Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance

WP5 Needs analysis

Report on the Needs Analysis conducted by

Syn-eirmos NGO of Social Solidarity

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I. INTRODUCTION

A. Presentation of the study

This is the final report on the analysis conducted by Babel Day Centre- Syn-Eirmos NGO of Social Solidarity concerning the health needs of Vulnerable Migrants and Refugees (VMR) for the MyHealth Project in the city of Athens (Greece). The study was conducted through a series of Individual Interviews [IDIs] and Focus Group Discussions [FGDs]. In particular, 4 FGDs and 6 IDIs were conducted with refugee and migrant women and professionals working in the field of health care and social support. The study was carried out by two researchers experienced in qualitative research and one undergraduate student in Social Anthropology who was an intern in BABEL at that time. Data collection took place from the 30th of March until the 4th of May 2018 and the data analysis and final report were finalized by the 25th of May 2018.

Details regarding the background of the Greek context, the methodologies, and the results of the study, are presented in the following sections. The overview of the results and informed consent documents are cited in the appendices.

B. Greek context

In 2015, Greece received approximately one million arrivals, experiencing the largest influx of migrants entering Europe on their journey to Western Europe. According to a UNHCR Monthly Report[1] that was published in March 2018, a total of 51.000 refugees are currently hosted in Greece. Out of those, 39.500 are living in the mainland while another 11.500 remain on five Greek islands under geographical restrictions until the completion of their asylum request procedure. This was a direct effect of the EU-Turkey agreement that was implemented on March18th, 2016 and that led to a drastic obstruction of flow: migrants became stranded on the Greek islands under the threat of being returned to Turkey or to their country of origin[2].

The skyrocketing of arrivals of migrants and refugees that took place in 2015 occurred in a time when the Greek state was going through a profound financial crisis. Bound by a Memorandum of Understanding, it not only had to face austerity measures, but also another big challenge: the urgency to provide physical protection and social support to these

[1] https://data2.unhcr.org/en/documents/download/63236

[2] http://www.consilium.europa.eu/en/press/press-releases/2016/03/18/eu-turkey-statement/

vulnerable populations. From this, two main problems emerged. The first challenge was the inability of the already problematic stagnating public sector to offer appropriate living conditions to the arriving populations and to provide adequate health and mental health care. European institutions, local and international NGOs, and multiple social solidarity movements, constituted an additional response covering for the deficit of the state. The second challenge was the creation of an efficient and beneficial support network connecting European institutions, NGOs and public sectors under a central authority responsible for the coverage of health and social support needs of migrants and refugees. Even though the state policy has been working in this direction, many deficits and limitations are still being observed.

At the institutional level, in the healthcare sector, law[3] 4386/2016 introduced on February 2016 provided uninsured Greek citizens and vulnerable populations access to the public health care system, regardless of their legal status. It also simplified bureaucratic processes[4] to a great extend. Furthermore, it implemented a very important change: it allowed undocumented migrants in a vulnerable state free access to public health care, whereas previous legislations prohibited any kind of health care to undocumented migrants, except in cases of emergency.

However, this change is not being implemented in practice, as was expressed by the participants of the project in the discussions.

Overall, the simplification of the procedure of issuing a Social Security Number (AMKA) for all Greek citizens and foreigners holding a Residence Permit, as well as the issuing of the special Aliens Health Care Card (KYPA) for the rest of the foreigners, were very positive reforms. However, in practice, the issue of the special Aliens Health Care Card (KYPA) was never implemented, resulting in the exclusion of the asylum seekers from the health care system. It was only on February 2018, when the additional circular 31547/9662/13.2.2018[5] was issued, that it was finally clarified that asylum seekers, beneficiaries of international protection and unaccompanied minors, have the right to issue a Social Security Number (AMKA) and gain free access to the public health care system.

[3] http://www.moh.gov.gr/articles/health/anaptyksh-monadwn-ygeias/3999-prosbash-twn-anasfalistwn-sto-dhmosio-systhma-ygeias

[4] https://mdmeuroblog.files.wordpress.com/2016/11/mdm-2016-legal-report-on-access-to-healthcare-in-17-countries-15112016.pdf

[5] http://www.odigostoupoliti.eu/amka-dikaiouxous-diethnous-prostasias-aitountes-asylo/

While there have been positive reforms on a policy level, things are different on a practical level. Specifically, health and social structures are inadequate, the public sector is stagnated and understaffed, and there is a lack of an organized migration policy and a plan for a long-lasting integration. These challenges prohibit the sufficient response to the migrants' and refugees' health and social needs. Due to the absence of a sufficient central coordinating authority, a large number of local and international NGOs took action, mainly in Athens and in the islands, through the provision of health/mental health care and social support to the newly arrived migrants and refugees.

The implementation of the Program "PHILOS- Emergency Health Response to Refugee Crisis"[6] in the summer of 2017 by the Hellenic Center for Disease Control and Prevention (HCDCP), under the supervision of the Greek Ministry of Health, reflects the efforts of the public sector to coordinate all interventions in the field of health/mental health care for migrants and refugees. The particular program aims for the reinforcement of public health structures, in order for them to fulfill the sanitary and psychosocial needs of migrants in sites across the mainland and the islands.

At the moment, UNHCR is still playing a very crucial role in the implementation and coordination of the humanitarian social support for the migrant/refugee population in Greece. UNHCR, among other responsibilities, is the main organization responsible for the accommodation of and cash-based assistance to eligible migrants. The Emergency Support to Integration and Accommodation Program (ESTIA)[7], which started in September 2017 and is funded by the Directorate-General for European Civil Protection and Humanitarian Aid (DG ECHO), is an endeavor which reflects the effort for cooperation among UNHCR, the Greek government, local authorities and NGOs. The program aims at the provision of urban accommodation (shared private apartments and buildings) and cash-based assistance to refugees and asylum seekers in Greece. Presently, the housing program accommodates 20.852[8] refugees and asylum seekers and the cash-based assistance program provides monthly cash-based assistance to 41.800[9] beneficiaries.

Despite the high numbers of beneficiaries, a large number of migrants, including those that are undocumented and those that have received a refugee status and are not considered vulnerable, are excluded from the above benefits. Thousands of people are still homeless,

[6] https://philosgreece.eu/en/home/about

[7] http://estia.unhcr.gr/en/home/

[8] http://estia.unhcr.gr/en/accommodation-programme-weekly-update-24-april-2018/

[9] https://data2.unhcr.org/es/documents/download/63374

living in open camps under harsh conditions, accommodated in squats or sleeping on the streets, and having no social support, facing the risk of a further deterioration of their health. In addition, a recent increase in the arrivals on the islands and on the northern mainland borders challenges the adequacy of the existing structures, and jeopardizes the ability of the services to provide decent living conditions for migrants and refugees, putting their health and mental health under serious risk.

II. METHODOLOGY

A. Process of Participant Recruitment

The recruitment of the participants, both professionals and refugees, was conducted by using purposive and convenience sampling. The basic requirements from *MyHealth Project* regarding the profile of the refugee participants in the FGDs and in the IDIs were that they should be vulnerable migrants and refugees (unaccompanied minors and women) who have been staying in Greece for no more than 4 years.

11 organizations offering health and social support to refugees and migrants in the city of Athens were contacted through e-mail and phone, and informative meetings were made. The organizations varied in terms of legal and institutional status, and service provisions. Additionally, personal contacts with professionals were made, drawing from a personal wider network that was built during the professional experience of the interviewers in the field. The majority of the contacted professionals of our personal network, and 4 out of 11 organizations accepted our invitation.

A total of 31 individuals participated in the IDIs and FGDs. Out of those, 9 were health and social support providers to refugees, and 22 were refugees.

The groupings of the FGDs with refugee and migrants participants were made according to their native language. The participants were only women, and they varied in terms of age, family status, country of origin, language, legal status, and living conditions. In addition, all refugee participants had lived in Greece for less than 3 years. The recruitment was limited to women because it was more feasible in terms of time restrictions, accessibility and legal limitations.

Even though the size of the sample was small for a comparative data analysis compared to the demographics of the participants, the variation in the sample's characteristics provided rich material which allowed for some interesting elaborations in our findings, as demonstrated in the results section.

All recruited professionals in the FGD were women of Greek origin, with an age range of 25 - 50 years old. The professional participants varied in terms of profession, type of working environment and services provided to migrants and refugees. From our own experience, these participants represent the average profile of professionals working in this field at that moment. However, there is no official data available regarding this issue. For a richer analysis

of objectives, additional IDIs were conducted with professionals that varied in gender, age and nationality.

One of the main difficulties that we faced in the participant recruitment procedure was the low percentage of organizations that responded to our invitation. Complex human resources procedures, characteristic of the organizational structure of the majority of these organizations, in addition to the increased workload, didn't facilitate our recruitment processes. Also, the difficulty in finding a time and place to conduct FGDs and IDIs with professionals resulted in drop outs. In particular, 3 out of 9 professionals had to cancel their participation and gave a very short notice.

