dans l'utilisation du système de santé ?

À sonder :

a) Si oui, avez-vous été investis dans ce type de travail ? (plaidoyer, éducation, information, socialisation, traduction)

b) Comment le travail s'est mis en place ? Comment l'agenda est défini ? Par des preuves de recherche ? Initiative politique ? Besoins palpables ? Demande des migrants ?
c) Quelles sont les meilleurs et pires aspects de ce travail ? Est-ce qu'il peut être amélioré ?

7. Comment est le niveau d'intégration/coopération entre les différents acteurs investis dans les services santé/social qui prennent en charge des migrants ?

À sonder :

a) Comment est le niveau de coopération au niveau national ?
b) Comment est le niveau de coopération au niveau régional, municipal ?
c) Comment est le niveau de coopération au niveau européen ?
d) Que pensez-vous de la coopération entre les différents niveaux ? Est-ce qu'il est déjà bon, est-ce qu'il y a des manques et qu'est-ce qui peut être amélioré ?

8. Fermeture: Est-ce qu'il y a des choses que vous voudriez ajouter, qui n'ont pas été abordé ?

Interview guide in Bulgarian

Ръководство за дискусия

1. Каква е била вашата ангажираност с предоставянето на здравни грижи за мигранти / бежанци?

а) Опишете всички агенции, включени в тази разпоредба.

б) Какво смятате за оптимално / адекватно предоставяне на здравни грижи за мигранти и бежанци?

в) Какви са трудностите при постигането на такава услуга?

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г) Броят на новопристигналите през 2015 г. повлия ли на предизвикателствата, които вече са съществували?

д) Получават ли новопристигналите лица различно предоставяне на здравни грижи в сравнение с другите пациенти / клиенти?

Получават ли по-качествени / достъпни / навременни услуги?

е) Получават ли по-лошо качество / недостъпни / по-малко навременни услуги?

ж) Има ли услуги, които новите пристигащи / уязвими мигранти не могат изобщо да имат достъп?

Можете ли да дадете примери за такива услуги?

з) Забелязали ли сте някакви разлики / промени при новопристигналите след 2015 г.?

и) Кои според вас са основните проблеми, пред които са изправени имигрантите / бежанците по отношение на предоставянето на здравни услуги?

й) Забелязали ли сте някакви различия между половете по отношение на предоставянето на здравни грижи?

к) Знаете ли за практики за включване или изключване в предоставянето на здравно обслужване на мигранти? Можете ли да ги опишете накратко?

2. Според вашия опит, от какво най-много се нуждаят мигрантите по отношение на физическа, умствена и стоматологична помощ?

а) Смятате ли, че има неотложни нужди, които мигрантите не изразяват? Ако е така, защо?

3. Възможно ли е местните служби да отговорят на тези нужди?

В зависимост от отговора, разгледайте причините

4. Какви инструменти или услуги ще ви помогнат да подпомогнете по-добре мигрантите / бежанците, за да се справите ефективно с посочените по-горе проблеми?

5. Смятате ли, че местните общности ще помогнат? Смятате ли, че местните общности играят роля в интеграцията на мигрантите и ако те го правят, може ли да да го развиете?

В зависимост от отговора, разгледайте причините

6. Необходимо ли е да се насочат мигрантите към това как да използват системата на здравеопазването?

а) Ако е така, участвали ли сте в този вид работа? (Изследвайте застъпничеството, образованието, информацията, социализацията, преводите)

б) Как започна работата? Как е настроен дневният ред? С научни доказателства? Политическа инициатива? Осезаема нужда? Търсенето на мигранти?

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в) Какви са най-добрите / най-лошите аспекти на тази работа? Може ли да се подобри?

7. Как бихте представили един интегриран модел на здравна услуга за сътрудничество във вашата среда?

а) Как е нивото на интеграция / сътрудничество между различните участници, участващи в предоставянето на миграционни здравни услуги? [Този въпрос ще трябва да бъде преформулиран в зависимост от начина на водене на дискусията]

б) Как е нивото на сътрудничество на национално ниво?

в) Как е нивото на сътрудничество на общинско или регионално ниво?

г) Как е нивото на сътрудничество на равнище ЕС?

д) Какви са вашите мисли за сътрудничеството между различните нива? Какво вече е добро, какво липсва и какво може да се подобри?

8. На финала: има ли нещо, което бихте искали да добавите, което все още не е обсъдено?

Interview guide in Spanish

1. Cuál ha sido tu involucramiento con el suministro de atención sanitaria para inmigrantes/refugiados?

Indagar contestando lo siguiente:

a) Describe todas las agencias involucradas en el suministro.

b) Qué consideras como un suministro sanitario óptimo/adecuado para inmigrantes y refugiados?

c) Cuáles son las dificultades cuando se obtiene dicho servicio médico?

d) El número de gente que llegó en 2015 ha influido en los desafíos/retos que ya existían?

e) Los que han llegado más recientemente son tratados de manera diferente que otros pacientes/clientes? ¿Consiguen mejor cualidad/ accesibilidad/ recepción de servicio?

f) Consiguen peor cualidad/ inaccesibilidad/ menos recepción de servicio?

g) Existen servicios los cuáles los inmigrantes nuevos/vulnerables no puedan acceder? ¿Puedes dar ejemplos de tales servicios?

h) Has notado alguna diferencia/ cambio des de las nuevas llegadas del 2015?

i) Cuáles dirías que son los problemas más importantes que los inmigrantes/refugiados se enfrentan en términos de suministro de atención sanitaria?

j) Has notado alguna diferencia de género en cuanto al suministro de asistencia sanitaria?

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k) Sabes de alguna práctica de inclusión o exclusión hacia los inmigrantes en el suministro de asistencia? ¿Puedes describirlas brevemente?

2. En tu experiencia, ¿qué es lo que dicen los inmigrantes que necesitan más en términos de cuidado físico, mental y dental?

Indaga:

a) Piensas que existen necesidades desconocidas urgentes, las cuáles los inmigrantes no piden/expresan? ¿Si es así, por qué?

3. Es posible para los servicios locales abordar estas necesidades?

Dependiendo de la respuesta, explora las razones.

4. Qué tipo de servicios o herramientas ayudaría mejor a asistir a los inmigrantes/ refugiados para así abordar efectivamente los problemas mencionados arriba?

5. Crees que las comunidades locales ayudarían? ¿Crees que tienen un rol en la integración de los inmigrantes, y si es así, puedes elaborar tu respuesta?

Dependiendo de la respuesta, explora las razones.

6.Hay necesidad de guiar a los inmigrantes en cómo usar el sistema sanitario?

Indaga:

a) Si es así, has estado implicado en este tipo de trabajo? (Explora si en derecho, educación, información, socialización, traducción)

b) Cómo fue el trabajo? Cómo se organizó? Por pruebas de investigación? Iniciativas políticas? Necesidades obvias? Petición/solicitud de inmigrantes?

c) Cuáles son los mejores/ peores aspectos de esta tarea? Puede mejorar?

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Part B – Physical and mental health among migrants and refugees in ten European countries: Survey results

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Background

Sampling Frame and Representativity

The lack of a representative sampling frame is a significant barrier to the typical representative survey (Ngwato, 2008; Platt et al., 2015; Vigneswaran and Quirk, 2012) Relying on administrative sampling frames to sample refugee populations results in samples dominated by more settled populations and, increasingly, second-generation respondents; administrative definitions of 'immigrant' fail for the same reason (Platt et al., 2015). Using official data such as census date would not be a useful indicator of settlement patterns because of the high mobility of refugees (Bloch, 1999). Furthermore, such data would provide underestimates of particular groups, especially those in temporary accommodation and those who are not literate in English (Bloch, 1999). Members are hard to locate and are therefore hard to identify for the purpose of sampling (Bloch, 1999). Debate about what standards of representativity are realistic persists, with some arguing that we should avoid quantitative population studies or set aside representativity (Vigneswaran and Quirk, 2012). Ultimately, research with migrants must to compromise and work with certain generalizability limitations and biases (Ngwato, 2008). The traditional standards of random sampling must be loosened to ensure the sample is actual representative of newcomer voices (Ogilvie et al.). Various methods of convenience sampling present a reliable alternative and a pragmatic approach to sampling for migrants and refugees (Vigneswaran and Quirk, 2012).

Respondent-Driven Sampling and Related Methods

Respondent-Driven Sampling (RDS), also known as Snowball Sampling or Chain Referral Sampling, is a promising method of addressing some of the sampling challenges associated with migrants and refugees. Instead of sampling individuals from a sampling frame, RDS samples individuals from a target population network, assumed to encompass all members through social ties (Platt et al., 2015). Seed members are recruited and interviewed, and they subsequently recruit referrals from their communities. While RDS works well with populations that may wish to remain anonymous to the researcher, it requires that the population is well-networked, so it may only sample settled migrants (Platt et al., 2015). Furthermore, even in well-networked populations, isolated members remain, and there can be overdependence on one network with similar experiences (Bloch, 1999). Platt et al. devised a researcher-led recruitment strategy, which adheres to the RDS concept, but instead involves gathering contact information and recruiting from respondent networks directly rather than letting the referral process unfold among the population (Platt et al., 2015). In this method, the research team calls seed respondents who have already participated in the survey to ask for the contact details of potential referrals in their network. The research team then calls the referred persons directly to screen their eligibility and invite them to take part. Simultaneously the researchers amend the questionnaire so that interviewers ask respondents directly for the contact details of persons they know who are eligible for the study. The contact details are passed to the research team to make contact. This method places the initiative in the hands of the researchers rather than the respondents (Platt et al., 2015).

Other Methods

Bloch suggests that Quota Sampling could be used as an alternative (Bloch, 1999). With this method, the interviewer has to find respondents who fit into certain pre-specified categories that are deemed to represent the survey population; thus the sample can reflect the experiences of refugees on key explanatory variables. However the rigidity of the quotas may have to be relaxed to allow interviews to complete fieldwork within a realistic time frame (Bloch, 1999). Some suggest the use of community gatekeepers or cultural brokers for recruitment (Ogilvie et al., 2008; Bloch, 1999). Locating refugees is difficult; leaders in the target communities can identify starting points, help facilitate the research, and encourage participation of potential respondents who would otherwise not be willing to be interviewed. Similarly, another pragmatic approach involves the use of community groups or service providers. Ngwato argues that non-representative surveys collected through 'service provider organizations' (SPOs) can be justified when migrants are self-settled in dispersed (especially urban) settings, and where the intended outcomes of the

research are (at least partly) to inform advocacy and 'action' (Ngwato, 2012). This is a cost-effective strategy as it involves existing organizations, and solves many of the logistical issues of sampling, including a significant reduction of the non-response rate. SPO-based surveying can introduce several biases, such as documentation bias when working with organizations like the UNHCR, but perhaps not any more than any other methodology (Ngwato, 2012).

Practical Barriers to Recruitment

Compared to populations with particular needs, such as those at risk of HIV, recent migrants may have less obvious reasons for being interested in the aims of a multi-topic survey (Platt et al., 2015). Recently arrived migrants may be working long hours and multiple jobs, with little time and energy for research participation (Platt et al., 2015; Ogilvie et al., 2008). Significant research funds may need to be allocated for recruitment, as there are often no additional benefits offered by such research (Platt et al., 2015; Ogilvie et al., 2008).

Anonymity and Disclosure

The legal status of migrants and refugees and the degree of stigma in the receiving community may lead potential participants to desire anonymity. Undocumented migrants are especially vulnerable; they may only be willing to be approached by trusted others, and may decline to provide identifying details (Platt et al., 2015). Even those with formal status may be distrustful or fearful of officials or interviews (Platt et al., 2015; Ogilvie et al., 2008). Recruitment through cultural gatekeepers or SPOs, for example, poses an issue as potential respondents are generally not anonymous to recruiters (Bloch, 1999; Ngwato, 2012). Furthermore, confidentiality is essential for any ethical qualitative research, especially with migrants and refugees (Mackenzie et al., 2007). Careless disclosure of information by researchers, or malicious disclosure by others, may increase the vulnerability of participants or compromise their safety (Mackenzie et al., 2007). Refugees are especially concerned that information about their personal circumstances would prejudice the host community against them. Researchers must consider the principle of respect, which entails a responsibility to be mindful of the trust that is being placed in them by refugees. Mackenzie et al. suggest including agreements relating to confidentiality in the consent process (Mackenzie et al., 2007).

Assuming Homogeneity of Cultural Group

Migrant and refugee communities are not homogenous (Ogilvie et al., 2008). Divisions related to national origin barriers, social class, age, religion, and gender may persist post-migration, even among immigrants from a similar geographic area that share a language (Platt et al.). This can affect both sampling, such as when using the RDS method, as well as the selection of interviewers; trust may or may not be greater within shared ethnocultural identities, particularly when other identities such as gender differ, affecting anonymity and/or confidentiality (Ogilvie et al.). In the interest of representativity, it is important to include individuals and groups who are multiply marginalized with regard to language, culture, nationality, race, and gender (Goodkind and Deacon, 2004). When a particular refugee community is considered homogenous, and thus a specific representative or representatives assumed to speak for all members, such marginalized individuals are overlooked (Goodkind and Deacon, 2004). For example, refugee women encounter numerous significant obstacles to their well-being in resettlement and frequently have needs that differ radically from those of refugee men (Goodkind and Deacon, 2004). However they often are not represented adequately in research or policy, as formal leaders who are taken as representative are most often men who do not represent the views and interests of women (Goodkind and Deacon, 2004).

Cultural Sensitivity

When developing the survey questions, it is important to note that some topics may be considered more sensitive by some cultural groups than others (Lee et al., 2014). Sensitive topics may be regarded as private, involve stigmatised behaviours, or evoke strong emotional feelings, and participants may even lack the vocabulary to discuss such issues as they may have never talked about such things before (Lee et al., 2014). However, cultural sensitivity in developing methodology extends beyond taboo topics. Power imbalances, institutional discrimination, and interpersonal relationships among those persons identified as colonizers or colonized, native born or immigrant, visible minority or White, are present in research interactions at many levels (Ogilvie et al., 2008). Researchers must reflect on their conscious or unconscious attitudes, behaviors, and prejudices in order to respect the needs and rights of the participant (Ogilvie et al., 2008). In the case of research with refugees, research team members should especially have knowledge of differences in immigration status and how such status may reflect the participant's experiences and sense of security (Ogilvie et al., 2008).

Language

Interpreters

The use of good quality interpreters is vital to carrying out interviews and analyses that are comprehensible within the culture's structure (Ogilvie et al., 2008). Working with an interpreter allows participants to participate in research from which they might otherwise be excluded (Lee et al., 2014). However working with interpreters presents some challenges. First, interpreters cannot complete forms or surveys; a health or social service worker must verbally ask clients each question on the form (Lee et al., 2014). The interpreter then interprets the question and the response, which is recorded. (Lee et al., 2014; Ogilvie et al., 2008). Second, language is a system of signs that incorporates cultural, historical, and geographic values, beliefs, and traditions (Ogilvie et al., 2008). Thus there is often no equivalence of meaning in concepts across cultures (Lee et al., 2014). Ultimately the interpreter is a participant in the research, and requires partnership with the research team to function effectively.

Translation

Translations can add significant monetary costs and time considerations to research projects (Lee et al., 2014). Translation of instruments and other research material is a complex and time-consuming process that includes many steps such as translation, back-translation, and forward-translation (Ogilvie et al., 2008). Moreover, the translations themselves may be problematic (Lee et al, 2014). It is important that the level of language is not too academic, and that the appropriate version of the language is used, as many different versions of the same language may exist across regions and countries (Lee et al., 2014). Furthermore, the same question cannot be asked to each respondent in the same way; words and expressions must be chosen so that they are meaningful and comparable when translated, with emphasis on meaning rather than the literal translation of questions (Lee et al., 2014; Ogilvie et al., 2008; Bloch, 1999). Otherwise meaningless translations can occur: for example asthma could become lung disease (Ogilvie et al., 2008). Translated documents should be translated back to ensure equivalency, and can potentially be given to community members for feedback on clarity and meaning (Lee et al., 2014).

Administering the survey

Administering the survey face-to-face is ideal, as response rates are much higher and open-ended questions can be used (Ogilvie et al., 2008; Bloch, 1999). Furthermore, potential participants with low literacy levels can be included (Bloch, 1999). The selection of the interviewer is crucial for both reasons of cultural sensitivity and in order for the research process to proceed smoothly. The fieldwork team must have prior knowledge about the communities; for example, for cultural and religious reasons it is essential to recruit a woman and a man for interviews with Somali refugees to match by gender (Ogilvie et al., 2008). However,

this cultural consideration of the interviewer presents another challenge, as there is contention about whether it is more appropriate for a cultural insider or outsider to conduct the interviews (Ogilvie et al., 2008). An insider would share the same country of origin or ethnocultural identity as the study population, and many argue that only insiders can understand and empathize with the experiences of participants (Ogilvie et al., 2008). In contrast, proponents of outsider research challenge the extent to which insiders can be objective and detached from the prejudices within the groups that they study, arguing that insiders may make presumptions about the data and portray information in a way that is advantageous to the interests of the community (Ogilvie et al., 2008). Ogilvie et al. suggest that community consultation collaboration can address potential insider–outsider biases and lack of understanding (Ogilvie et al., 2008).

Consent

The ethical principles of respect for persons and beneficence underpin the importance of informed consent in research. At minimum, participants must be fully informed about every stage of the research process, including purpose and benefits, and their agreement to participate must be fully voluntary (Mackenzie et al., 2007).

Autonomy
Consent assumes participants are autonomous, however in the context of refugee research, participants are vulnerable and thus protections for autonomy are often absent. They many have suffered serious trauma and struggle with their sense of identity. Their ability to exercise self-determination may be limited further because much of their lives are under the control of others and so they are at the mercy of officials. Finally, their autonomy could be further limited because they are unable to understand the benefits of the research, mistakenly believing that researchers have the power to influence their legal status (Mackenzie et al., 2007).

Power
Consent also assumes relatively equal positions of power, but power structures evolve in refugee settings like camps where 'community leaders' are often given formal roles by organizations like UNHCR and NGOs managing the camps. If cultural homogeneity is assumed, power is often bestowed on 'leaders' who lack the ability to operate democratically while ignoring rival factions. Researchers who depend on such 'leaders' to access the refugees may end up silencing the voices of those who need to be heard most because the 'leader' has the ability to control access. Such issues of power imbalance mean voluntariness of participation is undermined (Mackenzie et al., 2007).

The MigHealth-Care questionnaire

The questionnaire used for the Mig-HealthCare survey was purpose made in order to obtain information about the physical and mental health needs of migrants/refugees. Our aim was to capture information concerning previously less researched areas for example mental health, oral/dental health, gynecological issues etc.

The Mig-HealthCare questionnaire (Part B - Appendix 2) comprises 60 questions and is divided into the following sections.

- Demographics
- Household
- Education and employment
- General well being
- Access and interaction with health care services
- Screening

- Dental Care
- Immunization status
- Skin problems
- Women's Health
- Perceptions about health
- Current situation

The questionnaire was developed in English and then translated into French, Arabic, Somali, Pashto, and Dari. The questionnaires were completed in paper form with the help of a trained expert and an online database was created so as for each consortium partner to register online the responses (the online questionnaire form is available in https://docs.google.com/forms/d/e/1FAIpQLSfFfFKM4_ZBlWlJ40-cfI9LIOCLY0yAgYWuLQnvQry8PfJOoQ/viewform).

Pilot testing

A small pilot study was conducted before the final version of the questionnaire was administered to the target population. Using a convenience sampling approach, the draft version of the questionnaire was distributed to 6 individuals of different ethnic backgrounds and migration status. As a result of this process, minor issues with wording and grouping of questions for the sake of clarity and time requirements were resolved. The final version was then translated in to the rest of the languages.

Study population

The study population is defined as migrants/refugees who have been residing in Europe, for at least 6 months and up to 5 years. In order to be able to capture the recent migration flow, the main target nationalities are:

- Afghanistan
- Eritrea
- Gambia
- Iran
- Iraq
- Ivory Coast
- Nigeria
- Pakistan
- Somalia
- Syria

However, in countries where migrants/refugees population is considerably different due to geographic location/and or language/cultural norms, additional nationalities may be included, as long as they meet the inclusion criterion for length of stay in the EU.

Sampling

Given the inherent differences in the structures and ways of access to the migrant/refugee population per participating country, each partner recruits participants through the channels that they have access to. This may include but not limited to: refugee camps (temporary accommodation), migrants/refugees housing, community structures etc. An effort is made so that the sampling is roughly stratified by nationality and gender, according to the respective countries migrant/refugee population.

As the migrant population demographics change continually, and the study is of exploratory nature, proper sample size calculations are not straightforward. Instead, we follow a pragmatic approach based on the

resources available and aim for approximately 200 questionnaires in partner countries with a large migrant/refugee population (i.e. Greece). Other countries will strive for the same number of questionnaires but the expectation is that not all will reach that goal.

Questionnaires are filled in with the help of a trained interviewer. This is done either on a one-to-one basis or, alternatively administered to a group of respondents who are supervised / instructed by the trained interviewer. Interviews may be conducted either in each country's respective language, given that the respondent has an adequate command or in one of the languages in which the questionnaire is translated (Arabic, Somali, Farsi, Pashto and Urdu). In the latter case, the interviewer needs to be a native speaker of that language as well.

A log book is kept for the purpose of recoding non-response and the reasons for it (demographics of non-responders). Finally, each participant is informed on the general aims of the survey and gives his/her consent to participate through an informed consent form.

A log book and the methodology protocol used for this study can be found in Part B Appendix.

Study sample

In total, we have gathered 1,325 questionnaires from 10 member states. From these, 39 questionnaires referred to migrants residing more than 5 years in Europe and thus 1,286 questionnaires were included in the analysis. The distribution of questionnaires by country of interview is shown in Table 1.

Table 1: No. of questionnaires included in the analysis by country of interview

Country of interview	N (%)
Austria	113 (8.8)
Bulgaria	226 (17.6)
Cyprus	115 (8.9)
France	68 (5.3)
Germany	11 (0.9)
Greece	255 (19.8)
Italy	268 (20.8)
Malta	28 (2.2)
Spain	111 (8.6)
Sweden	91 (7.1)
Total	**1,286 (100.0)**

Demographics

In Table 2 is presented the distribution of migrants by country of birth. The respondents come from 70 countries, with the most coming from Syria (22.5%), Afghanistan (16.3%), Iraq (9.6%) and Nigeria (9.0%). Nationality resempled the country of birth. There were found 5 cases of migrants born in Syria with other nationality, 9 cases born in Afghanistan with other nationality (4 of which Iran and 4 Pakistan), 6 cases in Iran, 1 case in Nigeria and 3 cases in Somalia.

Table 2: No. of questionnaires included in the analysis by country of birth

Country of birth	N (%)
Syria	284 (22.5)
Afghanistan	206 (16.3)
Iraq	121 (9.6)
Nigeria	114 (9.0)
Somalia	50 (4.0)

Iran	47 (3.7)
Gambia	35 (2.8)
Senegale	34 (2.7)
Pakistan	31 (2.5)
Guinea	31 (2.5)
Cameroon	31 (2.5)
Ivory Coast	24 (1.9)
Mali	22 (1.7)
Ghana	20 (1.6)
Congo	17 (1.3)
Venezuela	15 (1.2)
Bangladesh	13 (1.0)
Other country	170 (13.4)

In Table 3 is presented the gender distribution of migrants by country of birth. In the total sample 64.5% of respondents are male and 35.5% female. However there are significant differences by country in the gender distribution (p-value<0.001). Migrants from Afghanistan (72.8%), Nigeria (68.4%) and Iran (68.1%) are in higher percentages male, whereas migrants from countries Syria (52.2%), Iraq (55.4%) and Somalia (51.1%) are in higher percentages female.

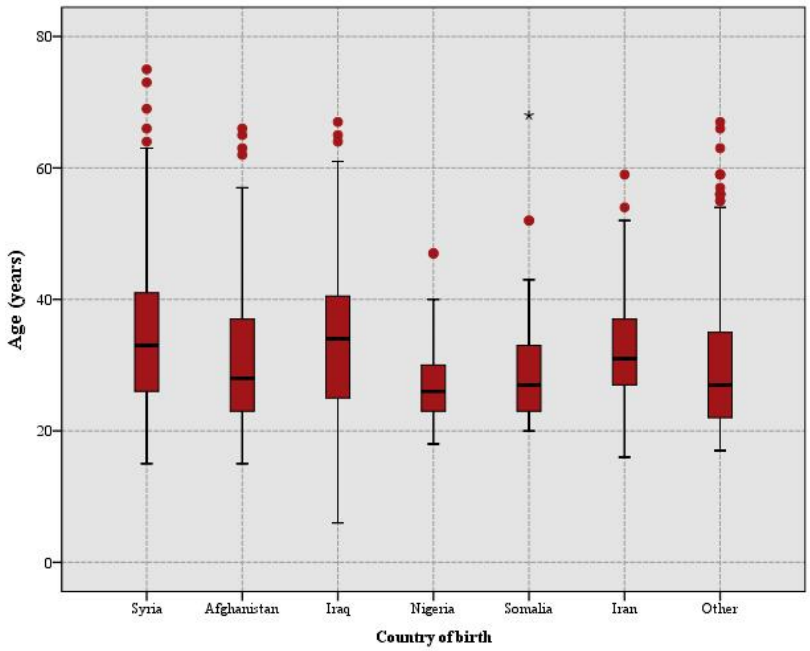
Table 3: Distribution of gender by country of birth

	Female [N (%)]	**Male [N (%)]**
Syria (N= 278)	145 (52.2)	133 (47.8)
Afghanistan (N= 206)	56 (27.2)	150 (72.8)
Iraq (N= 121)	67 (55.4)	54 (44.6)
Nigeria (N= 114)	36 (31.6)	78 (68.4)
Somalia (N= 47)	24 (51.1)	23 (48.9)
Iran (N= 47)	15 (31.9)	32 (68.1)
Other (N= 455)	107 (23.5)	348 (76.5)

Chi-square p-value< 0.001.

The mean age of all respondents is approximately 31 years old (standard deviation 10.7). 81.8% of the migrants is below 40 years old. In Figure 1 is observed the age distribution by country of birth. We observe that from countries like Nigeria and Somalia respondents are of younger age, compared to Syria, Iraq and Iran (p-value<0.001).

Figure 1: Distribution of age by country of birth



Kruskal Wallis p-value< 0.001

The languages in which most migrants have communication skills (see Table 4) is Arabic (50.5%), followed by English (46.5%) and in lower frequencies French (19.1%) and Italian (13.6%).

Table 4: Communication skills

Language skills	N (% of migrants)
Arabic	504 (50.5)
English	465 (46.5)
French	191 (19.1)
Italian	136 (13.6)
Spanish	103 (10.3)
German	55 (5.5)
Swedish	48 (4.8)
Bulgarian	11 (1.1)
Greek	10 (1.0)
Maltese	3 (0.3)

Household Characteristics

In Table 5 are presented the household characteristics of the participants. The sample is divided to single (47.1%) and engaged/married/lining with partner (45.3%). From those engaged/married/lining with partner, about one third (31.3%) are staying without their partner. 59.7% share the accommodation with non-family members (on average 5 members). 7.8% do not feel safe at all.

