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**Access to Health Care for Refugee Children and Unaccompanied
Minor Aliens in The Netherlands: A Qualitative Study**

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Preface

Before u lies my thesis which I am completing my MSc in Health Psychology and Technology at the University of Twente. This thesis is part of a Ph.D. study on the access to care for refugee children and unaccompanied minor aliens in the Netherlands. I had the opportunity to investigate the perspectives of refugee parents, UMAs, and health professionals regarding refugees' access to care in The Netherlands. This research convinced me of the importance and influence of policies that can offer appropriate care according to the complex health needs of refugees.

The subject of this thesis is very special to me, as I myself once fled to The Netherlands from Iran as a toddler with my parents. This allowed me to empathize with the situation and the needs of both the minors and the refugee parents. I have therefore experienced the focus group discussions as very special in which I have learned a lot about the implementation of this method and the needs of this vulnerable target group. I feel very privileged to be of value in this study and I hope this study gives researchers and policymakers perspective on the needs of the target group.

There are many people who have cooperated in the realization of this thesis: I would like to thank Albertine Baauw, MD, MScPH and Dr. Mariette Hoogsteder for giving me this opportunity and to cooperate with Chanine Brouwers to improve access to care for refugee children. My supervisors, Dr. Stans Drossaert and Dr. Peter ten Klooster for their guidance and feedback during my thesis. In particular, I would like to thank my dear partner, Mark van Duuren MSc, for his eternal support and creative solutions by my side who always kept believing in me. My dear mother, Zohre Faridani, and brother, Sam Fathi Afshar, who always supported me and gave me perspective throughout my study. I would also like to thank the participants of this study and the coordinators of the asylum seekers' centres for their cooperation who made this study possible. Furthermore, I would like to thank my mentor, Fernando Zacarias, MD, DrPH, for his guidance and uplifting speeches, and my dear friends, Ceren Avsar, Mieke van Melis, and Deby Ganga who supported me in many ways.

Wishing you much pleasure with reading.

Sogol Fathi Afshar,

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Abstract

Background: In The Netherlands, refugee children and unaccompanied minor aliens (UMAs) are a vulnerable group and health professionals perceive many challenges to provide them with appropriate care. This study aims to understand the perceived barriers of access to care, the experiences, and the needs of health care among refugee children and UMAs. Two linked studies were conducted to explore these issues through the lens of refugee parents, UMAs, and health professionals.

Methods: Two qualitative methods were employed: semi-structured focus group discussions with UMAs ($n = 8$) and parents of refugee children ($n = 23$), and semi-structured interviews with health professionals ($n = 6$). Transcripts of focus groups were inductively analysed and those of the interviews were deductively analysed using Levesque, Harris, and Russell's (2013) access to care framework.

Results: The results show that refugee parents highlighted key barriers to connect with healthcare services and to reach them in a timely manner. Cultural understanding of illnesses and the Dutch health system and poor health literacy influenced one's health-seeking behaviour and decision-making regarding health treatments negatively. Poor communication between healthcare services and a lack of human resources led to postponed care for refugee children. Additionally, refugees expressed a need for physical screening and mental care based on their country of origin, (pre-)war situation, and migration journey.

Conclusion: Overall, this studies' findings show that poor access to care is perceived to have consequences concerning the appropriateness of care, and care to be reached in a timely manner. The evidence yielded from this study, suggests that more attention needs to be paid for refugee children and UMAs concerning physical screening and mental care, improving cultural understanding of illnesses and the Dutch health system, shortage of human resources of services that provide refugee care, and the communication between these services. In turn, the aforementioned will improve access to care for refugee children and UMAs.

Keywords: The Netherlands, Refugee children, Unaccompanied minor alien, Refugee health, Healthcare access, Health needs, Healthcare barriers

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Abbreviations and Acronyms

COA	Central Reception for Asylum seekers [Centraal Opvang voor Asielzoeker]
EU	European Union
GGD	Community Health Service [Gemeenschappelijke Gezondheidsdienst]
GP	General Practitioner
GZA	Asylum Seeker Healthcare [Gezondheidszorg Asielzoekers]
IOM	International Organisation for Migration
JGZ	Youth Health Care [Jeugdgezondheidszorg]
METC	Medical Ethics Review Committee [Medisch-Ethische Toetsingscommissie]
PTSD	Posttraumatic Stress Disorder
UMA	Unaccompanied Minor Alien
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations International Children's Emergency Fund
VUMC	Vrije Universiteit Medical Centre
WHO	World Health Organisation

Introduction

By the end of 2017, 68.5 million people worldwide were forcibly displaced from their homeland as a result of persecution, conflict, or generalized violence due to war and instability (UNHCR, 2017). These include 25.4 million refugees, of which 52 percent were children below the age of 18 (UNHCR, 2017). As a large number of refugees travel to and through Europe in search of safety and security, they simultaneously come with various and complex health care problems that challenge national health care systems to support and facilitate their needs (Hunter, 2016; ISSOP, 2018; Robertshaw, Dhesi, & Jones, 2017).

A refugee is an individual who has fled his/her home country and cannot return home safely because his/her life is threatened by violence, conflict, or persecution (IOM, 2018). The term refugee is used in various contexts in The Netherlands, as the Dutch definition often includes asylum seekers, unaccompanied minor aliens (UMA), status holders, and undocumented individuals. Textbox 1 displays the definitions that come along with the term refugee, as retrieved from the handbook on procedures and criteria for determining refugee status by the United Nations High Commissioner for Refugees (UNHCR, 2019).

Textbox 1: Definitions

Asylum seeker	A person who formally applies for the right to remain in another country and keeps that status until the application has been concluded
Refugee	A person who has fled their home country and cannot return home safely because their life is threatened by violence, conflict, or persecution
Status holder	A person who has a residence permit in the Netherlands
Unaccompanied minor alien	An unaccompanied minor alien is a person who was under the age of 18 on arrival in the Netherlands, whose country of origin is outside the EU, and who travelled to the Netherlands without a parent or other relative
Undocumented	A person who is a foreign-born person and does not have the legal right to be or remain in the Netherlands

The number of displaced people globally has increased every year from 2012 (45.2 million) to 65.3 million in 2015 and record numbers in 2017 (68.5 million) (UNHCR, 2017). In 2017, Syria was the main country with the largest population where refugees originated from in Europe with more than 6.3 million people, following Afghanistan (2.6 million) and South-Sudan (2.4 million) (UNHCR, 2017). Among these displaced people are vulnerable children who are unaccompanied or separated from their families. In 2017, a number of 174.000 unaccompanied minors or separated children applied for asylum in Europe (UNHCR, 2017). Within Europe, The Netherlands has encountered high numbers of refugees and asylum

seekers with record numbers in 2015 (58.880 asylum seekers) who mostly originated from Syria (47%), Eritrea (14%), Iraq (6%), and 3.859 UMAs with a majority that were Syrian (38%) and Eritrean (32%) (IND, 2015). Thereafter, the number of asylum applications gradually decreased to 31.327 in 2017 who were mostly Syrian (35%), Eritrean (13%), and 1.181 UMAs with a majority that was Eritrean (41%) and Syrian (11%) (IND, 2017).

The numbers show a decline in the asylum applications of the past years, however, they still include a vulnerable group of refugee children and UMAs.

The Effects of Experiences Prior, During, and After The Migration Journey

Refugee children and UMAs are at risk concerning their health due to the consequences of the faced stressors in their country of origin, during their migration journey, and after arrival at the destination country at a young age (ISSOP, 2018). First of all, refugee children may be unvaccinated, or partially vaccinated, which increases the high-risk to vaccine-preventable diseases (Lam, McCarthy, & Brennan, 2015; Meiqari, Hoetjes, Baxter, & Lenglet, 2018; Pavli & Maltezou, 2017) because health care systems and vaccination services in their country of origin may be destroyed (Pavli & Maltezou, 2017). Likewise, infants who were born under circumstances without skilled postnatal care or new-born screening are at high-risk to malnutrition and vaccine-preventable diseases (Meiqari et al., 2018; Save The Children, 2014). In addition, refugee children may come from countries with a high incidence of nutritional deficiencies (Meiqari et al., 2018) and infectious diseases (Van Der Werf et al., 2018) such as tuberculosis (Odone et al., 2015), HIV (WHO & ECDC, 2018), hepatitis B and C (ECDC, 2016), malaria (Roggelin et al., 2016), communicable diseases (Pavli & Maltezou, 2017), and intestinal parasitic infections (Garg, Perry, Dorn, Hardcastle, & Parsonnet, 2005). Reasons for migration may result from suffered human rights abuses, endured war and conflict, or livelihood in extreme poverty (ISSOP, 2018; UNICEF, 2017). Hence, migrant children may have spent long periods without access to proper health care due to their pre-war situation and their migration journey (ISSOP, 2018). All these factors may have a disastrous impact on the overall health of refugee children and UMAs as a consequence of delayed, or inappropriate diagnosis and care.

Secondly, the exposure to dangerous and long migration journeys is detrimental for the physical and mental health of refugee children and UMAs (UNICEF, 2017). Migration routes may lead to malnutrition, dehydration, unsanitary living conditions, and deprivation of safety as they reflect the ravages of harsher climate on environments (UNICEF, 2017). Infants may suffer from severe malnutrition as breastfeeding becomes a challenge for the mother

because of not having enough breast milk, or being unable to feed the child because of illness or injury during the journey (Meiqari et al., 2018). Even in refugee camps, inadequate hygiene facilities and overcrowded accommodations increase the risks of communicable diseases (Pavli & Maltezou, 2017). In regard to the mental health, a migration journey is often marked with traumatizing experiences of (sexual) abuse, violence, exploitation, kidnapping, and trafficking that cause mental health problems (UNICEF, 2017). Studies into the mental health problems of refugee children and UMAs have shown high levels of trauma and distress at arrival in the destination country owing to traumatic and stressful experiences, such as anxiety, depression, posttraumatic stress disorder (PTSD) (Buchmüller, Lembcke, Busch, Kumsta, & Leyendecker, 2018; El Baba & Colucci, 2018; Hilal Yayan, 2018; Montgomery, 2011; Müller, Büter, Rosner, & Unterhitzberger, 2019; Nasıroğlu, Çeri, Erkorkmaz, & Semerci, 2018), attention problems and withdrawal behaviour (Buchmüller et al., 2018), and sleep disturbance (Montgomery, 2011). Traumatizing experiences and the separation and death of family members increase (the risks of) mental health problems and its consequences for the general health on the long run (Gušić, Malešević, Cardena, Bengtsson, & Søndergaard, 2018; UNICEF, 2017). In addition, a study by Hilal Yayan (2018) found a correlation between lower mental health status and diseases among refugee children. For example, a correlation was found between PTSD and lower general health status of refugee children. This indicates that the mental health of refugee children and UMAs reflects in their general health as it is shaped by traumatic experiences.

Finally, besides traumas, environmental conditions in the destination country may increase distress and mental health problems among refugee children and UMAs as well. Their housing, frequent change of locations (Goosen, Stronks, & Kunst, 2014; Nielsen et al., 2008), lack of toys, limited access to school, and lack of interaction with peers are daily stressors for children (ISSOP, 2018). Additionally, Miller and Rasmussen (2017) found that mental health problems are strongly linked to displacement-stressors such as discrimination, uncertainty regarding an asylum status, and a lack of access to basic resources over which refugees often have no control.

Given the above mentioned, it is of utmost importance that refugee children and UMAs can make use of appropriate and accessible health care services.

Healthcare Within The Dutch Asylum System

Various stakeholders are involved with the guidance of refugees towards the use of healthcare services in The Netherlands. Refugees are entitled to primary and secondary care

which is covered by the Asylum Seekers Medical Care Regulations (RMA) (RMA Healthcare, 2019). Primary care involves a general practitioner (GP) that is available in asylum centres and is provided by the Asylum Seeker Healthcare (GZA) (GZA, 2019). Regarding secondary care, the RMA covers almost the same benefits as the Dutch health system. However, it restricts the choice of provider (RMA Healthcare, 2019). Refugees do not pay for premiums or deductible since they hardly have any financial resources (RMA Healthcare, 2019).