B. Study Procedure

All FGDs with refugee and migrant women were conducted in quiet and comfortable spaces provided by the organizations upon their agreement, at a prearranged date and time. The FGD with the professionals took place at the Babel Day Centre following a scheduled appointment. Before the meeting, we explained in detail to all potential participants in the FGDs the aim of the study. In the FGDs with the refugee and migrant women, it was clarified in great detail that there should be no financial compensation, facilitation of their asylum process, or access to services.

The FGDs were conducted by a psychologist of Greek origin who was the main interviewer and facilitator of the FGDs, a social geographer with dual Greek and Tunisian nationality who came from Tunisia and was the co-interviewer during the FGDs, and a social anthropology student and trainee, also of Greek origin, who had a mainly observational role and was keeping notes throughout the FGDs. Following each FGD, the interviewers reviewed the important parts of the discussions and kept notes that would facilitate the process of data analysis.

Written informed consent (Appendix B) was obtained from each participant in the FGD with professionals. Oral informed consent (Appendix B) was obtained in the FGDs with refugee and migrant participants, as written informed consent was too sensitive among this population and therefore was not an appropriate way of obtaining consent. The same procedure was followed with the participants in the IDIs. In the consent forms, participants were asked for permission to be audio-recorded. Not all participants of the FGDs agreed. In one case, two participants refused to be recorded but agreed to be present if only notes would be taken during the discussion. Regarding the IDIs, only one key informant refused to be recorded. To ensure anonymity, all participants in the refugee FGDs received a colored paperboard which

was used as their code name during the discussion. Professionals in the FGDs were asked to choose a name that they liked and write it in the paperboard in front of them.

Two FGDs with refugee and migrant women were conducted in the participants' native languages, Farsi and Arabic, with the assistance of an interpreter. One FGD with refugees and migrants was conducted directly in French by the co-interviewer. A French interpreter was present, translating into Greek for the two other members of the projects' team.

All interviewers and interpreters were also female, a conscious decision since the FGDs and IDIs were conducted with refugee and migrant women. The interactions between the project team and the participants were facilitated due to the shared gender. In addition, the fact that the co-interviewer was Tunisian created a trustful environment with the participants in the FGDs. Also, the inevitable distinction between "researchers" and "study participants" in FGDs was limited, since a member of the project team was perceived from the participants as a "foreigner" as well.

Another factor that enhanced communication was that the organizations providing their spaces for the FGDs with refugee and migrant women had already established a trusting relationship with them through service provision. Participants and interviewers were introduced by each organization's referee, who could reassure participants prior to the FGDs that their confidentiality would be respected and that support in case of anxiety and tension would be provided.

C. Participants in Focus Groups Discussions (FGDs) and Individual Interviews (IDIs)

1. Focus Group Discussions with Refugee Women

Three FGDs were conducted with refugee women.

- **FGD1 with Farsi speaking refugee women (Table 1.)**

FGD1 with refugee women was composed of 10 Afghan women, Farsi speakers, of different ages and family statuses. All participants had been living in Greece for 2 up to 2 and a half years. Two women had received refugee status and the rest were asylum seekers, waiting for a decision on their asylum request. All of them were accommodated in shared apartments under an official accommodation scheme and were receiving monthly cash-based assistance.

The duration of the FGD1 was 70 minutes and the discussion was translated in Greek through a Farsi speaking interpreter. The FGD1 took place in a quiet and calm space that was provided by a Day Center for Refugees managed by a multinational association with a long term presence in the field of refugee support.

4 out of 10 participants did not sit through the discussion and left before the end of the FGD due to their participation in other activities.

Code Name	Country of Origin	Period of Stay in Greece	Legal Status	Accommodation Facility
Red	Afghanistan	2 years	AS	Apartment/ Official accommodation scheme
Green	Afghanistan	2 years	AS	Apartment/ Official accommodation scheme
Yellow	Afghanistan	2 years	AS	Apartment/ Official accommodation scheme
Purple	Afghanistan	2 years	RS	Apartment/ Official accommodation scheme
Orange	Afghanistan	2 years	AS	Apartment/ Official accommodation scheme
Blue	Afghanistan	2+ years	AS	Apartment/ Official accommodation scheme
Sky blue	Afghanistan	2 years	AS	Apartment/ Official accommodation scheme
Brown	Afghanistan	2 years	AS	Apartment/ Official accommodation scheme
Grey	Afghanistan	2 years	RS	Apartment/ Official accommodation scheme
White	Afghanistan	2+ years	AS	Apartment/ Official accommodation scheme

Table 1: FGD1 with Farsi speaking refugee women

RS= Refugee Status; AS=Asylum Seeker

- **FGD2 with French speaking refugee women (Table 2)**

The FGD2 was composed of 4 French speaking women of different ages, family statuses and nationalities. Their countries of origin were Gabon, Cameroon, Democratic Republic of the Congo (DRC) and Central African Republic (CAR). All participants had been living in Greece between 8 months and 2 years. Two of them were asylum seekers, waiting for the decision on their asylum request, and the other two had been rejected at the 1st instance and their appeal decision was pending. Three of them were accommodated in shared apartments under an official accommodation scheme. One of them was living in an unofficial shelter for refugee women, managed by a small local NGO in the city of Athens, which required the active participation of the tenants themselves.

The duration of the FGD was 80 minutes. The discussion was held directly in French by the co-interviewer who was the main facilitator. A French speaking interpreter was also present

translating from French to Greek to the other two members of the project team. The FGD took place in a quiet and calm space which was provided by a Day Centre for women refugees and was managed by a small local NGO in the city of Athens.

Code Name	Country of Origin	Period of Stay in Greece	Legal Status	Accommodation Facility
Sky blue	Gabon	8 months	AS	Apartment/UNHCR beneficiary
Blue	Cameroon	2 years	AR	Unofficial shelter for Migrant and Refugee Women/Local NGO
Yellow	Republic Democratic of Congo	2 years	AR	Apartment/UNHCR beneficiary
Purple	Central African Republic	1,5 years	AS	Apartment/UNHCR beneficiary

Table 2: FGD2 with French speaking refugee women

AS= Asylum seeker; AR= Asylum request rejection/ appeal at second instance

- **FGD3 with Arab speaking refugee women (Table 3)**

FGD3 was composed of 5 Arab speaking women of different ages and family statuses. All participants were living in Greece for 5 months to 2 years. The countries of origin were: Syria (3), Iraq (1) and Morocco (1). Two of them were subject to the Dublin III family reunification scheme and the decision on their transfer to Germany and Holland was pending. One participant was waiting for the decision on her asylum request and two of them had received refugee status. All of them were staying in a self-managed residence established in collaboration with a solidarity movement and had no access to any assistance program. All Arab speaking women, in contrast to the other refugee participants expressed extensively their intention to move to Europe.

Two of the participants refused to be audio recorded. A refugee woman said with anger: *"I have gone to one hundred organizations. Nobody helps me… No, I don't give my permission to be recorded!"* Then she cried. Another participant nodded. For the above reasons this FGD was not audio recorded. Instead, extensive notes were kept by the interviewers and the observer.

The duration of the FGD was 2 hours. The discussion was translated in Greek through the help of an Arab interpreter. FGD took place in a quiet space in the facility, where they were accommodated.

Code Name	Country of Origin	Period of Stay in Greece	Legal Status	Accommodation Facility
Red	Syria	5 month	FR	Self-managed residence/ Collaboration with a solidarity movement
Purple	Syria	2 years	RS	Self-managed residence/ Collaboration with a solidarity movement

Sky Blue	Iraq	8 months	AS	Self-managed residence/ Collaboration with a solidarity movement
Yellow	Syria	1+ years	RS	Self-managed residence/ Collaboration with a solidarity movement
Green	Morocco	1+ years	FR	Self-managed residence/ Collaboration with a solidarity movement

Table 3: FGD3 with Arab speaking Refugee women

FR=Request for Family Reunification; RS=Refugee Status; AS= Asylum Seeker

2. Focus Group Discussion with Professionals

- **FGD4 with professionals (Table 4)**

The FGD4 with professionals was composed of 6 health and social care providers. In particular:

- A medical doctor who was working in a clinic for migrants and refugees managed by an International NGO.
- A midwife and a nurse who were both working in an official accommodation scheme, the municipality of Athens, a local multinational association and a NGO.
- A social anthropologist who was working as a coordinator in a health program, managed by an International NGO in one of the camps for refugees.
- A social worker who was working in an official accommodation scheme for refugees, managed by the local public authority.
- A social worker who was working in a camp in Athens, managed by a medical institution of the public sector.

All participants were women between 25 to 50 years old and were selected based on time and availability. All of them were of Greek nationality. The duration of the discussion was 2 hours. The FGD took place in a quiet and calm space at the Day Centre Babel.