Table 5: Household characteristics

Marital status [N= 1,278; n (%)]	Single	602 (47.1)
	Engaged/married/living with partner	579 (45.3)
	Separated/ Divorced	47 (3.7)
	Widowed	50 (3.9)
From those engaged/married/living with partner: Is your partner/husband/wife with you right now? [N= 571; n (%)]	Yes	392 (68.7)
	No	179 (31.3)
Do you have children under 18 years old? [N= 1,028; n (%)]	Yes	521 (50.7)
	No	507 (49.3)
Where do you live right now? [N= 1,003; n (%)]	Tent	13 (1.0)
	Container	138 (11.0)
	Apartment/Home	484 (38.7)
	Dormitory/Home	266 (21.3)
	Streets/abandoned	17 (1.3)
Do you feel safe in your current accommodation? [N= 1,260; n (%)]	Not safe at all	98 (7.8)
	Somewhat safe	160 (12.7)
	Fairly safe	322 (25.6)
	Fully safe	680 (54.0)
Do you share this accommodation with non-family members? [N= 1,248; n (%)]	Yes	745 (59.7)
	No	503 (40.3)
If yes, with how many *[Mean (sd)]*		4.57 (5.42)

The distribution of the first three characteristics are presented separately for each country of birth in the Figures A1-A3, while the last three are presented by the country of interview in Table A.1 and in Figures A4-A5 in Appendix A.

Education and employment

On average the migrants have completed 7.5 years (standard deviation 5.5) in school. As depicted in Table 6, more educated are those from Iran (mean 10.0 years, st.dev. 5.1) and Iraq (mean 8.3 years, st.dev. 5.3) and less educated those from Somalia (mean 5.0 years, st.dev. 4.1).

Table 6: Distribution of number of completed school years by country of birth

Country of birth	Mean (95% Confidence interval)
Syria (N= 284)	7.05 (6.40, 7.70)
Afghanistan (N= 206)	6.96 (6.21, 7.71)
Iraq (N= 121)	8.31 (7.36, 9.26)
Nigeria (N= 114)	7.11 (6.21, 8.00)
Somalia (N= 50)	4.96 (3.80, 6.12)
Iran (N= 47)	9.96 (8.46, 11.46)
Other (N= 464)	8.03 (7.51, 8.56)
Total (N= 1286)	7.54 (7.24,7.84)

Kruskal Wallis p-value< 0. 001

As displayed in Table 7, 47.5% of migrants declare they receive a regular income. There are significant differences (p-value<0.001) among the host countries, with 89.5% of migrants in Austria and 79.2% in Greece declaring they receive regular income, as opposed to 10.7% in Bulgaria and 27.1% in Italy. From

those receiving income 37.3% receive from government allowance, 25.9% from an NGO/UNHCR and 27.8% have paid job.

Table 7: Distribution of the question "Do you receive a regular income?", by country of interview

Country of interview	No [N (%)]	Yes [N (%)]
Austria (N= 105)	11 (10.5)	94 (89.5)
Bulgaria (N= 224)	200 (89.3)	24 (10.7)
Cyprus (N= 94)	41 (43.6)	53 (56.4)
France (N= 48)	28 (59.3)	20 (41.7)
Germany (N= 9)	3 (33.3)	6 (66.7)
Greece (N= 212)	44 (20.8)	168 (79.2)
Italy (N= 266)	194 (72.9)	72 (27.1)
Malta (N= 26)	7 (26.9)	19 (73.1)
Spain (N= 111)	75 (67.6)	36 (32.4)
Sweden (N= 91)	20 (22.0)	71 (78.0)
Total (N= 1,186)	623 (52.5)	563 (47.5)

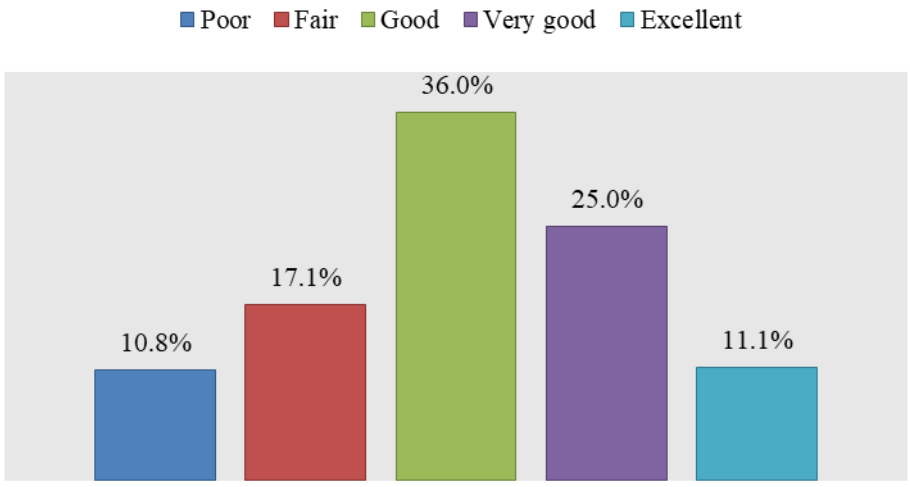
Chi-square p-value< 0.001

General well being

The average Body Mass Index of migrants was found equal to 24.7 (95% confidence interval 24.5-24.9; median 24.2). Approximately 3.1% of migrants were found underweight, 31.4% overweight and 9.4% obese.

In terms of general health perception, 10.8% of migrants state that their health is poor and 17.1% fair (see Figure 2).

Figure 2: Distribution of the question "In general, would you say your health is:"



The SF-36 general health, vitality and mental health subscale scores have been computed. These scores take values from 0 to 100, with lower values signaling more disability. The average mental health score was equal to 60.1 (std.dev. 21.4), the mean vitality score equal to 56.7 (std.dev. 23.0) and the average

general health score equal to 49.8 (std. dev. 11.8). Note that, in general, normative scores for EU populations lie above 65.

It is interesting to examine how these scores vary by country of birth. As presented in Table 8 and Figure 3, higher mental health scores display migrants from Nigeria (mean 65.0) and Syria (64.2) and lower migrants from Iran (50.6) and Afghanistan (51.0). Higher Vitality scores present again migrants from Nigeria (63.4) and other country (60.8) and lower migrants from Afghanistan (44.7) and Somalia (47.0). For General Health scores, we observe lower scores for migrants from Iran (46.6) and Syria (48.8).

Table 8: Distribution of SF-36 scores by country of birth

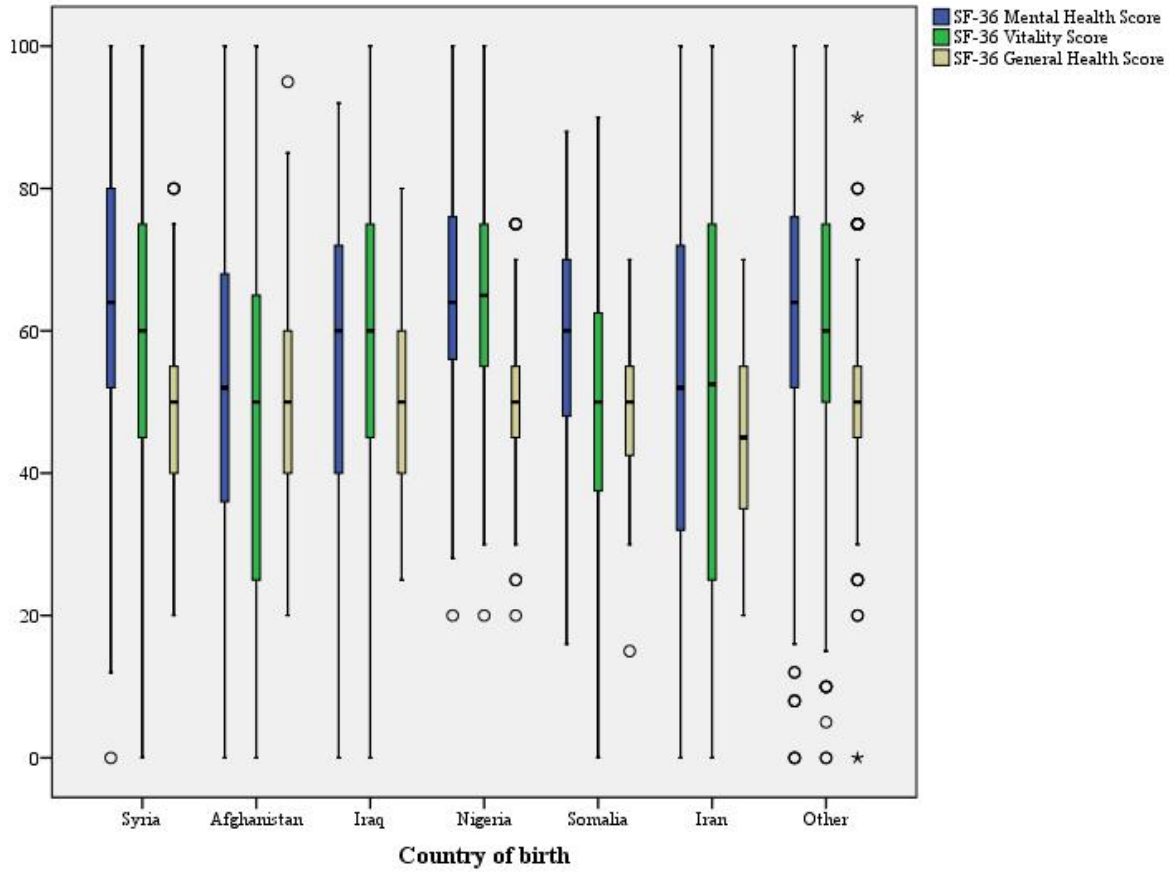
SF- 36 scores	Country of birth	Mean (95% Confidence Interval)
Mental Health Score	**Syria** (N= 207)	64.15 (61.47, 66.84)
	Afghanistan (N= 180)	50.98 (47.46, 54.49)
	Iraq (N= 96)	55.21 (50.56, 59.86)
	Nigeria (N= 113)	64.96 (61.96, 67.96)
	Somalia (N= 44)	58.45 (52.76, 64.15)
	Iran (N= 44)	50.55 (42.83, 58.26)
	Other (N= 426)	62.99 (61.07, 64.90)
	Total (N= 1,110)	60.11 (58.85, 61.37)
Vitality Score	**Syria** (N= 212)	58.56 (55.56, 61.56)
	Afghanistan (N= 181)	44.67 (40.91, 48.43)
	Iraq (N= 99)	56.92 (52.09, 61.75)
	Nigeria (N= 114)	63.38 (60.32, 66.44)
	Somalia (N= 45)	47.00 (40.80, 53.20)
	Iran (N= 44)	48.75 (40.05, 57.45)
	Other (N= 428)	60.75 (58.77, 62.72)
	Total (N= 1,123)	56.65 (55.30, 58.00)
General health score	**Syria** (N= 212)	48.75 (47.22, 50.28)
	Afghanistan (N= 173)	50.52 (48.31, 52.73)
	Iraq (N= 106)	50.28 (48.00, 52.57)
	Nigeria (N= 112)	50.04 (48.13, 51.96)
	Somalia (N= 43)	49.07 (45.76, 52.38)
	Iran (N= 43)	46.63 (42.42, 50.83)
	Other (N= 423)	50.28 (49.24, 51.32)
	Total (N= 1,112)	49.82 (49.12, 50.51)

Kruskal Wallis test for equality of SF-36 Mental Health Score by country of birth p-value< 0. 001

Kruskal Wallis test for equality of SF-36 Vitality Score by country of birth p-value< 0. 001

Kruskal Wallis test for equality of SF-36 General health Score by country of birth p-value= 0. 262

Figure 3: Distribution of SF-36 scores by country of birth



In Table 9 and Figure 4 is presented the distribution of SF-36 scores by country of interview. There are statistically significant differences of all three SF-36 scores with respect to country of interview (p-value<0.001). Higher Mental health scores display migrants in Sweden (mean 65.1) and Italy (65.3), while lower scores have the migrants in Cyprus (53.6) and Greece (53.7). With respect to Vitality, higher scores present migrants in Spain (65.8), Italy (64.1) and Austria (62.5), while lower scores are presented in Germany (41.8) and Greece (47.4). Finally, higher General Health scores display migrants in Malta (52.3) and Greece (51.9), while migrants in Bulgaria (46.3) and Austria (46.9), scored lower.

Table 9: Distribution of SF-36 scores by country of interview

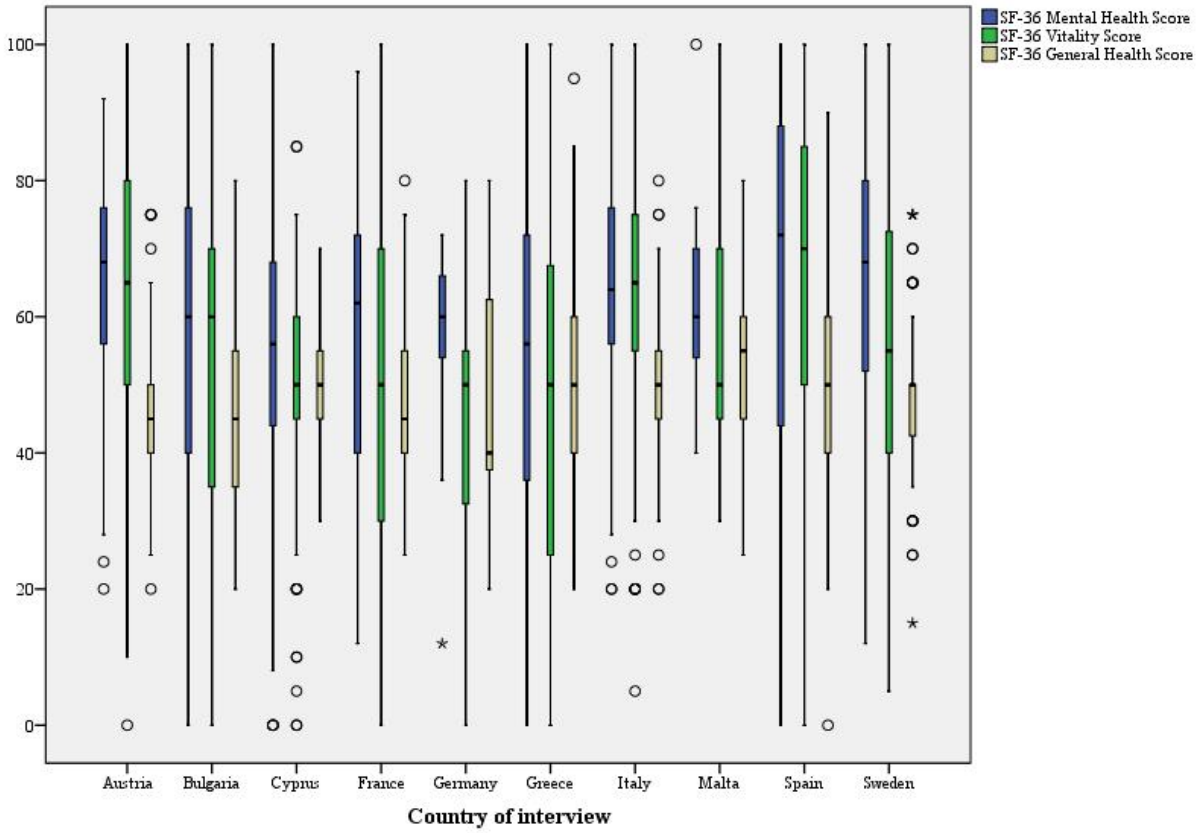
SF-36 scores	Country of interview	Mean (95% Confidence Interval)
Mental Health Score	**Austria** (N=113)	64.11 (61.12, 67.10)
	Bulgaria (N=115)	55.13 (50.43, 59.83)
	Cyprus (N=113)	53.63 (49.91, 57.34)
	France (N=49)	58.45 (51.98, 64.91)
	Germany (N=11)	55.64 (43.77, 67.50)
	Greece (N=222)	53.66 (50.51, 56.80)
	Italy (N=266)	65.34 (63.55, 67.12)
	Malta (N=20)	64.00 (57.60, 70.40)
	Spain (N=110)	64.58 (59.44, 69.72)
	Sweden (N=91)	65.14 (61.07, 69.21)
Vitality Score	**Austria** (N=113)	62.52 (58.75, 66.30)
	Bulgaria (N=123)	55.04 (50.17, 59.91)
	Cyprus (N=114)	50.70 (47.71, 53.70)
	France (N=48)	49.69 (42.70, 56.68)
	Germany (N=11)	41.82 (25.97, 57.66)
	Greece (N=225)	47.38 (43.98, 50.78)
	Italy (N=266)	64.08 (62.14, 66.02)
	Malta (N=22)	51.14 (39.79, 62.48)
	Spain (N=110)	65.77 (61.09, 70.46)
	Sweden (N=91)	55.99 (51.67, 60.31)
General Health Score	**Austria** (N=110)	46.91 (44.95, 48.87)
	Bulgaria (N=126)	46.31 (44.10, 48.52)
	Cyprus (N=109)	51.06 (49.68, 52.43)
	France (N=43)	49.77 (46.12, 53.41)
	Germany (N=11)	47.27 (35.22, 59.32)
	Greece (N=223)	51.88 (49.99, 53.78)
	Italy (N=268)	50.69 (49.59, 51.79)
	Malta (N=20)	52.25 (46.15, 58.35)
	Spain (N=111)	50.18 (47.55, 52.81)
	Sweden (N=91)	48.41 (46.09, 50.72)

Kruskal Wallis test for equality of SF-36 Mental Health Score by country of interview p-value< 0. 001

Kruskal Wallis test for equality of SF-36 Vitality Score by country of interview p-value< 0. 001

Kruskal Wallis test for equality of SF-36 General health Score by country of interview p-value< 0. 001

Figure 4: Distribution of SF-36 scores by country of interview



Access and interaction with health care services

36.9% of the respondents stated that did not need health care services during the last 6 months, 42.8% stated that they needed and had access to them and 14.6% that they needed and did not have access to them. In Table 10 are presented the problems interfered with access to healthcare services, on basis of the migrants that stated that they needed access. The most frequent problems are related to long waiting times (48.6% of migrants stated that), not knowing where to go (32.9%), not being able to organize an appointment (32.3%), lack of communication and understanding of doctors and their instructions (30.1%), and long distances (28.7%).

Table 10: Frequencies of problems with accessing the healthcare

Problems with accessing healthcare	N (% migrants)
Long waiting times	173 (48.6%)
Not knowing where to go	117 (32.9%)
Not being able to organize an appointment	115 (32.3%)
Lack of communication and understanding of doctors and their instructions	107 (30.1%)
Long distance	102 (28.7%)
Feeling that you don't get the care you need	91 (25.6%)
Lack of understanding of the Health Care System	88 (24.7%)
Feeling uncomfortable	83 (23.3%)
High cost	64 (18.0%)
Provision/availability of medication	60 (16.9%)
Feeling discriminated against	57 (16.0%)
The behaviour of health professionals (doctors/nurses etc)	53 (14.9%)
The behaviour of administrative staff (secretaries/reception staff etc)	44 (12.4%)
Fear of the doctors	35 (9.8%)
Fear of medical examinations	34 (9.6%)
Fear of having problems with the authorities	24 (6.7%)

With respect to chronic diseases (Table 11), 36.6% of migrants stated that had caries (bad teeth), 34.9% headaches / migraines, 29.6% psychological diseases, 27.2% sleep disorders and 20.7% a disease related to bone and muscle. 18.4% indicated they had eye diseases and 16.8% skin diseases. 15.9% of migrants stated that they suffer from gastrointestinal disease, 14.2% from ear, nose and throat diseases, 13.4% from chronic problems from injury/ accidents, 13.3% from respiratory disease, 11.2% from high blood pressure, 10.3% urinary infections, 9.6% heart disease, 9.4% diabetes, 8.2% kidney disease, 3.7% tuberculosis, 2.7% cancer and brain stroke and 2.6% AIDS/HIV.

Table 11: Frequencies of Chronic Diseases

Chronic diseases	N (% migrants)
Caries (Bad teeth)	281 (36.6%)
Headaches / Migraines	268 (34.9%)
Psychological disease (depression, anxiety, worry, stress)	227 (29.6%)
Sleep disorders	209 (27.2%)
Disease related to bone and muscle	159 (20.7%)
Eye diseases	141 (18.4%)
Skin diseases	129 (16.8%)
Gastrointestinal disease	122 (15.9%)
Ear, Nose and Throat diseases	109 (14.2%)
Chronic problems from injury/accidents	103 (13.4%)
Respiratory disease (asthma, chronic bronchitis, pneumonia)	102 (13.3%)
High blood pressure	86 (11.2%)
Urinary infections	79 (10.3%)
Heart disease	74 (9.6%)
Diabetes	72 (9.4%)
Kidney disease	63 (8.2%)
Tuberculosis	28 (3.7%)
Cancer	21 (2.7%)
Brain stroke	21 (2.7%)
AIDS/HIV	20 (2.6%)

During their interactions with healthcare services 60.1% of the migrants stated that they needed translation always or most of the times (Table 12). 61.0% were helped by a professional, 15.3% by a family member and 7.9% by nobody. 13.1% of the migrants stated that during the last 6 months needed medication and were not able to take it. The majority of migrants (71.9%) do not believe they have worse access to health care services compared to local people.

Table 12: Access to healthcare

Question	N	Percent
During your interactions with healthcare services, were you in need for a translation? (N= 1,178)		
Never	264	22.4
Few times	207	17.6
Most times	248	21.1
Always	459	39.0
When translation was needed, who assisted you? (N= 946)		
A professional (translator/cultural mediator)	577	61.0
A family member/friend	145	15.3
Nobody was available	75	7.9
During the last 6 months did you need to take medication and were not able to? (N= 1,084)		
I did not need to take medication during the last 6 months	418	38.6
I needed to take medication during the last 6 months and I had access to them	524	48.3
Yes, I needed medication and I was not able to take it	142	13.1
Do you believe that you have worse access to health services compared to the local people? (N= 1,080)		
No	776	71.9
Yes	304	28.1

The characteristics shown in this section are presented by country of birth or by country of interview in Tables A2-A5 and in Figures A6-A9 in Appendix A.

Screening

5.1% of migrants declared they had a colonoscopy in the past, only 20.4% of female migrants had a Pap Test in the past and 12.8% a mammogram (Table 13).

Table 13: Screening

	N	Percent
Have you ever had a colonoscopy? (N= 1,187)		
No	1,064	89.6
Yes	60	5.1
I don't know	63	5.3
Have you ever had a Pap Test/cervical cancer screening? (N= 543)		
No	412	75.9
Yes	111	20.4
I don't know	20	3.7
Have you ever had a mammogram? (N= 455)		
No	452	85.0
Yes	68	12.8
I don't know	12	2.2

Dental Care

17.4% of migrants consider their dental condition as poor and 26.6% fair. 27.3% have visited a dentist during the last year, while 23.7% have never visited a dentist or a dentist's clinic. 10.4% do not brush their teeth every day; 29.4% of migrants do not know where to go in case they need a dentist.

Table 14: Dental Care

	N	Percent
How would you describe the condition of your TEETH or DENTURES? (N= 1,237)		
Poor	215	17.4
Fair	329	26.6
Good	357	28.9
Very good	207	16.7
Excellent	129	10.4
How long has it been since you last visited a dentist or a dentist's clinic for any reason? (N= 1,229)		
I have never visited a dentist or a dentist's clinic	291	23.7
More than 5 years	100	8.1
Between 2-5 years ago	140	11.3
Between 1-2 years ago	211	17.2
Less than 12 months ago	335	27.3
Do Not Remember	152	12.4
Do you brush your teeth every day? (N= 1,231)		
No	128	10.4
Yes	1,103	89.6
Do you know where to go in case you need a dentist? (N= 1,125)		
No	365	29.4
Yes	876	70.6

Immunization status

73.3% of migrants (874 out of 1,193 valid answers) do not have a vaccination card and 26.7% do so. In Table 15 is presented the distribution of immunizations by disease. It is evident that the percentages of migrants having received immunization either in the present country or in the country of entry in the EU are quite low (range from 6.9% for influenza to 21.3% for Tetanus).

Table 15: Have you received immunization for any of the following diseases? (either in the present country or in the country of entry in the EU)

Disease	% I don't know	% No	% Yes	N*
Hepatitis A	16.9	68.0	15.2	1,030
Hepatitis B	14.9	67.4	17.7	1,024
Influenza	16.3	76.8	6.9	954
Measles	16.0	70.1	13.9	1,006
Pneumococcus (pneumonia)	16.3	70.9	14.8	1,008
Polio (all in adult booster shots)	15.7	69.5	14.8	1,003
Tuberculosis	15.2	68.7	16.1	1,008
Tetanus	14.7	64.0	21.3	1,027

Note: There were many missing values in the specific diseases (ranging from 256 to 332 out of 1,286 cases by disease), since many migrants not having immunized and responded that do not have immunization card did not feel these questions. Thus, in case of missing values in a specific disease, if the migrant did not have immunization card the response was set to no.

The characteristics concerning the participants' immunization status are presented separately for each country of interview in Figures A9-A17 in the Appendix. In Table A.6 characteristics for the immunization status of the children are shown for the total sample, based on the answers given by their parents.

Skin problems

17.6% of migrants (212 out of 1,203 valid answers) responded they had itching at the moment (with intensity on average of 2.8 in a scale from 0 to 10) and 12.0% (125 out of 1,039) a rash.

Women's Health

52.6% of female respondents answered they have visited a gynecologist/midwife while in their current country. 45.0% prefer to be seen by a gynecologist, 10.8% by a midwife, while 44.2% have no preference. 32.5% state they have been pregnant while in this country. 10.0% of them had abortion and 15.0% miscarriage. The majority of them (92.8%) gave birth in a public hospital/clinic. It is interesting to note that on average female migrants who had a pregnancy in their life (508 affirmative responses) had on average 2 pregnancies, 20.1% of them had 4 or more pregnancies, while 16.1% of them had 4 or more labors. These above characteristics are presented separately for each country of interview in Figures A18-A21 in the Appendix.

Table 16: Women's Health

	N	Percentage
Have you visited a gynaecologist/midwife while in this country? (N= 458)		
No	217	47.4
Yes	241	52.6
Do you prefer to be seen by a gynaecologist or a midwife for your gynaecology related issues? (N= 398)		
Gynecologist	179	45.0
Midwife	43	10.8
No preference	176	44.2
Have you been pregnant since you were in this country? (N= 382)		
No	258	67.5
Yes	124	32.5
If yes, what was/is the outcome? (N= 120)		
Miscarriage	18	15.0
Abortion	12	10.0
Labor/Birth	65	54.2
I am currently pregnant	25	20.8
If you have been pregnant in this country where did you give birth (or are going to give birth)? (N= 83)		
At home	2	2.4
Public hospital/clinic	77	92.8
Do not know/Remember	4	4.8

Perceptions about health

As displayed in Table 17 the most important health issues for the migrants are related to teeth problems (52.5% of the respondents), headaches/migraines (37.3%), worry/anxiety (33.8%) and sleep problems (33.3%). The migrants are less worried about traditional medicine (8.0%), immunizations (10.5%) and ear problems (13.4%).