Upon arrival in The Netherlands, the Central Reception for Asylum Seekers (COA) is responsible for the housing and guidance of refugees (COA, 2018). Within six weeks, they will receive an invitation for a medical and psychological intake at a COA-location, which will be performed by the Youth Health Care (JGZ) and the Community Health Service (GGD) (Baauw, Slinger, & Goosen, 2017; COA, 2018). By means of this intake, the physical health of a child is evaluated, and, if necessary, a vaccination plan will be set up (COA, 2018). A child may be transferred to a specialist when necessary (Baauw et al., 2017). However, some risk factors to the health of refugee children and UMAs may be overlooked since laboratory tests on the nutritional status, infectious diseases, and the existence of geographically determined occurrence of diseases are not part of the inventories (Baauw et al., 2017).

Given the current inventories, an extension of the physical screening might be necessary. In particular, since refugee children are more prone to specific infectious diseases (Van Der Werf et al., 2018) as they origin/migrate from countries with a high incidence of such diseases.

Barriers to Access Health Care Services

Healthcare policies should make appropriate and accessible healthcare services possible for refugee children. However, several studies show that access to health care services in Western countries is not always guaranteed for refugees. As a matter of fact, access to health care is mostly restricted in host countries with great variation in entitlements (Norredam, Mygind, & Krasnik, 2006; WHO, 2010). Norredam et al. (2006) conducted a comparative study on the standards of health care provision for asylum seekers in 25 European Union (EU) countries. They found that the extent of medical screening varies within the EU and that access to health care is legally restricted to emergency care only within ten out of 25 EU-countries. Moreover, access to care differs in EU countries due to different entitlements to care and legal frameworks of the asylum process (Bradby, Humphris, Newall, & Phillimore, 2015; Pavli & Maltezou, 2017). In addition, a number of studies found barriers

among refugees to access care, such as communication difficulties, cultural problems, poor health literacy, and financial difficulties (Bradby et al., 2015; Norredam et al., 2006; Pavli & Maltezos, 2017; Sheikh-Mohammed, Raina MacIntyre, Wood, Leask, & Isaacs, 2006).

Evidently, access to care mostly depends on the legal rights within the host country. In addition, access to care is influenced by the barriers among refugees. However, no studies were found so far regarding the (barriers) access to care among refugee children and UMAs.

Challenges for Health Professionals

Not only refugees but also health professionals experience challenges concerning the provision of care for refugee children and UMAs. Recent studies have shown that health professionals in The Netherlands faced, and still face, many challenges at their practice with high numbers of refugee children due to the increased migration flow since 2015. This is evident in a Dutch study that analysed 68 cases of reported barriers by paediatricians, from November 2015 till January 2017, via an online system where they report predefined conditions (Baauw et al., 2018). Paediatricians reported barriers that influenced the health outcome of refugee children. The most important barriers were the frequent relocations of refugee children and their unknown medical history. Other barriers were poor handsoff of medical records, poor health literacy of the refugees, and cultural differences between the refugees and paediatricians (Baauw et al., 2018). In particular, poor handsoff of medical records led to poor communication between health professionals, which, in turn, impacted the provision of care for refugee children (Baauw et al., 2018). Regarding the frequent relocations, studies found an increase in the mental health problems among asylum-seeking children which were associated with a high frequency of relocations and protracted stays at asylum centres (Goosen et al., 2014; Nielsen et al., 2008).

Health professionals encounter many challenges to provide optimal care for refugee children, which may hamper the provision of appropriate health care. However, access to care for refugee children and UMAs has not been addressed specifically from the perspective of health professionals so far.

A Conceptual Framework of Access to Care

Levesque, Harris, and Russell (2013) describe access to care as ‘the possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care’ (p. 4). The framework is based on the experiences and resistances faced by individuals regarding five dimensions of accessibility of services: 1) approachability; 2)

acceptability; 3) availability and accommodation; 4) affordability; 5) appropriateness (Levesque et al., 2013). In addition, five corresponding abilities of individuals interact with the dimensions of accessibility to generate access: 1) ability to perceive, 2) ability to seek, 3) ability to reach, 4) ability to pay, 5) ability to engage (Levesque et al., 2013). Figure 1 shows the interaction of both dimensions while the arrow displays their sequence to engage in care.

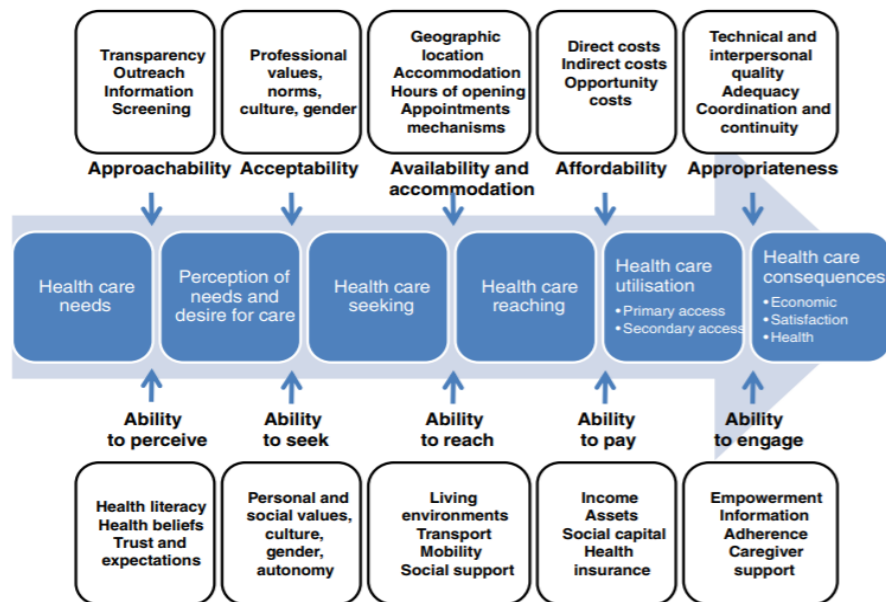


Figure 1. A conceptual framework of access to health care (Levesque et al., 2013). Reprinted from ‘Patient-centred access to health care: conceptualising access at the interface of health systems and populations’ by J-F. Levesque, M.F. Harris, and G. Russell, 2013, *International Journal for Equity in Health*, 12 (1), p. 5.

First, ‘approachability’ relates to individuals that face health needs and who can identify healthcare services and information sources; ‘ability to perceive’ relates to the ability to identify the need for care (Levesque et al., 2013). Poor health literacy and the lack of awareness on the rights to healthcare that influence one’s health-seeking experience (Baauw et al., 2018; Rosiek, 2017). Second, ‘acceptability’ relates to cultural and social factors that influence one’s ability to seek and accept care; ‘ability to seek’ relates to factors that influence the intention to acquire care (Levesque et al., 2013). Language difficulties and cultural differences may lead to communication difficulties and misunderstanding (Baauw et al., 2018; Bradby et al., 2015; Pavli & Maltezos, 2017). Third, ‘availability and accommodation’ relates to the presence of health services and whether they can be reached physically in a timely manner; ‘ability to reach’ relates to means that permit one to physically reach services (Levesque et al., 2013). Legal restrictions to care can be detrimental for refugees to access

services (Norredam et al., 2006; Pavli & Maltezou, 2017). Fourth, ‘affordability’ relates to time and resources to make use of services; ‘ability to pay’ relates to one’s financial capacity to afford the costs of services (Levesque et al., 2013). Insufficient financial means is a barrier to access care and may be influenced by bureaucratic entitlements (Bradby et al., 2015; Norredam et al., 2006; Pavli & Maltezou, 2017; WHO, 2010). Finally, ‘appropriateness’ relates to a fit between the quality of services and one’s ‘ability to engage’ in healthcare by participating in health-related decisions (Levesque et al., 2013). The quality of health services concerns the assessment of health problems and required treatments, and the technical and interpersonal quality of healthcare services (Levesque et al., 2013). Communication difficulty is a barrier that leads to poor engagement with health services (Baauw et al., 2018; WHO, 2010). The framework takes many factors into account that relate to access care.

However, little research has been found in which Levesque's et al. (2013) framework is employed among refugees’ access to care. A recent Malaysian study explored the health needs and access barriers among refugees and asylum-seekers from the perspective of health professionals (Chuah, Tan, Yeo, & Legido-Quigley, 2018). Chuah et al. (2018) used the access framework as a foundation and related its dimensions to access barriers. Subsequently, they found key barriers that were linked to poor health literacy, language and cultural difficulties, legal restrictions that confined access to care, financial difficulties, and poor engagement in healthcare due to communication difficulties (Chuah et al., 2018). The outcomes correspond with those of previous studies concerning access to care among refugees (Norredam et al., 2006; Pavli & Maltezou, 2017; Sheikh-Mohammed et al., 2006). Noteworthy, no studies were found that employed this framework to view access to care among refugee children and UMAs.

Up to now, one study explored the barriers of paediatricians in the provision of care to refugee children (Baauw et al., 2018), but not among both UMAs and refugee children. No research has been done in The Netherlands on access to care for refugee children and UMAs. Therefore, this study aims to explore the gap in our scientific knowledge concerning the needs, expectations, and experiences of UMAs and parents of refugee children with respect to healthcare and access to care in The Netherlands. Specifically, the research question is, ‘How do UMAs and parents of refugee children experience health care and its access in The Netherlands?’ The sub-question is, ‘What are perceived barriers of health professionals to provide care to refugee children and UMAs based on the framework of access to care by Levesque et al. (2013)?’

Methods

This qualitative study was carried out from November 2018 to February 2019 as part of a larger PhD research project that explores and addresses refugees' health issues and needs in The Netherlands. Therefore, this study was carried out together with another study; the perceptions of parents of refugee children and UMAs on an initial health screening upon entry in The Netherlands that contains a medical and psychological assessment program. Two qualitative sub-studies were conducted: substudy 1, focus groups with UMAs and parents of refugee children, and substudy 2, interviews with health professionals who provide care/policy to refugee children and UMAs.

Ethics

This study was approved by the ethical standards of the Medical Ethics Review Committee (METC) of the Rijnstate Hospital Arnhem and the University of Twente. It has also been qualified by Nidos, who gave permission to conduct focus groups with the UMAs (NIDOS, 2018). Prior to the data collection, participants received an informed consent with details of the study. Signed consent was obtained for participation, including the permission to be audio-recorded and to be quoted anonymously in research outputs, as privacy and confidentiality were ensured. In accordance with the VUmc, the audio-recordings were deleted. The transcripts and the signed informed consents will be archived in a secured digital database of the VUmc for ten years.

Sub Study 1: Focus Group Discussions with UMAs and Parents Of Refugee Children

Participants. By means of convenience sampling, participants were included if they met the following inclusion criteria: 1) unaccompanied minor aliens who are 15 to 18 years old; 2) refugee parents with children living in The Netherlands below the age of 18; 3) participants who speak Arabic (Iraq), Dari (Afghanistan), Farsi (Iran), or Tigrinya (Eritrea) as they were placed in a focus group where all participants speak the same language.

Prior to the recruitment of participants, the permission of Nidos was asked to approach the UMAs (NIDOS, 2018). Nidos is an independent guardian institution that performs custody tasks for UMAs. At the same time, two asylum seekers' centres in Arnhem were approached, of which the staff were asked for their permission to conduct the focus groups; a small residential facility for male UMAs, and asylum seekers' centre for refugee families. Thereafter, information was shared with the staff via email and telephone contact regarding the recruitment of participants and the procedure of the focus groups. The staff of the asylum

seekers' centres recruited participants based on the inclusion criteria and informed them orally about the research and, subsequently, they received an informed consent form in their own language (see Appendix A; Part 1). Accordingly, recruited participants showed their interest by filling in the informed consent form and registered with their coordinator to attend the focus group.