Code Name	Gender	Estimated Age	Profession	Type of Working Environment
Zozo	Female	30-40	Nurse	Accommodation facility /Cooperation with local authority, local NGO and multinational association
Maria	Female	25-35	Midwife	Accommodation facility /Cooperation with local authority, local NGO and multinational association
Elpida	Female	30-40	Social anthropologist	Coordinator of Health Program in camps/International NGO

Eva	Female	25-35	Social scientist	Accommodation facility/ Local authority
Iokasti	Female	30-40	Medical doctor	Migrant/Refugees Clinic/International NGO
Mado	Female	40-50	Social worker	Camp in Athens/Public Sector

Table 4: FGD4 with Professionals

3. Individual Interviews with Refugee and Migrant Women

3 IDIs with refugee women from different countries were conducted

- **KIR1**: A married Moroccan woman, 25 years old with one child. She has been living in Greece since 2015. The interview was not audio-recorded.
- **KIR2**: A married Syrian woman, 28 years old with one year old child. The family is living in Greece for more than 2 years. They have refugee status and are living in a rented apartment.
- **KIR3**: A married Sudanese woman, 22 years old with no children. She is living in Greece for more than 2 years. Her asylum request was rejected. She and her husband are accommodated in an official accommodation program.

All interviews conducted directly in Arabic by the co-interviewer. The duration of the interviews varied from 20 to 60 minutes.

Code Name	Country of Origin	Period of Stay in Greece	Legal Status	Accommodation Facility	Family Status
KIR1	Morocco	3 years	IP	Apartment/Personal rental	Married/One child
KIR2	Syria	2+ years	RS	Apartment/Personal rental	Married/One child
KIR3	Sudan	2+ years	AR	Apartment/UNHCR beneficiary	Married /No child

Table 5: Individual Interviews with Refugee Women

KIR= Key Informant Refugee; IP=Beneficiary of International protection for humanitarian reasons; AR= Asylum request rejection/ appeal at second instance

4. Individual Interviews with Professionals

3 IDIs with professionals from various backgrounds were conducted.

- **KIP1**: One female psychologist, aged between 25 and 35, who was working in a Day Centre for social support of migrants/ refugees.

- **KIP2**: One female psychiatrist, aged between 30 and 40, who was working in a public psychiatric clinic.
- **KIP3**: One male Arab speaking interpreter, aged between 40 and 50, with Palestinian origin, who was working in a program of an international NGO, which allocated interpreters to the public hospitals in Athens.

The duration of the interviews varied from 45 to 60 minutes.

Code Name	Gender	Estimated Age	Profession	Type of Working Environment
KIP1	Female	25-35	Psychologist	Day Center for migrants/ refugees- International NGO
KIP2	Female	30-40	Psychiatrist	Public Psychiatric Clinic
KIP3	Male	50-60	Interpreter	Public Hospitals/ International NGO

Table 6: Individual Interviews with Professionals

KIP= Key Informant Professional

D. Data Analysis

This particular research is based on a qualitative approach, as the main goal is to gain a deeper understanding of the participants' health and mental health care needs (Vaismoradi, Turunen, Bondas, 2013). A content-thematic data analysis has been employed throughout the process, due to the method's capability to "map" a wide range of content appearing across the data material, enabling us to summarize and formulate them appropriately (Green and Thorogood, 2018). This kind of analysis requires a series of common steps to be followed: familiarization with the data, theme identification and data set coding, which will help extract the key findings (Green and Thorogood, 2018). The transcriptions of the IDIs and FGDs have been studied and re-examined thoroughly by all project members involved. In the cases where the interviews were carried out in the participants' native language (one focus group and three individual interviews), the transcriptions were written in the corresponding language and later translated into Greek. The participants' demographic information, such as gender, age and nationality, as well as other informational data such as legal status, living conditions and accommodation facility, were also noted and taken into account. An important first step to the analysis, following the transcription process, was the discussion of the extra linguistic elements and the group dynamics between the participants, which were noted during the FGDs. The transcripts and the observation field notes were initially formed into broader themes. The participants' most representative quotes were chosen and seperated from the rest of the text. They were coded based on the frequency of their occurrence across the research material and the importance of the given information. Then, the quotes were formed into

segments and decoded into subcategories. In the second part of the coding process, these subcategories were broadened and developed (Saldana, 2009) into the research Key Findings. Finally the themes were completed and able to offer a clear image of the refugees' health/mental health care needs.

III. RESULTS

> **"If the reception to the hospital is good, then the patient, even before they are treated, will already be healed." (Yellow-FGD2)**

A. Key Finding 1: Systemic flaws affect well being

The refugee managing policies, as well as the deficits of the medical and the social system for the support of migrants and refugees may have serious consequences on the physical and mental health of the latter. In almost all the FGDs conducted with women refugees, many aspects of this issue were expressed. In the FGDs with health and social support professionals, structural issues were addressed, and participants expressed their frustrations about their job, resulting from the fact that serious social problems that migrants and refugees face "tie their hands".

- **"Waiting" affects well being**

The extended period of wait, which all refugees are subjected to due to serious delays in the asylum process and the issue of their legal documents may be the cause of grave psychological detriment.

> "Waiting for the documents causes many health issues, mainly psychological issues [...] which result in an openly manifested change in behavior. From being good and cooperative, you can see them after 4-5 months starting to react differently, starting to get pissed, to break down [...]" (KIP3)

> "I have nothing, no documents, this is what bothers me at the moment, I have a white piece of paper; they told me at Katechaki (Asylum Service) to wait... I have no peace within me." (Blue-FGD2)"

Waiting can be exceptionally detrimental to the women who are alone in Greece, with no supportive social network. As well as for those women who want to reunite with their families in other European countries.

> "I went back home [...] But there, without the children [...] my daughters and my son are in Germany [...] I cannot live without my children, there's no point [...] They told me come and the process (family reunification) will take 1 month but now it's 6 months." (Red-FGD3)

- **The instrumentalization of "vulnerability"**

Policies managing refugees on the basis of their vulnerability have reinforced the idea that vulnerability can increase the chances of being accepted for asylum within Greece or any other European country, as well as increase the chances of gaining favorable benefits such as

transfer from a camp to an apartment, and so on. This results, quite reasonably, to vulnerability being used by refugees as a tool, as a survival strategy. However, at its extreme, this use of vulnerability can have serious consequences for the health of refugees who, having no other way out, may end up expressing self-harming behaviors.

> "There was some very important medication that he purposely didn't take, medication which would prevent him from being contagious to everyone around him [...] And even with all the dangers having been explained to him, that he could cause harm to himself and others around him, his purpose was to obtain vulnerability, to get the paper." (Iokasti-FGD4)

> "A family I've been following told me straight forward. The woman was impregnated because that would help even more [...] They go to the doctor to get the paper, not to get checked out." (Eva-FGD4)

Particularly enlightening, regarding the issue of vulnerability proof, was the response of an Arab-speaking woman to our question about whether refugees know of, or have received services from, a mental health institution.

> "Let me tell you why refugees go to psychiatrists and psychologists [...] Because when we apply for asylum, the first thing they ask us is 'do you have a psychiatric certificate?'. Without it, we are just an ordinary case, but with it we become a unique case." (Purple-FGD3)

- **Inequalities in the distribution of the humanitarian aid**

Apart from the institutional policies of refugee management, another factor affecting the living conditions of refugees, and by extension their psychological and physical health, is the uneven distribution of humanitarian aid, which commonly depends on nationality and legal status.

> "I had no financial aid, like the 480 Euros the Syrians and the Iraqis [...] had." (KIR1)

> "We live here, in a squat, no organization comes to help us [...] when there is no organization to help you, then everything is difficult for you [...]" (Green-FGD3)

It was also observed that the humanitarian provision is often distributed randomly and in a non-systematic way, resulting in the exclusion of refugees who are in the same condition, sharing the same needs, from basic services. This uneven distribution of humanitarian aid may heavily affect the health of the refugees being excluded, and create deeply rooted inequalities among them.

> "Those undocumented, it's crazy! They can't even go to the accommodation facilities for abused women. There may be a woman undergoing abuse and she won't be accepted. She will continue living on the streets, where she will continue to be abused and subjected to violence. They are truly the most exposed people." (Elpida-FGD4)

- **Absence of coordination by the state causes insecurity**

The absence of state control and the lack of central coordination in the organizations involved with managing refugees reinforce a sense of insecurity. This was expressed by both the professionals and the women refugees who do not enjoy the privileges of an officially organized service provision.

> "Look around, in this squat, the authorities don't come to check up on us, they don't care... We have met some good people here, but we could have encountered people who take advantage of refugees... there are some minors, some women who are alone and the state does not do anything to make sure that things are going well... fortunately, things are going well." (Purple-FGD3)

The professionals stressed the fact that the simultaneous presence of multiple structures and organizations does not provide substantial help and that there is an urgent need for a central mechanism that will control and coordinate organizational action. A female professional mentioned with intensity:

> "There should be some control, so that all of this can be put in order. There can't be 5,000 organizations, where anyone can do whatever they want and support something different; there needs to be a central axis, providing real help to all of this." (Zozo-FGD4)

Refugees staying in apartments, who receive some support from NGOs, have not mentioned the need for a centrally coordinated support system.

- **Difficulties in daily life, lack of descent housing and employment affect migrants'/refugees' mental health and do not allow for future planning**

The difficulties in everyday life can be the source of great anxiety for women refugees, who, quite often, live in Greece alone with under-aged children and face difficulties managing even their basic everyday needs.