Table 17: Which of the following health issues are important to the migrants

Health issues	N (% migrants)
Teeth problems	558 (52.5%)
Headaches/migraines	396 (37.3%)
Worry/anxiety	359 (33.8%)
Sleep problems	354 (33.3%)
Back pain	322 (30.3%)
Skin problems	294 (27.7%)
Eye problems	293 (27.6%)
Muscular and Bone problems	288 (27.1%)
Gastrointestinal	283 (26.6%)
Respiratory problems	275 (25.9%)
Chest pain	236 (22.2%)
Overweight/obesity	173 (16.3%)
Recurrent and continuous pain from e.g. older injuries or surgical operations	152 (14.3%)
ONLY WOMEN: Gynecological Problems	149 (14.0%)
Ear problems	142 (13.4%)
Immunizations	112 (10.5%)
Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	85 (8.0%)

Migrants want to receive more information in higher percentages (see Table 18) about their rights and how to use health care services (65.7%), healthy teeth and oral health (40.7%), nutrition and exercise (34.5%) and coping with worry and anxiety (33.4%).

Table 18: For which of the following health issues migrants need to receive more information about

	N (% migrants)
Rights and how to use health care services	639 (65.7%)
Healthy teeth and oral health	396 (40.7%)
Nutrition and exercise	336 (34.5%)
Coping with worry and anxiety	325 (33.4%)
Availability of mediators and translators	272 (28.0%)
Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	238 (24.5%)
Vaccinations	191 (19.6%)
Child health, Pregnancy and family planning	159 (16.3%)
Tobacco use	150 (15.4%)
Diabetes	142 (14.6%)
Alcohol consumption risks	132 (13.6%)

Migrants when they face a medical problem they tend in higher percentages to go to a public hospital (51.6%), go to a clinic/doctor (39.9%) or go to the pharmacy (31.6%). However, 11.8% of them tend to wait for the problem to pass, 10.6% go to family/friends and 5.8% turn to traditional medicine. It is interesting to note that about 21.1% of them go to a private doctor, whereas 18.8% go to a clinic outside the camp. They tend to follow similar practices for their children (see Table 19).

Table 19: What migrants and their children do when they face a medical problem

Setting	For themselves	For their children
	N (% migrants)	N (% migrants)
I go to a clinic/doctor (in camps)	461 (39.9%)	172 (14.9%)
I go to a clinic (not hospital) outside camp	217 (18.8%)	81 (7%)
I go to a private doctor/GP	243 (21.1%)	79 (6.8%)
I go to a pharmacy	365 (31.6%)	131 (11.4%)
I go to a public hospital (free)	596 (51.6%)	231 (20%)
I go to a private hospital (fee needs to be paid)	57 (4.9%)	25 (2.2%)
I go to family/friends	122 (10.6%)	45 (3.9%)
I help myself	249 (21.6%)	50 (4.3%)
I wait for the problem to pass	136 (11.8%)	32 (2.8%)
I turn to traditional medicine (homeopathy, acupuncture, self-made healing procedures)	67 (5.8%)	24 (2.1%)

As displayed in Table 20 most migrants (73.7%) do not have a preference on the health personnel that treats them. However 35.8% of women migrants prefer the health personnel to be also a woman. The above characteristics are presented separately for each country of interview in Tables A7-A8 and in Figures A22-A24 in the Appendix.

Table 20: Preference of health personnel gender, according to migrants' gender

		Health personnel gender		
		Male	Female	No preference
Gender [N (%)]	**Female**	7 (1.8)	143 (35.8)	250 (62.5)
	Male	110 (15.3)	35 (4.9)	576 (79.9)
Total sample [N (%)]		117 (10.4)	178 (15.9)	826 (73.7)

Current situation

As displayed in Table 21, migrants (that on basis of selection criteria have entered the EU less than 5 years ago) left on average their country of origin about 3 years ago approximately (40 months) and arrived in Europe on average about 23 months ago, with the average time to enter Europe being 17 months after leaving their country of origin. They live in the country of interview on average for 22 months.

Table 21: Length of stay (in months) in the country of interview, in Europe and time since left the country of origin

	Mean (SD)	95% Confidence Interval	
		Lower Bound	Upper Bound
Months since left the country of origin	39.5 (47.1)	36.6	42.4
Months since arrived in Europe	23.1 (13.7)	22.3	24.0
Months since arrived in this country	22.0 (13.6)	21.2	22.9
Months since left the country of origin until entering EU	16.7 (46.1)	13.8	19.6
Months since entering EU to reach the current country	1.4 (4.9)	1.1	1.7

SD: Standard Deviation

In Figure 5 is displayed the error bar (showing the mean and the confidence interval) for months taken for the migrants to enter EU since leaving their country of origin (here is displayed as a proxy the country of birth we have related data). For all countries it is needed on average 10-15 months. However for migrants from Afghanistan it was needed on average 40 months.

In Figure 6 is displayed the error bar (showing the mean and the confidence interval) for months taken for the migrants to reach the current country since entering EU. It is evident that this time interval is close to

zero for countries like Greece, Italy and Bulgaria, since these are countries of entry in the EU. Migrants needed about 1.5 months since entering EU to reach Spain and Sweden, 2.5 months to reach Cyprus, 3 months to reach Austria, 5 months to reach France and about 8 months to reach Malta.

Figure 5: Months since left the country of origin until entering EU, by country of birth (displayed is the mean time needed and the confidence interval by country of birth)

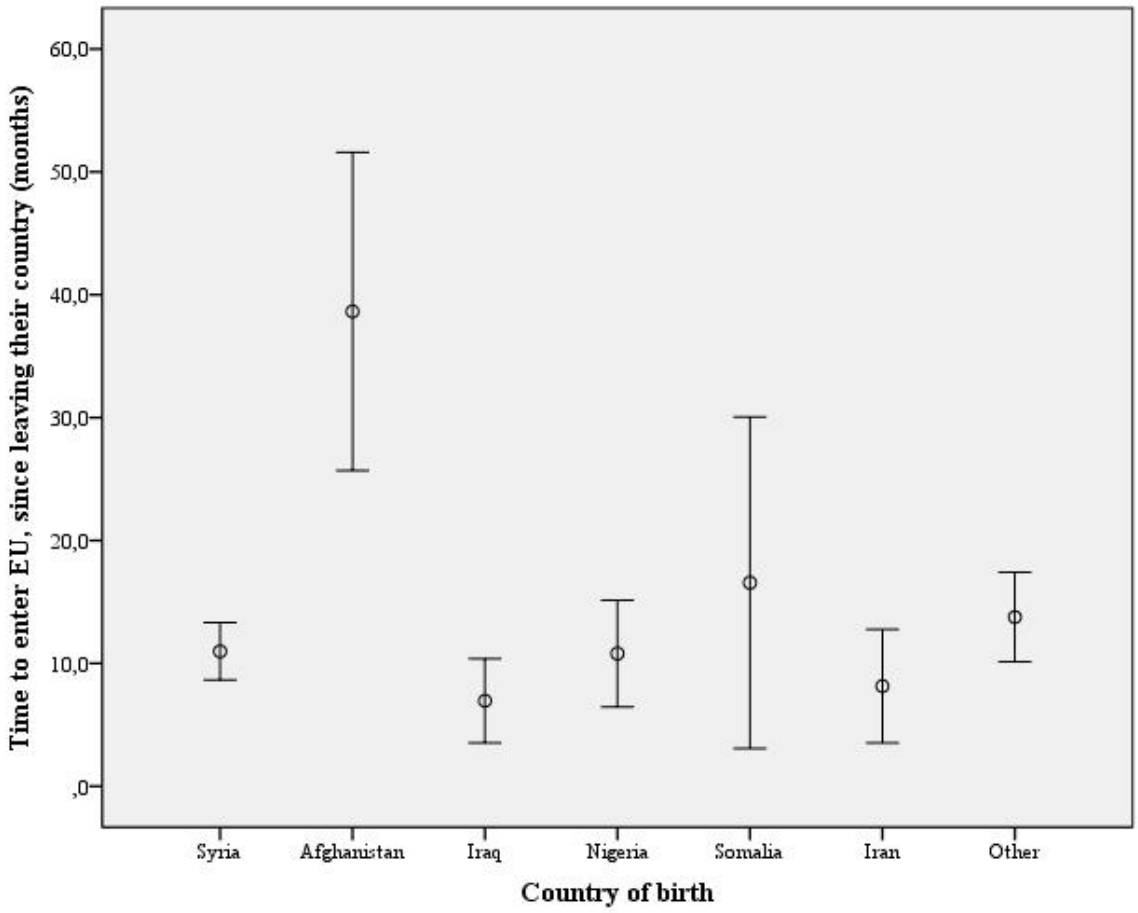
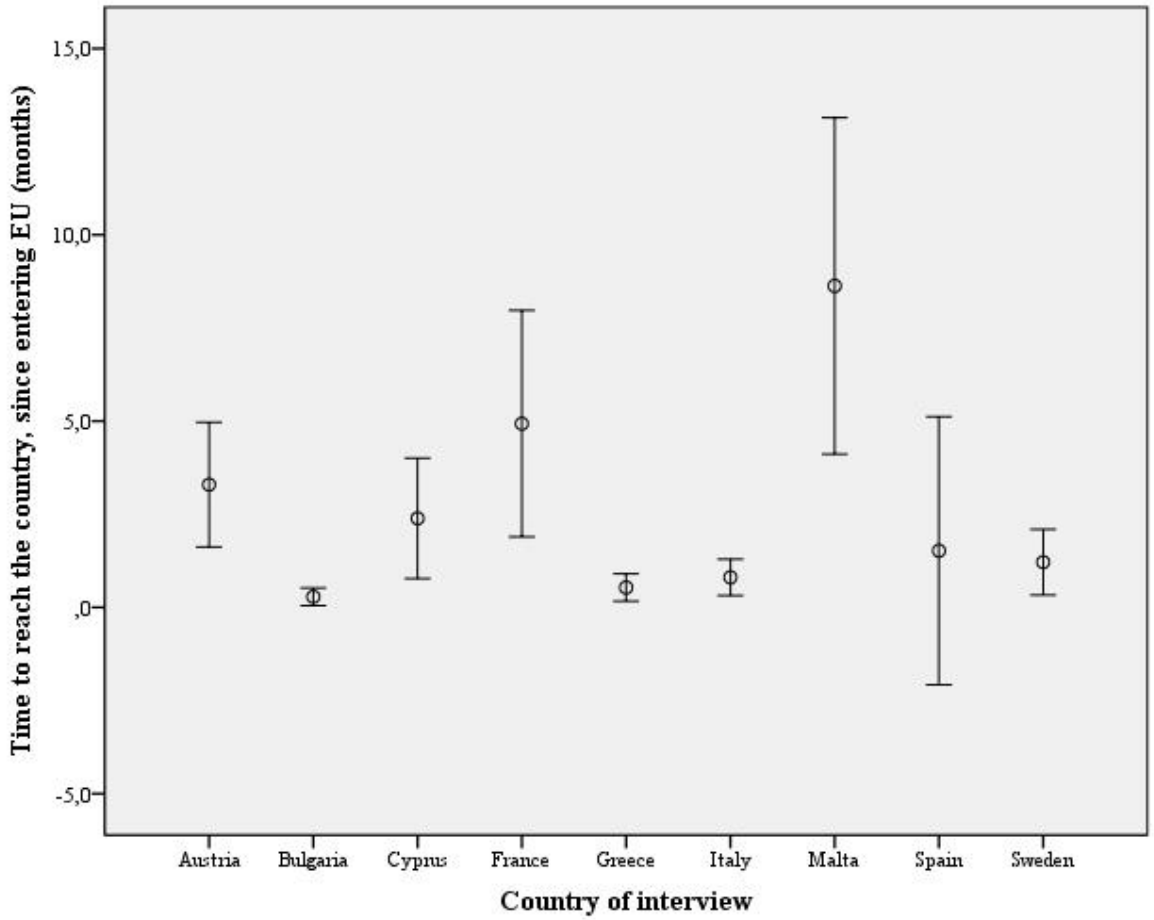


Figure 6: Months since entering EU to reach the current country, by country of interview (displayed is the mean time needed and the confidence interval by country of interview)



The 56.9% of migrants entered EU through Turkey and the 26.3% via Libya (see Table 22). All other countries (gates of entry) represent rather small percentages (in total below 12%).

Table 22: From where did the migrants cross into Europe

	N	Percentage
Turkey	692	56.9
Libya	320	26.3
Lebanon	20	1.6
Egypt	6	0.5
Morocco	34	2.8

As presented in Table 23 the majority of migrants in Germany (100%), Italy (93.1%), France (92.2%) and Austria (81.3%) consider these countries as their final destination. Inversely only the 35.9% of migrants in Greece and 42.9% in Malta consider these countries as their final destination.

The majority of migrants (53.8%) seem to have requested an asylum. The percentage is above 78.0% in all countries, except Bulgaria that the percentage of migrants asking asylum is low (13.1%) and Spain where the respective proportion of migrants asking for asylum is 27.8%. In total, 27.8% of migrants have been

granted asylum, with higher percentages observed in France (65.9%) and Austria (42.9%). Only 46.6% of migrants approximately, have a permit to stay (even temporarily) in these countries, with the percentages being significantly differentiated among the 10 EU- countries.

Table 23: Country of final destination, asylum and residence permit by country of interview

Country of Interview	Is this country your final destination?	Did you ask for asylum in this country?	Have you been granted asylum?	Do you have any other kind of permit to stay in this country?
Austria	81 (73.0)	90 (83.3)	48 (42.9)	59 (53.6)
Bulgaria	138 (61.6)	29 (13.1)	30 (23.3)	1 (0.4)
Cyprus	76 (67.9)	107 (96.4)	23 (21.3)	61 (57.0)
France	47 (92.2)	41 (85.4)	29 (65.9)	21 (45.7)
Germany	11 (100.0)	10 (90.9)	3 (27.3)	8 (80.0)
Greece	83 (35.9)	183 (77.9)	84 (37.3)	98 (43.6)
Italy	243 (93.1)	263 (98.1)	41 (15.6)	210 (79.8)
Malta	9 (42.9)	25 (89.3)	5 (20.0)	24 (92.3)
Spain	99 (89.2)	30 (27.8)	15 (13.8)	33 (30.0)
Sweden	81 (91.0)	71 (78.0)	33 (36.3)	51 (56.0)

Note: The results are presented in the form N (%), where N and the respective percentage represent the participants who answered YES to these questions.

Conclusions

The analysis was based on 1,286 questionnaires gathered in 10 EU-member states, answered by adult migrants residing less than 5 years in the specific country. Most migrants were born in Syria (22.5%) and Afghanistan (16.3%), followed by Iraq (9.6%) and Nigeria (9.0%). Approximately two in three migrants are male, whereas 81.8% of migrants are below 40 years old. The migrants left their country of origin on average 3 years ago and needed 10-15 months to enter Europe, except migrants from Afghanistan that needed on average 40 months. They live in the country of interview for approximately two years. The vast majority of migrants entered Europe via Turkey (56.9%) and Libya (26.3%).

The majority of migrants (59.7%) share their accommodation with non-family members, whereas 7.8% do not feel safe at all, the main problems appearing in France (24%), Greece (17%) and Cyprus (16%). The majority of migrants in Austria, Greece and Malta receive a regular income (in most cases either by UNHCR, an NGO or government allowance). On the other hand, most migrants in Bulgaria, Italy, Spain and France do not receive a regular income.

28% of migrants stated that their health is poor or fair. Lower SF-36 mental health and vitality scores presented migrants from Iran, Afghanistan and Somalia, whereas lower general health scores migrants from Iran and Syria.

57.4% of migrants needed health care services during the last 6 months, however approximately 15% of them did not have access to them. The most frequent problems were long waiting times, not being able to organize an appointment, not knowing where to go, lack of communication and long distances.

The most frequent chronic health problem migrants phase is caries (bad teeth) (36.6%) and headaches/migraines (34.9%), followed by psychological disease (29.6%) and sleep disorders (27.2%). However it is important to note that a significant proportion of migrants stated that they suffer from gastrointestinal disease (15.9%), respiratory disease (13.3%), urinary infections (10.3%), heart disease (9.6%), diabetes (9.4%), kidney disease (8.2%), tuberculosis (3.7%), brain stroke (2.7%), cancer (2.7%) and AIDS/HIV (2.6%).

In accordance to the above, the most frequent health issues found important by migrants is teeth problems (52.5%), headaches/migraines (37.3%), worry/anxiety (33.8%) and sleep problems (33.3%). Approximately two out of three migrants want to receive more information about their rights and how to use health care services. 77.6% of migrants needed translation during their interaction with healthcare services at least few times. However the majority of migrants (71.9%) do not believe they have worse access to health care services compares to local people.

The vast majority of migrants (73.3%) do not have a vaccination card and the percentages having received immunization after entering EU are rather low for all diseases (ranging from 6.9% for influenza to 21.3% for Tetanus). Only 20.4% of female migrants had a Pap Test/cervical cancer screening in the past and only 12.8% a mammogram. Approximately one in three women have been pregnant since entering the current EU country, whereas one in four of them had miscarriage or abortion.

Summing up, most of the migrants face common medical problems such bad teeth, headaches and psychological problems. However long waiting times, not knowing where to go and lack of communication are barriers to access to healthcare. The fact that the vast majority of migrants is not immunized, although a significant proportion of them suffers from serious chronic diseases, whereas limited screening takes place for female migrants, poses serious threats for both migrants' and public health.

Part B - References

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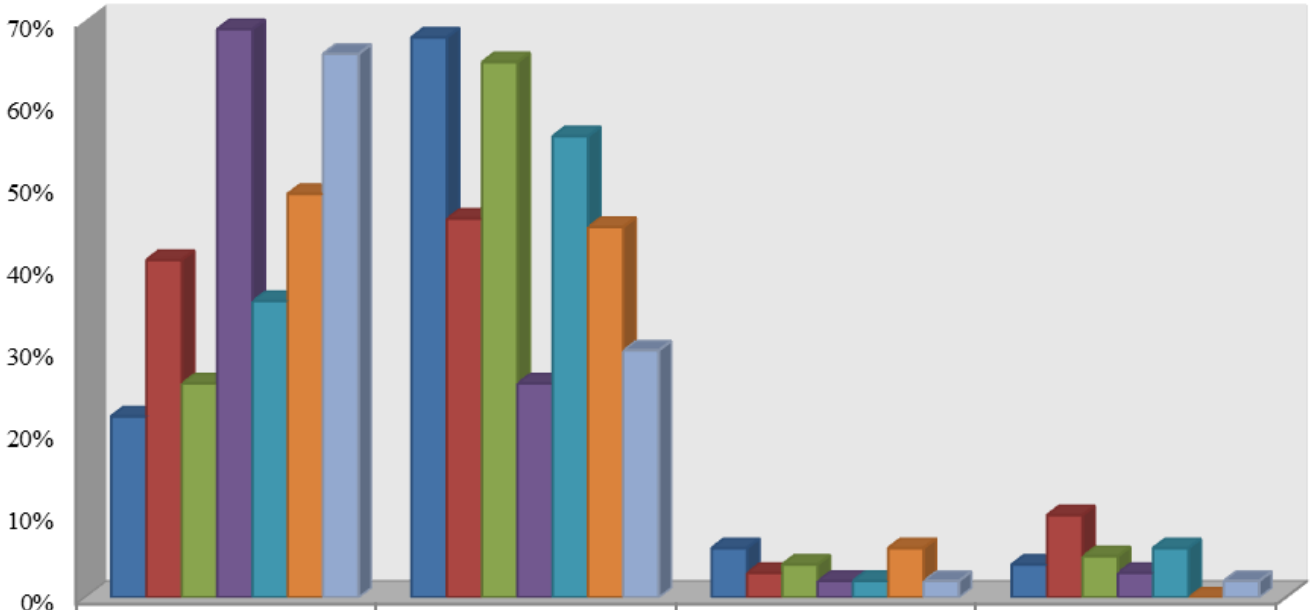
Part B – Appendix 1: STATISTICAL APPENDIX

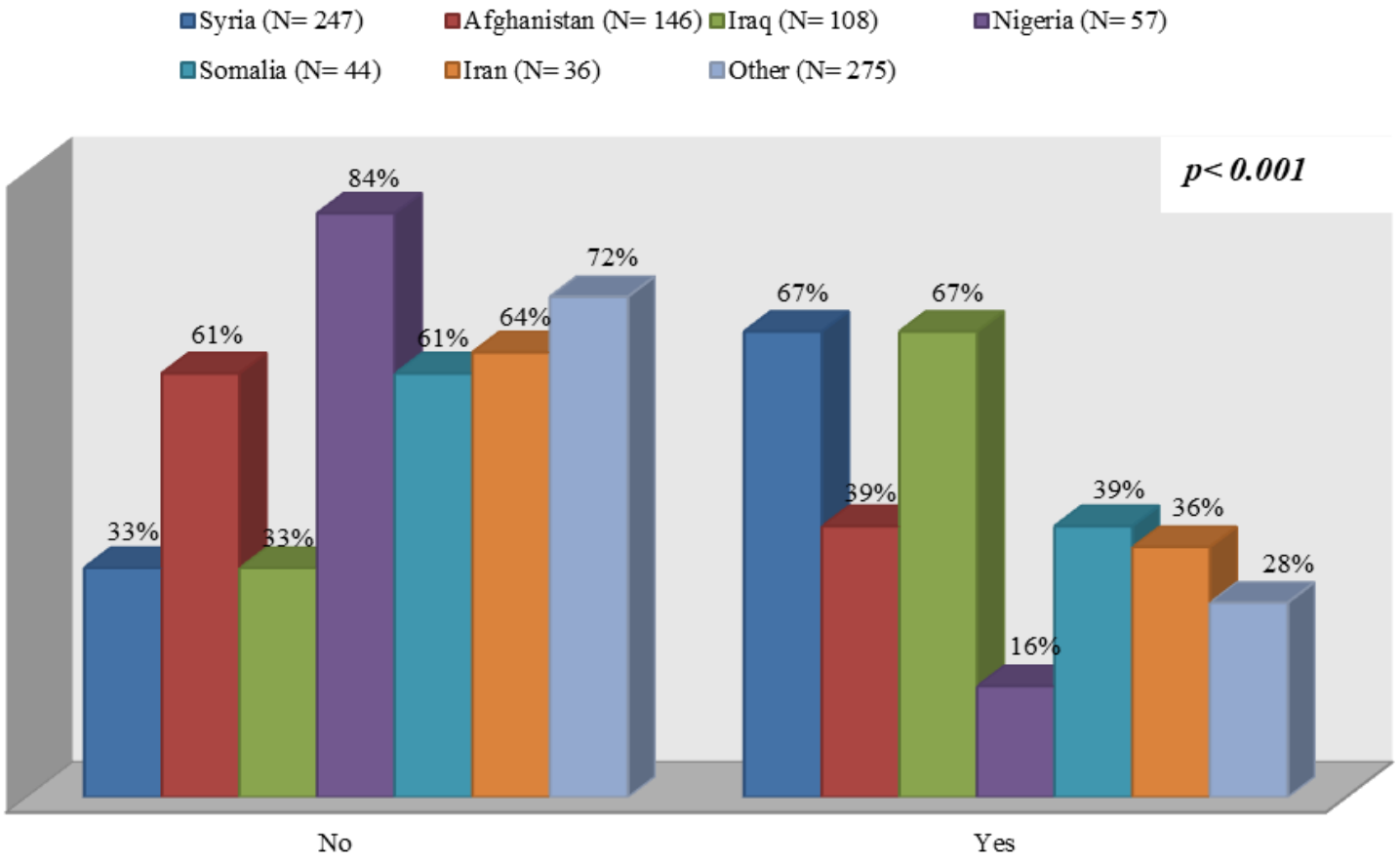
Figure A.1: Marital status of participants, by country of birth



	Single	Engaged/married/living with partner	Separated/Divorced	Widowed
Syria (N= 278)	22%	68%	6%	4%
Afghanistan (N= 204)	41%	46%	3%	10%
Iraq (N= 121)	26%	65%	4%	5%
Nigeria (N= 114)	69%	26%	2%	3%
Somalia (N= 50)	36%	56%	2%	6%
Iran (N= 47)	49%	45%	6%	0%
Other (N= 458)	66%	30%	2%	2%

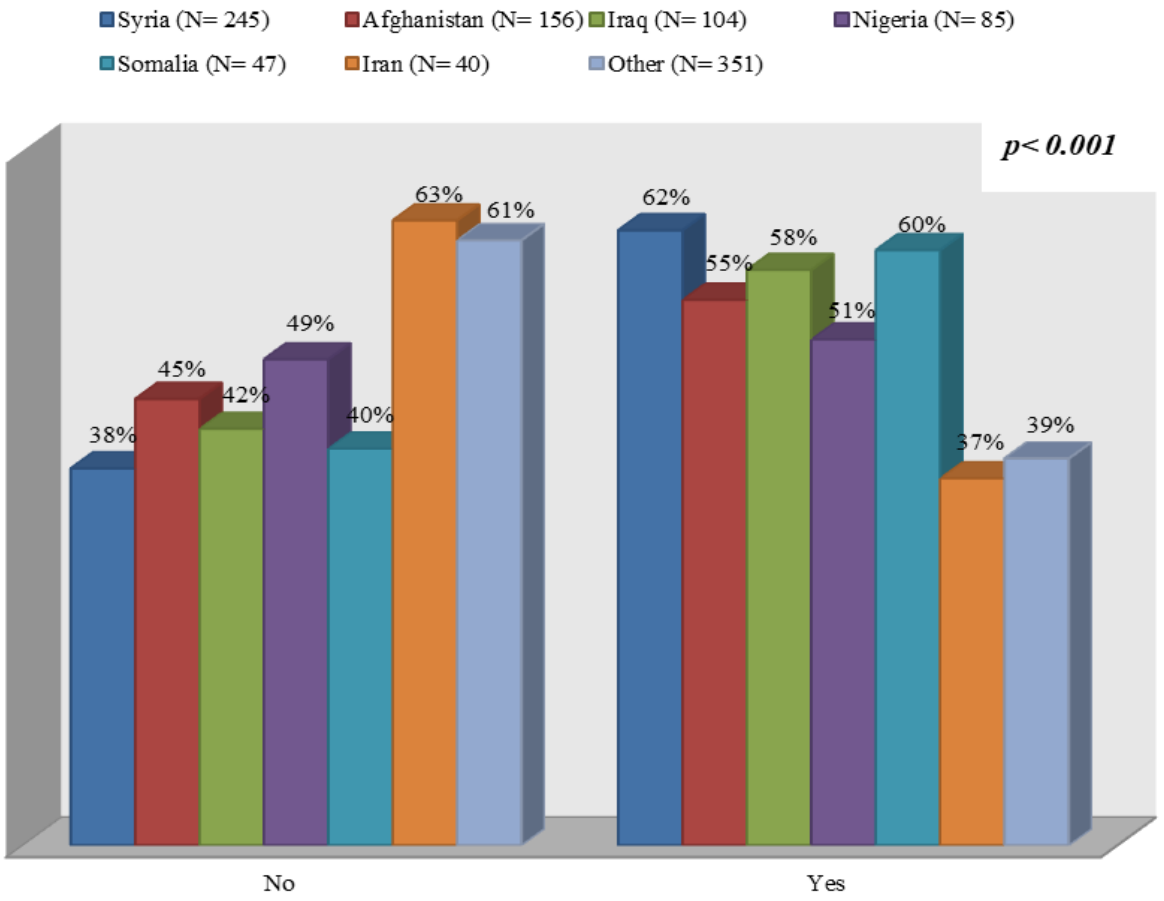
Note: p-value is based on Pearson chi-square test.