A total of 31 participants volunteered their time for the focus groups. Initially, 24 recruited refugee parents agreed on participating in the study. However, one refugee parent did not turn up during the focus group, and therefore, 23 participated ($n = 23$: 11 women; 12 men). Six UMAs were recruited. Two extra UMAs wanted to participate in the study after they were informed about the study by the initial recruited UMAs ($n = 8$).

Procedures. First, recruited participants received an informed consent in their mother language that informed them about the study and its purpose, which was signed prior to their participation (see Appendix A; Part 1). After that, the focus groups were conducted in November and December 2018, in a private room at the asylum seekers' centres. The focus groups of the refugee parents consisted of one male group, one female group, and two mixed groups of male and female parents. A different interpreter was present for each focus group to translate the conversations according to the mother language of the group members to and from Dutch. Two researchers were present along with an experienced paediatrician who supported health-related questions. The participants were orally informed about their privacy, anonymity, and their right to withdraw from the study at any time. With the permission of all participants, the focus groups were audio-recorded except for one, of which notes/quotes were taken to use as a transcription. Each focus group lasted approximately 90 minutes. At the end of the focus group, the participants had the opportunity to ask questions and received a voucher of fifteen euros. The size of the focus groups varied from five to eight people, which is advantageous as information was provided and gathered quickly (Wong, 2008). Group members were homogenous as all participants were either refugee parents or UMAs from the same asylum seekers' centre and spoke the same language. Such homogeneity within the group encourages participants to talk freely and share experiences (Wong, 2008).

Instruments. Semi-structured focus groups were used to gain knowledge about attitudes, thoughts, and feelings towards health care upon entry in The Netherlands, including the use of health care services by refugee children and UMAs. Beforehand, a topic guide was developed by means of an extensive literature review and two training sessions by the Royal Tropical Institute with several health professionals on the cultural sensitivity of the

target group (KIT Royal Tropical Institute, n.d.). Open-ended questions reflected on the access to care, experiences with healthcare services, expectations of health care, and the perceived needs of refugees (see Appendix B; Table 2.1). Examples of questions were as followed: 1) ‘How do you experience access to healthcare within The Netherlands?’; 2) ‘How do you experience the health care (for your child) in The Netherlands?’; 3) ‘What were your expectations about the health care in The Netherlands?’; 4) ‘What do you need to receive optimal care for your child?’. Open-ended questions were flexible and permitted the moderator to follow arguments that diverged from the guides (Jamshed, 2014). Verbal and non-verbal interactions with the group, as well as the interaction between the group members, served as complementary information (Kitzinger, 1994; Wong, 2008).

Data Analysis. Data from the study on initial health assessment for refugees were included in the data analysis as information may be complementary to answer the research question. Data from the audio-recordings were transcribed verbatim. Transcriptions were imported in Atlas.ti 8 to analyse the results (Atlas.ti, 2019). An inductive approach was used to analyse the data based on the objective and the research question of this study. First, data was iterative-inductively analysed, which means that the coding process (open, axial, selective coding) was carried out in exactly the same manner each time and executed multiple times (Thomas, 2006). Prior to the coding process, the raw text was read several times to get familiar with its content. Second, by means of open coding, concepts were labelled, and categories were developed by one coder. In addition, a second coder reviewed the coding process, which led to some adjustments within the axial and selective codes. Third, labelled concepts were interrelated to each other to a higher order, which is also called axial coding. Lastly, via selective coding, some categories were chosen to be the core category and other subcategories were related to that category (Thomas, 2006).

Sub Study 2: Interviews with Health Professionals

Participants. By means of convenience sampling, health professionals were included if they met all of the following inclusion criteria: 1) health professionals who work in the field of refugee health policy, or provide healthcare services to refugee children, asylum-seekers’ children, or UMAs; 2) health professionals with an expertise in refugee child/youth health.

Prior to the recruitment of interviewees, information was gathered via the staff of the asylum seekers’ centres on health professionals who provide health care to refugee children and UMAs. This gave a total of ten potential health professionals, which were initially

approached via a recruitment email. One response was received to the first email. Reminder emails were sent ten days after the initial invitation email and led to three responses. After that, the other remaining health professionals were contacted by telephone of whom four were unreachable and two were recruited.

Initially, a total of ten health professionals were invited to the study. Four health professionals were unreachable as they did not respond to emails or calls. Six health professionals participated as interviewees ($N = 6$; 5 women; 1 man).

Procedures. First, recruited interviewees received an informed consent in Dutch via email that informed them about the study and its purpose, which was signed prior to their participation (see Appendix B; Part 2). After that, five semi-structured interviews were scheduled with six health professionals in January and February 2019. The interviews were performed in Dutch by the two researchers. Three interviews took place at the working location of the health professionals, of which one interview consisted of two interviewees, and two interviews were conducted via a conference call by telephone. The interviewees were also informed orally about their privacy, anonymity, and their right to withdraw from the study at any time. With the permission of the interviewees, the interviews were audio-recorded, and quotes/notes were taken to use as a transcription. Interviews lasted approximately 60 minutes. At the end of the interviews, the interviewees had the opportunity to ask questions and received a voucher of ten euro.

Instruments. Semi-structured interviews were used to gain knowledge about refugee-perceived health care upon entry in The Netherlands, including the use of health care services by children and UMAs from the perspective of health professionals (see Appendix B; Table 2.2). Beforehand, the topic guide was developed by means of the framework of access to care by Levesque's et al. (2013), which served as a foundation for this study. Open-ended questions reflect on the five key access dimensions and their corresponding patient abilities. Examples of questions were as followed: 1) approachability and the ability to perceive reflect on the health literacy of refugees, 'What do refugee parents and UMAs know about the health system and their right to healthcare?'; 2) acceptability and the ability to seek reflect on language, cultural, and social factors determine refugees' ability to obtain and accept care, 'To what extent do you experience that language, culture and religion influence the care you provide?'; 3) availability, accommodation and the ability to reach reflect on refugees' who reach care physically and in a timely manner, 'What can you tell about refugees who want to reach your care in the form of transport/language?'; 4) affordability and the ability to pay

reflect on the costs of healthcare services that influence access to care, ‘To what extent does it happen that patients have to pay extra for transport, medication or additional medical assistance?’; 5) appropriateness and the ability to engage, ‘Do you think that your patients understand you sufficiently during your consultation?’. The advantage of doing interviews is that its focused on the perceptions of one individual and therefore the responses were not influenced by other individuals’ opinions (Irvine, Drew, & Sainsbury, 2013).

Data Analysis. Data from the study on initial health assessment was included in the data analysis as information may be complementary to answer the research question. Data from the audio-recordings were transcribed verbatim. Transcriptions were imported in Atlas.ti 8 to analyse the results (Atlas.ti, 2019). A combined technique of inductive and deductive approach was used to analyse the data based on the objective and the sub-question of this study, of which the deductive approach was mainly employed. The inductive approach was used to overcome the limitation of the deductive analysis (Thomas, 2006). First, data was deductively analysed as a pre-set coding scheme was developed based on the key access dimensions and their corresponding patient abilities by Levesque et al. (2013). Second, all answers within one category were further analysed into subcategories, using inductive analysis. By means of inductive analysis, open, axial, and selective coding were employed (Thomas, 2006). A second coder reviewed the coding process, which led to some adjustments within the axial and selective codes

Results

In this chapter, the results from the focus groups with refugee parents and UMAs will be discussed, and subsequently the results from the interviews with the health professionals.

Sub Study 1: Focus Groups with Refugee Parents and UMAs

Characteristics of participants. A diverse group of participants from nine nationalities were present in the study (see Table 1). The number of children among refugee parents varied from one to twelve. The age of UMAs ranged from 15 to 17 years.

Table 1

Characteristics of participants

	Refugee parents (<i>n</i> = 23)	UMAs (<i>n</i> = 8)
Gender		
Male	11	8
Female	12	0
Age (years)		
15		1
16		5
17		2
Country of Origin		
Afghanistan	4	0
Eritrea	0	5
Guinee	0	1
Iran	2	0
Iraq	2	0
Jordan	1	0
Kuwait	2	0
Sudan	0	2
Syria	11	0
No. of Children per parent		
< 2	3	
3	5	
4	9	
5	1	
6	1	
7 - 12	4	

After analysing the outcomes, three inductively coded themes emerged that will be discussed in detail below. The first theme demonstrates the barriers to access healthcare (see Table 1.1). The second theme demonstrates the perceived needs of participants that would promote better healthcare services (see Table 1.2). The final theme demonstrates the expectations of

participants regarding concepts of health and healthcare services compared to their country of origin (see Table 1.3).

Barriers to access healthcare. The first theme reflects the access barriers to healthcare and is composed of eight subcategories (see Table 1.1). The most frequently mentioned subcategories are the referral difficulties and the long waiting times to connect with healthcare services.

Table 1.1

Barriers to access healthcare

Barriers to access healthcare as..	Refugee parents (n = 23)	UMAs (n = 8)	Total (N = 31)	Example of quote
Long waiting times	4	-	4	'[Family] were waiting there and then [nurse] says "today it won't work anymore, so you have to wait until next time".'
Referral difficulties	4	-	4	'We need a better referral to specialists that doesn't remain unnoticed'
Insufficient consulting hours of the GZA	3	-	3	'that there is someone instead of 1 hour, [...] someone on Friday, a nurse or doctor.'
Difficulty navigating through the healthcare system	1	1	2	'I don't speak the language, I don't know how to get there. Last time I went [to the doctor], but I couldn't find it.'
Health professional is absent	1	-	1	'her son was very sick. He had a fever. [Mother] had called and they told her that the doctor was on vacation.'
Incorrect treatments	1	-	1	'Her daughter had an infection. They gave drops that didn't work. They didn't do any examinations.'
Poor support from GZA	1	-	1	'But it is the GZA, [...] or the COA. They organize that its bad for refugees here.'
Postponed care due to a relocation	1	-	1	'They moved and now they start over again, [...] but nothing has happened so far.'

Note. N = the number of focus groups that represent the subcategories.

Long waiting times start from the moment that refugee parents were reaching out for health care until they connect with healthcare services to receive the needed health care. Refugee parents expressed that caregivers would only help when health needs were very urgent. Referral difficulties were perceived as wrong, neglected, or postponed referrals from healthcare services to connect with other healthcare providers. A refugee parent described how a wrong referral delayed the care her son needed:

'[Asylum seekers' centre] sent [mother and son] to another hospital outside of Arnhem. They couldn't take photos there so they sent them back to another hospital

where they could take photos. Where it went wrong, is the referral from the asylum seekers' centre. They should have referred to the right hospital and that may have caused a delay. He had broken fingers. It takes a long time for someone to be helped. The procedure and from one doctor to another doctor takes a long time. ' - Syrian mother of four children

Insufficient consulting hours at the GZA was furthermore mentioned as a barrier to access healthcare. Refugee parents worried to be unable of reaching care in a timely manner when they needed care outside the working hours of the GZA. Specifically, when the GP was only available for one day in the week and when there was no professional to reach out to in the weekend. Moreover, due to overcrowded waiting rooms during the one-hour walk-in, there was insufficient time to provide everyone with a consultation. Subsequently, many children were not seen by the GP and parents were advised to try again another time.

Additionally, refugee parents and UMAs perceived difficulty to navigate through the healthcare system, as they were unable to reach healthcare services in an urban setting. Regarding the absence of a health professional, some refugee parents experienced postponed care because the doctor was on a vacation, or health professionals were absent.