> "Stress there (pointing to her stomach), I feel pain in my stomach [...] I need to buy diapers, milk. I can't speak the language so that I can find work [...] To go ask for a job, even more with the child in the stroller. It is difficult to walk with the child in my arms [...] How am I supposed to move? I need to pay for the bus first. I paid to come here [...]" (Yellow-FGD2)

The need for descent housing has also been intensely expressed by women refugees. However, this issue of better accommodation was only expressed by women living in accommodation facilities and self-managed residencies not by women living in a shared apartment provided by official accommodation programs.

> "I don't sleep [...] Too many noises. There (in the accommodation facilities) we need to work, we need to clean [...] you need to pay for food yourself. To help the refugees, but I am also a refugee. And thus I suffer." (Blue-FGD2)

These structural problems faced in every-day life also affect the professionals in the field. The sense that their interventions are not completed successful, that they may "bend over backwards to make every effort and in the end achieve nothing" (Eva-FGD4), very often causes frustration, as illustrated below:

> "It intercepts what I am trying to provide, when I told a person basically living on the streets, without thinking about it, that he should cook hot meals for morning, lunch and dinner [...] I realized then that what I might take for granted is not at all a given for somebody else." (Zozo-FDG4)

However, the narratives of the women refugees concerning the hardships of everyday life were often counter-balanced by the positive experiences that they have had in relation to Greece and the ways in which they have been treated by Greeks.

> "Greece is the best country in Europe, we don't forget that. The weather is very nice, the beaches, the people are very good. [...] But there is no job." (Green-FGD3)

The narratives of the French-speaking women regarding the hardships of everyday life were also remarkable. In contrast to the narratives of the Arab and Farsi-speaking women, French-speaking women expressed that they have received discriminative treatment in the medical sector and in public spaces as well.

> "There was a young nurse, I was the only black woman in the room, this young nurse, only her, would laugh with the other women but not with me [...] She could try to laugh with me too! She can't discriminate based on color." (Sky blue-FGD2)

Although many women expressed the wish to stay, ideally, in Greece, the shortage of employment and educational opportunities does not allow them to invest in the country and annuls any plan they could make for the future.

> "They always put up a wall in front of you [...] I have my lawyer's degree, I have received a scholarship for Budapest. Here, all this is useless. I won't choose Greece, since they give me nothing I won't give anything either [...]" (Purple-FGD3)

> "Most children don't learn anything here, they don't go to school [...] like my son, who is 17 years old." (Red-FGD3)

B. Key Finding 2: Lack of migrant oriented medical services

The present report also investigates specific medical services and practices that do not correspond sufficiently to the increased and specific needs of the hosted populations. This includes a shortage in certain medical specialties and services which are most needed by the women refugees and the need to adjust medical practices based on particular needs of populations coming from different cultural backgrounds.

- **Lack of specific medical specialties and services**

The vast majority of the professionals, as well as some of the refugee women, reported that the gynecological examinations, such as simple ultrasounds, but also the more specialized prenatal tests, such as the level II ultrasound, the nuchal translucency scan and the Doppler ultrasound, as well as the continuous observation of the pregnant women were insufficient.

> "The appointment for the ultrasound is after two or three months […] These people can't afford to give 25 or 50 Euros to do an ultrasound, something basic in a pregnancy." (Maria-FGD4)

There have also been reported shortages in specialties, such as endocrinologists, gastroenterologists and dentists.

> "The big difference with the Greek general population is that some diseases have different impact. It is clear that there is a high percentage of diabetes in this population. So, those two specialties, gastroenterologist and endocrinologist are in big shortage and we have a great problem because those are the specialties with great demand." (Iokasti-FGD4)

Finally, the professionals referred to the lack of specialized pediatric specialties, while at their great majority, the mothers referred to the lack of structures for the vaccination of children.

> "[...] You know what, the interpreters problem is a fake one. Where are the resources? Where are children's vaccines?" (KIR1)

Furthermore, the difficult access to medication for those uninsured, only in possession of a social security number (AMKA), has been mentioned as one of the central deficits of the medical health care.

> "Me and my son we've got AMKA, but I still need to pay for the meds." (Sky Blue-FGD3)
>
> "Medication is expensive and sometimes I don't buy it." (KIR1)

- **Need for medical services adapted to the cultural background of women refugees**

The need to staff the medical services with female health professionals and more specifically, with female gynecologists, has emerged as a vital issue from the professionals.

> "Women could leave aside a health issue they might have had until a female doctor or nurse would come along, so that they could be helped." (Elpida-FGD4)

This need was also expressed by the Arab-speaking women. However, the responses to whether the need for female gynecologists is covered by the medical care system or not, vary. It has been ascertained that the differences in opinions depend on both the personal

experience of each woman and on whether they were referring to services they received from the public sector or an NGO.

> "The difference between Greece and Iraq is that there, in the maternity hospital, there are only female doctors, whereas here there are only men." (Sky blue-FGD3)

However, an Arab-speaking woman, referring to a medical service provided by an NGO, says:

> "We are often asked if we prefer to have a woman as a doctor [...] especially in relation to gynecology [...] and when there is only one doctor, they do all they can so that you won't feel uncomfortable, they give you shirts, they partly cover you up [...]" (Green-FGD3)

- **Need for linguistically adapted medical services**

The linguistic problem and the lack of medical structures and mental health structures providing sufficient interpreting services was one of the main issues emerging in all FGDs.

> "The public health care system was not designed nor restructured to handle refugees [...] For those not speaking the language it's much harder. They can't book an appointment, there are no maps in the streets, their language is very different [...] Document-wise, there is nothing in their language, nor in English, nothing, nothing. For instance, they need to sign a consent form for a surgery. How?" (Elpida-FGD4)

> "The language. When I was sick, I went to the […] hospital, I don't speak English, a little bit Greek. "Fever, fever (in Greek) ..." for the woman in the reception it was all the same whether I was there or not. The translators were not there [...] This is the language doing that!" (Yellow-FGD2)

There is a difference in sufficiency of interpretation between the medical services provided by the public sector and the respective services provided by the international NGOs and other organizations. The latter seem to cover for the inefficiencies of the former.

> "It is the NGO (that helps me)[10] that books my appointments. The number "1535", how am I supposed to communicate with the receptionist in the hospital? In Greek?" (Green-FGD3)

Although a gradual implementation of programs for the staffing of public hospitals with interpreters and cultural mediators (funded by international organizations and the Ministry of Health) begun in the summer of 2017, staffing is still insufficient.

> "I was at the Children's Hospital; there aren't interpreters too often. And even when there are, quite often they are not available and they leave after 16:00." (Sky Blue-FGD3)

[10] The participants often refer to specific NGOs. For the purposes of this research we considered that mention of the names of NGOs is not purposeful. In those cases, we simply mention the specific NGO as NGO.

Although it appears that presently this program is not being employed to its maximum capacity, all the professional informants have agreed that it is a very beneficial program that needs to be more sufficiently staffed.

In the mental health sector, the language impediment has not been surpassed, as mentioned distinctively by an Arab-speaking woman:

> "Sometimes a person can go through difficult times and experience great pressure and not be able to share this with anyone, they need someone to help solve their problems [...] maybe someone needs an interpreter and the interpreter does not respect confidentiality [...] Do you know what I mean? This is the reason why a person can be reluctant to visit a psychologist [...] They may remember me, run into me by chance. I cannot entrust my problems to someone in any other language other than my mother tongue [...]" (KIR2)

Nonetheless, at their entirety, the participants did not seem to consider language as an obstacle impeding their visit to a psychologist. Many of the women participants were followed by a psychologist and/or a psychiatrist and they were all aware of who they should address to receive psychological/psychiatric support. An informant also reported that, upon their arrival to the camps, the first information they receive concerns the provision of mental health care services.

However, all health professionals agreed that the most insufficient medical services, vis-a-vis the satisfaction of the particular linguistic needs of the refugees, were the public psychiatric clinics. The problem of linguistic communication regarding metal health and psychiatric treatment can have grave consequences to the already shaken psychological health of those refugees.

> "If, for instance, a refugee is agitated, which means to be aggressive, or to express tension because [...] no one has explained to him why he is in that position [...] the tolerance the nurse, for example, is going to show will be much less than the tolerance they will show to someone speaking Greek [...] That is, due to the inability to communicate, even a lower scale tension that would not result in bed restraint for someone speaking Greek, will result in the restraint of a refugee. Physical restraints, at times chemical restraint as well, which prolong the period of hospitalization; they suffer much more, they experience this whole procedure as torture, because they don't understand its meaning [...]" (KIP2)

There has been no report of an experience of psychiatric hospitalization by any of our informants regarding themselves or other refugees.

One of the professional informants reported that the language barrier can conceal the professionals' prejudice, a remark not voiced by the majority of the professionals, however.

> "Yes, the main obstacle is language, but because of prejudice... Behind the language argument can hide one's lack of will to pay attention to a person who is of darker color, who is Arab, who is of any other cultural origin, or anything else [...]" (KIP2)

- **Differences in the perception of therapy and health care system**

The difficulty of adjusting the medical services and the mental health services to the refugees' needs does not only concern particular shortages and insufficiencies of the health care system, but it also concerns differences in deeply rooted cultural perceptions with regard to health, illness and treatment.