Figure A.2: Distribution of migrants living with their partner/husband/wife right now (yes) or not (no), by country of birth (on basis of those who are engaged/married/living with partner)



Note: p-value is based on Pearson chi-square test.

Figure A.3: Distribution of migrants based on whether they have children aged under 18 years old, or not, by country of birth (on basis of those who are engaged/married/living with partner)



Note: p-value is based on Pearson chi-square test.

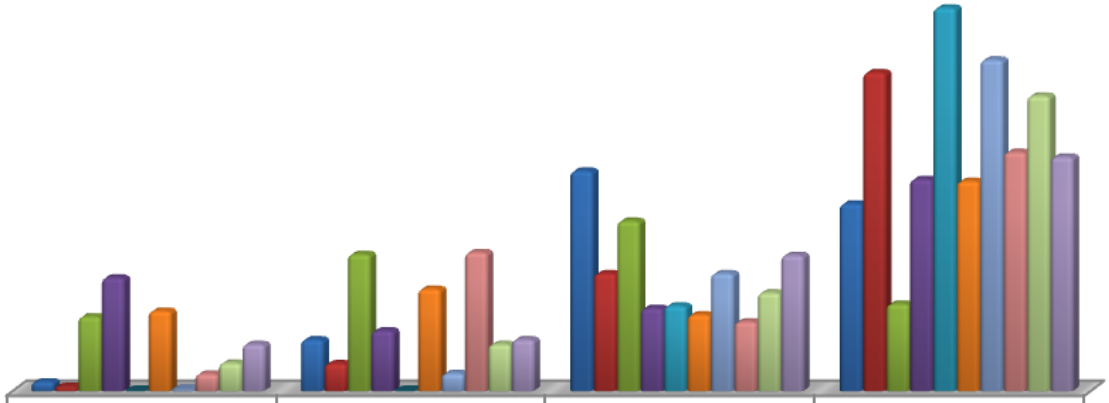
Table A.1: Type of residence, by country of interview

N (%)	Tent	Container	Apartment/ Home	Dormitory/Homeless shelter	Streets/abandoned buildings
Austria	0 (0)	0 (0)	77 (69)	20 (18)	0 (0)
Bulgaria	0 (0)	0 (0)	4 (2)	174 (80)	0 (0)
Cyprus	0 (0)	0 (0)	89 (84)	7 (7)	2 (2)
France	3 (5)	0 (0)	34 (56)	9 (15)	10 (16)
Germany	0 (0)	0 (0)	11 (100)	0 (0)	0 (0)
Greece	7 (3)	126 (51)	107 (43)	6 (2)	1 (1)
Italy	0 (0)	0 (0)	14 (5)	0 (0)	0 (0)
Malta	3 (11)	12 (43)	7 (25)	0 (0)	0 (0)
Spain	0 (0)	0 (0)	57 (52)	49 (45)	4 (4)
Sweden	0 (0)	0 (0)	84 (92)	1 (1)	0 (0)

Pearson chi-square test $p< 0.001$

Figure A.4: Degree of safety in migrants' accommodation - By country of interview

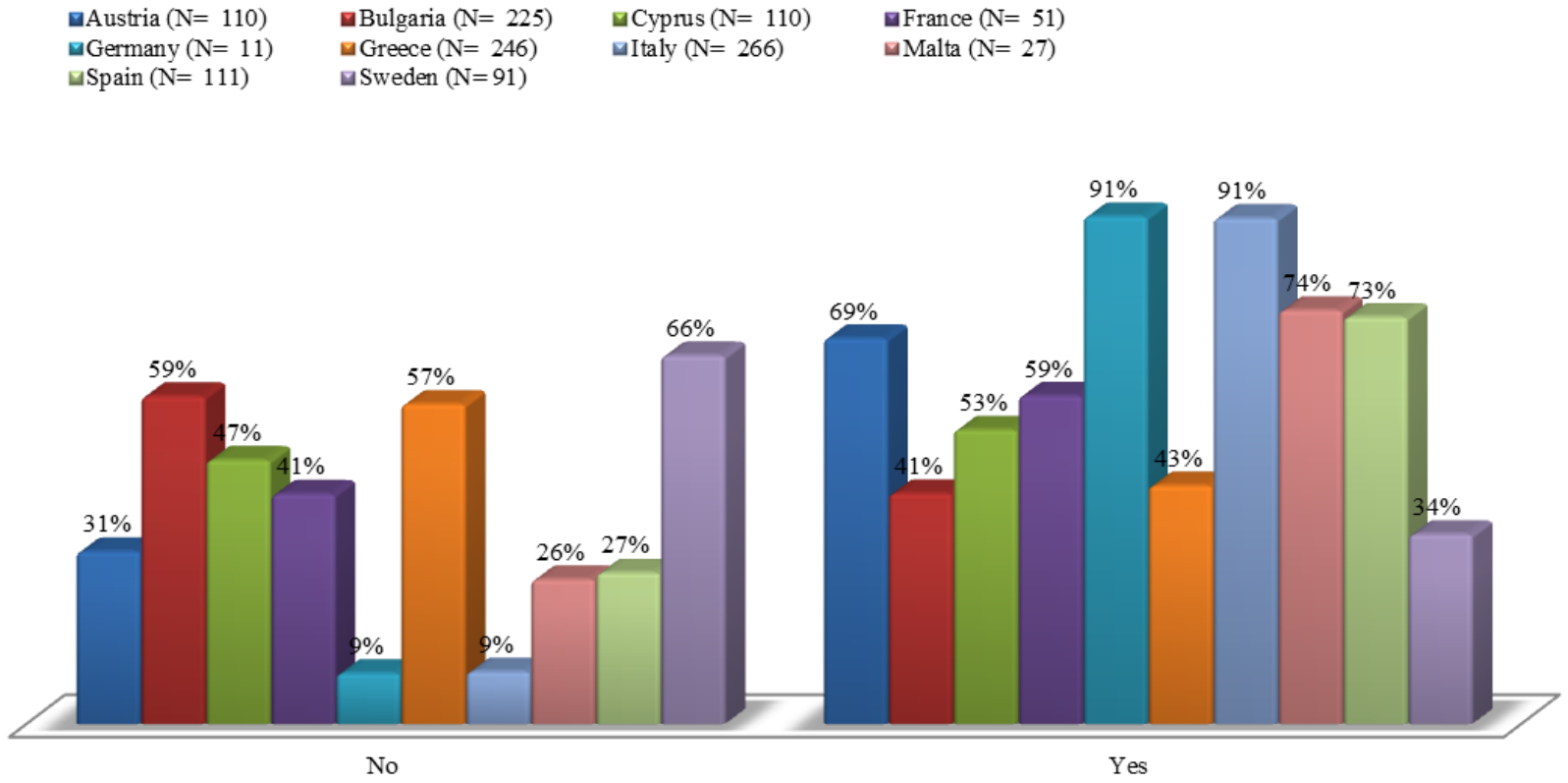
p< 0.001



	Not safe at all	Somewhat safe	Fairly safe	Fully safe
Austria (N= 111)	2%	11%	47%	40%
Bulgaria (N= 219)	1%	6%	25%	68%
Cyprus (N= 113)	16%	29%	36%	19%
France (N= 62)	24%	13%	18%	45%
Germany (N= 11)	0%	0%	18%	82%
Greece (N= 252)	17%	22%	16%	45%
Italy (N= 263)	0%	4%	25%	71%
Malta (N= 27)	4%	30%	15%	51%
Spain (N= 111)	6%	10%	21%	63%
Sweden (N= 91)	10%	11%	29%	50%

Note: p-value is based on Pearson chi-square test.

Figure A.5: Do you share this accommodation with non-family members? By country of interview



Note: p-value is based on Pearson chi-square test.

Table A.2: During the last 6 months did you need to use health care services but were not able to? By country of interview

N (%)	I did not need health care services during the last 6 months	Yes. I needed health care services and I had access to them	Yes. I needed health care services and was not able to access them
Austria (N= 113)	29 (25.7)	69 (61.1)	14 (12.4)
Bulgaria (N= 226)	102 (45.1)	121 (53.5)	0 (0)
Cyprus (N= 115)	41 (35.7)	44 (38.3)	19 (16.5)
France (N= 68)	12 (17.6)	23 (33.8)	14 (20.6)
Germany (N= 11)	1 (9.1)	5 (45.5)	4 (36.4)
Greece (N= 255)	82 (32.2)	62 (24.3)	85 (33.3)
Italy (N= 268)	126 (47.7)	122 (45.5)	5 (1.9)
Malta (N= 28)	9 (32.1)	13 (46.4)	6 (21.4)
Spain (N= 111)	35 (31.5)	56 (50.5)	19 (17.1)
Sweden (N= 91)	37 (40.7)	35 (38.5)	19 (20.9)

Pearson chi-square test p< 0.001

Table A.3: Chronic diseases by country of birth

	Responses		Percent of Migrants		Responses		Percent of Migrants
	N	Percent			N	Percent	
Country of birth: Syria				**Country of birth: Afghanistan**			
Diabetes	28	4.8%	17.1%	Diabetes	10	2.1%	6.9%
Cancer	9	1.6%	5.5%	Heart disease	24	5.1%	16.7%
Heart disease	19	3.3%	11.6%	High blood pressure	12	2.5%	8.3%
High blood pressure	31	5.3%	18.9%	Disease related to bone and muscle	33	6.9%	22.9%
Disease related to bone and muscle	43	7.4%	26.2%	Respiratory disease (asthma. chronic bronchitis. pneumonia)	27	5.7%	18.8%
Respiratory disease (asthma. chronic bronchitis. pneumonia)	29	5.0%	17.7%	Kidney disease	15	3.2%	10.4%
Kidney disease	21	3.6%	12.8%	Brain stroke	2	.4%	1.4%

Brain stroke	10	1.7%	6.1%	Psychological disease (depression. anxiety. worry. stress)	62	13.1%	43.1%
Psychological disease (depression. anxiety. worry. stress)	45	7.8%	27.4%	Gastrointestinal disease	17	3.6%	11.8%
Gastrointestinal disease	29	5.0%	17.7%	Tuberculosis	1	.2%	.7%
AIDS/HIV	8	1.4%	4.9%	Chronic problems from injury/accidents	14	2.9%	9.7%
Tuberculosis	8	1.4%	4.9%	Sleep disorders	42	8.8%	29.2%
Chronic problems from injury/accidents	17	2.9%	10.4%	Urinary infections	16	3.4%	11.1%
Sleep disorders	47	8.1%	28.7%	Ear. Nose and Throat diseases	19	4.0%	13.2%
Urinary infections	21	3.6%	12.8%	Eye diseases	35	7.4%	24.3%
Ear. Nose and Throat diseases	25	4.3%	15.2%	Skin diseases	26	5.5%	18.1%
Eye diseases	31	5.3%	18.9%	Caries (Bad teeth)	76	16.0%	52.8%
Skin diseases	26	4.5%	15.9%	Headaches / Migraines	44	9.3%	30.6%
Caries (Bad teeth)	64	11.0%	39.0%				
Headaches / Migraines	69	11.9%	42.1%				
Country of birth: Iraq				**Country of birth: Nigeria**			
Diabetes	13	4.5%	15.9%	Diabetes	2	1.7%	3.8%
Cancer	4	1.4%	4.9%	Heart disease	1	.8%	1.9%
Heart disease	9	3.1%	11.0%	High blood pressure	4	3.3%	7.7%
High blood pressure	13	4.5%	15.9%	Disease related to bone and muscle	5	4.1%	9.6%
Disease related to bone and muscle	23	8.0%	28.0%	Respiratory disease (asthma. chronic bronchitis. pneumonia)	8	6.6%	15.4%
Respiratory disease (asthma. chronic bronchitis. pneumonia)	12	4.2%	14.6%	Kidney disease	1	.8%	1.9%
Kidney disease	7	2.4%	8.5%	Psychological disease (depression. anxiety. worry. stress)	14	11.6%	26.9%
Brain stroke	4	1.4%	4.9%	Gastrointestinal disease	10	8.3%	19.2%
Psychological disease (depression. anxiety. worry. stress)	26	9.0%	31.7%	AIDS/HIV	4	3.3%	7.7%
Gastrointestinal disease	10	3.5%	12.2%	Tuberculosis	3	2.5%	5.8%
AIDS/HIV	2	.7%	2.4%	Chronic problems from injury/accidents	12	9.9%	23.1%
Tuberculosis	2	.7%	2.4%	Sleep disorders	9	7.4%	17.3%
Chronic problems from injury/accidents	13	4.5%	15.9%	Urinary infections	5	4.1%	9.6%
Sleep disorders	25	8.7%	30.5%	Ear. Nose and Throat diseases	6	5.0%	11.5%

Urinary infections	15	5.2%	18.3%
Ear. Nose and Throat diseases	12	4.2%	14.6%
Eye diseases	18	6.3%	22.0%
Skin diseases	17	5.9%	20.7%
Caries (Bad teeth)	34	11.8%	41.5%
Headaches / Migraines	29	10.1%	35.4%
Country of birth: Somalia			
Diabetes	7	5.7%	20.6%
Cancer	3	2.4%	8.8%
Heart disease	3	2.4%	8.8%
High blood pressure	6	4.9%	17.6%
Disease related to bone and muscle	10	8.1%	29.4%
Respiratory disease (asthma. chronic bronchitis)	4	3.3%	11.8%
Kidney disease	3	2.4%	8.8%
Brain stroke	2	1.6%	5.9%
Psychological disease (depression. anxiety. worry. stress)	8	6.5%	23.5%
Gastrointestinal disease	7	5.7%	20.6%
AIDS/HIV	2	1.6%	5.9%
Tuberculosis	2	1.6%	5.9%
Chronic problems from injury/accidents	6	4.9%	17.6%
Sleep disorders	11	8.9%	32.4%
Urinary infections	5	4.1%	14.7%
Ear. Nose and Throat diseases	7	5.7%	20.6%
Eye diseases	7	5.7%	20.6%
Skin diseases	5	4.1%	14.7%
Caries (Bad teeth)	10	8.1%	29.4%
Headaches / Migraines	15	12.2%	44.1%
Country of birth: Other			
Diabetes	11	1.8%	4.2%
Eye diseases	8	6.6%	15.4%
Skin diseases	9	7.4%	17.3%
Caries (Bad teeth)	7	5.8%	13.5%
Headaches / Migraines	13	10.7%	25.0%
Country of birth: Iran			
Diabetes	1	1.0%	3.1%
Heart disease	4	3.8%	12.5%
High blood pressure	3	2.9%	9.4%
Disease related to bone and muscle	9	8.6%	28.1%
Respiratory disease (asthma, chronic bronchitis)	4	3.8%	12.5%
Kidney disease	2	1.9%	6.3%
Psychological disease (depression, anxiety, worry, stress)	16	15.2%	50.0%
Gastrointestinal disease	2	1.9%	6.3%
Chronic problems from injury/accidents	3	2.9%	9.4%
Sleep disorders	9	8.6%	28.1%
Urinary infections	2	1.9%	6.3%
Ear, Nose and Throat diseases	10	9.5%	31.3%
Eye diseases	7	6.7%	21.9%
Skin diseases	6	5.7%	18.8%
Caries (Bad teeth)	14	13.3%	43.8%
Headaches / Migraines	13	12.4%	40.6%

Cancer	5	.8%	1.9%
Heart disease	14	2.3%	5.4%
High blood pressure	17	2.7%	6.6%
Disease related to bone and muscle	36	5.8%	13.9%
Respiratory disease (asthma, chronic bronchitis)	18	2.9%	6.9%
Kidney disease	14	2.3%	5.4%
Brain stroke	3	.5%	1.2%
Psychological disease (depression, anxiety, worry, stress)	56	9.0%	21.6%
Gastrointestinal disease	47	7.6%	18.1%
AIDS/HIV	4	.6%	1.5%
Tuberculosis	12	1.9%	4.6%
Chronic problems from injury/accidents	38	6.1%	14.7%
Sleep disorders	66	10.6%	25.5%
Urinary infections	15	2.4%	5.8%
Ear, Nose and Throat diseases	30	4.8%	11.6%
Eye diseases	35	5.6%	13.5%
Skin diseases	40	6.4%	15.4%
Caries (Bad teeth)	76	12.2%	29.3%
Headaches / Migraines	85	13.7%	32.8%
Diabetes	11	1.8%	4.2%

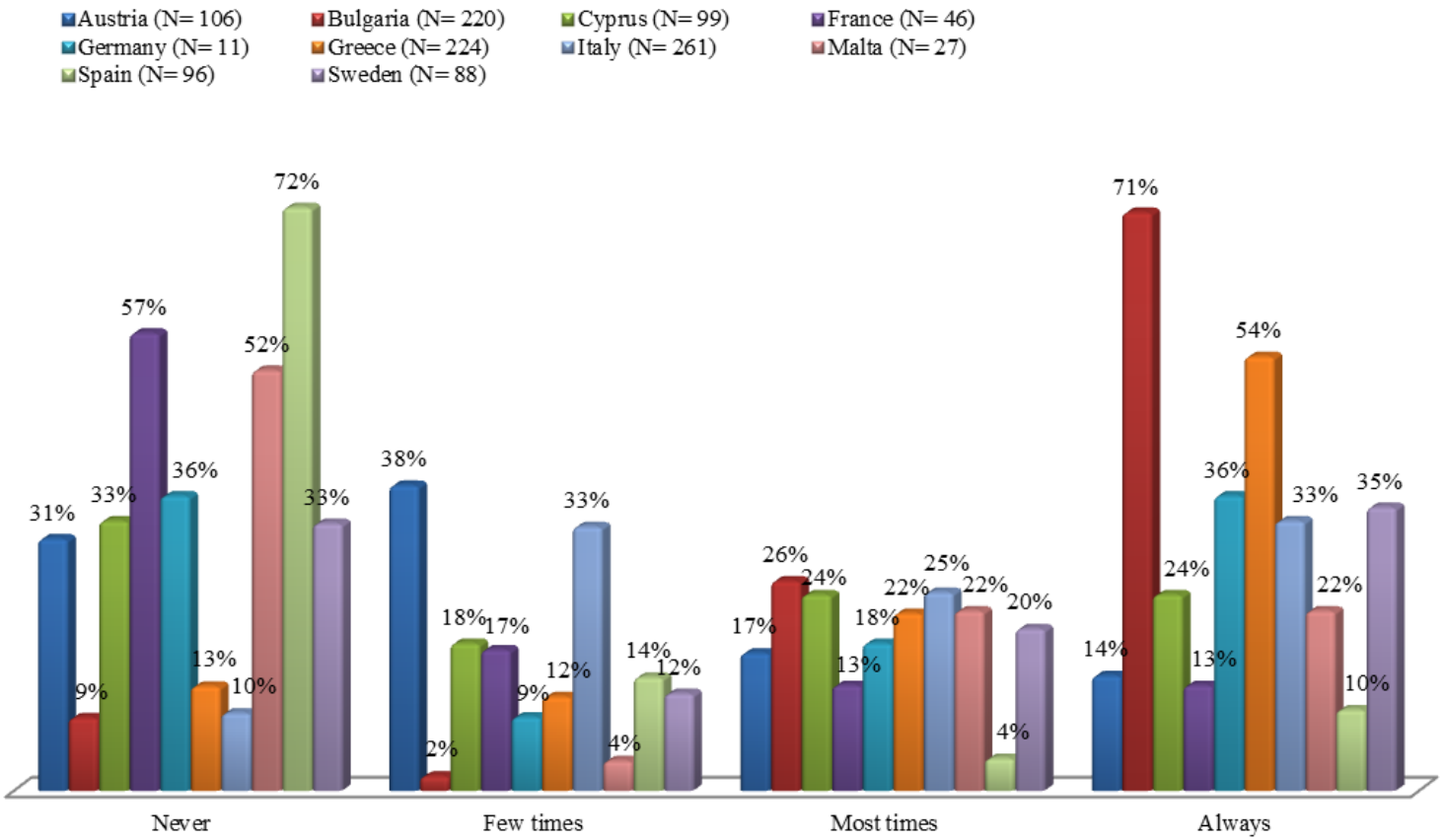
Table A.4: Percentage of participants who took medication, visited a doctor, an emergency department or a hospital, among those suffering from one of the listed chronic diseases, in the total sample

Chronic disease (% Yes)	Medication	Doctor (GP or specialist)	Emergency department	Hospitalization
Diabetes	62.5	56.9	13.9	15.3
Cancer	19.0	19.0	19.0	14.3
Heart disease	31.1	35.1	12.2	8.1
High blood pressure	38.4	40.7	10.5	5.8
Disease related to bone and muscle	29.6	36.5	6.9	5.7
Respiratory disease (asthma, chronic bronchitis, pneumonia)	45.1	49.0	17.6	14.7
Kidney disease	31.7	34.9	20.6	17.5
Brain stroke	9.5	9.5	4.8	9.5
Psychological disease (depression, anxiety, worry, stress)	26.4	31.7	6.2	5.3
Gastrointestinal disease	37.7	36.9	8.2	7.4
AIDS/HIV	20.0	20.0	0.0	0.0
Tuberculosis	21.4	21.4	0.0	10.7
Chronic problems from Injury/accidents	27.2	34.0	10.7	9.7
Sleep disorders	26.3	23.0	2.9	2.4
Urinary infections	30.4	30.4	5.1	2.5
Ear, Nose and Throat diseases	41.3	32.1	5.5	3.7
Eye diseases	24.8	27.7	7.1	2.8
Skin diseases	38.8	41.1	7.8	5.4
Caries (Bad teeth)	31.0	35.6	6.4	2.1
Headaches / Migraines	43.7	30.2	6.3	3.4
ONLY WOMEN Gynecological diseases (vaginitis, HPV infection etc)	36.8	42.6	7.4	8.8
ONLY WOMEN Pregnancy/Birth	31.7	39.7	12.7	23.8

Table A.5: Mean score (on a scale 1 to 5), 95% confidence interval and percentage of participants answering "Always" and "Never true" to the listed statements, among those who visited a doctor, an emergency department or a hospital, for their chronic disease

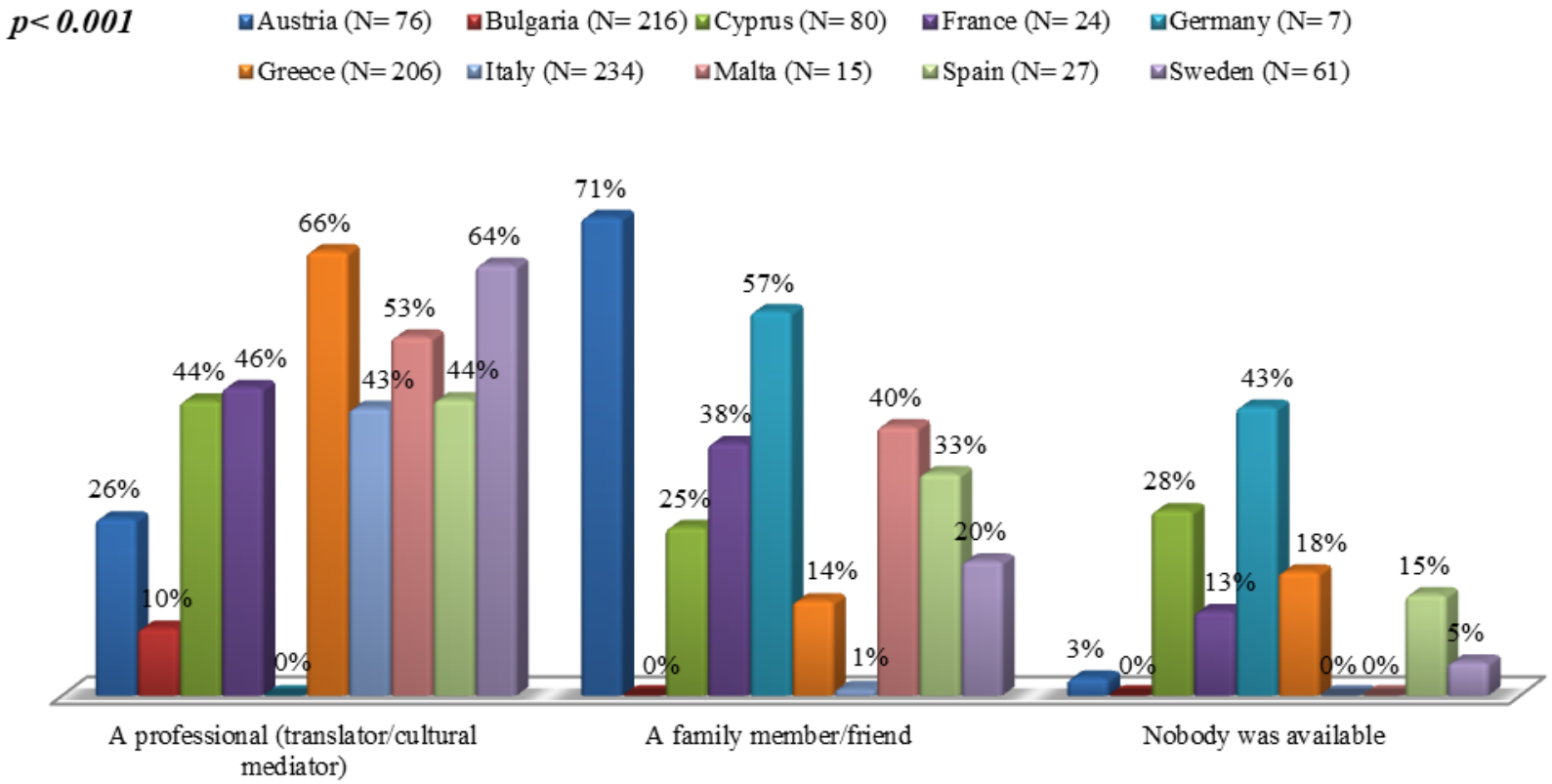
Statement:	Mean (95% C.I) on a scale 1 to 5	% Always true	% Never true
You are treated with less courtesy than other people	1.7 (1.6, 1.8)	75	66.5
You are treated with less respect than other people	1.7 (1.6, 1.8)	6.5	67.4
You receive poorer service than others	1.8 (1.7, 1.9)	7.8	63.4
A doctor or nurse acts as if he or she thinks you are not smart	1.7 (1.6, 1.8)	5.3	68.0
A doctor or nurse acts as if he or she is afraid of you	1.5 (1.4, 1.6)	3.6	76.5
A doctor or nurse acts as if he or she is better than you	1.7 (1.6, 1.8)	7.0	65.7
You feel like a doctor or nurse is not listening to what you were saying	1.8 (1.7, 1.9)	7.0	64.9

Figure A.6: During your interactions with healthcare services, were you in need for a translation? By country of interview



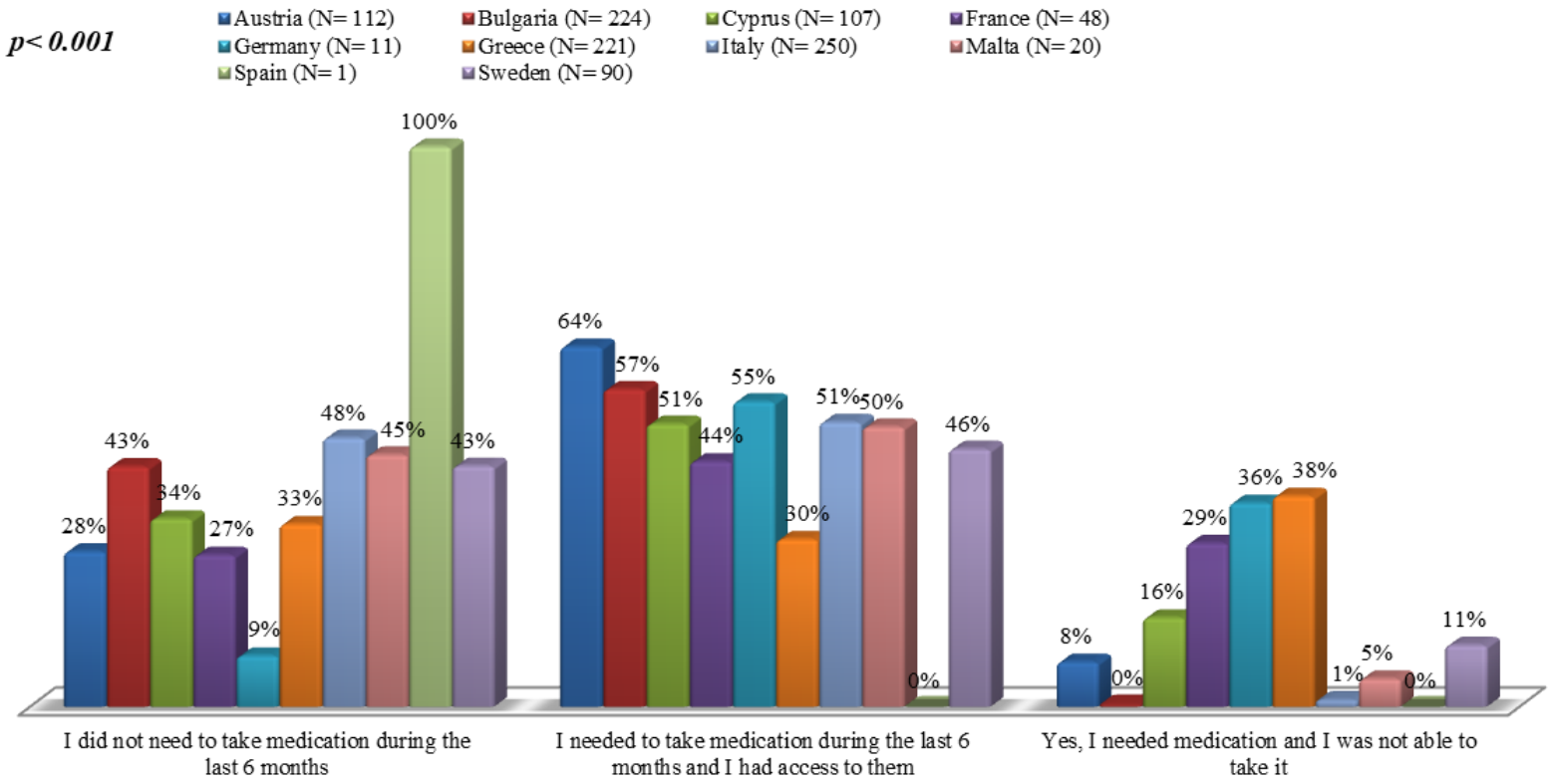
Note: p-value is based on Pearson chi-square test.