Moreover, refugees believed that they received poor support from GZA to involve in care and decision-making regarding treatments. They expressed that inappropriate care was caused by poor assessments or poor treatments. For example, a refugee parent mentioned how her daughter received an incorrect treatment:

'They gave drops that didn't work. They didn't do any examinations. The second time, she suffered even more from it, so, they gave paracetamol. In the end, it came all the way to her lungs. So, she had some kind of infection in her lungs until they had to give her very heavy medication.' - Syrian mother of four children

Furthermore, relocations within the asylum system led to postponed care since care could not be reached physically in a timely manner. Refugee parents mentioned that the transfer of medical files to the new asylum seekers' centre got postponed after a relocation. Therefore, health professionals began the examinations all over again, as the results from earlier examinations could not be traced.

Perceived health needs. The second theme relates to the perceived health needs mentioned by refugees. This theme consists of three subcategories, of which the most frequently mentioned is mental care for trauma (see Table 1.2).

Table 1.2

Perceived health needs

Perceived health needs for..	Refugee parents (<i>n</i> = 23)	UMAs (<i>n</i> = 8)	Total (<i>N</i> = 31)	Example of quote
Mental care for trauma	4	1	5	‘More attention to mental health. It’s not visible in someone and stress manifests itself in depression.’
Physical examinations upon arrival in NL	3	1	4	‘They come from their home country with a certain disease. It would be good to do a blood test.’
Education on disease prevention	1	-	1	‘We want to know what kind of diseases there are in The Netherlands. How do we prevent that? What are we doing about it? We don't know that’.

Note. *N* = the number of focus groups that represent the subcategories.

Refugee parents expressed the need for mental health care for their children as they noticed their abnormal behaviour due to traumatizing experiences. Some children experienced bombardments or travelled by boat during the migration journey, which, for example, resulted in the fear of swimming. A Syrian father of seven children clarified: *‘Children experienced everything from bombing and war. When they hear that an airplane is flying above, they run to their father. [...] Just because of the sound of an airplane.’* The lack of mental health screening or care was perceived as a threat to their children’s lives. Hence, refugee parents preferred someone to consider the impact of trauma on their children’s health:

‘It’s very important to resolve that now and to treat it. That child is seven years old. If you treat him now, you’ll be fine. But if you only do that at the age of 18, he already has difficult behaviour.’ - Syrian father of four children

UMAs also required mental health care due to experienced trauma and misery during their migration journey. They believed that there was no attention to their mental health:

‘Nobody asks about the stressful situation. They don’t know that we suffer from it and then we just continue with it. We don’t talk about it so openly. We keep that to ourselves. People aren’t interested, so nothing happens with it.’ – 16-year-old Eritrean

Furthermore, refugee parents and UMAs both expressed the need for physical screening upon arrival in The Netherlands that includes a blood test on diseases, infections, and deficiencies due to their (pre-) war situation, or their migrant journey:

‘What we want is for the COA to bring someone or an organization who really pays attention to the fact that we are people who come from war. We come from a difficult situation. We need more attention because we also come with diseases.’ - Syrian father of seven children

In fact, a 16-year-old Eritrean boy got exposed to tuberculosis during the migration journey. However, he was not screened on health issues or diseases in the asylum seekers’ centre upon arrival in The Netherlands. After a relocation, he was referred to a doctor who diagnosed him with tuberculosis.

Moreover, refugee parents required education on health and disease prevention, due to poor health literacy concerning the Dutch disease prevalence and most common diseases.

Expectations compared to the country of origin. The third theme relates to a dissonance between the expectations and the experiences of care, which were shaped by pre-existing health beliefs and expectations of healthcare compared to the home country (see Table 1.3). This theme consists of two subcategories, of which the most frequently mentioned is the restricted access to antibiotics.

Table 1.3

Expectations compared to the country of origin

Expectations compared to home country regarding..	Refugee parents (n = 23)	UMAs (n = 8)	Total (N = 31)	Example of quote
Restricted access to antibiotics	4	-	4	‘In Syria, if you go to the pharmacy and you say I want antibiotics, you will get it.’
Distrust in the role of GP	3	-	3	‘What we find notable here is that we have a general practitioner here, not a specialist.’

Note. N = the number of focus groups that represent the subcategories.

Refugee parents mentioned that they got used to readily available, or prescribed antibiotics as in their country of origin. The required authorisation of a health professional to access medicine was perceived as frustrating and disappointing, especially when health professionals recommended the intake of water and paracetamol.

Furthermore, refugee parents questioned the role of a GP, since it does not exist in their country of origin. They believed that one should have immediate access to a medical specialist whenever they needed like in their home country. Refugee parents distrusted the competence of a GP compared to a medical specialist. They felt restricted to access hospital

care since the authorisation of a GP is required to do so. According to a Syrian father of two children: ‘*Why is the general practitioner here just a general practitioner? You must get a referral to go to the specialist. Why is it like that?*’ Likewise, some refugee parents distrusted nurses and assistants and perceived them as incompetent compared to a medical doctor.

Overall, sub study one demonstrates refugees’ perceived barriers to connect with healthcare services and insufficient support from these services when reaching out for care. The perceived barriers resulted mainly in postponed care, or incorrect treatments. Cultural health beliefs regarding the role of GPs and access to medicine were shaped by experiences from the country of origin, which led to misunderstanding and distrust in the Dutch health system. Refugee parents and UMAs mentioned to need more suitable mental care and physical screening due to trauma and contracted diseases from their (pre-)war situation and migration journey.

Sub Study 2: Findings from Interviews with Health Professionals

Characteristics of participants. A diverse group of health professionals was present in the study (see Table 2). Four interviewees were health professionals who provide care to refugee children and/or UMAs on a regular basis, daily or weekly. Two interviewees were health professionals who work in the health policy of refugee children and UMAs.

Table 2

Characteristics of Interviewees

	Gender	Type of Interview	Professional Position in Refugee Health
HP1	Female	Face-to-face	Paediatric Haematologist ^b
HP2	Female	Face-to-face	General Practitioner GZA ^b
HP3.1 ^a	Female	Face-to-face	Manager JGZ ^c
HP3.2	Female	Face-to-face	Strategic Advisor JGZ ^c
HP4	Female	Telephone	Nurse JGZ (children 4-18 years) ^b
HP5	Male	Telephone	Doctor JGZ (children 0-18 years) ^b

Note. ^a Double interview with two interviewees. ^b Provides health care on a regular basis daily/weekly. ^c Works in the health policy of refugees.

Six deductively coded themes emerged from the interviews that are illustrated in Table 2.1.

The first five themes reflect the five access to care dimensions by Levesque's et al. (2013).

The sixth theme reflects suggestions to improve healthcare as mentioned by the interviewees.

Table 2.1

Access to care related to dimensions of care by Levesque et al. (2013)

Themes of access dimensions ^a	Subcategories	N	Example of quote
Approachability	Poor health literacy	4	‘They don't always know. Sometimes I have to explain it a lot.’
	Contradicting health beliefs	2	‘In their home country, they are used to always leaving with a pill. Well, that is very difficult for general practitioners to explain that that doesn't help.’
	Lack of knowledge about health care rights	1	‘They sometimes do not know that the care is free and also the follow-up care that comes with it.’
Acceptability	Cultural differences	3	‘I notice that the cultural aspect is sometimes difficult.’ because it is very different than the Dutch culture.’
	Language difficulties	1	‘They remain a vulnerable group. That you cannot express yourself properly, is just more difficult.’
Availability and accommodation	Legal restrictions disallow treatments	2	‘They must first have a status to be entitled to certain provisions.’
	Understaffing	2	‘You sometimes notice that you have too few staff.’
	Insufficient consultation hours	2	‘What I really encounter is, I don't have enough time.’
	Time taken away from other patients' consultation	1	‘But what I do is also the nurse's consultation hours. So, I am constantly disturbed.’
	Transportation difficulties	1	‘Not at all so obvious that the other person has a car and can reach us, that they know the way with public transport well.’
Affordability	Medication costs	1	‘If you have to take it chronically and you have such a budget, then it really adds up.’
Appropriateness	Poor communication between services	3	‘Communication is poor between the COA and the GGD.’
	Poor transfer of medical files	2	‘I get no report from anyone. I thought, where do I start?’
	Postponed care due to relocations	1	‘At the time, there was contact with another hospital about it. But, the child got fallen out of care due to relocations.’
Suggestions to improve care	More consultation hours	3	‘We can improve access by having more consultation hours.’
	More experienced staff	2	‘There just needs to be one more doctor, another day, and a nurse with more experience in screening.’
	More education for UMAs on healthy lifestyle	2	‘I think you have to invest very intensively on healthy foods, smoking and alcohol.’
	Cooperation with a pedagogue	1	‘Something like a pedagogue should be present.’
	Cooperation with a paediatrician	1	‘More cooperation with a paediatrician.’

Note. N = the number of interviewees who have mentioned the subcategories. ^a = Dimensions of access to care by Levesque et al. (2013) linked to the subcategories.

Approachability. This first theme relates to refugees in how they identify the existence of healthcare services according to their health needs (Levesque et al., 2013). Likewise, information sources regarding services and activities relate to the approachability of healthcare services and are determined by one's health literacy and health beliefs (Levesque et al., 2013). This theme consists of three subcategories, of which the most frequently mentioned

is poor health literacy.

Several health professionals mentioned that refugees had poor health literacy. Poor health literacy implies poor knowledge to identify and perceive the existence of healthcare services according to their needs (Levesque et al., 2013). Health professionals frequently provided information about procedures and services. For example, they translated brochures themselves to different dialects in order to make their services more understandable and approachable for refugees. Correspondingly, health professionals perceived that poor health literacy depends on one's education level and communication skills:

'It's not that there are leaflets at every doctors' practice. The somewhat low-educated group, regardless of which country they come from, have a harder time since they use the internet less, make less use of other resources that are there for everyone.' (HP1)

Moreover, approachability is also determined by health beliefs that influence one's ability to perceive health needs (Levesque et al., 2013). Health professionals perceived that health beliefs of refugee parents and UMAs often contradict with that of the Dutch health system:

'They don't take the general practitioner seriously anyway. They want to go to the hospital right away. They really come for very small things because they are actually used to that, but they are not concerned with that either. So, that's just a really big problem.' (HP3.1)

In addition, the approachability of healthcare services is influenced by the lack of knowledge about the rights to health care. Health professionals perceived how refugee parents and UMAs were anxious to mention contracted diseases and health issues from their (pre-)war situation or migration journey. They feared possible consequences for their permit residence.

Acceptability. The second theme relates to language, cultural, and social factors that influence one's ability to seek and accept care (Levesque et al., 2013) and consists of two subcategories. Cultural differences is the most frequently mentioned subcategory as health professionals struggled to provide optimal care because of refugees' religion, traditions, and herbs. For example, in contradiction to the advice of health professionals, refugee parents refused to remove the spleen of their child, as they wanted to remain with their own traditions and herbs:

'We wanted to surgically remove the and that was refused. [...] It turned out that what was still playing in the family was still about medicine and traditions. We had a lot of

conversations about that. So, child protection and the Board of Directors assessed my judgement. To what extent can we go along with the wishes of parents, when is the child in danger, how can we do that within the safe margins? We even internationally asked other doctors: 'do you have another idea?'' (HP1)

Furthermore, religion also influences the decision making of refugees to seek and accept healthcare treatments. Therefore, health professionals perceived cultural differences as challenging. For example, refugee parents wanted the permission of a religious leader prior to healthcare treatments: *'They actually want confirmation from a priest. If he says 'No, don't take the treatment'. [...] The treatment doesn't happen.'* (HP1).