> "We could speak a little more Arabic ourselves, or a little more Farsi, and they, from their side, could speak a lot more Greek and so the difference wouldn't be so great as to how each one experiences their health and what they expect... in other words, what pain means. For us, pain means one thing, for a completely different culture it means something completely different and for a northern culture it means also something completely different." (Iokasti-FGD-4)

Medication as an inextricable part of the treatment, unwillingness to be hospitalized, and lack of punctuality regarding medical appointments, are three aspects that emerged during the FGDs with the professionals and the refugees. Some of them were clearly stated by the professionals whereas others surfaced through the juxtaposition of responses given by the refugees and the professionals.

> "I think I saw it particularly with Syrians and Afghans, if your medical advice is not accompanied by some sort of medical treatment, it is as if you have not taken into consideration their existing problem." (Elpida-FGD4)

Quite often, the Farsi-speaking women spoke about the lack of efficient medical treatment.

> "Well, they don't really give much medication; they give little meds, which don't help with anything. The doctor gave me a pill, and all night long my body was sweating, it did not help me at all, I was just sweating all night long, nothing more." (White-FGD1)

> "I went to the doctor and didn't give me any medication, and said it's nothing, you'll be fine. And every time I go to the doctor, they all say the same, it's nothing, you'll be fine […]" (Yellow FGD1)

One of the male informants, working as a cultural mediator for Arab-speaking people, described how the unwillingness of migrants/ refugees to be hospitalized can often create clashes with local native doctors in the hospitals. He reported with surprise:

> "They don't want to stay in the hospital! I'm telling you, they have a completely different culture […] The only thing they're interested in, from the day they are admitted is when they are going to be released, they don't ask, for instance, about their health, what did the doctor tell you and all of that, they go crazy, they sign and they leave; I've seen it many times. They sign, taking responsibility for their release, and they leave." (KIP3)

An Arab-speaking woman certified that hospitalization, when it comes to treatment, can be very stressful for her.

> "I don't hide anything, but when I got there I said nothing. My temperature was rising and they brought in an army doctor to examine me, but I didn't say I have cancer because I was afraid they might cut off my breasts." (Green-FGD3)
>
> "When I came from Turkey, at some point while I was walking I fell from some height and I got seriously hurt in my back, in my lower back, here (showing the body part). When they examined me I said, I'm fine, just so I wouldn't be admitted to a hospital." (Red-FGD3)

The professionals during the FGD expressed, at their majority, their discontent when, after they have done everything at their power to book an appointment for a refugee, they don't show up or they are late which results in them missing the appointment. A professional reminds us:

> "There is a different perception of time. The 8-hour workday and the appointments are relevant concepts and it's understandable. They might be working all day long, from sunrise till dawn, and perhaps it might not be perceived that an appointment at 3, right in the middle of the day, means we meet at 3 o'clock. It might mean around 3, two hours more or less doesn't make much difference." (Elpida-FGD4)

C. Key Finding 3: Quality of health/mental health care

The insufficiency in the quality of the medical care for refugees was expressed mainly via their discontent for delays in booking appointments, indifference and allocation of insufficient time from the side of the health care personnel. Nonetheless, refugees seem to be trusting of doctors. The lack of cross-cultural training for psychiatrists and the absence of professional protocol for the interpreters/ cultural mediators may also have multiple consequences for the quality of the services provided.

- **Prolonged delays for medical appointments**

Delays in medical care, and specifically in booking appointments, was expressed by the entirety of the refugee groups, as well as by some of the professionals, as the main problem in relation to the qualitative satisfaction of their needs.

> "Someone may live, die, be buried and come back to life before they can get an appointment to a hospital." (Purple-FGD3)

The professionals proposed the creation of specific structures providing specific medical specialties that have proven to have great delays in appointment booking, such as ultrasounds for women and an endocrinologist in order to satisfy urgent needs of the refugee populations. The refugees insist on a solution to this problem as well.

> "I think that hospitals cannot manage too many patients, that's why there are delays in booking appointments [...] something must be done in order to address this issue and create clinics for refugees, because health is the most important thing." (KIR3)

> "I don't know if it's the system or not, but they assign appointments way too slowly, I was in line for one and a half year before I could book an appointment. And then another 9 months to have the surgery. They perform surgery first to those at greatest need and then they take the rest little by little [...] The system is very slow, that's the problem" (Grey-FGD1)

- **The "give us time…" request**

Delays in appointments, long hours of waiting and adverse conditions existing in many medical services of NGOs and public hospitals, as a result of the inefficiency of the structures to accommodate the needs of the increased population, are often interpreted as indifference and form a painful experience.

> "They give us little time [...] The doctors don't do their jobs well. They are doing things fast so that patients will leave." (Orange-FGD1)

> "We are sick, we are in pain, we wake up at 5:00 to find a spot in line, [...] and if it's cold, if it's snowing, or raining or if it's hot and sunny, we stand there [...] I don't speak only for myself, I speak for everyone. It is truly painful [...] people suffering and having some that lie on the ground." (Sky Blue-FGD2)

> "I stand in line at 06:30 in the morning... We are just a number to them [...]" (KIR1)

The indifference projected by the medical staff and the demand for "more time..." was a recurring reference in the reports of the participating refugees. Although professionals don't interpret it as indifference, but instead as an inescapable consequence of the shortage of personnel in their services, they also identify themselves as being in a difficult position.

> "It is important how much attention a doctor pays to them. Because when a doctor has to see 150 people within 8 working hours, they have to allocate very little time to each one. At the […] hospital when we book a simple appointment for people with cancer, we are told that we must explain the problem within 10 minutes because they have the next appointment waiting. This is the time we are given, this is the time we can take up" (Maria-FGD4)

Another interesting perspective was provided by the professionals, who stated their own demand for more time, in a period when, even after two years of massive refugee flows entering the country, professionals continue to work under emergency conditions.

> "From my experience in the medical service, what I remember the most is the urgency [...] you need to do everything at an extreme speed and you don't have time to think, not yourself, not anything. The employee doesn't have any time or space [...] to look back and share maybe something with the coworkers or with someone else." (Elpida-FGD4)

At their majority, however, the refugees expressed their trust in Greek doctors and the quality of medical procedures themselves.

> "They are excellent, excellent doctors [...] and at the NGOs." (Grey-FGD3)

However, most of the Farsi-speaking women expressed their intense discontent with the inefficiency of treatment and the lack of quality gynecological services.

> "We do not have a good gynecologist; wherever we went we had a problem. Wherever we go they tell us, you are fine, you don't have a problem. I see that I am in pain, but the doctors tell me you are fine, go home, why have come to us?" (White-FGD1)

It's noteworthy that the first thing the professionals mentioned during the FGD, when asked to share their opinions on the medical needs of the refugees, was that often stress and anxiety experienced by the refugees is translated by them to a physical problem.

> "There is much anxiety and stress building up in their lives and as a result they have a very immediate need to access the health care system (...) Obviously, all this stress they have been through (...) they feel that something is wrong and they want to check for everything because this is the only way they can take it all out." (Zozo-FGD4)

> "Mainly what they describe at first, when there isn't a clearly medical problem demanding hospitalization, is usually the great stress and the anxiety they experience." (Maria-FGD4)

A professional, conveying her experience from working in a refugee camp, notes that the space of the clinic constituted a meeting place for the refugees. The same can be extrapolated by the remark below as well:

> "When I was at the camp I went to the doctor every week for my problem and now, for the past 8 months I've been living in an apartment, I have gone to the gynecologist twice, but nothing has changed." (Yellow-FGD1)

Based on the above, it seems to be crucial that the demand for medical care expressed by the refugees be understood, as it doesn't merely extend to covering the immediate medical/ physical needs, but quite possibly, it covers over demands concerning the overall care provided by the receiving country.

Furthermore, a professional mentions that the stress experienced by refugees, in those cases that it has bodily manifestations, is not interpreted culturally as a psychological phenomenon related to the living conditions, but as something physical, biological. It is exceptionally important that the cultural differences in the interpretation of psycho-somatic phenomena be taken into consideration when trying to understand the medical needs of the refugees.

- **Lack of training in cultural sensitivity for professionals affects the quality of service provision**

The lack of specialized training for interpreters and psychiatrists seemed to have a serious impact on the quality of the services provided. Most of the participants mentioned that it is a matter of chance whether the professional interpreter or psychiatrist will deliver quality professional services. *It depends on the person, after all* (KIP1). Some of the female refugees, although not all of them, mentioned multiple times that they felt that interpreters might be judgmental toward them or even offensive.

> "Some say, for instance, "why are you saying that? Don't say that. What's that you're saying?"" (Yellow-FGD1)

This can even result in refugees refraining from seeking help from services providing psychological support.