Figure A.7: When translation was needed, who assisted you? By country of interview



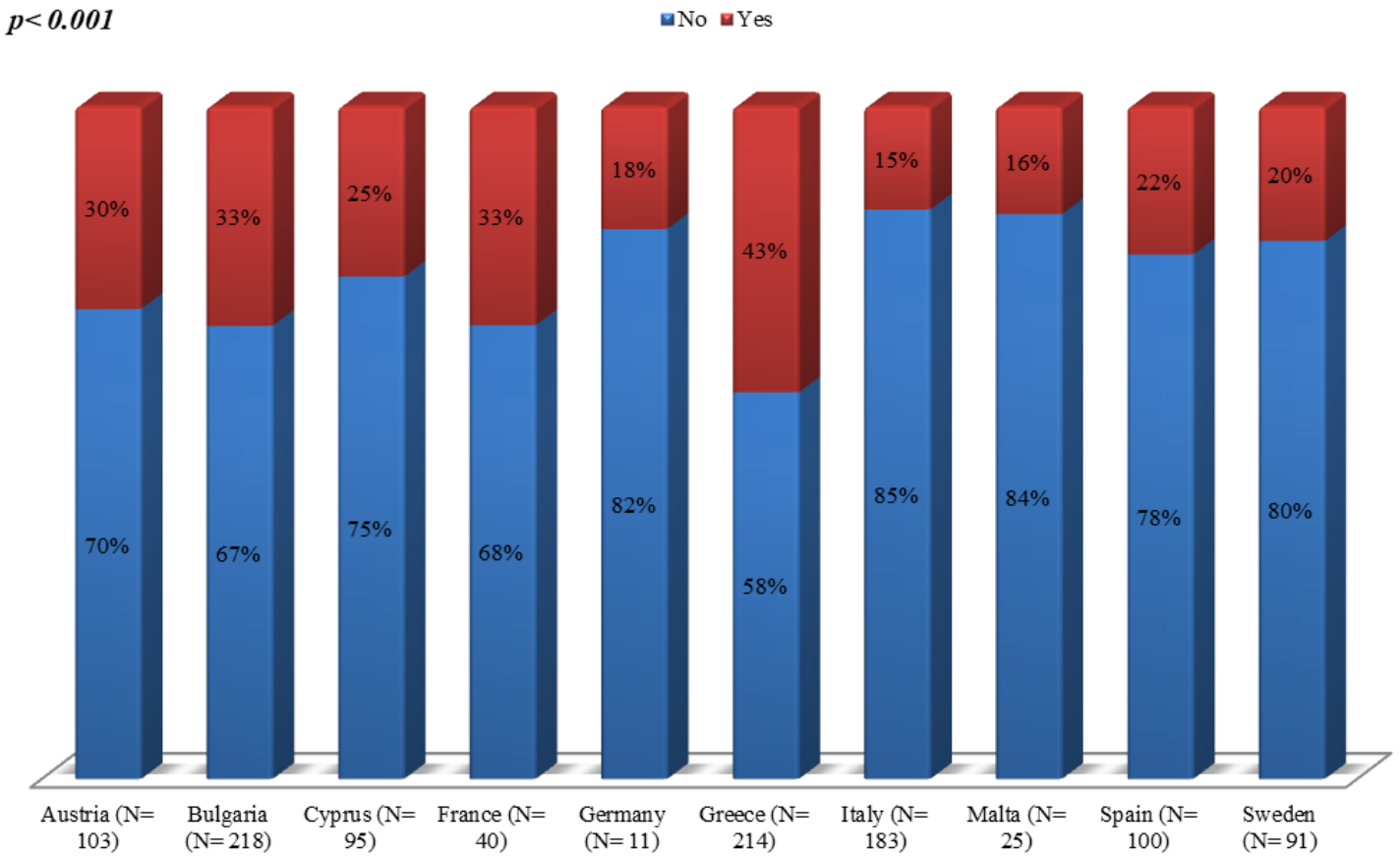
Note: p-value is based on Pearson chi-square test.

Figure A.8: During the last 6 months did you need to take medication and were not able to? By country of interview



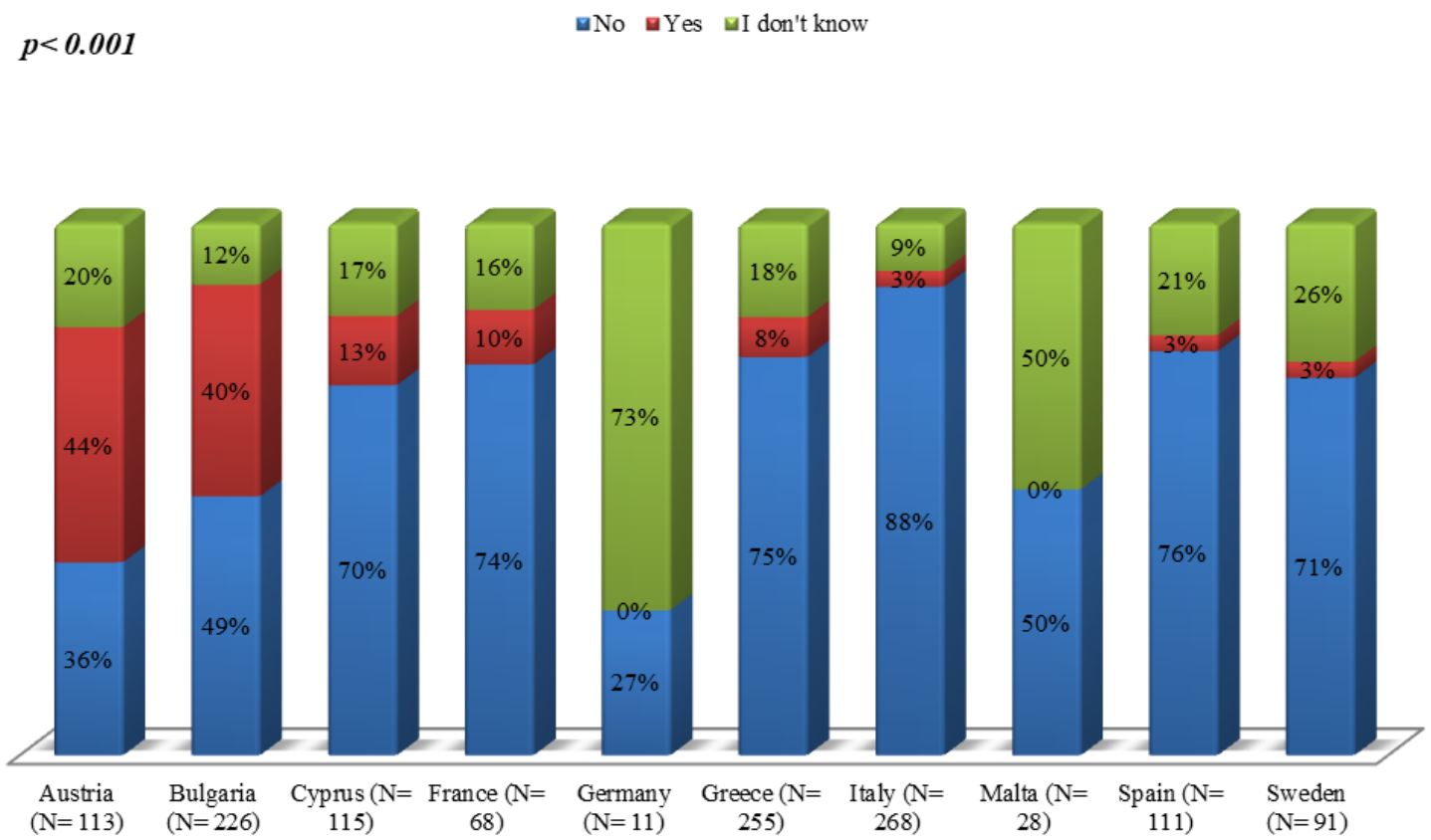
Note: p-value is based on Pearson chi-square test

Figure A.9: Do you believe that you have worse access to health services compared to the local people? By country of interview



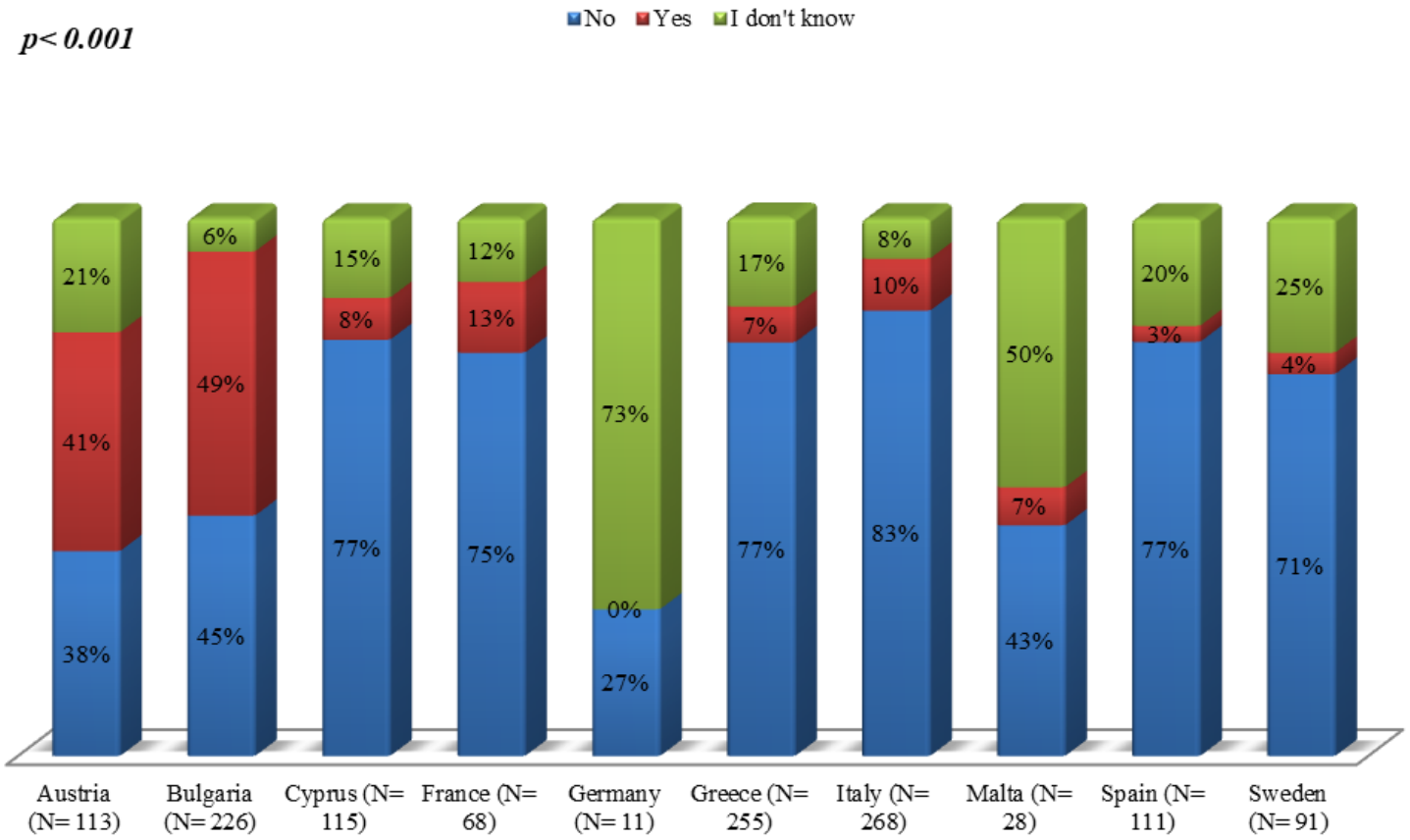
Note: p-value is based on Pearson chi-square test.

Figure A.10: Have you received immunizations for Hepatitis A? By country of interview



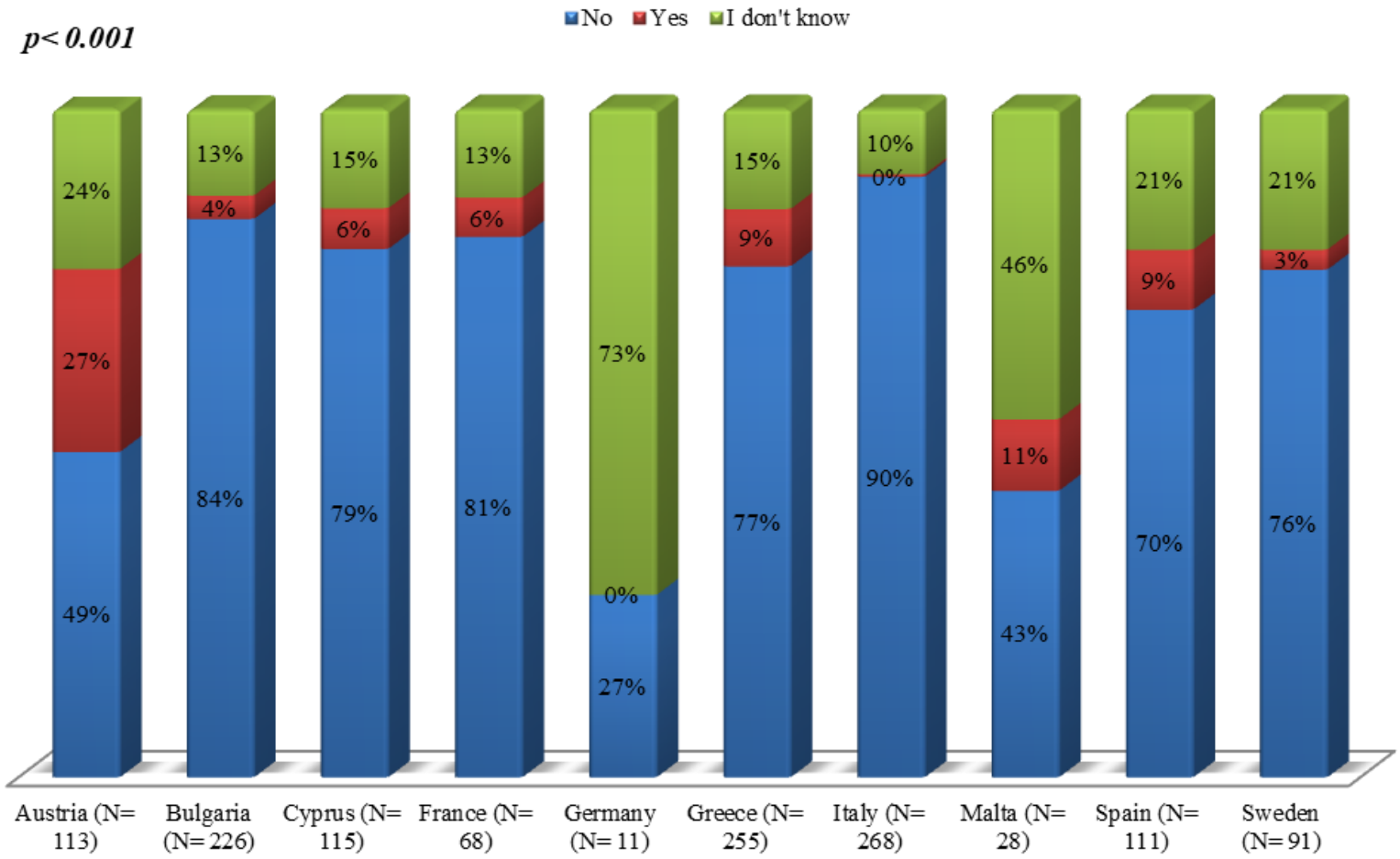
Note: p-value is based on Pearson chi-square test.

Figure A.11: Have you received immunizations for Hepatitis B? By country of interview



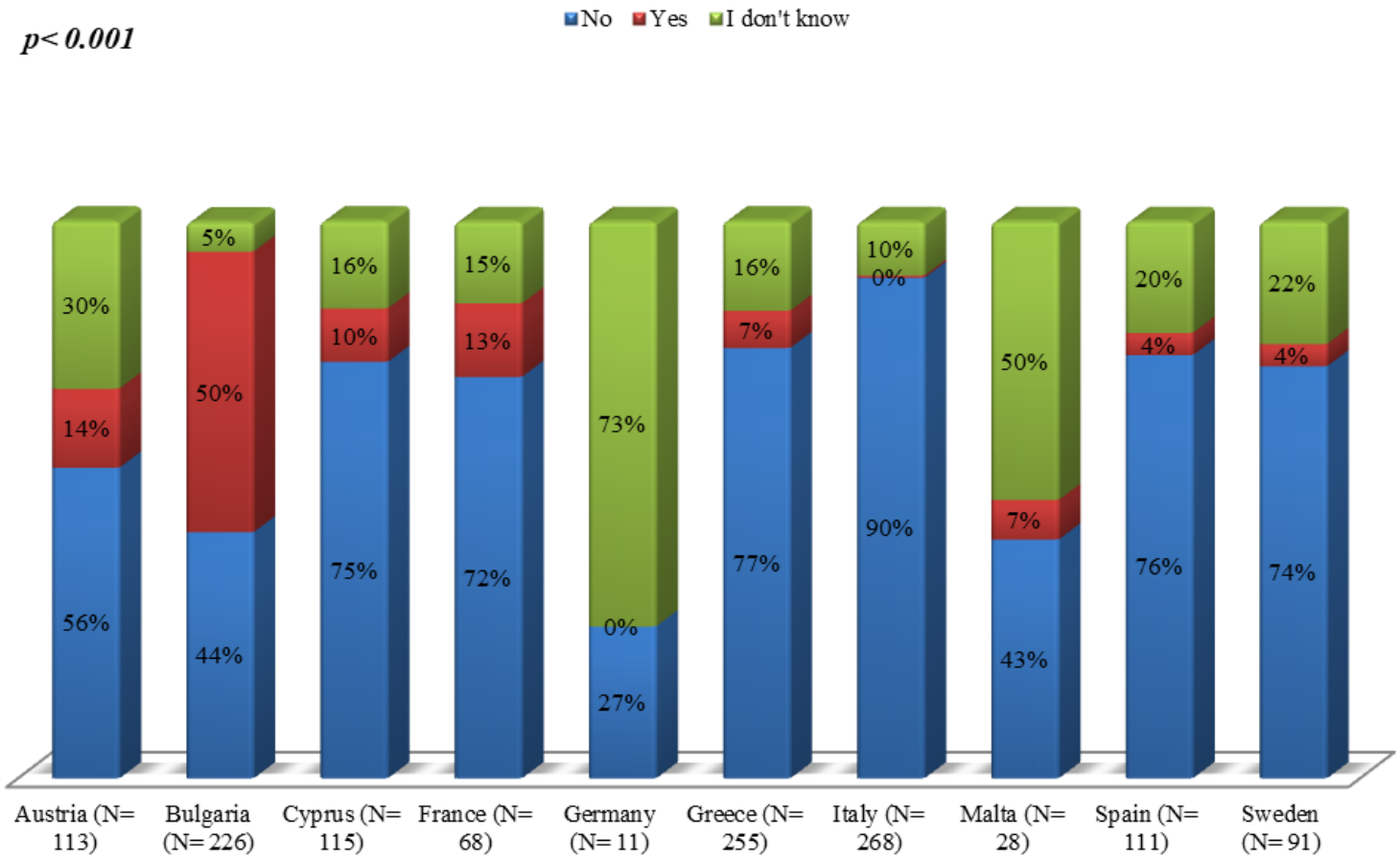
Note: p-value is based on Pearson chi-square test.

Figure A.12: Have you received immunizations for influenza? By country of interview



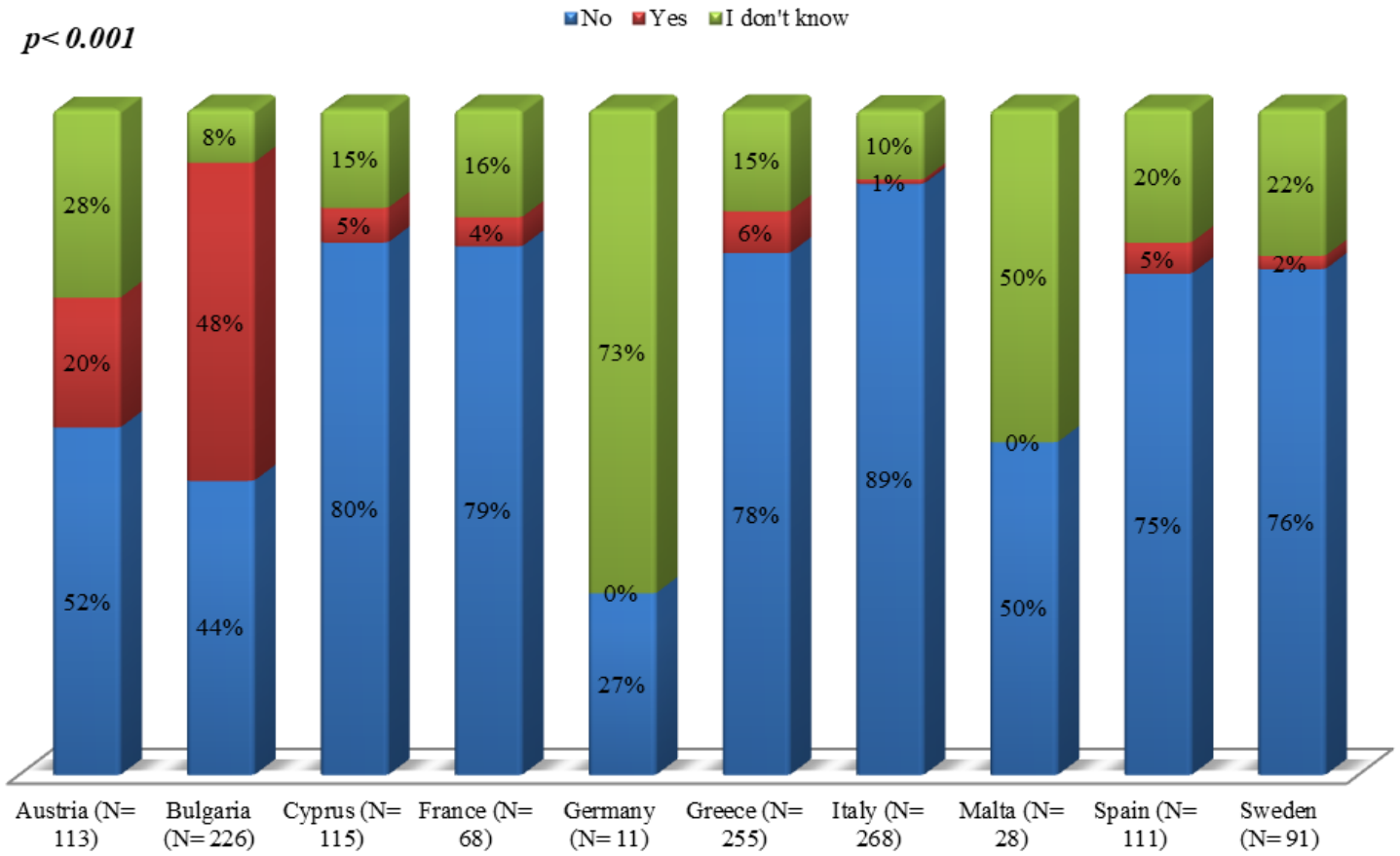
Note: p-value is based on Pearson chi-square test.