Moreover, language difficulties led to communication difficulties and misunderstanding with refugee parents and UMAs. Health professionals used telephone interpreters and in some cases personal interpreters. However, more time was spent on explaining health procedures than on treating patients. Some hospitals provided leaflets in foreign languages, but these were still inconvenient for those who were illiterate, or unfamiliar with a certain dialect. For example, illiteracy led to difficulties to navigate through the healthcare system:

'For one family that I've been in charge of since 2016, I need a personal interpreter for that. [...] A mother with four daughters, she turned out to be illiterate. You realize that if you don't speak the language and you are also illiterate, then just going to the x-ray department, or get a lab shot is hard. She can't find her way in the hospital. [...] Via google, I use a lot of images to show that her medications were first at the second indent, but we will increase the dosage now to the third indent and then check as indicated.' (HP1)

Availability and accommodation. The third theme relates to the presence of health professionals and whether healthcare services can be reached physically and in a timely manner (Levesque et al., 2013). For example, legal restrictions were a barrier to access services in a timely manner when refugees had no legal status yet. Some services agreed to shoulder the costs for urgent treatments since refugee children and UMAs were unable to finance treatments:

'You must first have a status to be entitled to facilities. For example, a girl had a medical treatment in Iran. That treatment had to be continued, but that wasn't possible because she had no status yet. This took a month. Those are the rules.' (HP5)

Moreover, health professionals experienced staff shortage to provide care to refugees. They believed that the high demand in the asylum seekers' centre led to long waiting times and postponed care. Therefore, health professionals clarified that the asylum seekers' centre required more staff to meet the needs of refugees. Consequently, agendas of health professionals became full and patients were seen later than desirable:

'There is still too much work and then sometimes there is no more time scheduled because you have a full agenda. [...] you have too few staff. But I see that as a problem. So, sometimes you see the children later.' (HP4)

In addition, health professionals perceived insufficient consultation hours as problematic with regard to the high demand in the asylum seekers' centre. For example, the GP was scheduled for one day per week and perceived this as a poor work schedule. Specifically, since the waiting room was overcrowded every week due to many walk-ins.

'That is a bit of a problem there because I notice that we are getting more and more difficult cases and one day is simply not enough for me. So, the other days the doctor's assistant has to do it together with the nurse.' (HP2)

On the other hand, to aid the GP, the nurse also began to see patients, since the GP could not carry the high demands of the refugees. However, the nurse needed the expertise of the GP during her consultation hours. Consequently, time was taken away from other patients' consultations of the GP as well as from the nurse. Therefore, the GP and the nurse both had continuously insufficient consultation hours, which was perceived as a barrier for refugees to reach healthcare in a timely manner.

Transportation was also perceived as a barrier to reach care physically. According to health professionals, refugees experienced difficulties to navigate through the healthcare system, due to language difficulties and the use of public transport. Therefore, some hospitals considered refugees' logistic situation when referring them to another care provider, for example, by referring them to a service that is closer to refugees' residence.

Affordability. The fourth theme reflects the financial capacity of refugees to afford the costs of healthcare services (Levesque et al., 2013). Medication costs were perceived as a barrier to insufficient financial means to access care. The Dutch health system provides refugees with a health insurance that covers their medications and treatments (RMA Healthcare, 2019). However, some medications and vaccines, that were required on a regular basis, became unaffordable:

'For example, vitamin D or folic acid are not the most expensive boxes, only two euros. But, if you have to take it chronically and you have a tight budget, then it really adds up. Vaccinations that we sometimes prescribe, requested a personal contribution, ranging from 12 to 60 euros. Therefore, we have said about the latter, that we cannot do that as a hospital. So, this is at the expense of the hospital.' (HP1)

Appropriateness. The fifth theme relates to a fit between the quality of healthcare services and one's health needs within a timely manner (Levesque et al., 2013). The quality of services is associated with the assessment and treatment of health problems, and the technical and interpersonal quality of healthcare services that are provided (Levesque et al., 2013). This theme consists of three subcategories, of which the most frequently mentioned is poor communication between services.

Health professionals perceived poor communication between services, particularly regarding relocations of refugee children and changes within their health status. The impact of poor communication between health services affected their interpersonal quality, which, in turn, was perceived as detrimental concerning the provision of care:

'Communication is poor between the COA and the GGD. We invite children from the GGD and in meanwhile the children have already been relocated. The COA should have communicated that a long time ago. This is still not well arranged.' (HP5)

For example, health professionals required advice from other professionals to provide better care for refugee children with complex health needs:

'What I still miss as a doctor is perhaps a little more cooperation with a paediatrician because I really have difficult cases. A paediatrician that I can call and ask them for advice, but the threshold is still a bit high. For example, I diagnose Thalassemia, or I suspect Thalassemia or I have all of those weird blood results that I think: what should I do with it, do I have to do anything with it or not?' (HP2)

Additionally, a poor transfer of medical files influenced the interpersonal quality of care. Files were missing, or transferred late by other services due to accumulations of work, or poor communication. Consequently, the provision of appropriate care became postponed, which was perceived as detrimental for the health outcome of refugee children and UMAs:

'They had been in The Netherlands for six days or so. Those were two sisters, nine and ten years old, seriously and severely disabled. They just don't make contact and they

were on fathers' and mothers' lap. [...] They both weighed seven and a half kilos [...] Simply completely malnourished, never had really good care, you can see that. For epilepsy they had medication, but the dosage was not very clear, and the nutritional status was very poor. One child was in an epileptic seizure for two days. [...] Too little has been alarmed. Occupational therapy was already there, [...] I don't know through whom [...] But I get no report from anyone about 'we have seen those children [...]there must be immediate care.' [...] I thought, where do I start? I feel alone in that.' (HP2)

Furthermore, frequent relocations within the asylum system correspond with the quality of healthcare services. According to health professionals, refugees were relocated to another asylum seekers' centre, while the current treatment was unfinished. Prior to the relocation, a health professional assessed and treated health needs, while after the relocation, another health professional had to start that process all over again. This was perceived as detrimental and crucial time wasted for the health outcomes of refugee children and UMAs which led to postponed care:

'We had a family from the asylum seekers' centre where the child was diagnosed with sickle cell disease from the heel prick. [...]At the time, there was contact with another hospital about it. But, the child got fallen out of care due to relocations.' (HP1)

Suggestions for improvement. The health professionals suggested improvements to care for refugee children and UMAs. This theme consists of five subcategories, of which the most frequently mentioned category is more consultation hours.

Health professionals suggested more consultation hours, which, in their opinion, would lead to shorter waiting times and better access to care for refugee children. Experienced staff was also required due to the high demands of refugees with complex health needs. In addition, one extra day for the GP, another doctor, and an experienced nurse was required.

More education was suggested for UMAs to promote a healthy lifestyle regarding sexual health, nutrition, smoking, and alcohol. According to health professionals, UMAs are more prone to an unhealthy lifestyle since they have no parents with them and have different views on lifestyle due to cultural differences. Moreover, cooperation with a pedagogue and a paediatrician would enable a better provision of care by identifying the complex health needs of refugee children and UMAs.

Overall, sub-study two demonstrates that health professionals perceived refugees as a population with complex health needs. Refugees were perceived to require more time and

commitment due to their poor health literacy and different cultural understanding of illnesses and healthcare systems. In addition, health professionals emphasized on poor communication between services and staff shortage. Furthermore, they highlighted difficulties with the transfer of medical files after refugees' relocations and insufficient consultation hours that restrict them from providing appropriate care to refugee children and UMAs. Therefore, health professionals suggested more consultation hours, experienced staff, and cooperation with a paediatrician and a pedagogue, in order to improve access to care for refugee children and UMAs.

Integrating perspectives

Concluding, barriers to access services include refugees' cultural understanding of illnesses and the healthcare system, which influences their decision-making according to their health needs. In particular, refugees questioned the role of the GPs, referrals, waiting lists, and access to medicine, since primary care does not exist in their country of origin.

Health professionals acknowledged the aforementioned barriers which influenced their provision of care to refugee children and UMAs. Furthermore, health professionals perceived barriers to provide care due to refugees' poor health literacy and cultural differences. According to health professionals, these barriers influenced refugees' ability to identify healthcare services and health-seeking behaviour according to their health needs. Additionally, health professionals perceived barriers that influenced the reachability of care due to poor communication between services, insufficient consultation hours, and difficulties with the transfer of medical files after relocations of refugees. Moreover, both refugee parents and UMAs mentioned a need for a physical and mental health screening upon arrival in The Netherlands due to trauma and contracted diseases from their (pre-)war situation and migration journey.

Discussion

Our study identified multiple factors that are acting as barriers to proper access to care among refugee children and UMAs in The Netherlands.

This study describes the needs, expectations, and experiences of UMAs and parents of refugee children with respect to healthcare and access to care in The Netherlands. Therefore, the research question of this study is:

‘How do UMAs and parents of refugee children experience health care and its access in The Netherlands?’

Overall, the major findings show that refugees highlight several barriers to connect with healthcare services physically and in a timely manner, such as long waiting times, referral difficulties, and insufficient consulting hours. Moreover, the majority of refugees mentioned that they require a physical and mental health screening due to traumas from their (pre-)war situation and migration journey. Furthermore, pre-existing health beliefs and cultural differences about illnesses and the health system influence the decision-making in health procedures negatively. In addition, health professionals correspondingly highlight communication and reachability difficulties between healthcare services. These include the understaffing of services and complications in transferring medical files, which led to postponed care among refugee children and UMAs.

The majority of refugees perceived the poor availability of services as detrimental since it led to postponed care with consequences such as wrong diagnoses and unnecessary time-consuming treatments. The aforementioned relate to the ‘availability and accommodation’ of services, according to Levesque's et al. (2013) access to care framework, and whether they can be reached physically in a timely manner. Refugees were often unable to access care physically and in a timely manner due to long waiting times, referral difficulties, insufficient consulting hours, and absent health professionals. Refugee parents believed that healthcare services do not possess the capacity to meet their health requirements and fear the consequences for the health outcomes of their children. Similarly, health professionals perceived striking understaffing and insufficient consulting hours, which led to postponed care among refugee children and UMAs as well. Therefore, health professionals required more staff to meet the perceived health needs of refugees, which, in their opinion, could promote shorter waiting times.

An explanation for the understaffing could be the restricted subsidies by the government that confine services to employ more staff in order to meet the demands of the refugees. The similar experienced lack of appropriate care by health professionals could explain and validate the perceived barriers by refugee parents to access care. A recent Malaysian study by Chuah et al. (2018) found that access to care was limited due to a similar lack of human resources to provide care for refugees. Additionally, a study by Lawrence and Kearns (2005) in New Zealand found similar shortages in workforces which increase workload, stress, long waiting times, and referral difficulties among health professionals that treat refugees.

A practical implication could be the employment of more capacity regarding staff or time for consultations. In turn, this will make waiting times shorter and mitigate the risk of postponed care. However, if The Netherlands is planning to welcome more refugees, according to statistics by the Immigration and Naturalization Service in June 2019 (IND, 2019), a better time-frame and reimbursement for health professionals are advised to add in the policy.

Moreover, the majority of refugees perceived inappropriate care by health professionals due to missing medical files after a relocation within the asylum system, which led to perceived incorrect treatments and postponed care. These relate to the appropriateness of healthcare services that assess the health needs and required treatments correctly in a timely manner (Levesque et al., 2013). Health professionals themselves highlighted the poor communication between services due to the poor transfer of medical files where records from earlier examinations could not be traced. For example, the JGZ-nurses were responsible for the transfer of medical files in addition to all their other duties. However, the high workload and the demanding duties of the nurses' position in the asylum seekers' centre, led to a delayed transfer of patients documents and postponed care.

The aforementioned example has an adverse impact on the provision of appropriate care among refugee children and UMAs. A recent Dutch study by Baauw et al. (2018) found that poor health outcomes among refugee children were associated with a lack of a central medical record form that enables professionals to access to a database with electronic patient documents. They also reported that the medical records from the JGZ are not available when a refugee child is referred to another healthcare service, since most Dutch health services and especially the JGZ, are not connected with each other.