> "I don't trust interpreters. Sometimes they say more than the doctor has said [...] They know we need them and that we cannot answer. Sometimes they are not very professional. I told my problems (to a psychologist), problems I didn't want my husband to know [...] the interpreter, or the psychologist told my husband [...] but the psychologist is under doctor-patient confidentiality [...] I think it was the interpreter." (KIR1)

The inefficient cross-cultural awareness of psychiatrists in public hospitals was put forward emphatically by the professionals and it has emerged as one of central problems in relation to the quality of the mental health services provided, an issue affecting gravely the mental health of the refugees.

> "We, as psychiatrists, don't have the appropriate training as to how to examine a person with an interpreter [...] I have seen psychiatrists addressing the interpreter in relation to what is wrong with the patient, they don't address the patient in first person singular, they don't look at the patient [...] we speak Greek among us, so the patient does not understand what is being discussed [...] and a person in a psychotic state or under great stress or even suffering from paranoia symptoms, listening to people around speaking in a language they cannot understand and knowing that we talk about them! Well, you can see all this is tough on them." (KIP2)

D. Key Finding 4: Facilitations and barriers in the accessibility of health/mental health care services

The simplification of the procedure followed to issue an AMKA number makes extremely easier the access to health care for refugees, as mentioned by the entirety of the professionals as well as the refugees. However, the ones without an AMKA number continue to be excluded from essential medical services, which may have serious consequences for their health. The accompaniment of refugees by a professional social worker/ interpreter during a visit to the hospital has been highlighted as one of the main ways to overcome the obstacles refugees face when it comes to health care services. On the other hand, having to use an escort

undermines the autonomous use of the services, resulting in refugees being tied to the availability or not of one of the professionals.

- **Systemic inclusions and exclusions**

It was commonly agreed among the professionals that the simplification of the procedure to acquire an AMKA number for the ones applying for asylum, as well as for the ones having received recognition as refugees, essentially put into action in February 2018, is particularly helpful for the refugees regarding the access to the health care system, not merely on an institutional level but also in practice. The refugees themselves recognize fully the possibilities this regulation provides.

> "I have an AMKA number; this allows me to take care of myself everywhere, this really helps, if it weren't for this I don't know what I would do." (Blue-FGD2)

Despite all this, there are vital exclusions from the health care system in place for those with no AMKA number, which tends to be equivalent to an undocumented migrant.

> "There are people who do not have an AMKA number, who face serious chronic health issues and need surgery to which they have no access whatsoever. There are many times when I feel that my hands are tied." (Iokasti-FGD4)

The refugees, in almost all the FDGs, seem to recognize the inequalities generated among refugees based on their legal status and on their ability to acquire an AMKA number, and often they seem grateful for their luck.

> "There are others who have been here for two years and they don't even have the documents to issue an AMKA number so that they can get treatment [...] I have access to the hospital, I have AMKA. But those without this little card over there, imagine! And what do they do when they're sick? They go to the NGOs and they tell them 'Come back tomorrow, come back tomorrow, come back tomorrow'; they only give them meds, there is no doctor to examine them and even though they take the meds, the pain doesn't go away." (Sky Blue-FGD3)

- **Complex bureaucratic procedures of the health care system**

Apart from the necessary documents and the language barriers, access to the national health care system is further impeded by the complexity of the system itself, as distinctly mentioned by a professional:

> "I remember I tried to prepare a presentation about how the Greek health care system is structured and I ended up, after I don't know how many hours, having made 42 slides with no cohesion whatsoever [...] It is completely chaotic." (Iokasti-FGD4)

Mainly the Arab-speaking women who need to use more autonomously the health care system, due to the lack of an organization assisting them, also mention the difficulties they face due to the complexity of the system.

> "The language is a problem but so is the system. The system is very very complicated." (Purple-FGD3)

> "One hospital sends me to the other, one place to have the tests, another to get the results, they keep sending me from hospital to hospital; I have been to all of them. I carry 27 documents with me." (Green-FGD3)

Apart from the complexity of the system itself, basic differences between the health care system of the country of origin and that of the receiving country can further impede the comprehension of and the adjustment to the health care system of the receiving country for the refugees.

> "They come with the illusion that the doctor will see them, will give them their meds, and they will go. Simple as that. But it's not like that here [...] On many occasions they have told me, that no, we in Syria just go to the pharmacy, ask for the medicine and they give it to us. They have a different system." (KIP3)

It is also rather impressive, how the difficulties and anxieties of the refugees were expressed, regarding the initial full support of the organizations upon arrival at the country, while later on, they were expected to become more autonomous in their use of health care services. Those reports are important, because they reflect the course of transition from the management of health care provision for the refugees by the NGOs, to the national health care system, and the impact this has on the refugees themselves.

> "When I was pregnant they took good care of me, they were the ones setting up appointments for me [...] Lately, they have stopped. I had to go find the IKA in my neighborhood [...] because I went to the […]NGO to have my child vaccinated, but they won't accept me anymore, they told me that from now on I need to go to IKA since I now have AMKA [...] So, if my child were sick, I would have to call and book an appointment?" (Sky Blue-FGD2)

On the other hand, when the Farsi-speaking women were asked by the interviewer, what is it that they do when they, or their child, need to visit the doctor, they all answered without exception:

> "I call my NGO and they set up an appointment for me and accompany me to the doctor." (Grey-FGD1)

- **The access depends on the accompaniment**

The lack of infrastructures, the insufficient interpreting services in hospitals, lack of a central source for the provision of information regarding the health care system, its complexity and the adverse living conditions impede drastically the possibility of autonomous use of the health care system by the refugees. This results in the establishment, on multiple occasions, of the accompaniment of a professional as a necessary condition for the refugees to enjoy health care and other types of services.

> "For many things they unfortunately need an escort, because the hospital itself cannot support them, and it's different than in the case of a Greek person who can read the signs [...] It is extremely difficult." (Elpida-FGD4)

> "I am lucky... I go to the NGO and they send me a girl who speaks French. When I have any problem or an appointment somewhere, I call her [...] She escorts me everywhere." (Blue-FGD2)

The important issue that arose through all the FGDs with the refugees is that, in the end, the ease or difficulty with which refugees can access the health care services is in conjuncture with the availability of the relevant professional, the social worker and/or the cultural mediator of an organization, to provide support and accompany them.

> "In the [...] NGO it depends, someone can be good and help us, as they should, but some others may not... It depends on the quality of the person." (Grey-FGD1)

The random and non systematic way in which said support is provided creates inequalities among refugees.

> "I go alone. The social worker does not answer my calls and does not take care of me as he does with the other women." (White-FGD1)

> "I know people from Iraq who have asked for help from NGOs and they have the taxi sent to their homes to take them to the hospital." (Red-FGD3)

The need for accompaniment becomes even more imperative in the case of psychiatric patients in public hospitals. The treatment of a patient depends on how much their escort will be convincing that the person being accompanied needs to be hospitalized, putting the latter in a position of a patient by proxy.

> "If this person comes unaccompanied [...] and they come across them, say in the street, they don't have anyone to explain to them where they are, why they are brought here... which detriments gravely their already shaken psychological condition [...] Whether they will be hospitalized or not in the psychiatric clinic depends on how their escort will make their argument and not by what the person their self is going to say. So [...] the better the NGO professional is as an effective mediator, the more the health care professional will want to help." (KIP2)

E. Key Finding 5: Autonomy, dependency and integration

The incapability of the system to create the conditions for the most autonomous use possible of the health care system by the refugees themselves is the cause of great unrest for the professionals, in relation to the grave consequences refugees' dependency on a time consuming and perplexed health care system might have on the health of the refugees and of their children. Their incapability to achieve autonomy and their prolonged exclusion from the social web are some of the main detrimental factors for the physical and psychological health of the refugees.

> "They might have something going on with their child, and they can't call for help. We need to call the interpreter first to get all this process going and on many occasions a life might be lost during all this process [...] They stay in the camps for a long time, the process should get started from there already; to learn the language first. This doesn't exist anywhere and it's very important." (Maria-FGD4)

- **The language issue**

The issue of the refugees' autonomy extends beyond the narrow framework of medical care and essentially reflects the need to develop policies which will enhance autonomous living and integration into the wider social life for the hosted populations. The designation of language acquisition as a pillar for social integration was centrally expressed by both the professionals and the refugees. However, the views on whether language learning is a responsibility of the refugees themselves, as well as whether the acquisition of the language is the main way to surpass the obstacles impeding people from different cultural backgrounds from finding a meeting point in the new receiving country differ, both among the professionals and among the refugees.

Some of the professionals, having noticed a certain reluctance by the refugees to learn the Greek language, mentioned that it is crucial for refugees themselves to understand the need to learn the language, in order for them to achieve autonomy.

> "Protection does not mean accompaniment [...] I believe that they mainly need to understand that, if they aspire to living in Greece, [...] they need to attend language courses." (Mado-FGD4)

Refugees' reports regarding language learning reveal their wish as well as their anxieties related to their adjustment to the receiving country.