Figure A.13: Have you received immunizations for Measles? By country of interview



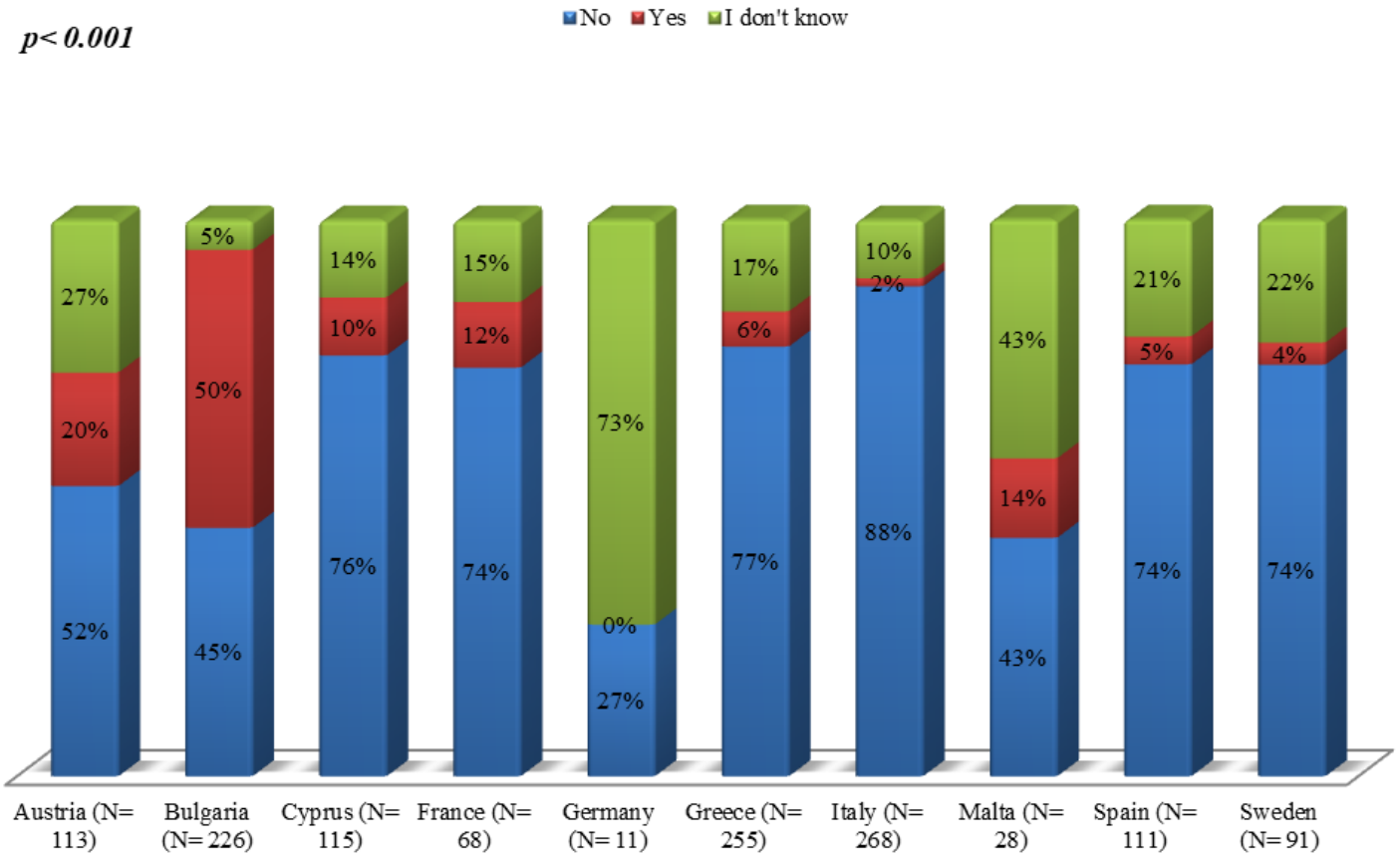
Note: p-value is based on Pearson chi-square test.

Figure A.14: Have you received immunizations for Pneumiciccus (pneumonia)? By country of interview



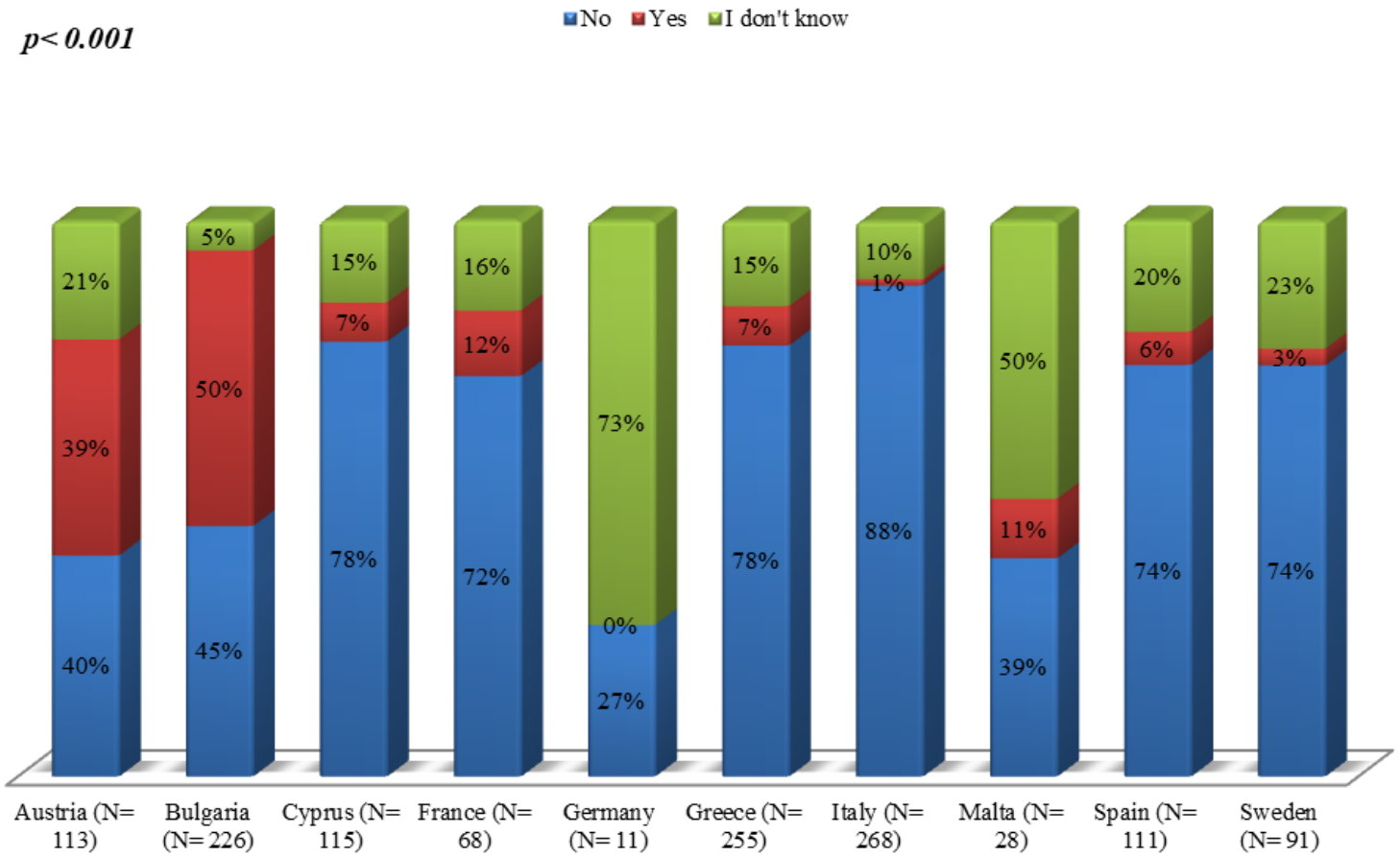
Note: p-value is based on Pearson chi-square test.

Figure A.15: Have you received immunizations for Polio (all in adult booster shots)? By country of interview



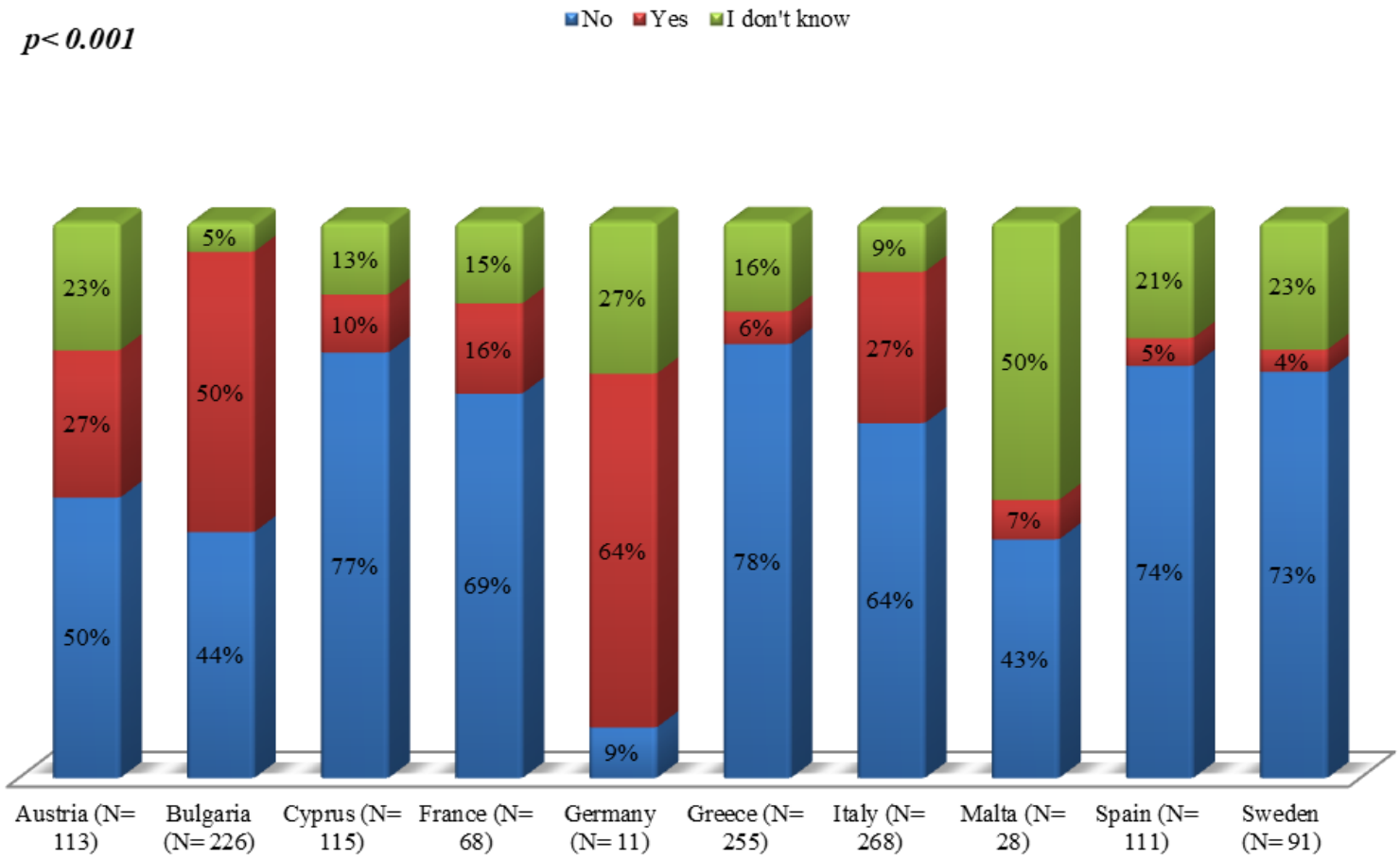
Note: p-value is based on Pearson chi-square test.

Figure A.16: Have you received immunizations for Tuberculosis? By country of interview



Note: p-value is based on Pearson chi-square test.

Figure A.17: Have you received immunizations for Tetanus? By country of interview

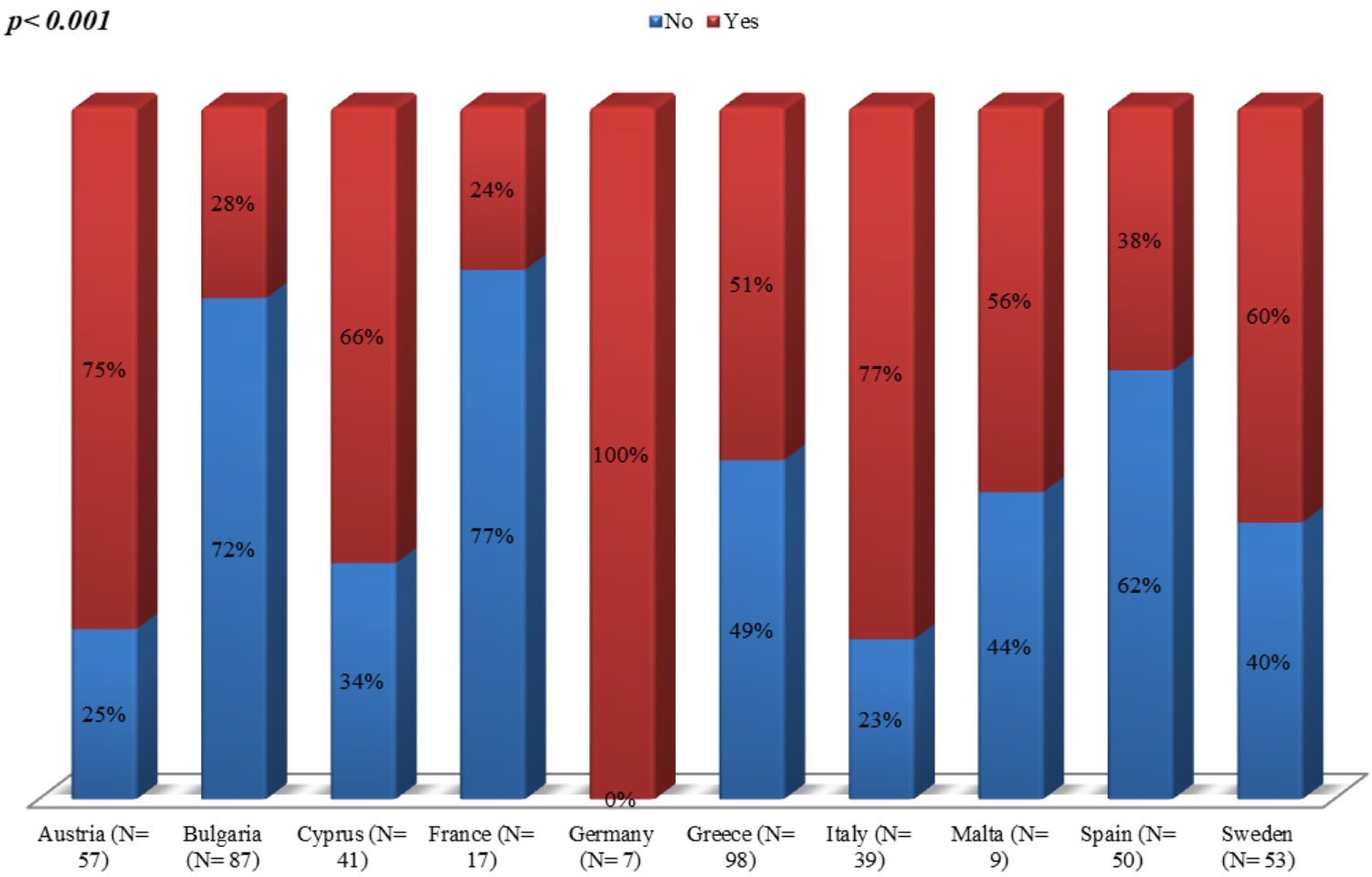


Note: p-value is based on Pearson chi-square test.

Table A.6: Percentage of positive parents' answers concerning whether their children (aged under 18) have received vaccinations for any of the listed diseases

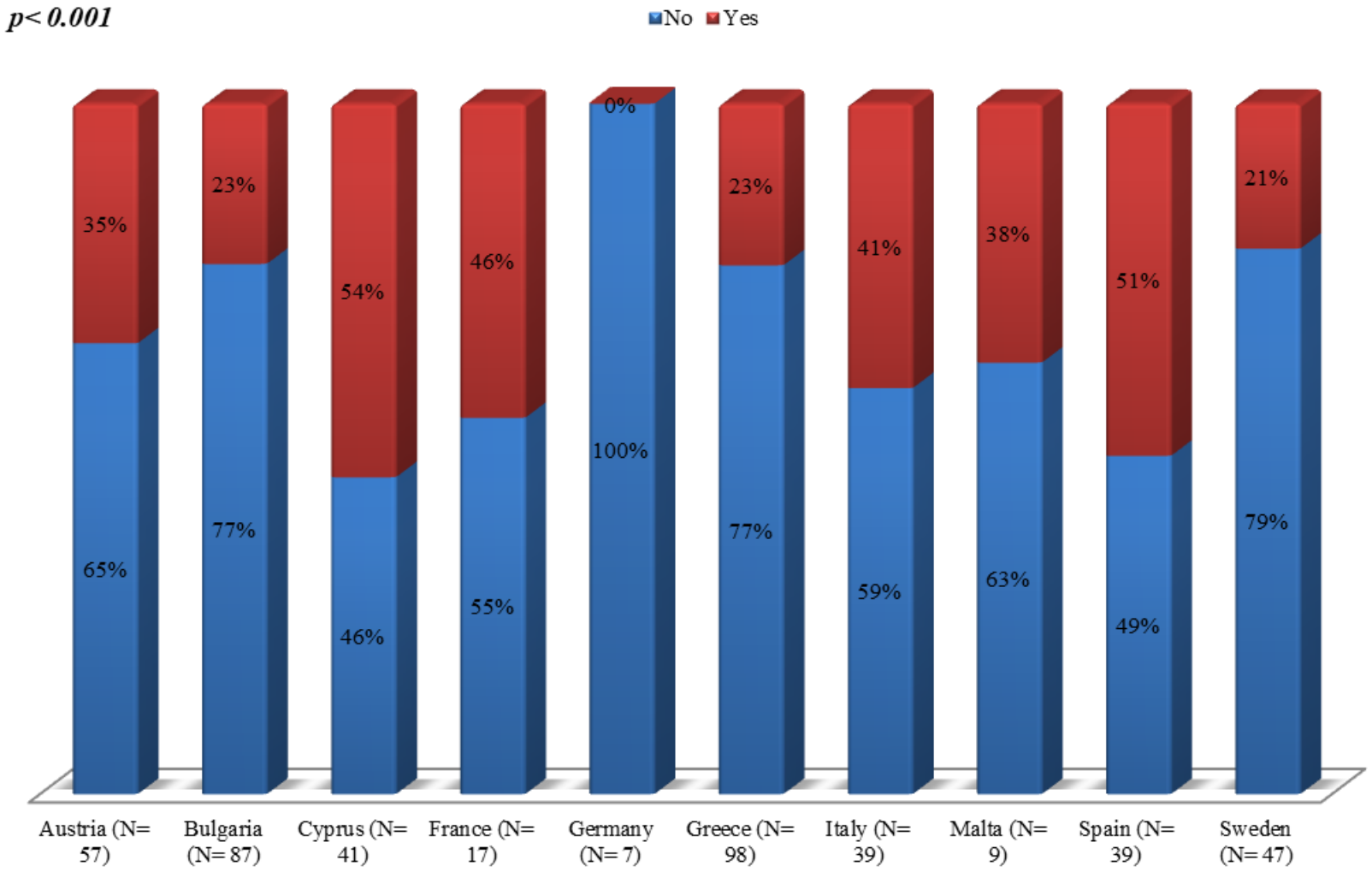
	First child	Second child	Third child	Fourth child	Fifth child
Does your child have a vaccination card?					
% Yes	17.7	12.1	6.2	3.0	1.2
Have your child received vaccinations for any of the diseaseases listed below? (% Yes)					
MMR	17.0	11.4	5.7	2.6	0.7
DTaP	12.6	7.9	4.2	1.6	0.5
Polio	12.7	8.2	4.2	1.7	0.5
Pneumococcal	11.4	7.6	4.1	1.9	0.6
Chickenpox	9.2	5.8	2.9	1.2	0.2
Meningitis	10.5	7.0	3.7	1.2	0.1
Hepatitis A	11.7	7.5	4.1	1.9	0.6
Hepatitis B	14.2	9.8	4.9	2.5	0.8
Influenza	8.1	5.6	2.7	1.0	0.2

Figure A.18: Have you visited a gynaecologist/midwife while in this country? By country of interview



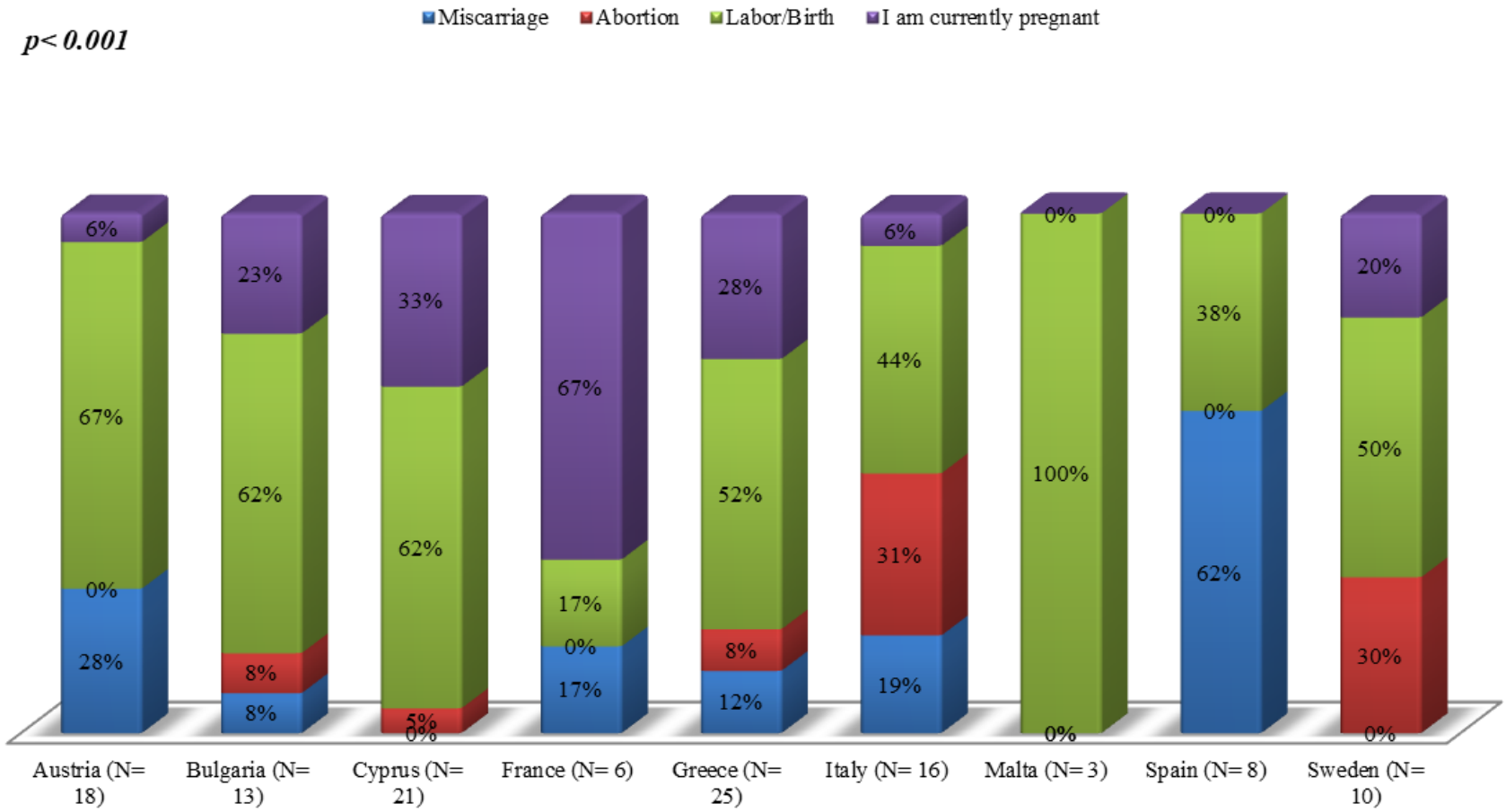
Note: p-value is based on Pearson chi-square test.

Figure A.19: Have you been pregnant since you were in this country? By country of interview



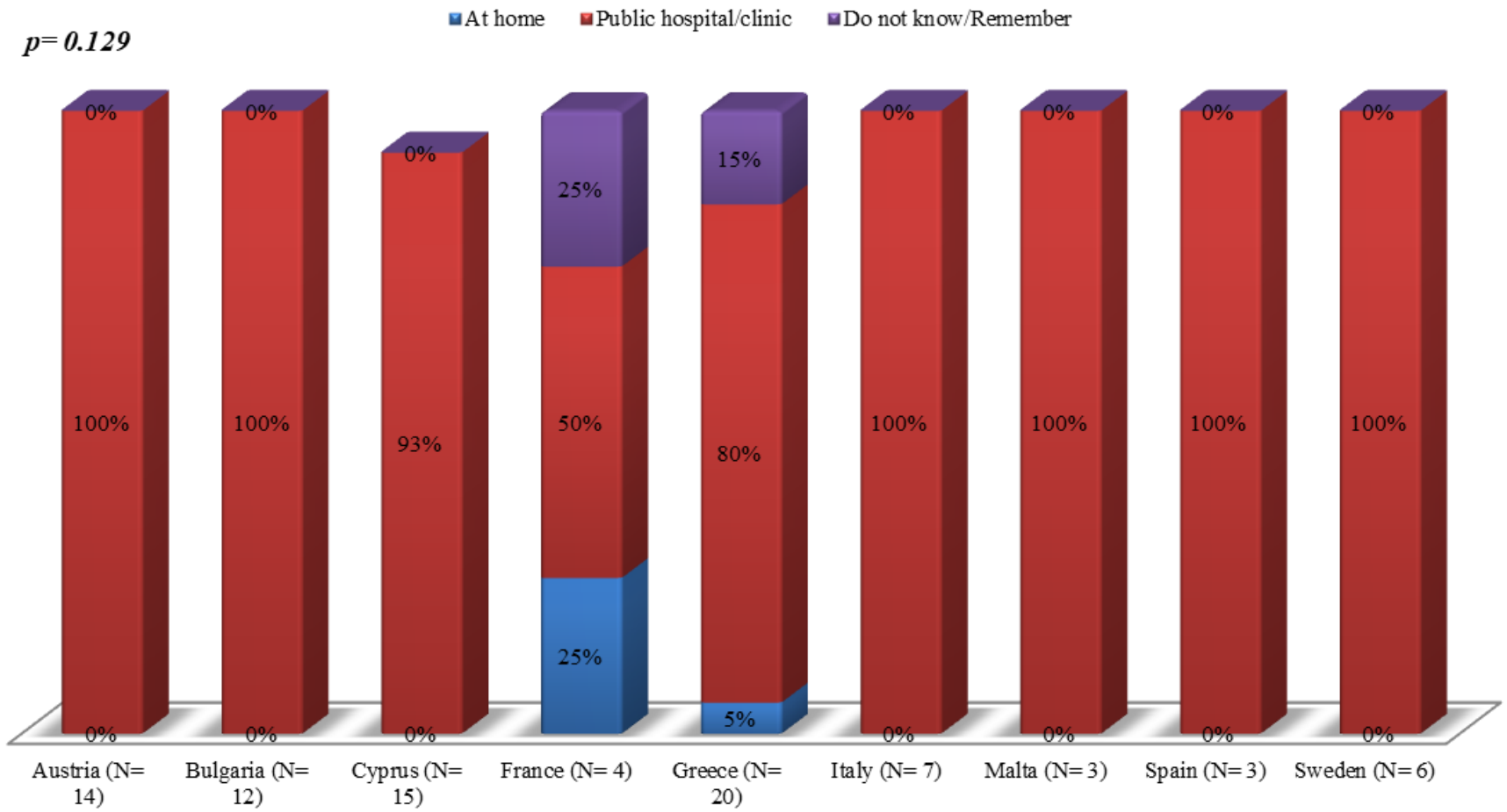
Note: p-value is based on Pearson chi-square test.