One should keep in mind that health professionals, especially those who provide care to refugees, have high demanding positions since refugees require more time and commitment

due to their communication difficulties and complex health needs. Therefore, a practical implication could be that a dedicated person coordinates and manages the transfer of medical patient records to other services instead of the nurses. Another practical implication can be a central medical record that gives access to health services to a database with refugees' medical records, which is also suggested by (Baauw et al., 2018). Another practical implication is the implementation of an electronic patient file for refugees which has not been implemented in The Netherlands yet. This electronic patient file enables refugees to carry their personal medical document in person and contains one's health data and information. Examples can already be found in the EU with starting initiatives such as the Electronic Personal and Health Record (e-PHR) (IOM, 2016).

A different cultural understanding of illnesses and healthcare systems among refugees was evident and influenced their decision-making in health assessments and treatments negatively. Refugees were unfamiliar with aspects of the Dutch health system, such as access to medicine, role of a GPs, waiting lists, and referral to medical specialists. Therefore, frustrations were demonstrated and could be explained since all participants originated from countries with no system of primary care, direct access to medical specialists and antibiotics. This may have coloured their perception of the Dutch healthcare system. Likewise, health professionals acknowledged the aforementioned factors which influenced, according to them, the decision-making of refugee parents in contrast to what they were advised regarding their children's treatments.

Overall, it seems that refugees' cultural beliefs influence their ability to perceive and seek care, which is a barrier to access adequate care according to one's health needs. Previous studies found similar findings among refugees in New Zealand (Lawrence & Kearns, 2005), the UK (O'Donnell, Higgins, Chauhan, & Mullen, 2007), and the USA (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009), and suggested organisations to promote awareness on how the health system works in the host country.

Therefore, a practical implication can be to implement health educators that provide a more thorough and up-to-date orientation about the Dutch health system in the mother language of refugees, particularly regarding the role of GPs, referral to a medical specialist, and access to medicine. This will presumably increase knowledge and understanding among refugee parents and UMAs and, in turn, improve access to care.

Furthermore, the majority of refugees highlight a need for physical and mental health screening, especially more support for mental health. Refugee parents and UMAs highlight a health screening due to experienced trauma and contracted diseases from their (pre-)war

situation and migration journey. In particular, refugee parents noticed how the behaviour of their children became abnormal and believed that the absence of mental care was a threat to their children's lives. Previous studies found high levels of trauma and distress among refugee children and UMAs at arrival in the host country, due to trauma, such as anxiety, depression, PTSD (Buchmüller et al., 2018; El Baba & Colucci, 2018; Hilal Yayan, 2018; Montgomery, 2011; Müller et al., 2019; Nasıroğlu et al., 2018), attention problems and withdrawal behaviour (Buchmüller et al., 2018), and sleep disturbance (Montgomery, 2011). Other studies have looked into the infectious diseases (Van Der Werf et al., 2018) and nutritional deficiencies (Meiqari et al., 2018) that correlate with the high incidence of these diseases in the country of origin of refugee children and UMAs. The aforementioned risk factors to the health of refugee children and UMAs currently may be overlooked. Laboratory tests on the nutritional status, infectious diseases, and the existence of geographically determined occurrence of diseases are not part of the current inventories in the Dutch health screening (Baauw et al., 2017).

A practical implication is a screening on geographically determined occurrence of diseases, which is also suggested by previous studies (Kärki et al., 2014; Pavli & Maltezos, 2017). This might be beneficial as refugee children and UMAs are prone to certain diseases based on the epidemiology of their country of origin. Another practical implication is to meet the needs for mental health care for refugees by preparing and implementing positions that are specialized in trauma caused by war and migration journeys. However, one should keep in mind the cultural sensitivity of these vulnerable groups.

Strengths, Limitations, and Recommendations for Research

This study has contributed to an understanding of the health needs, expectations, and experiences of refugee children and UMAs to access care within the Dutch context. Previous studies have focussed on either the services (Baauw et al., 2018) or the users of care regarding refugee health in The Netherlands (Kalverboer et al., 2017). A key contribution of this study is the triangulation of findings from refugee parents, UMAs, and health professionals. Refugees received care by the same health professionals in this study within the same environmental setting. Therefore, the interviews with health professionals provided an alternative perspective on this topic.

Another strength is that prior to the execution of this study, focus groups were prepared and performed under the guidance of multiple experienced professionals in refugee health and children's health. The researchers of this study had previous experiences with this

target group and were in some cases able to speak in the native language of the refugees. This created trust and recognition which enabled the refugees to express themselves in an even more natural way during the focus groups.

Furthermore, a strength in this study is the presence of a diverse group of refugees who participated, of which nine nationalities, and shared their perspectives on healthcare and its access in The Netherlands. The diversity made sure it would not be strictly biased documentation of a certain culture or belief. In addition, diversity was present among the interviewees who shared their perspective from different positions in refugee health.

Moreover, another strength is that generic issues emerged from the focus groups and the interviews. Some issues could be interrelated with each other. For example, the understaffing and the need for more consultation hours of health professionals relate to the perceived insufficient consultation hours by refugee parents. Apart from generic issues, differences regarding barriers to access care were evident in refugees' critical view of the health care system. However, as all refugees originated from the Middle Eastern or Sub-Saharan Africa, their lack of knowledge and dissonance about the Western healthcare system could have influenced their opinions and views.

This study had some limitations. A relatively small sample ($N = 31$; of which refugee parents $n = 23$, $n = 8$ UMAs) was present in this study. UMAs were harder to reach than refugee parents and, therefore, the sample consisted of male minors. Female UMAs were not part of this study because of time constraints. Likewise, the health professionals were also hard to reach, which led to a small sample size ($n = 6$). In addition, UMAs' perspectives on health are less integrated in this study compared to refugee parents since they had little experience with the Dutch healthcare system.

Levesque's et al. (2013) access to care framework was suitable to identify the barriers to care among refugees through the lens of health professionals. However, we encountered challenges in attempting to employ the framework among the refugees. Patient-related abilities and perspectives to care were harder to identify for this target group. Therefore, the usefulness of the framework is being questioned for this particular target group and was perceived as a limitation. Further research is recommended to consider a more divergent perspective on how refugees' perceive care.

Moreover, there was no opportunity for the researchers to sample participants of the focus groups according to their ethnicity since the staff of the asylum seekers' centre recruited them according to inclusion criteria. Therefore, the sample was selected from a population that was available at the time of recruitment. This possibly influenced the sample of the focus

groups, which led to some groups that were partly dictated by Syrian participants and others consisted of mixed ethnicities.

Within focus groups, one side effect can be peer pressure which could have been an issue. Some participants were predominantly ruling over the group, while others shared their opinions only when they were specifically asked to do so. In addition, the use of interpreters may have influenced the findings of the focus groups. Despite explicit instructions given by the researchers, some interpreters may have adjusted participants' message. This made it sometimes difficult to understand whether it was the participants' opinion or the interpreters' refined view.

Further future research is recommended to examine how social determinants of health influence access to healthcare services among refugee children and UMA since Levesque's et al., (2013) framework did not consider this. A recent Australian study investigated the influence of social determinants to access healthcare services for refugees on different levels, such individual, interpersonal, environmental, organisational and policy levels (Taylor & Lamaro Haintz, 2018). Further research is also recommended to consider the funding and employment of human resources at asylum seekers' centres to meet the demands and complex health needs of UMAs and refugee children. Further research is recommended to investigate the utilization of the e-PHR (IOM, 2016) and its cost-effectiveness in The Netherlands.

Conclusion

Refugee children and UMAs are prone to physical and mental illnesses and maintain a vulnerable population in The Netherlands. Despite the availability of healthcare services, access barriers remain a challenge for these groups. Generic issues and differences emerged between refugees' and health professionals perspective concerning refugee children's access to care. Generic issues include barriers to connect with services and to reach them in a timely manner, particularly due to referral, waiting lists, and insufficient consulting hours. Cultural understanding of illnesses and the Dutch health system influenced the decision-making of refugees to involve with care, particularly the role of GP's and access to antibiotics were questioned. Evidently, health professionals perceived barriers for refugees due to poor health literacy, cultural understanding, lack of human resources to meet refugees' health needs, poor communication between services, poor transfer of medical files. Overall, the evidence yielded from this study, suggests that more attention needs to be paid on the capacity of services that provide refugee care, communication between these services, and the cultural understanding of illnesses and the Dutch health system to improve access to care.

References

- Atlas.ti. (2019). ATLAS.ti 8 Windows. Retrieved January 8, 2019, from <https://atlasti.com/product/v8-windows/>
- Baauw, A., Rosiek, S., Slattery, B., Chinapaw, M., van Hensbroek, M. B., van Goudoever, J. B., & Kist-van Holthe, J. (2018). Pediatrician-experienced barriers in the medical care for refugee children in the Netherlands. *European Journal of Pediatrics*, 177(7), 995–1002. <https://doi.org/10.1007/s00431-018-3141-y>
- Baauw, A., Slinger, K., & Goosen, S. (2017). Komt een vluchtelingenkind op uw spreekuur... *Migranten En Global Health*, (1), 10–16.
- Bradby, H., Humphris, R., Newall, D., & Phillimore, J. (2015). *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region Health Evidence Network Synthesis Report 44*. Copenhagen, Denmark. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/289246/WHO-HEN-Report-A5-2-Refugees_FINAL.pdf?ua=1
- Buchmüller, T., Lembcke, H., Busch, J., Kumsta, R., & Leyendecker, B. (2018). Exploring Mental Health Status and Syndrome Patterns Among Young Refugee Children in Germany. *Frontiers in Psychiatry*, 9(212), 1–12. <https://doi.org/10.3389/fpsy.2018.00212>
- Chuah, F. L. H., Tan, S. T., Yeo, J., & Legido-Quigley, H. (2018). The health needs and access barriers among refugees and asylum-seekers in Malaysia: A qualitative study. *International Journal for Equity in Health*, 17(1), 1–15. <https://doi.org/10.1186/s12939-018-0833-x>
- COA. (2018). *Gezondheidszorg voor asielzoekers in Nederland*. Retrieved from https://www.coa.nl/sites/www.coa.nl/files/paginas/media/bestanden/factsheet_gezondheidszorg_maart_final_0.pdf
- ECDC. (2016). *Epidemiological assessment of hepatitis B and C among migrants in the EU/EEA*. Stockholm, Sweden. <https://doi.org/10.2900/05429>
- El Baba, R., & Colucci, E. (2018). Post-traumatic stress disorders, depression, and anxiety in

- unaccompanied refugee minors exposed to war-related trauma: a systematic review. *International Journal of Culture and Mental Health*, 11(2), 194–207.
<https://doi.org/10.1080/17542863.2017.1355929>
- Garg, P. K., Perry, S., Dorn, M., Hardcastle, L., & Parsonnet, J. (2005). Risk of Intestinal Helminth and Protozoan Infection in a Refugee Population. *The American Society of Tropical Medicine and Hygiene*, 73(2), 386–391. Retrieved from
<http://www.ajtmh.org/docserver/fulltext/14761645/73/2/0730386.pdf?expires=1554846595&id=id&accname=guest&checksum=28904984C088CCCB15A091B477D9A95>
- Goosen, S., Stronks, K., & Kunst, A. E. (2014). Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children: A longitudinal medical record study. *International Journal of Epidemiology*, 43(1), 94–104.
<https://doi.org/10.1093/ije/dyt233>
- Gušić, S., Malešević, A., Cardena, E., Bengtsson, H., & Søndergaard, H. P. (2018). “I feel like I do not exist:” A study of dissociative experiences among war-traumatized refugee youth. *Psychological Trauma: Theory, Research, Practice, and Policy*, 10(5), 542–550.
<https://doi.org/10.1037/tra0000348>
- GZA. (2019). General practitioner’s care for asylum seekers. Retrieved March 13, 2019, from
<https://www.gzasielzoekers.nl/en/>
- Hilal Yayan, E. (2018). Post-traumatic stress disorder and mental health states of refugee children. *Archives of Psychiatric Nursing*, 32(6), 885–889.
<https://doi.org/10.1016/j.apnu.2018.07.003>
- Hunter, P. (2016). The refugee crisis challenges national health care systems. *EMBO Reports*, 17(4), 492–495. <https://doi.org/10.15252/embr.201642171>
- IND. (2015). *Asylum Trends Monthly Report on Asylum Applications in The Netherlands and Europe Colophon*. Rijswijk, The Netherlands. Retrieved from
https://ind.nl/en/Documents/AT_December_2015.pdf
- IND. (2017). *Asylum Trends Monthly Report on Asylum Applications in The Netherlands*. The Hague, The Netherlands. Retrieved from
https://ind.nl/en/Documents/AT_December_2017.pdf
- IND. (2019). *Asylum Trends Monthly Report on Asylum Applications in The Netherlands*. The