When the Farsi-speaking women were asked whether it would be more convenient if the signs in hospitals were written in their language as well, in order for them to have easier access, a suggestion put forth during the FGD with the professionals, one of them replied:

> "If they have the signs translated and things like that, we will never learn the language. It's very lazy [...] For a year now I have been trying to learn the language but I've learnt nothing. I push myself to learn, I don't know what I will do. But that thing with the sings is very lazy." (Red-FGD1)

Three Syrian women in the FGD of the Arab-speaking women answered our question on what needs to be done in order for the health care system to improve, as follows:

> - "Your doctors need to speak English." (Purple-FGD3)
>
> - "You need to learn Arabic." (Red-FGD3)
>
> - "No, you need to learn Greek", comes as a reply to the woman speaking before. (Yellow-FGD3)

Both the professionals and the refugees referred to the inadequate support of the state, regarding the implementation of programs for the systematic and quality learning of the Greek language.

> "There are no real centers where one can learn the language [...] there are lessons provided by NGOs, but they are not serious, they don't suffice for learning the language [...] It's easy to learn some words, you don't need a lesson for that [...] But I am talking about practicing the foreign language." (KIR1)

What is more, a refugee expressed her wish to make learning Greek obligatory.

> "They should make us attend Greek school [...]" (Red-FGD3)

- **An integration planning or a prolonged response to an emergency refugee "crisis"?**

A crucial question, to which we received some enlightening answers from the entirety of the participants in the FGDs and the IDIs, was whether it is enough for a receiving country to respond to the needs of the hosted populations in terms of an emergency. It was shown that a long term plan for the integration of refugees is crucial.

> "The way the country and the EU respond at the moment to the refugee crisis is in terms of an emergency [...] We talk about people who have been living in the country for a year and a half now and somehow, there needs to be found a way and a space for them to learn where they are. And all programs running at the moment have no such orientation. Up till now, it has been about treating the symptom, in all aspects." (Elpida-FGD4)

Both our professional and refugee informants expressed their views and their concerns about how this sense of autonomy and control over someone's everyday life can be possible in a new place.

The women themselves felt the need to express their demand for autonomous living conditions, while at the same time they experience ambivalence, insecurity and anxiety as to how they are going to adjust to their new receiving place.

> "In other European countries they teach them how to be autonomous, how to live in the new country [...] here, in the apartments, they just have rules dictating who can come in, when you can come in, when you can go out, like a prison." (Green-FGD3)

> "I can cook... I come from Aleppo, our kitchen is renowned. If I had a kitchen just for myself I could cook whatever I wanted! It wouldn't be like here, where everything is programmed and dictated [...] where we cook for everyone." (Red-FGD3)

On the other hand, one informant, working as a cultural mediator in public hospitals, notes:

> "I understand they... feel insecurity, for instance, moving even within the hospital, and they need you to be with them at the specific floor, to get the results yourself, or to hand the blood tests to the doctors, the labs and all that yourself; I mean you feel that they don't help either, they don't help." (KIP3)

However, the terms of the emergency in which the country responds to the refugee crisis, in combination with the inadequate infrastructures and the serious shortages do not allow for a successful response to the above mentioned demands, in order for the country to provide relief to the inescapable insecurities of the refugees during their effort to adjust to the new country. As one of the professional informants mentions, what is desired is to provide the appropriate support through education, with ultimate goal the gradual autonomy and integration of the refugees.

> "Accompaniment is a way to show them how to do things the first time; we go with them once, twice, to show them how you can get here. But unfortunately there is never the time to make the trip in terms of instruction and empowerment. That is, we may do this together today, but tomorrow you will do it on your own." (Elpida-FGD4)

- **Active social life for women and integration**

Apart from the language and autonomous living conditions, it is very important for the women to have the possibility to achieve an active social life. However, the cultural and religious particularities call for a redefinition of the terms in which social integration is possible in the new country. A refugee informant, referring to the rest of the women refugees, says:

> "It is impossible for them to have their wives drink coffee; the cafes also serve alcohol... Even to have them over for coffee at my house, they can't come alone... Either I have to go get them, or their husbands need to accompany them to my door... They are afraid in this neighborhood... they say there are so many thefts going on... they don't feel safe." (KIR1)

It's obvious that it's necessary to adjust the integration programs to the special needs of specific populations and especially to the needs of women, whose autonomy is restricted by other factors, such as age, single parenting, etc.

It was remarkable that the women refugees showed very little interest in the "RefAid" application we showed them. It seemed that most of them were not at all familiar with such technological means and they could not understand the logic behind it and the use for it. Only one of the refugees downloaded the application in her mobile and understood how she could use it. It was ascertained that, in order for an application to be useful to women refugees, there must occur some prior further action of support and education concerning Internet search in general.

From our contact with organizations involved in refugee support and their actions, we observed that Day Centers for women refugees offering activities with which the women were already familiar in their country of origin, such as sewing and knitting as well as other activities they learn here, to which they can assign meaning, and which constitute one of their most significant resorts and perhaps the only way they can acquire an active position within social life.

> "We make bracelets here, and we said one another, we are friends and we gather here." (Grey-FGD1)

The institutionalization of vulnerability, widely observed, ranging from the instrumentalization of vulnerability to the internalized perception of the woman refugee as weak and dependent, suspends the enhancement of the autonomy and the care for the mental health of the refugee women in general.

> "Let alone if we think of them as merely ill fated. Because, unfortunately, this is what we do [...] We always take for granted, right from the beginning, that they are vulnerable and they have some problem. Some, beside what they have gone through, might have encountered a chance to live the way they truly want to live. We don't help those [...] If we treat them as vulnerable cases, they will remain vulnerable." (Maria-FGD4)

However, some of the women, who apart from the adverse conditions of everyday life have to face discriminatory and racist behaviors, prioritize their standing up against the belittlement they often experience in their everyday life. And, as one of them reminds us, every woman fights in her own way to claim an active position in social life and visibility in the public sphere and she "has a mouth to speak with".

> "I can tell you plenty about this. I was frustrated. I have been to many hospitals. When I came here, I first didn't know where the reception was, I got pushed, but I am courageous and God gave me a mouth to get informed about everything and speak, because, even if I don't understand, I speak. Because if I don't ask about something I will be lost. God gave

me that strength, to have a mouth I can speak with, get informed. They push me around and I keep speaking. This is how I find someone to help me." (Blue-FGD2)

IV. Limitations

Although the refugee participants in FGDs and IDIs differed in terms of age, nationality, living conditions etc. which was sufficient for the purpose of this project, it must be mentioned that there were no undocumented migrants/refugees included, nor were included migrants/ refugees residing in a camp, who could offer an important insight to the migrant/refugee medical/ mental health needs. During the FGDs and IDIs many of the refugee women participants were accompanied by their children, which affected their availability and commitment to the discussion. Additionally, the fact that the FGDs, except for one, were held in the native language of the refugees through the help of an interpreter could result to a great loss of rich information which cannot be transmitted through interpreting. We realized also that the audio recording of the interviews and discussions, though very useful, can also affect the interview process in multiple ways. It was remarkable that the participants in the FGD which was not audio recorded, participated very actively in the discussion and were really committed in the whole process.

V. Conclusions

The precarious living conditions to which the women refugees are exposed, as well as the inequalities engendered by refugee management policies and the distribution of the humanitarian aid, can lead to the deterioration of the health/mental health of the refugees. The stress and the anxiety that refugees experience, due to these precarious living conditions, are often bodily manifested and are expressed through an urgent demand for medical care. As mentioned by the majority of the participants in the FGDs and IDIs, deficiencies in some often needed medical specialties such as gastroenterologists, endocrinologists and dentists, and in highly requested medical services such as specialized gynecological exams, systematic follow up for pregnant women, vaccinations for the children and free access to medication, are additional burdens to the health of refugees.

The majority of our informants reported that insufficiently staffed interpreting services and the absence of female gynecologists in the public sector reveals the lack of migrant oriented medical services. Although, in general, it seems that refugee women trust the doctors in Greece, the majority of them criticized the Greek medical system for the prolonged delays in the booking of appointments, the indifference and the limited availability of doctors, resulting in little time being assigned to them. This resulted on many occasions, to feelings of devaluation and suffering.

Through the implementation of the AMKA issuing law, access to national health care system is considered easy. However, the exclusion of the undocumented migrants from this initiative, except in cases of emergency, had serious consequences upon their health and mental health. The ascertained dependency of the refugee women on the availability of professionals to accompany them to the medical services, which was considered necessary due to the lack of supportive structures able to facilitate the independent use of the health care system, was a finding of high importance. This dependency, which can also lead to serious health/mental health problems for the refugees and which is additionally expanded to other aspects of social life, impedes them from achieving an autonomous life. The above fact indicates that the country still responds to the needs of the hosted populations in terms of emergency.

The need for an integration planning in order to reinforce the autonomous and independent living of refugees, contradicting the notion of the weak and dependent refugee women is crucial. Additionally, if we consider health not as fragmented to bodily and psychic manifestations but as a whole, and if we consider cure not only as the coverage of the immediate medical needs, then we can understand that an effective response to the

health/mental health needs of refugees demands a wider and overall care for the integration of refugees and that their requests very often concern their equal position in the receiving country.