Figure A.20: If you were pregnant, what was the outcome? By country of interview



Note: p-value is based on Pearson chi-square test.

Figure A.21: If you have been pregnant in this country where did you give birth (or are going to give birth)? By country of interview



Note: p-value is based on Pearson chi-square test.

Table A.7: Important health issues as perceived by migrants, in each country of interview

	Respones		Percent of migrants		Respones		Percent of migrants
	N	Percent			N	Percent	
Country of interview: Austria (N= 110)				**Country of interview: Bulgaria (N= 114)**			
Teeth problems	42	12.3%	38.2%	Teeth problems	72	20.7%	63.2%
Skin problems	33	9.7%	30.0%	Skin problems	37	10.7%	32.5%
Respiratory problems	10	2.9%	9.1%	Respiratory problems	25	7.2%	21.9%
Gastrointestinal	11	3.2%	10.0%	Gastrointestinal	28	8.1%	24.6%
Chest pain	6	1.8%	5.5%	Chest pain	12	3.5%	10.5%
Headaches/migraines	44	12.9%	40.0%	Headaches/migraines	25	7.2%	21.9%
Back pain	28	8.2%	25.5%	Back pain	17	4.9%	14.9%
Overweight/obesity	16	4.7%	14.5%	Overweight/obesity	8	2.3%	7.0%
Sleep problems	34	10.0%	30.9%	Sleep problems	24	6.9%	21.1%
Worry/anxiety	31	9.1%	28.2%	Worry/anxiety	37	10.7%	32.5%
Eye problems	14	4.1%	12.7%	Eye problems	33	9.5%	28.9%
Immunizations	2	.6%	1.8%	Immunizations	5	1.4%	4.4%
Ear problems	7	2.1%	6.4%	Ear problems	6	1.7%	5.3%
Muscular and Bone problems	26	7.6%	23.6%	Muscular and Bone problems	9	2.6%	7.9%
Recurrent and continuous pain from e.g. older injuries or surgical operations	9	2.6%	8.2%	Recurrent and continuous pain from e.g. older injuries or surgical operations	2	.6%	1.8%
ONLY WOMEN: Gynecological Problems	15	4.4%	13.6%	*ONLY WOMEN:* Gynecological Problems	6	1.7%	5.3%
Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	13	3.8%	11.8%	Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	1	.3%	.9%
Country of interview: Cyprus (N= 105)				**Country of interview: France (N= 46)**			
Teeth problems	37	9.4%	35.2%	Teeth problems	25	12.4%	54.3%
Skin problems	19	4.8%	18.1%	Skin problems	17	8.4%	37.0%
Respiratory problems	21	5.3%	20.0%	Respiratory problems	15	7.4%	32.6%
Gastrointestinal	22	5.6%	21.0%	Gastrointestinal	13	6.4%	28.3%

Chest pain	12	3.0%	11.4%	Chest pain	10	5.0%	21.7%
Headaches/migraines	48	12.2%	45.7%	Headaches/migraines	15	7.4%	32.6%
Back pain	45	11.4%	42.9%	Back pain	12	5.9%	26.1%
Overweight/obesity	14	3.6%	13.3%	Overweight/obesity	8	4.0%	17.4%
Sleep problems	42	10.7%	40.0%	Sleep problems	17	8.4%	37.0%
Worry/anxiety	38	9.6%	36.2%	Worry/anxiety	16	7.9%	34.8%
Eye problems	29	7.4%	27.6%	Eye problems	17	8.4%	37.0%
Immunizations	3	.8%	2.9%	Immunizations	7	3.5%	15.2%
Ear problems	6	1.5%	5.7%	Ear problems	7	3.5%	15.2%
Muscular and Bone problems	29	7.4%	27.6%	Muscular and Bone problems	9	4.5%	19.6%
Recurrent and continuous pain from e.g. older injuries or surgical operations	8	2.0%	7.6%	Recurrent and continuous pain from e.g. older injuries or surgical operations	11	5.4%	23.9%
ONLY WOMEN: Gynecological Problems	13	3.3%	12.4%	*ONLY WOMEN:* Gynecological Problems	2	1.0%	4.3%
Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	8	2.0%	7.6%	Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	1	.5%	2.2%
Country of interview: Germany (N= 11)				**Country of interview: Greece (N= 232)**			
Teeth problems	8	16.3%	72.7%	Teeth problems	176	10.6%	75.9%
Skin problems	3	6.1%	27.3%	Skin problems	99	6.0%	42.7%
Respiratory problems	2	4.1%	18.2%	Respiratory problems	106	6.4%	45.7%
Gastrointestinal	5	10.2%	45.5%	Gastrointestinal	81	4.9%	34.9%
Chest pain	3	6.1%	27.3%	Chest pain	98	5.9%	42.2%
Headaches/migraines	3	6.1%	27.3%	Headaches/migraines	128	7.7%	55.2%
Back pain	7	14.3%	63.6%	Back pain	98	5.9%	42.2%
Overweight/obesity	4	8.2%	36.4%	Overweight/obesity	77	4.6%	33.2%
Sleep problems	3	6.1%	27.3%	Sleep problems	112	6.7%	48.3%
Worry/anxiety	1	2.0%	9.1%	Worry/anxiety	131	7.9%	56.5%
Eye problems	2	4.1%	18.2%	Eye problems	116	7.0%	50.0%
Immunizations	1	2.0%	9.1%	Immunizations	64	3.9%	27.6%

Ear problems	2	4.1%	18.2%	Ear problems	79	4.8%	34.1%
Muscular and Bone problems	4	8.2%	36.4%	Muscular and Bone problems	109	6.6%	47.0%
ONLY WOMEN Gynecological Problems	1	2.0%	9.1%	Recurrent and continuous pain from e.g. older injuries or surgical operations	74	4.5%	31.9%
				ONLY WOMEN: Gynecological Problems	62	3.7%	26.7%
				Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	51	3.1%	22.0%
Country of interview: Italy (N= 231)				**Country of interview: Malta (N= 25)**			
Teeth problems	83	11.0%	35.9%	Teeth problems	7	9.9%	28.0%
Skin problems	51	6.8%	22.1%	Skin problems	3	4.2%	12.0%
Respiratory problems	58	7.7%	25.1%	Respiratory problems	7	9.9%	28.0%
Gastrointestinal	76	10.1%	32.9%	Gastrointestinal	6	8.5%	24.0%
Chest pain	62	8.2%	26.8%	Chest pain	6	8.5%	24.0%
Headaches/migraines	86	11.4%	37.2%	Headaches/migraines	3	4.2%	12.0%
Back pain	52	6.9%	22.5%	Back pain	4	5.6%	16.0%
Overweight/obesity	17	2.3%	7.4%	Sleep problems	8	11.3%	32.0%
Sleep problems	66	8.8%	28.6%	Worry/anxiety	6	8.5%	24.0%
Worry/anxiety	39	5.2%	16.9%	Eye problems	5	7.0%	20.0%
Eye problems	32	4.2%	13.9%	Immunizations	3	4.2%	12.0%
Immunizations	14	1.9%	6.1%	Ear problems	3	4.2%	12.0%
Ear problems	13	1.7%	5.6%	Muscular and Bone problems	3	4.2%	12.0%
Muscular and Bone problems	56	7.4%	24.2%	Recurrent and continuous pain from e.g. older injuries or surgical operations	4	5.6%	16.0%
Recurrent and continuous pain from e.g. older injuries or surgical operations	25	3.3%	10.8%	ONLY WOMEN Gynecological Problems	3	4.2%	12.0%
ONLY WOMEN Gynecological Problems	20	2.7%	8.7%				
Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	3	.4%	1.3%				
Country of interview: Spain (N= 100)				**Country of interview: Sweden (N= 89)**			
Teeth problems	46	14.4%	46.0%	Teeth problems	62	18.6%	69.7%

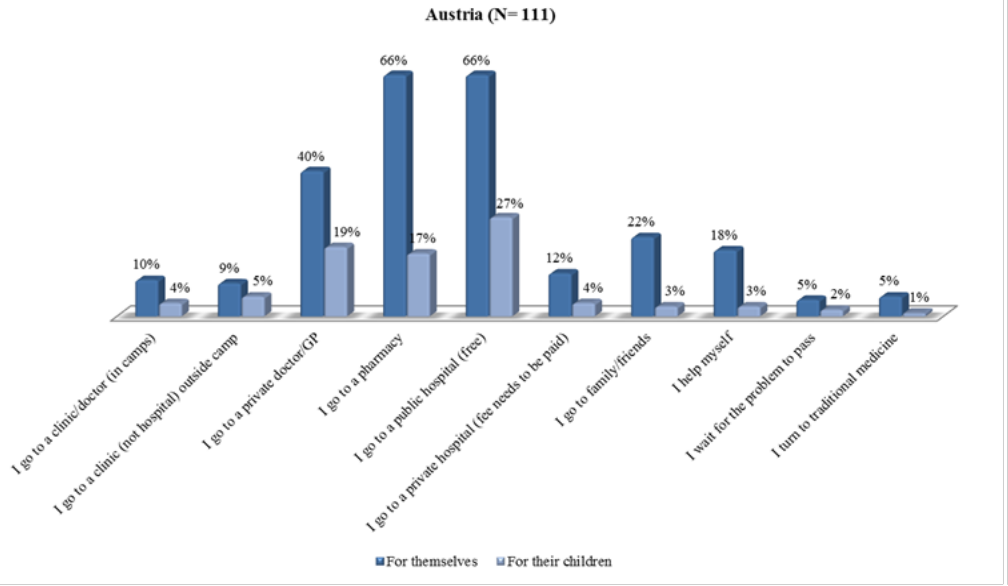
Skin problems	13	4.1%	13.0%	Skin problems	19	5.7%	21.3%
Respiratory problems	14	4.4%	14.0%	Respiratory problems	17	5.1%	19.1%
Gastrointestinal	19	6.0%	19.0%	Gastrointestinal	22	6.6%	24.7%
Chest pain	19	6.0%	19.0%	Chest pain	8	2.4%	9.0%
Headaches/migraines	30	9.4%	30.0%	Headaches/migraines	14	4.2%	15.7%
Back pain	23	7.2%	23.0%	Back pain	36	10.8%	40.4%
Overweight/obesity	11	3.4%	11.0%	Overweight/obesity	18	5.4%	20.2%
Sleep problems	22	6.9%	22.0%	Sleep problems	26	7.8%	29.2%
Worry/anxiety	32	10.0%	32.0%	Worry/anxiety	28	8.4%	31.5%
Eye problems	20	6.3%	20.0%	Eye problems	25	7.5%	28.1%
Immunizations	8	2.5%	8.0%	Immunizations	5	1.5%	5.6%
Ear problems	9	2.8%	9.0%	Ear problems	10	3.0%	11.2%
Muscular and Bone problems	23	7.2%	23.0%	Muscular and Bone problems	20	6.0%	22.5%
Recurrent and continuous pain from e.g. older injuries or surgical operations	12	3.8%	12.0%	Recurrent and continuous pain from e.g. older injuries or surgical operations	7	2.1%	7.9%
ONLY WOMEN Gynecological Problems	12	3.8%	12.0%	ONLY WOMEN Gynecological Problems	15	4.5%	16.9%
Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	6	1.9%	6.0%	Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	2	.6%	2.2%

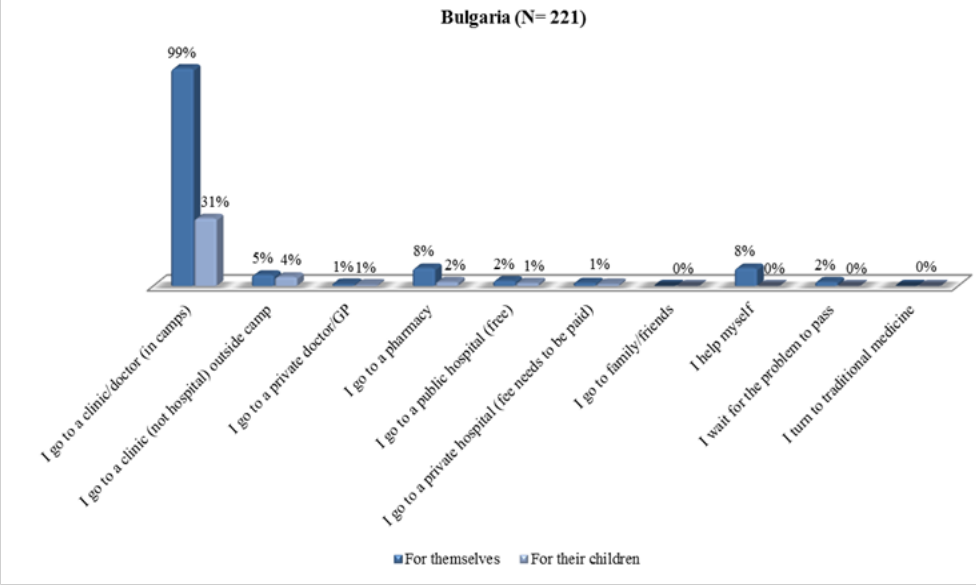
Table A.8: Health issues for which migrants need more information, in each country of interview

		Respones					Respones		
		N	Percent	Percent of migrants			N	Percent	Percent of migrants
Austria (N= 107)	Rights and how to use health care services	58	21.6%	54.2%	**Bulgaria (N= 117)**	Rights and how to use health care services	89	53.6%	76.1%
	Coping with worry and anxiety	24	9.0%	22.4%		Coping with worry and anxiety	17	10.2%	14.5%
	Diabetes	9	3.4%	8.4%		Diabetes	3	1.8%	2.6%
	Healthy teeth and oral health	31	11.6%	29.0%		Healthy teeth and oral health	19	11.4%	16.2%
	Nutrition and exercise	36	13.4%	33.6%		Nutrition and exercise	2	1.2%	1.7%
	Alcohol consumption risks	16	6.0%	15.0%		Alcohol consumption risks	1	.6%	.9%
	Tobacco use	34	12.7%	31.8%		Tobacco use	2	1.2%	1.7%
	Child health, Pregnancy and family planning	20	7.5%	18.7%		Child health, Pregnancy and family planning	3	1.8%	2.6%
	Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	18	6.7%	16.8%		Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	4	2.4%	3.4%
	Vaccinations	7	2.6%	6.5%		Vaccinations	6	3.6%	5.1%
	Availability of mediators and translators	15	5.6%	14.0%		Availability of mediators and translators	20	12.0%	17.1%
Cyprus (N= 103)	Rights and how to use health care services	81	21.0%	78.6%	**France (N= 36)**	Rights and how to use health care services	18	16.8%	50.0%
	Coping with worry and anxiety	48	12.4%	46.6%		Coping with worry and anxiety	16	15.0%	44.4%
	Diabetes	17	4.4%	16.5%		Diabetes	6	5.6%	16.7%
	Healthy teeth and oral health	43	11.1%	41.7%		Healthy teeth and oral health	12	11.2%	33.3%
	Nutrition and exercise	51	13.2%	49.5%		Nutrition and exercise	15	14.0%	41.7%
	Alcohol consumption risks	18	4.7%	17.5%		Alcohol consumption risks	4	3.7%	11.1%
	Tobacco use	17	4.4%	16.5%		Tobacco use	3	2.8%	8.3%
	Child health, Pregnancy and family planning	21	5.4%	20.4%		Child health, Pregnancy and family planning	7	6.5%	19.4%
	Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	23	6.0%	22.3%		Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	11	10.3%	30.6%
	Vaccinations	27	7.0%	26.2%		Vaccinations	9	8.4%	25.0%
	Availability of mediators and translators	40	10.4%	38.8%		Availability of mediators and translators	6	5.6%	16.7%
Germany (N= 11)	Rights and how to use health care services	9	22.0%	81.8%	**Greece (N= 194)**	Rights and how to use health care services	128	12.9%	66.0%
	Coping with worry and anxiety	3	7.3%	27.3%		Coping with worry and anxiety	112	11.3%	57.7%
	Diabetes	2	4.9%	18.2%		Diabetes	71	7.2%	36.6%
	Healthy teeth and oral health	10	24.4%	90.9%		Healthy teeth and oral health	140	14.1%	72.2%
	Nutrition and exercise	3	7.3%	27.3%		Nutrition and exercise	119	12.0%	61.3%
	Child health, Pregnancy and family planning	2	4.9%	18.2%		Alcohol consumption risks	54	5.4%	27.8%

	Vaccinations	5	12.2%	45.5%		Tobacco use	65	6.5%	33.5%
	Availability of mediators and translators	7	17.1%	63.6%		Child health, Pregnancy and family planning	71	7.2%	36.6%
						Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	59	5.9%	30.4%
						Vaccinations	70	7.0%	36.1%
						Availability of mediators and translators	104	10.5%	53.6%
Italy (N= 218)	Rights and how to use health care services	147	23.8%	67.4%	**Malta (N= 23)**	Rights and how to use health care services	8	15.4%	34.8%
	Coping with worry and anxiety	52	8.4%	23.9%		Coping with worry and anxiety	8	15.4%	34.8%
	Diabetes	16	2.6%	7.3%		Diabetes	3	5.8%	13.0%
	Healthy teeth and oral health	70	11.3%	32.1%		Healthy teeth and oral health	6	11.5%	26.1%
	Nutrition and exercise	65	10.5%	29.8%		Nutrition and exercise	8	15.4%	34.8%
	Alcohol consumption risks	31	5.0%	14.2%		Alcohol consumption risks	1	1.9%	4.3%
	Tobacco use	18	2.9%	8.3%		Tobacco use	1	1.9%	4.3%
	Child health, Pregnancy and family planning	17	2.8%	7.8%		Child health, Pregnancy and family planning	7	13.5%	30.4%
	Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	100	16.2%	45.9%		Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	3	5.8%	13.0%
	Vaccinations	44	7.1%	20.2%		Vaccinations	3	5.8%	13.0%
	Availability of mediators and translators	57	9.2%	26.1%		Availability of mediators and translators	4	7.7%	17.4%
Spain (N= 81)	Rights and how to use health care services	50	29.9%	61.7%	**Sweden (N= 83)**	Rights and how to use health care services	51	27.9%	61.4%
	Coping with worry and anxiety	32	19.2%	39.5%		Coping with worry and anxiety	13	7.1%	15.7%
	Diabetes	4	2.4%	4.9%		Diabetes	11	6.0%	13.3%
	Healthy teeth and oral health	33	19.8%	40.7%		Healthy teeth and oral health	32	17.5%	38.6%
	Nutrition and exercise	11	6.6%	13.6%		Nutrition and exercise	26	14.2%	31.3%
	Alcohol consumption risks	3	1.8%	3.7%		Alcohol consumption risks	4	2.2%	4.8%
	Tobacco use	3	1.8%	3.7%		Tobacco use	7	3.8%	8.4%
	Child health, Pregnancy and family planning	5	3.0%	6.2%		Child health, Pregnancy and family planning	6	3.3%	7.2%
	Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	10	6.0%	12.3%		Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	10	5.5%	12.0%
	Vaccinations	11	6.6%	13.6%		Vaccinations	9	4.9%	10.8%
	Availability of mediators and translators	5	3.0%	6.2%		Availability of mediators and translators	14	7.7%	16.9%

Figure A.22: What migrants do for themselves and their children when they face a medical problem in Austria, Bullgaria and France





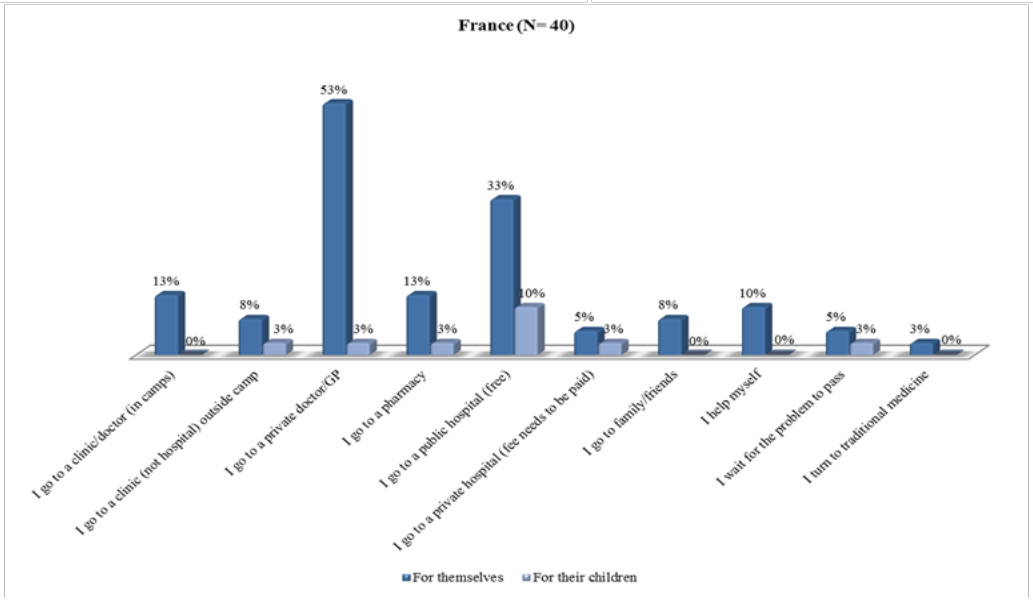
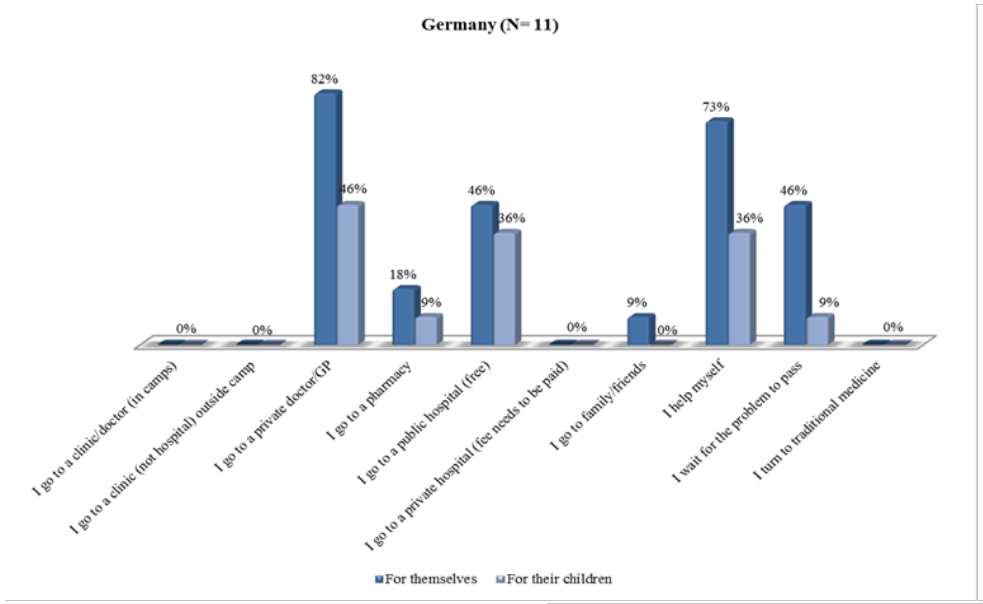
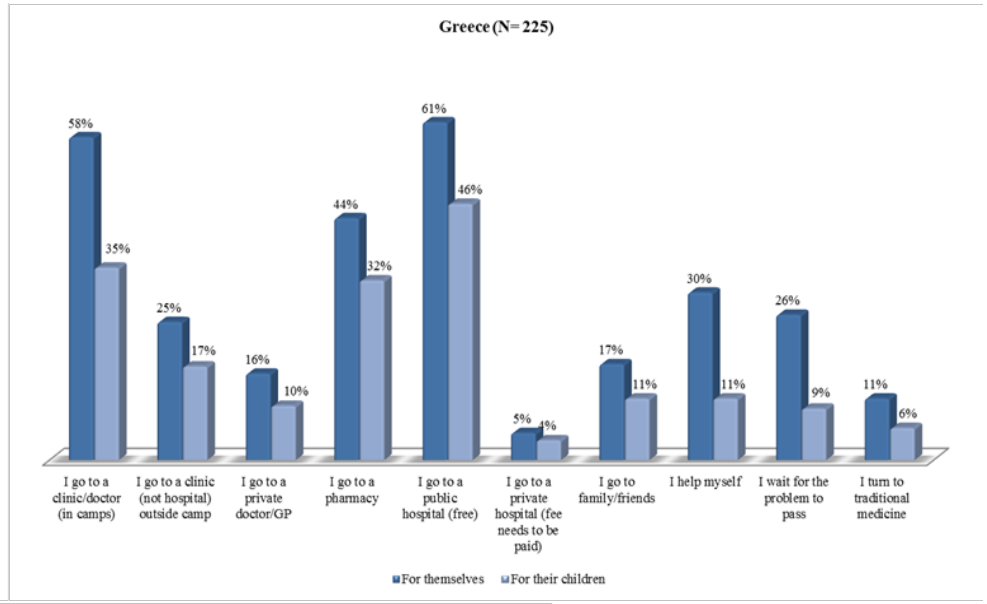


Figure A.23: What migrants do for themselves and their children when they face a medical problem, in Germany, Greece and Italy