- Hague, The Netherlands. Retrieved from https://ind.nl/en/Documents/AT_Juni_2019.pdf
- IOM. (2016). E-PHR | Re-health. Retrieved July 26, 2019, from <https://www.re-health.eea.iom.int/e-phr>
- IOM. (2018). Key Migration Terms. Retrieved December 13, 2018, from <https://www.iom.int/key-migration-terms>
- Irvine, A., Drew, P., & Sainsbury, R. (2013). ‘Am I not answering your questions properly?’ Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research*, 13(1), 87–106.
<https://doi.org/10.1177/1468794112439086>
- ISSOP. (2018). ISSOP position statement on migrant child health. *Child: Care, Health and Development*, 44(1), 161–170. <https://doi.org/10.1111/cch.12485>
- Kalverboer, M., Zijlstra, E., van Os, C., Zevulun, D., ten Brummelaar, M., & Beltman, D. (2017). Unaccompanied minors in the Netherlands and the care facility in which they flourish best. *Child & Family Social Work*, 22(2), 587–596.
<https://doi.org/10.1111/cfs.12272>
- Kärki, T., Napoli, C., Riccardo, F., Fabiani, M., Dente, M., Carballo, M., ... Declich, S. (2014). Screening for Infectious Diseases among Newly Arrived Migrants in EU/EEA Countries—Varying Practices but Consensus on the Utility of Screening. *International Journal of Environmental Research and Public Health*, 11(10), 11004–11014.
<https://doi.org/10.3390/ijerph111011004>
- KIT Royal Tropical Institute. (n.d.). Education, training and coaching. Retrieved April 3, 2019, from <https://www.kit.nl/service/training-coaching-education/>
- Kitzinger, J. (1994). The methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health & Illness*, 16(1), 103–121.
<https://doi.org/10.1111/1467-9566.ep11347023>
- Lam, E., McCarthy, A., & Brennan, M. (2015). Vaccine-preventable diseases in humanitarian emergencies among refugee and internally-displaced populations. *Human Vaccines & Immunotherapeutics*, 11(11), 2627–2636.
<https://doi.org/10.1080/21645515.2015.1096457>
- Lawrence, J., & Kearns, R. (2005). Exploring the “fit” between people and providers:

- Refugee health needs and health care services in Mt Roskill, Auckland, New Zealand. *Health and Social Care in the Community*, 13(5), 451–461.
<https://doi.org/10.1111/j.1365-2524.2005.00572.x>
- Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12(1), 1–9. <https://doi.org/10.1186/1475-9276-12-18>
- Meiqari, L., Hoetjes, M., Baxter, L., & Lenglet, A. (2018). Impact of war on child health in northern Syria: the experience of Médecins Sans Frontières. *European Journal of Pediatrics*, 177(3), 371–380. <https://doi.org/10.1007/s00431-017-3057-y>
- Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology and Psychiatric Sciences*, 26(2), 129–138. <https://doi.org/10.1017/S2045796016000172>
- Montgomery, E. (2011). Trauma, exile and mental health in young refugees. *Acta Psychiatrica Scandinavica*, 124(440), 1–46. <https://doi.org/10.1111/j.1600-0447.2011.01740.x>
- Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health*, 34(6), 529–538. <https://doi.org/10.1007/s10900-009-9175-3>
- Müller, L. R. F., Büter, K. P., Rosner, R., & Unterhitzberger, J. (2019). Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: a cross-sectional study. *Child and Adolescent Psychiatry and Mental Health*, 13(1), 8. <https://doi.org/10.1186/s13034-019-0268-1>
- Nasıroğlu, S., Çeri, V., Erkorkmaz, Ü., & Semerci, B. (2018). Determinants of psychiatric disorders in children refugees in Turkey's Yazidi refugee camp. *Psychiatry and Clinical Psychopharmacology*, 28(3), 291–299. <https://doi.org/10.1080/24750573.2017.1422958>
- NIDOS. (2018). Missie Nidos. Retrieved January 9, 2019, from <https://www.nidos.nl/home/missie-en-visie-van-nidos/missie-nidos/>
- Nielsen, S. S., Norredam, M., Christiansen, K. L., Obel, C., Hilden, J., & Krasnik, A. (2008). Mental health among children seeking asylum in Denmark-the effect of length of stay and number of relocations: a cross-sectional study. *BMC Public Health*, 8, 1–9.

<https://doi.org/10.1186/1471-2458-8-293>

- Norredam, M., Mygind, A., & Krasnik, A. (2006). Access to health care for asylum seekers in the European Union—a comparative study of country policies. *European Journal of Public Health*, 16(3), 285–289. <https://doi.org/10.1093/eurpub/cki191>
- O'Donnell, C. A., Higgins, M., Chauhan, R., & Mullen, K. (2007). “They think we’re OK and we know we’re not”; A qualitative study of asylum seekers’ access, knowledge and views to health care in the UK. *BMC Health Services Research*, 7(75), 1–11. <https://doi.org/10.1186/1472-6963-7-75>
- Odone, A., Tillmann, T., Sandgren, A., Williams, G., Rechel, B., Ingleby, D., ... McKee, M. (2015). Tuberculosis among migrant populations in the European Union and the European Economic Area. *European Journal of Public Health*, 25(3), 506–512. <https://doi.org/10.1093/eurpub/cku208>
- Pavli, A., & Maltezou, H. (2017). Health problems of newly arrived migrants and refugees in Europe. *Journal of Travel Medicine*, 24(4), 1–8. <https://doi.org/10.1093/jtm/tax016>
- RMA Healthcare. (2019). *Regeling Medische zorg Asielzoekers*. Retrieved from https://www.rmasielzoekers.nl/Portals/8/docs/20190121_RMA_2019_def.pdf?ver=2019-01-21-173057-357
- Robertshaw, L., Dhesi, S., & Jones, L. L. (2017). Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: a systematic review and thematic synthesis of qualitative research. *BMJ*, 7(8), 1–18. <https://doi.org/10.1136/bmjopen-2017-015981>
- Roggelin, L., Tappe, D., Noack, B., Addo, M. M., Tannich, E., & Rothe, C. (2016). Sharp increase of imported Plasmodium vivax malaria seen in migrants from Eritrea in Hamburg, Germany. *Malaria Journal*, 15(1), 325. <https://doi.org/10.1186/s12936-016-1366-7>
- Rosiek, S. (2017). *Bottleneck analysis In the health care for refugee children in the Netherlands*. The Vrije Universiteit Amsterdam.
- Save The Children. (2014). *A Devastating Toll. The impact of three years of war on the health of Syria’s children*. London, UK. Retrieved from <https://www.savethechildren.org/content/dam/global/reports/emergency-humanitarian->

response/devastating-toll-14.pdf

- Sheikh-Mohammed, M., Raina MacIntyre, C., Wood, N. J., Leask, J., & Isaacs, D. (2006). Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *Medical Journal of Australia*, 185(11–12), 594–597. [https://doi.org/10.1016/0168-1176\(86\)85009-1](https://doi.org/10.1016/0168-1176(86)85009-1)
- Taylor, J., & Lamaro Haintz, G. (2018). Influence of the social determinants of health on access to healthcare services among refugees in Australia. *Australian Journal of Primary Health*, 24(1), 14. <https://doi.org/10.1071/PY16147>
- Thomas, D. R. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, 27(2), 237–246. <https://doi.org/10.1177/1098214005283748>
- UNHCR. (2017). *Global Trends FORCED DISPLACEMENT IN 2017*. Retrieved from <https://www.unhcr.org/5b27be547.pdf>
- UNHCR. (2019). *Handbook on Procedures and Criteria for Determining Refugee Status / Under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees*. Retrieved from <https://www.unhcr.org/3d58e13b4.html>
- UNICEF. (2017). *A Child is a Child: Protecting children on the move from violence, abuse and exploitation*. New York, NY, USA: UNICEF. <https://doi.org/10.1177/001440299105700302>
- Van Der Werf, J., Derrough, T., Duffell, E., Pharris, A., Suk, J., De, H., ... Lefevre, V. (2018). *Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA*. Stockholm, Sweden. <https://doi.org/10.2900/154411>
- WHO. (2010). *How health systems can address health inequities linked to migration and ethnicity*. Copenhagen, Denmark: WHO Regional Office for Europe.
- WHO, & ECDC. (2018). *HIV/AIDS surveillance in Europe 2018*. Copenhagen, Denmark. <https://doi.org/10.2900/523723>
- Wong, L. P. (2008). Focus group discussion: a tool for health and medical research. *Singapore Med J*, 49(3), 256–261. Retrieved from <http://smj.sma.org.sg/4903/4903me1.pdf>

Appendix A: Informed Consent Forms

Part 1. Informed Consent for the FGDs

Research Project Title: Health care services for refugee children in The Netherlands

Researchers: Chanine Brouwers (MSc Student Health and Society) & Sogol Fathi Afshar (MSc student Health Psychology and Technology).

1. **Purpose of the Research:** You are invited to participate in a focus group. The purpose of this focus group is to gain insight into how refugees experience health care services for refugee children in The Netherlands. Information learned in this focus group will be used in a report and will be made available to relevant organizations in order to improve health care services for refugee children in The Netherlands.
2. **Procedure:** As part of this study, you will be placed in a group consisting of six people in total. The focus group discussion will be conducted by the two female researchers mentioned above, in the (*address location AZC or KWE*), in a private setting. A doctor will be present to support the researchers and to answer any questions from you as a participant. The discussion in the focus group will be audio-recorded and a note-taker will be present. Access to the recordings will be limited to the researchers and destroyed/deleted after being transcribed and translated.

Please note that there are no right or wrong answers in focus group discussions. We want to hear the many varying viewpoints and would like for everyone to contribute their thoughts.

3. **Duration of Procedures:** The focus groups will last approximately 1.5 hours.
4. **Statement of Participation:** Participation in this project is voluntary. You will receive a €15 voucher as compensation for your participation. You may withdraw and discontinue participation at any time. You have the right to decline to answer any question or stop participating in the study.
5. **Confidentiality:** Researchers will take every precaution to maintain the confidentiality of the data. Your responses will remain confidential and no names will be included in any reports. However, the nature of focus groups prevents researchers from guaranteeing complete confidentiality. If you choose to participate, you will be asked to respect the privacy of other participants by not disclosing any content discussed during the study. You do not have to share any personal or private information if you do not feel comfortable to. Researchers will keep any information that may identify you confidential in any reports or transcripts.
6. **Contacts for questions:** You have the right to ask any questions. This research study has been reviewed and approved by the Medical Ethical Committee of Rijnstate Hospital Arnhem. For questions or concerns regarding this study, you may contact
 - The primary investigator: *Albertine Baauw, Pediatrician, MscPH, Doctor International Healthcare and Tropical Medicine at Rijnstate Hospital Arnhem* (albertine.baauw@icloud.com, tel.: +31 6 28 26 55 51 or +31 88 00 58 888)
 - Mariëtte Hoogsteder: *Researcher VU University Medical Center, Public Health / Amsterdam Public Health Institute* (m.hoogsteder@vumc.nl, tel.: +31 20 44 45 965)

Declaration of Consent Form

- I have read and understood the information letter. I could ask questions and all my questions about the study have been answered. I had sufficient time to decide whether to participate;
- I know that participating is voluntary and that at any time I can decide not to participate or to stop the study. I do not have to give a reason for that;
- I give my consent to the collection and use of my data in the manner as described and for the purposes stated in the information letter;
- I understand that the interview will be recorded. I give my consent to make (audio) recordings and to take notes;
- I want to participate in this research study.