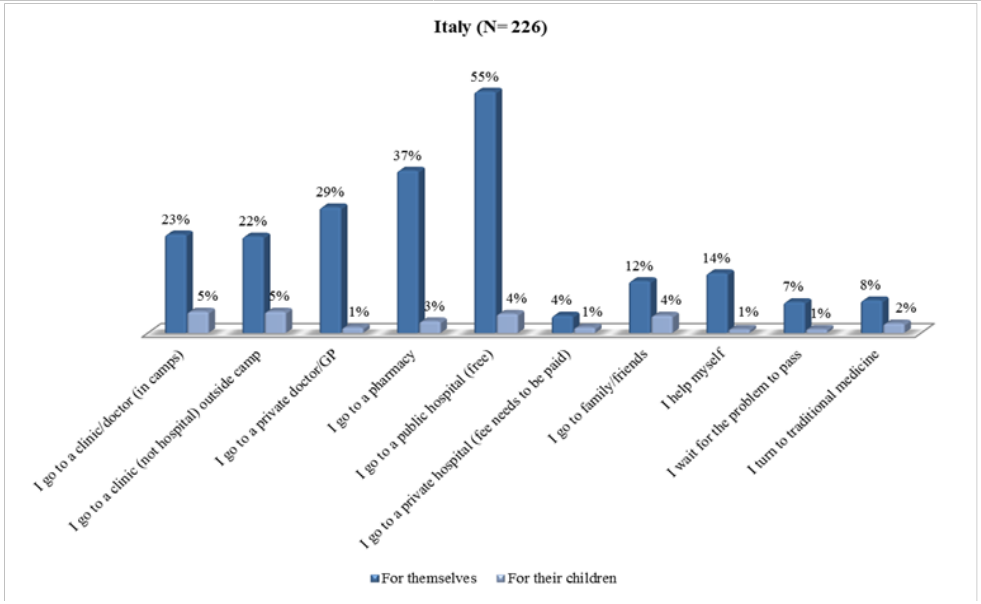
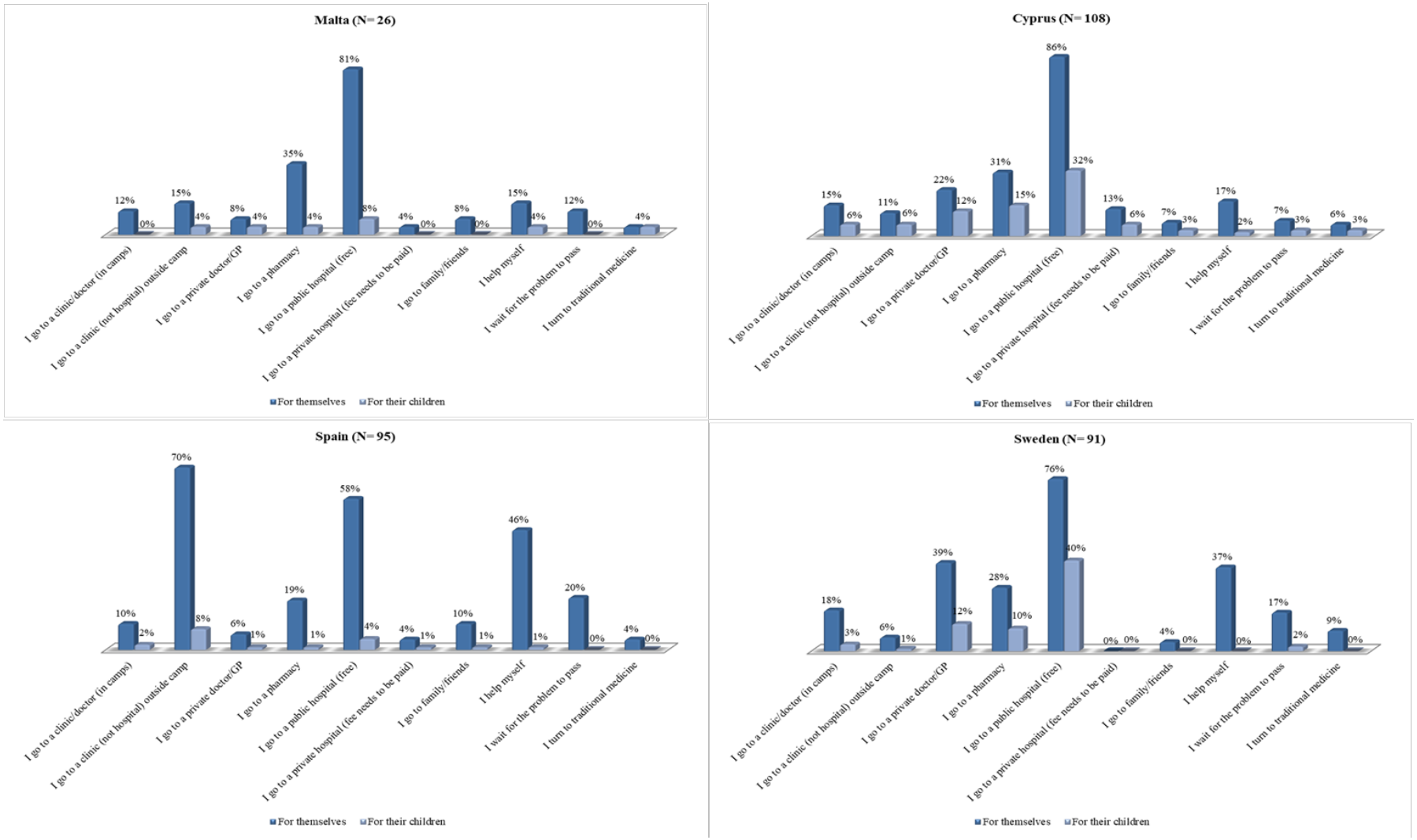


Figure A.24: What migrants do for themselves and their children when they face a medical problem, in Malta, Cyprus, Spain and Sweden



Part B – Appendix 2: The MIGHEALTHCARE questionnaire

Migrant/Refugee Survey Questionnaire-MIGHEALTHCARE

Date of interview:	/ / 2018	Questionnaire ID

Country of interview: Interviewer code: Language of Interview: Location of interview:

Demographics

1. Gender: ☐ Male(1) ☐ Female(2) ☐ Other(0)
2. Year of birth :
3. Age :
4. Country of birth *(Choose one)*:
☐(1)Afghanistan ☐(2) Eritrea ☐(3)Gambia ☐(4)Guinea (Conakry) ☐(5) Iran ☐ (6)Irak ☐ (7) Ivory Coast
☐(8)Nigeria ☐(9) Pakistan ☐(10) Somalia ☐(11) Syria ☐(0) Other, please, specify: (a)_____
5. Nationality/Ethnicity (*Choose all that apply*):
☐(1) Afghanistan ☐(2) Eritrea ☐(3)Gambia ☐(4) Guinea (Conakry)☐(5)Iran☐(6)Irak ☐(7)Ivory Coast☐(8)Kurdish
☐(9)Nigeria ☐(10) Pakistan ☐ (11)Palestinian ☐ (12)Somalia ☐ (13)Syria ☐ (14)Other, please, specify (15)__
6. Do you have basic communication skills in any of the following languages (*Choose all that apply*):
☐(a)Arabic☐(b) Bulgarian☐(c) English☐(d)French☐(e)German☐(f) Greek☐(g)Italian☐(h) Maltese☐(i)Spanish
☐ (j)Swedish ☐(k) Other

Household

7. Marital status: (*Choose one*)
☐(1) Single *Please proceed to question 9* ☐ (2)Engaged/married/living with partner ☐ (3)Separated/ Divorced ☐(4) Widowed
8. Is your partner/husband/wife with you right now?
☐ (1)Yes ☐ (0)No
9. Do you have children who are younger than18 years old?
☐(0) No *If no, please proceed to question 10* ☐ (1)Yes

Order of Child	Year and Month born(q)	Living with you now (w)	Order of Child	Year and Month born(q)	Living with you now (Y/N)(w)
(a)First	Y:____ M:___	☐(1)Yes ☐(0)No	(d)Fouth	Y:____ M:___	☐(1) Yes ☐(0)No
(b)Second	Y:____ M:___	☐ (1)Yes ☐(0)No	(e)Fifth	Y:____ M:___	☐ (1)Yes ☐(0)No
(c)Third	Y:____ M:___	☐ (1)Yes ☐(0)No			

10. Where do you live right now? (*Choose one*)
☐ (1)Tent ☐ (2)Container ☐ (3)Apartment/Home ☐(4) Dormitory/Homeless shelter ☐ (5)Streets/abandoned buildings
☐ (0) Other, please specify: (a)_____
11. Do you feel safe in your current accommodation ? (*Choose one*)
☐ (1)Not safe at all ☐ (2)Somewhat safe ☐ (3)Fairly safe ☐(4) Fully safe
12. Do you share this accommodation with non-family members?
☐ (0)No ☐ (1)Yes If yes, then with how many?(a)_____

Education and employment

13. Number of completed school years (*add all levels of education received*): _____
14. Do you receive a regular income? (*any income on a daily/weekly/monthly basis*)
☐ (0)No *If no, please proceed to question 15.* ☐(1) Yes If yes, is this income from:
☐(a) An NGO/UNHCR ☐(b) Paid job☐(c)Government allowance/ Unemployment benefit ☐(d)Other , please specify (e)_____

General well being

15. What is your current height? (*in cm*): _____
16. What is your current weight (*in kg*): _____
17. In general, would you say your health is: (*Choose one*)
☐(5) Excellent ☐ (4)Very Good ☐ (3)Good ☐ (2)Fair ☐(1) Poor
18. How TRUE or FALSE is each of the following statements for you ?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
(a) I seem to get sick a little easier than other people	1	2	3	4	5
(b) I am as healthy as anybody I know	1	2	3	4	5
(c) I expect my health to get worse	1	2	3	4	5
(d) My health is excellent	1	2	3	4	5

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19. The following questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
(a) Did you feel full of pep?	1	2	3	4	5	6
(b) Have you been a very nervous person?	1	2	3	4	5	6
(c)Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
(d) Have you felt calm and peaceful?	1	2	3	4	5	6
(e) Did you have a lot of energy?	1	2	3	4	5	6
(f) Have you felt downhearted and blue?	1	2	3	4	5	6
(g) Did you feel worn out?	1	2	3	4	5	6
(h) Have you been a happy person?	1	2	3	4	5	6
(i) Did you feel tired?	1	2	3	4	5	6

Access and interaction with health care services

20. During the last 6 months did you need to use health care services but were not able to?

☐ (0) I did not need health care services during the last 6 months

☐ (1) Yes, I needed health care services and I had access to them during the last 6 months

☐ (2) Yes, I needed health care services and was not able to access them *If yes, please indicate the problems that most usually appeared*

Problems	Interfered with access	Problems	Interfered with access
(a) Not knowing where to go		(i) Lack of understanding of the Health Care System	
(b) Not being able to organise an appointment		(j) Fear of having problems with the authorities	
(c) Long waiting times		(k) Fear of the doctors	
(d) High cost		(l) Fear of medical examinations	
(e) Long distance		(m) Feeling discriminated against	
(f) The behaviour of health professionals (doctors/nurses etc)		(n) Feeling that you don't get the care you need	
(g) The behaviour of administrative staff (secretaries/reception staff etc)		(o) Provision/availability of medication	
(h) Lack of communication and understanding of doctors and their instructions		(p) Feeling uncomfortable	
(q) Other, please specify			

21. Do you suffer from any of the following chronic diseases or long term conditions? (tick all that apply)

			In the last six months did you visit…			
Condition	**(a) (1)Y/N(0)** *(If yes, please proceed to columns b-f)*	**(b) Medication for this condition**	**(c) Doctor (GP or specialist)**	**(d) Emergency department (To see a doctor of any specialty)**	**(e) Hospitalization**	**No of nights at the hospital(f)**
(1) Diabetes						
(2) Cancer						
(3) Heart disease						
(4) High blood pressure						
(5) Disease related to bone and muscle						
(6) Respiratory disease (asthma, chronic bronchitis, pneumonia)						
(7) Kidney disease						

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			In the last six months did you visit…			
Condition	**(a) (1)Y/N(0)** *(If yes, please proceed to columns b-f)*	**(b) Medication for this condition**	**(c) Doctor (GP or specialist)**	**(d) Emergency department (To see a doctor of any specialty)**	**(e) Hospitalization**	**No of nights at the hospital(f)**
(8) Brain stroke						
(9) Psychological disease (depression, anxiety, worry, stress)						
(10) Gastrointestinal disease						
(11) AIDS/HIV						
(12) Tuberculosis						
(13) Chronic problems from Injury/accidents						
(14) Sleep disorders						
(15) Urinary infections						
(16) Ear, Nose and Throat diseases						
(17)Eye diseases						
(18) Skin diseases						
(19) Caries (Bad teeth)						
(20) Headaches / Migraines						
ONLY WOMEN (21) Gynecological diseases (vaginitis, HPV infection etc)						
ONLY WOMEN (22) Pregnancy/Birth						
(23) Other please, specify						

22. If the response to any of the above c-e columns is yes, during your consultations did you feel that:

	Always true	←			Never true
(a) You are treated with less courtesy than other people	5	4	3	2	1
(b) You are treated with less respect than other people	5	4	3	2	1
(c) You receive poorer service than others	5	4	3	2	1
(d) A doctor or nurse acts as if he or she thinks you are not smart	5	4	3	2	1
(e) A doctor or nurse acts as if he or she is afraid of you	5	4	3	2	1
(f) A doctor or nurse acts as if he or she is better than you	5	4	3	2	1
(g) You feel like a doctor or nurse is not listening to what you were saying	5	4	3	2	1

23. During your interactions with healthcare services, were you in need for a translation?
☐ (1)Never (*Proceed to Question 25*) ☐(2) Few times ☐ (3)Most times ☐(4) Always

24. When translation was needed, who assisted you? *(Refer to the most usual experience)*
☐ (1) A professional (translator/cultural mediator) ☐ (2) A family member/friend ☐ (3) Nobody was available
☐(4) Other, please specify _____

25. During the last 6 months did you need to take medication and were not able to?
☐(1) I did not need to take medication during the last 6 months
☐(2) I needed to take medication during the last 6 months and I had access to them
☐(3) Yes, I needed medication and I was not able to take it

(a) If yes, which was the most important reason? (*Choose One*)
☐ (1) I did not know where to get medication ☐(2) I was afraid of the side effects of the drugs prescribed ☐ (3) Other, please specify:

26. Do you believe that you have worse access to health services compared to the local people? (*Referring to the country of interview*)
☐ (1) Yes ☐ (0) No

Screening

27. Have you ever had a colonoscopy?
☐(0) No ☐ (1) Yes ☐ (2) I don't know

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If yes, when was the last time?	Month		Year	

If the responder is a man, proceed to Question 30

28. Have you ever had a Pap Test /cervical cancer screening?
☐(0) No ☐ (1) Yes ☐ (2) I don't know

If yes, when was the last time?	Month		Year	

29. Have you ever had a mammogram?
☐(0) No ☐ (1)Yes ☐ (2) I don't know

If yes, when was the last time?	Month		Year	

Dental Care

30. How would you describe the condition of your TEETH or DENTURES?
☐ (5) Excellent ☐ (4) Very Good ☐ (3) Good ☐ (2) Fair ☐ (1) Poor

31. How long has it been since you last visited a dentist or a dentist's clinic for any reason?
☐(1) I have never visited a dentist or a dentist's clinic ☐(2) More than 5 years ago ☐(3) Between 2-5 years ago
☐(4) Between 1-2 years ago ☐(5) Less than 12 months ago ☐(6) Do Not Remember

32. Do you brush your teeth every day?
☐ (1)Yes ☐(0) No

33. Do you know where to go in case you need a dentist?
☐ (1)Yes ☐(0) No

Immunization status

34. Do you have a vaccination card?
☐ (1)Yes ☐ (0)No

(a)Are the following questions going to be filled in with a vaccination card at hand?
☐ (1)Yes ☐(0) No

(b)Is (country of Interview) the first country of entry in the EU?
☐ (1)Yes ☐(0) No

35. Have you received immunizations for any of the following?

Disease	**Present country (3)**	*If present country is not country of entry* **Country of Entry in the EU (4)**
(a)Hepatitis A	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(b)Hepatitis B	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(c)Influenza	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(d)Measles	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(e)Pneumococcus (pneumonia)	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(f)Polio (all in adult booster shots)	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(g)Tuberculosis	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know
(h)Tetanus	☐(1)Yes ☐(0)No ☐(2)Don't Know	☐(1)Yes ☐(0)No ☐(2)Don't Know

The following question needs to be answered only by parents.

36. For each of your children, aged under 18, please tick the vaccinations they have received (including in this country):

(A) Does your child have a vaccination card?	Child 1	Child 2	Child 3	Child 4	Child 5
	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(a)MMR	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(b)DTaP	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
Polio(c)	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(d)Pneumococcal	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(e)Chickenpox	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(f)Meningitis	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(g)Hepatitis A	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(h)Hepatitis B	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK
(i)Influenza	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK	☐(1)Yes ☐(0)No ☐(2)DK

CHAFEA
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CARDET OXFAM mig Health Care

Skin problems

37. At the moment do you have itching?
☐ (1)Yes ☐(0) No *Go to Question 39*

38. If you have itching, please rate you itching intensity by marking the number (0-10) that best describes your itching during the past week, including today:

10: Worst Imaginable Itch										0: No itch
10	9	8	7	6	5	4	3	2	1	0

39. At the moment do you have a rash?
☐ (1)Yes ☐ (0) No

Women's Health

If responder is a man, proceed to Question 46

40. Have you visited a gynecologist / midwife while in this country?
☐(1) Yes ☐ (0)No

41. Do you prefer to be seen by a gynecologist or a midwife for your gynecology related issues?

(1)Gynecologist		(2)Midwife		(3)No preference	

42. No of pregnancies _____ *(Include all pregnancies, also miscarriages/abortions)*
43. No of labors _____
44. Have you been pregnant since you were in this country?
☐(0) No *Proceed to Question 46* ☐ (1)Yes
(a) If yes, what was/is the outcome?
☐ (1)Miscarriage ☐ (2)Abortion ☐(3) Labor / Birth ☐ (4)I am currently pregnant
If your answer is "Labor/Birth" or "I am currently pregnant, proceed with question 45, otherwise, go to Question 46

45. If you have been pregnant in this country where did you give birth (or are going to give birth)? (*Choose one, refer to the most recent pregnancy in this country, if multiple*)
☐ (1)At home ☐ (2)Public hospital/clinic ☐ (3)Private hospital/clinic ☐ (4)Other, please specify _____
☐ (5)Do not know/Remember

Perceptions about health

46. Which of the following health issues are important to you *(tick 3-5 most important)*?

Health Issues		Health Issues		Health Issues	
(a)Teeth problems		(g)Back pain		(m)Ear problems	
(b)Skin problems		(h)Overweight/obesity		(n)Muscular and Bone problems	
(c)Respiratory problems		(i)Sleep problems		(o)Recurrent and continuous pain from e.g. older injuries or surgical operations	
(d)Gastrointestinal		(j)Worry/anxiety		*ONLY WOMEN* (p) Gynecological Problems	
(e)Chest pain		(k)Eye problems		(q)Traditional medicine (homeopathy, acupuncture, self-made healing procedures)	
(f)Headaches/migraines		(l)Immunizations			

47. Do you need to receive more information about *(tick all that apply)*:

Health Issues		Health Issues		Health Issues	
(a)Rights and how to use health care services		(e)Nutrition and exercise		(i)Sexually Transmitted Disease e.g. HIV/AIDS, Hepatitis	
(b)Coping with worry and anxiety		(f)Alcohol consumption risks		(j)Vaccinations	
(c)Diabetes		(g)Tobacco use		(k)Availability of mediators and translators	
(d)Healthy teeth and oral health		(h)Child health, Pregnancy and family planning			
(l)Other, please, specify:					

48. What do you or your children do, when you face a medical problem? (*Choose all that apply*)

Setting	(a)Myself	(b)My children
(1)I go to a clinic/doctor (in camps)		
(2)I go to a clinic (not hospital) outside camp		
(3)I go to a private doctor/GP		
(4)I go to a pharmacy		
(5)I go to a public hospital (free)		
(6)I go to a private hospital (fee needs to be paid)		
(7)I go to family/friends		

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(8)I help myself		
(9)I wait for the problem to pass		
(10)I turn to traditional medicine (homeopathy, acupuncture, self made healing procedures)		

49. Do you prefer health personnel to be:
☐(1) a man ☐(2) a woman ☐ (3) I don't have a preference

Current situation		
	Month	Year
50. When did you leave your country?		
51. When did you arrive in Europe? (*First point of entry in Europe*)		
52. When did you arrive in this country? (*Country where interview takes place*)		

53. From where did you cross into Europe? (*Last non-EU country before entering Europe*)
☐ (1) Libya ☐ (2) Morocco ☐ (3) Turkey ☐ (4) Other, please, specify: _____

54. Is this country your final destination? (*Country of interview*)
☐(1) Yes ☐(0) No

55. Did you ask for asylum in Europe? (*In any country in the EU*)
☐(1) Yes ☐ (0)No

56. Did you ask for asylum in this country? *(Country of interview)*
☐(1) Yes ☐(0) No

57. Have you been granted asylum? (*In any country in the EU*)
☐(1) Yes ☐ (0)No

58. Do you have any other kind of permit to stay in this country? *(Country of interview)*
☐ (1) Yes ☐ (0)No

59. Is there anything else you would like to tell us?

Thank you very much for your participation!

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Part B - Appendix 3: MigHealth care Survey Methodology Guidelines

1. General Methodology Considerations

a. Sampling

The study population is defined as migrants/refugees who reside in Europe (country of interview or other EU country), for at least 6 months and up to 5 years. The nationalities that define the study population are:

- Afghanistan
- Eritrea
- Gambia
- Iran
- Iraq
- Ivory Coast
- Nigeria
- Pakistan
- Somalia
- Syria

In countries where the total number of questionnaires required for the survey cannot be reached, additional nationalities that comprise a large part of the local refugee/migrant population from third countries (outside Europe) and are not among the ones mentioned above may be included, as long as they meet the inclusion criterion for length of stay in the EU.

We aim for 500 questionnaires per partner. Each partner is requested to make an attempt that the sample's basic demographics (nationality & gender) are roughly proportional to the distribution of the migrant/refugee population of the partner's country.

b. Participants recruitment

Given the inherent differences in the structures and ways of access to the migrant/refugee population per participating country, each partner is expected to choose the most appropriate/efficient way of recruiting respondents. If project members will be recruiting individual respondents themselves, the following aspects should be taken into consideration: 1) be informed about the best times to recruit respondents at any given site, and 2) determine what interview setting, considering the possibilities on site, offers the most comfort, privacy and autonomy to respondents. In any case, the way of recruitment should be clearly stated in order to be accounted for in the statistical analysis.

c. Data collection process – Log book

It is important that we keep track of the response rate and responders' characteristics that affect it. For this reason it is necessary that a Logbook is kept (see attached file). The interviewer should fill in the requested fields for every potential participant approached, and record her/ his characteristics connected with the inclusion criteria, and whether she/he is willing to participate in the survey. The Log Book can be

filled in electronically or manually, per interviewer on a daily or weekly basis, as long as the unique identification codes provided are kept in order.

Please remember that the responses recorded are only those exactly given by the interviewee.

d. Interviewers

Surveys may be filled out in the following languages:

- In each country's respective language or English, given that the respondent has an adequate command, or if an interpreter is present to translate questions / answers.
- In one of the languages in which the questionnaire will be translated (Arabic, Somali, Farsi, Pashto and Urdu). In that case, the interviewer needs to be a native speaker of that language as well, or be accompanied by an interpreter.

Interviewers need to be trained in the content and flow of the questionnaire and the filling of the Log book (see below). Each interviewer should be assigned a unique number in a manner described below (section 2). To minimize discomfort among respondents, female interviewers (and interpreters) should be preferred for female respondents, and male interviewers (and interpreters) for male respondents.

e. Informed consent

Each participant should be informed on the general aims of the survey and give his/her consent to participate. This consent form should be kept together with the questionnaire. It will be a short description of the survey and a simple YES/NO answer for participation. The interviewer will be required to write down the questionnaire ID on the consent form, and ask the respondent for a signature (?).

f. Data collection method

Questionnaires should be filled in with the help of a trained interviewer. This could be done either on a one-to-one basis or, alternatively administered to a group of respondents who are supervised / instructed by the trained interviewer. For reasons of efficiency, the latter strategy is preferred. The interviewer should be present throughout to assist with any questions that respondents may have. Respondents should be encouraged to fill out the questionnaires by themselves. However, respondents who are illiterate will require the interviewer to read out questions and write down the answers respondents provide. In this case, a one-to-one interview is the only option. For reasons of comparability, consistency and practicality (length, level of difficulty, monitoring of response rates), different methods of data collection (phone/web/only self-administration) are excluded.

Specific guidance for the questionnaire:

- Explain to respondents what certain terms mean, if they are unfamiliar with them. For example, explain that 'respiratory' refers to 'lungs and windpipe'. However, refrain from going into too much detail for sensitive terms.
- Provide additional explanation if questions are unclear to respondents.

- Use the final question of the survey (open question) to record any relevant information that the respondent has given during the interview, but which was not captured by the previous questions.

g. Record keeping

Partners should keep records of all documents pertaining to the survey such as questionnaires, consent forms, daily activity sheets (log book), and interviewers' names as described below (section 2) in case these are needed for quality control or verification purposes. These may also be requested as evidence that the survey was conducted. Please ensure the safety of your record keeping.

2. Questionnaire fields clarifications

Interviewer code: Each partner/country should assign interviewers codes according to the following rationale:

- A 5-digit code where the first two digits denote the country two-letter EU code (DE for Germany, EL for Greece etc). The other three digits should be uniquely assigned to each interviewer.
- Each partner is responsible for the unique identification code assignment (RevID), as well as for keeping a record with the following records:
    - The RevID
    - Their name
    - Their nationality
    - Their native language
    - Their proficiency in the country of interview language (Y/N)

Language of interview: Should always be filled in, irrespective of the language of the questionnaire.

Location of interview: State where the interview takes place (i.e. Apartment/ Camp/Street /Slam/ Cultural Center/Health Center etc.). The partners should instruct the interviewers to a uniform description of location as much as possible.

Question 12, years of education: Include all years of education and sum them. For example, an individual who went to elementary school (6y), high school (6y) and a 3-year University degree has 15 years of education. Input 0 for no education.

Questions 16,17,18: These questions are part of the SF-36 Questionnaire which is a validated instrument to measure Quality of life. Translations for these questionnaires should be taken from the respective language's (validated) translated version of SF-36.

For Questions that have a Yes/No option (8,19,20,34,35,45, & 46) An answer should be given for all question items – do not leave empty items that are a "No"

Question 13: make sure the interviewee understands what income means i.e. any source of money received IN THIS COUNTRY.

Question 20: interviewer should emphasize that columns c to e only apply to the last 6 months. Also if member of family has a chronic condition, make a note at the end of the questionnaire.

Question 34: we record vaccination received only while in the EU (not in the country of origin)

Question 44: make sure to record facts NOT wishes e.g. “I want to give birth to a private hospital”.

Interviewer’s comments: In this section please record any important additional information or observations not pertaining to the questionnaire.

Part B – Appendix 4: Consent Cover Letter

Dear Participant,

I invite you to participate in a research study entitled: **Physical and mental Health needs of migrants/refugees.** The purpose of the research is to determine the health needs of migrants and refugees as well as their needs in relation to accessing health care services in this country.

The research is being conducted within the EU co funded project: 'Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities' - NUMBER — 738186 — Mig-HealthCare.

Your participation in this research project is completely voluntary. You may decline altogether, or leave blank any questions you don't wish to answer. There are no known risks to participation beyond those encountered in everyday life. Your responses will remain confidential and anonymous. Data from this research will be kept under lock and key and reported only as a collective combined total.

By ticking the "agree" button below you indicate that:

- you have ready the above information
- you voluntarily agree to participate
- you are at least 18 years of age

If you do not wish to participate in the research study, please decline participation by ticking on "disagree" button.

☐ Agree

☐ Disagree

Part B – Appendix 5: Interview Log Book

Record ID in this LogBook	**Unique Interviewer code**	**Gender of responder, fill without asking**	**Ask Ethnicity**	**Ask responder how long has she/he been in Europe, Insert Y/N, if NO**	**Ask if he/she is willing to participate in survey**	**If Questionnaire is conducted, questionnaire ID**
ID	Interviewer Code	Gender	Ethnicity	6 months < Stay <5 years	Consent (Y/N)	Questionnaire ID