Name Participant:

Participant Signature

____/____/____
Date

Nidos Signature

____/____/____
Date

Declaration of Researchers

- I have fully informed this participant about the research mentioned.
- If information becomes known during the study that could influence the consent of the participant, I will notify him or her in due time.

Researcher Signature

____/____/____
Date

Researcher Signature

____/____/____
Date

Personal data

Country of origin:

Age:

Asylum status: ☐ Waiting for asylum ☐ Status holder

In The Netherlands since:

Part 2. Informed Consent for the Interviews

Research Project Title: Health care services for refugee children in The Netherlands

Researchers: Chanine Brouwers (MSc Student Health and Society) & Sogol Fathi Afshar (MSc Student Health Psychology and Technology).

7. **Purpose of the Research:** You are invited to participate in an interview. The purpose of this interview is to gain insight into how refugees experience health care services for refugee children in The Netherlands. Information learned in this interview will be used in a report and will be made available to relevant organizations in order to improve health care services for refugee children in The Netherlands.
8. **Procedure:** As part of this study, you will be interviewed by the two female researchers mentioned above, in a private setting, coordinated with you. The interview will be audio-recorded and notes will be made. Access to the recordings will be limited to the researchers and destroyed/deleted after being transcribed and translated.

Please note that there are no right or wrong answers in this interview. We want to hear the many varying viewpoints and would like for you to contribute your thoughts.

9. **Duration of Procedures:** The interview will last approximately one hour.
10. **Statement of Participation:** Participation in this project is voluntary. You will receive a €10 voucher as compensation for your participation. You may withdraw and discontinue participation at any time. You have the right to decline to answer any question or stop participating in the study.
11. **Confidentiality:** Researchers will take every precaution to maintain the confidentiality of the data. Your responses will remain confidential and no names will be included in any reports. You do not have to share any personal or private information if you do not feel comfortable to. Researchers will keep any information that may identify you confidential in any reports or transcripts.
12. **Contacts for questions:** You have the right to ask any questions. This research study has been reviewed and approved by the Medical Ethical Committee of Rijnstate Hospital Arnhem. For questions or concerns regarding this study, you may contact
 - The primary investigator: *Albertine Baauw, Pediatrician, MscPH, Doctor International Healthcare and Tropical Medicine at Rijnstate Hospital Arnhem* (albertine.baauw@icloud.com, tel.: +31 6 28 26 55 51 or +31 88 00 58 888)
 - Mariëtte Hoogsteder: *Researcher VU University Medical Center, Public Health / Amsterdam Public Health Institute* (m.hoogsteder@vumc.nl, tel.: +31 20 44 45 965)

Declaration of Consent Form

- I have read and understood the information letter. I could ask questions and all my questions about the study have been answered. I had sufficient time to decide whether to participate;
- I know that participating is voluntary and that at any time I can decide not to participate or to stop the study. I do not have to give a reason for that;
- I give my consent to the collection and use of my data in the manner as described and for the purposes stated in the information letter;
- I understand that the interview will be recorded. I give my consent to make (audio) recordings and to take notes;
- I want to participate in this research study.

Name Participant:

Participant Signature

____/____/____
Date

Nidos Signature

____/____/____
Date

Declaration of Researchers

- I have fully informed this participant about the research mentioned.
- If information becomes known during the study that could influence the consent of the participant, I will notify him or her in due time.

Researcher Signature

____/____/____
Date

Researcher Signature

____/____/____
Date

Appendix B: Topic Guides

Table 2.1

Topic guide of the focus groups

Thema	Vragen
Experiences (20 min)	<p>a. Wat kunt u zich herinneren van het eerste contact tussen een jeugdarts en uw kind in Nederland, waarbij bijvoorbeeld vaccinaties werden gegeven?</p> <ul style="list-style-type: none"> - Was u als ouder daarbij? - Waar/wanneer was dat? - Waar werd naar gekeken? - In hoeverre was het duidelijk voor u wat er gebeurde? (informatie of kennis?) <p>b. Wat heeft u als positief ervaren bij dit contact met een jeugdarts of jeugdverpleegkundige?</p> <ul style="list-style-type: none"> - En wat als minder positief? (bijvoorbeeld taal, informatievoorziening, soort vaccinaties, follow-up, etc.)
Ideal initial health assessment according to refugees (30 min)	<p>a. Wat verwachtte u van de Nederlandse preventieve gezondheidszorg (voor uw kind)?</p> <ul style="list-style-type: none"> - Wat verwachtte u aan zorg in het AZC? - Welke vaccinaties? - Testen voor ziekten uit land van afkomst (welke ziekten)? - Zorg voor psychische gezondheid? <p>b. Wat vindt u van de aandacht voor fysieke gezondheid in het nieuwkomersonderzoek?</p> <ul style="list-style-type: none"> - Voldoende/onvoldoende. - Hoe zou dit verbeterd kunnen worden? - Waar moet meer aandacht voor komen? <p>c. Wat vindt u van de aandacht voor psychische gezondheid in het nieuwkomersonderzoek?</p> <ul style="list-style-type: none"> - Voldoende/onvoldoende. - Hoe zou dit verbeterd kunnen worden? Waar moet meer aandacht voor komen?

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- d. Wanneer in Nederland een kind geboren wordt, wordt zo snel mogelijk een paar druppels bloed afgenomen uit de hiel van het kind om te onderzoeken op een 31 zeldzame ziektes, zoals thalassemie en sikkelcelziekte. Dit is een vorm van preventieve zorg. Wat herinnert u zich van de preventieve zorg in uw thuisland?
- Hoe verschilt deze vorm van preventieve zorg met die in Nederland?
 - Wat vindt u van dit verschil?
- e. In uw land van herkomst komen andere ziektes voor dan hier in Nederland, bijvoorbeeld *ziektes. Hier wordt u(w kind) niet standaard op getest bij binnenkomst in Nederland. Wat vindt u hiervan?
- Is dit nodig? Waarom wel/niet? Welke ziektes?
- *Anemie, hemoglobinopathie, hepatitis B en C, HIV, (latente) tuberculose, parasitaire infecties
- f. Hoe zou u graag willen dat het nieuwkomersonderzoek door de jeugdverpleegkundige en jeugdarts in het AZC, die nu bestaat uit een gesprek en eventuele vaccinaties, eruit ziet?

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- Accessibility of health care services according to refugees (30 min) **Part of this study**
- a. Hoe ervaart u de toegang tot de gezondheidszorg?
- Weet u waar u heen moet als uw kind ziek is?
 - Weet u hoe u een afspraak met de (huis)arts moet maken?
- b. Wat verwachtte u van de gezondheidszorg in Nederland?
- Wat wel/wat niet?
- c. Hoe verschilt de toegang tot de Nederlandse gezondheidszorg met die van uw thuisland?
- d. Hoe ervaart u de gezondheidszorg voor uw kind in Nederland?
- Welke problemen ervaart u?
 - Bijvoorbeeld: overplaatsingen tussen AZC's, geen medische geschiedenis/medisch dossier, communicatieproblemen met arts, informatievoorzieningen, culturele verschillen.
- e. Waar heeft u behoefte aan om optimale zorg voor uw kind te ontvangen?

Table 2.2

Topic Guide of the Interviews

Thema	Vragen
Introductie	<ul style="list-style-type: none"> - Doel en structuur van het interview - Audio opname en anonimiteit
Algemeen	<ul style="list-style-type: none"> a. Hoe lang werkt u al met vluchtelingen kinderen en wat is uw rol? b. Wat zijn de landen van afkomst van de kinderen met wie u werkt? c. Hoeveel vluchtelingenkinderen ziet u ongeveer per maand?
Initial health assessment	<ul style="list-style-type: none"> - Korte uitleg preventieve gezondheidszorg en rol van JGZ a. Wat vindt u van het huidige nieuwkomersonderzoek (anamnese en vaccinaties)? <ul style="list-style-type: none"> - De ziektes waarvoor gevaccineerd wordt - Aandacht voor psychische gezondheid. - Informatievoorziening hieromheen. - Volledigheid/omvattendheid. Denkt u dat het nieuwkomersonderzoek aansluit op de gezondheidsbehoeften van vluchtelingenkinderen? b. Vluchtelingen kinderen hebben andere gezondheidsbehoeften dan Nederlandse kinderen wat betreft de gezondheidszorg. Kunt u vertellen wat in uw ervaring de behoeften van vluchtelingenkinderen zijn? - Ervaringen en behoeften die uit FGD zijn gekomen voorleggen en vragen naar herkenning. c. In het land van herkomst komen andere ziektes voor dan hier in Nederland (bijv. anemie, hemoglobinopathie, hepatitis B en C, HIV, (latente) tuberculose, parasitaire infecties). Vluchtelingenkinderen worden hier niet preventief op getest bij binnenkomst in Nederland. Wat vindt u hiervan? d. Als het mogelijk zou zijn om vluchtelingenkinderen te onderzoeken op veelvoorkomende ziektes uit land van herkomst als onderdeel van het nieuwkomersonderzoek, wat zou u daarvan vinden? <ul style="list-style-type: none"> - Voordelen/ Nadelen? e. Hoe zou u het nieuwkomersonderzoek door de jeugdverpleegkundige en jeugdarts graag willen zien in Nederland?

Accessibility to healthcare <i>Part of this study</i>	<p>Availability - Ability to perceive</p> <ul style="list-style-type: none"> a. Wat voor kennis heeft u over de achtergrond van uw patienten? b. Wat weten de vluchtelingouders/kinderen /AMV'ers over de gezondheidssystemen en het recht op gezondheidszorg? <p>Acceptability - Ability to seek</p> <ul style="list-style-type: none"> c. Hoe kunnen ze toegang krijgen tot de zorg die u ze verleent? d. In hoeverre ervaart u dat taal, cultuur en religie van invloed zijn op de zorg die u verleent? - Hoe gaat u hiermee om? - Hoe denkt u dat dit kan worden verbeterd? <p>Availability & Accommodation - Ability to reach</p> <ul style="list-style-type: none"> e. Wat kunt u vertellen over vluchtelingen die uw zorg willen bereiken in de vorm van transport/taal? - Wat voor hulp krijgen ze daarbij aangeboden? <p>Affordability - Ability to pay</p> <ul style="list-style-type: none"> f. In hoeverre zijn uw patienten op de hoogte van hun zorgverzekering en hun eigen risico om de nodige zorg te benutten? g. In hoeverre komt het voor dat patienten voor transport, medicatie of aanvullende medische hulp moeten bijbetalen? <p>Appropriateness - Ability to engage</p> <ul style="list-style-type: none"> h. Heeft u het idee dat uw patienten u voldoende begrijpen tijdens uw consult? - Zo ja, hoe handelt u tot zij u begrijpen? Zo nee, waar ligt dit aan? <p>Afsluiting/Dankwoord</p> <ul style="list-style-type: none"> i. Ervaart u verder nog barriers om vluchtelingkinderen optimale zorg te verlenen? j. Waar denkt u dat behoefte aan ter verbetering van de (toegankelijkheid) zorg voor vluchtelingkinderen?
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