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APPENDIX A: RESULTS OVERVIEW

Key Finding 1: Systemic flaws affect well being

- "Waiting" affects well being
- The instrumentalization of "vulnerability"
- Inequalities in the distribution of the humanitarian aid.
- Absence of coordination by the state causes insecurity
- Difficulties in daily life, lack of descent housing and employment affect migrants'/refugees' mental health, and do not allow for future planning

Key Finding 2: Lack of migrant oriented medical services

- Lack of specific medical specialties and services
- Need for medical services adapted to the cultural background of women refugees
- Need for linguistically adapted medical services
- Differences in the perception of therapy and health care system

Key Finding 3: Quality of health/mental health care

- Prolonged delays for medical appointments
- The "give us time…" request
- Lack of training in cultural sensitivity for professionals affects the quality of service provision

Key Finding 4: Facilitations and barriers in the accessibility of health/mental health care services

- Systemic inclusions and exclusions
- Complex bureaucratic procedures of the health care system
- The access depends on the accompaniment

Key Finding 5: Autonomy, dependency and integration
▪ The language issue ▪ An integration planning or a prolonged response to an emergency refugee “crisis”? ▪ Active social life for women and integration

APPENDIX B: CONSENT FORMS FOR FOCUS GROUP DISCUSSIONS/INDIVIDUAL INTERVIEWS

ORAL CONSENT FORM
MIGRANT/REFUGEE PARTICIPANTS IN FOCUS GROUP DISCUSSIONS

Project's Title:	MyHealth - Models to engage Vulnerable Migrants and Refugees in their health, through community empowerment and learning Alliance
Partner:	Babel Day Centre-Syn-eirmos NGO of Social Solidarity
Researchers:	Nefeli Roumelioti Samia Samara Aikaterini Kasimi

Introduction

You are being asked to participate in a focus group that has to do with the inquiry of the experiences of immigrants and refugees regarding their access and use of the healthcare services in Athens. The aim of the study is the deeper understanding of the real needs of migrants/refugees regarding the provision of healthcare services and their access to them. The ultimate purpose of this project is to improve the healthcare services of vulnerable immigrants and refugees newly arrived to Greece by developing and implanting models based on the know-how of a European multidisciplinary network. Your opinions and ideas about these specific issues, your experiences, your needs and your evaluation of the healthcare provision system in Athens are very important for the fulfillment of the goals of this study.

Further information on this European program will be found at the following link : http://healthonthemove.net

Description of the study procedure

If you agree to participate, we will have an interview with you which will look more like a conversation about the topic related to the study. All opinions are acceptable and there is no wrong answer. We are very interested to learn about your thoughts/ideas/difficulties on what you are currently experiencing regarding your access to health care services. You will not have to answer any questions that you are uncomfortable with, and you can stop the interview at any time. The interview will be conducted by two researchers and one interpreter and will last 90 minutes.

The interview will be audio-recorded, if you agree on this. The records of this study will be kept strictly confidential. If you don't agree with the audio-recording, we would like to have your permission to take extensive notes.

Confidentiality

This study is anonymous. Your name will nowhere be used during the analysis. We will not include any information in any report that would make it possible to identify you. Anonymous quotations will be submitted for publication without giving any details that could lead to individual participant identification.

All material will be kept in secured storage for at least 5 years and only Syn-eirmos staff could access it.

Benefits and Risks

There are no direct benefits from your participation in the study. There will be no remuneration for participation in this study or any costs involved to participate.

However, we hope that the results can lead to improved health services for the migrants in Greece.

The only risk of your participation in this study is the time spent on this interview.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. The participation is voluntary. You may refuse to take part in the study at any time without any effect on the services you are receiving. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the interview at any point during the process.

Right to Ask Questions and Report Concerns

You have the right to ask questions about the focus group before, during or after the research. We advise you to feel free to contact us anytime, Samia Samara at samara.s.samia@gmail.com or by telephone at 6985076336 and Nefeli Roumelioti at nefeliroum@gmail.com or by telephone 6984 904646.

CONSENT FORM
PROFFESIONAL PARTICIPANTS IN FOCUS GROUP DISCUSSION

Project's Title:	MyHealth - Models to engage Vulnerable Migrants and Refugees in their health, through community empowerment and learning Alliance
Partner:	Babel Day Centre-Syn-eirmos NGO of Social Solidarity
Researchers:	Nefeli Roumelioti Samia Samara Aikaterini Kasimi

This participant information form is to help you decide whether you would like to take part in the presented Focus Group. Please take your time to read this form and ask questions if you would like. If you decide to participate, you will be asked to sign this document which shows you consent to participate. If you wish not to participate, or you would like to withdraw at any given point, this will not have any effect to your employer. If you decide to participate you will be provided with a personal copy of the present form.

If this consent form contains words you do not understand, please ask to clarify those. It is important that you understand the purpose of this study and how your participation can contribute to it.

Introduction

You are being asked to participate in a focus group that has to do with the inquiry of the experiences of immigrants and refugees regarding their access and use of the healthcare services in Athens. The aim of the study is the deeper understanding of the real needs of migrants/refugees in terms of quality and access to health and also for health professionals and other support services. The ultimate purpose of this study is to improve the healthcare services of vulnerable immigrants and refugees newly arrived to Greece by developing and implanting models based on the knowhow of a European multidisciplinary network. Your opinions and ideas as healthcare providers or /and professionals in social services for migrants and refugees dealing with these specific issues, in addition with your rich experience in the field, are of great importance for the fulfillment of the goals of this study.

Further information on this European program will be found at the following link : http://healthonthemove.net

Description of the study procedure

If you agree to participate, we will have an interview with you which would look like a conversation related to the topic of this study. All opinions are acceptable and there is no wrong answer. We are mainly interested to hear your thoughts/ideas/opinions on how you evaluate the needs of migrants/ refugees regarding health care provision and access to healthcare services in the city of Athens. Additionally, it is important to identify the basic needs and

obstacles you are facing in your working environment. You will not have to answer any questions that you are uncomfortable with, and you can stop the interview at any time. The discussion will be held in Greek, it will last approximately 90 minutes and will be conducted by the two researchers.

The interview will be audio-recorded, if you agree on this. The records of this study will be kept strictly confidential. If you don't agree, we would like to have your permission to take extensive notes.

Confidentiality

This study is anonymous. Your name will nowhere be used during the analysis. We will not include any information in any report that would make it possible to identify you. Anonymous quotations will be submitted for publication without giving any details that could lead to individual participant identification.

All material will be kept in secured storage for at least 5 years and only Syn-eirmos staff could access it.

Benefits and Risks

There are no direct benefits from your participation in the study. There will be no remuneration for participation in this study or any costs involved to participate.

However, we hope that the results can lead to improved health services for the migrants in Greece.

The only risk of your participation in this study is the time spent on this interview.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. The participation is voluntary. You may refuse to take part in the study at any time without any effect on the services you are receiving. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the interview at any point during the process.

Right to Ask Questions and Report Concerns

You have the right to ask questions about the focus group before, during or after the research. We advise you to feel free to contact us anytime, Samia Samara at samara.s.samia@gmail.com or by telephone at 6985076336 and Nefeli Roumelioti at nefeliroum@gmail.com or by telephone 6984 904646.

By signing below, I show that the investigators explained to me extensively the purpose of the study, clarified the study procedure and I agree to participate in this study.

Date:

Name of Participant in the Focus Group	Signature of Participant

Names of Researcher	Signature of Researcher

CONSENT FORM
INDIVIDUAL INTERVIEWS (MIGRANTS/REFUGEES)

Project's Title :	MyHealth - Models to engage Vulnerable Migrants and Refugees in their health, through community empowerment and learning Alliance
Partner:	Babel Day Centre-Syn-eirmos NGO of Social Solidarity
Researchers:	Nefeli Roumelioti Samia Samara Aikaterini Kasimi

Introduction

You are being asked to participate in an individual interview which is about how migrants and refugees experience their access and provision of healthcare services in Athens. The aim of the interview is a deeper understanding of the real needs of migrants/refugees regarding the provision of healthcare services and their access into them. The ultimate purpose of this project is to improve the healthcare services for vulnerable migrants and refugees newly arrived to Greece by developing and implanting models based on the know-how of a European multidisciplinary network. Your opinions and ideas about these specific issues, your experiences, your needs and your evaluation of the healthcare provision system in Athens are very important for the fulfillment of this project.

Participants Information Sheet for Individual Interview

Your participation on the research is voluntary. The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time without any effect*. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any question that you are uncomfortable with as well as to withdraw completely from the interview at any point during the process.

There are no direct benefits or any remuneration for you to participate in the study and there are no foreseen risks.

However, we hope that results from you and others can lead to improved health services for the migrants in Greece.

The interview will be audio-recorded, only if you agree on this. The records of this study will be kept strictly confidential. If you don't agree with the audio-recording, i would like to have your permission to take extensive notes.

This study is anonymous. Your name will nowhere be used during the analysis. I will not include any personal information in any report we may publish that would make it possible to identify you. Anonymous quotations will be submitted for publication without giving any details that could lead to individual participant identification.

You are fully encouraged to ask me any question you want during or after the research. If you have any further questions about the study, at any time feel free to contact me, Samia Samara at samara.s.samia@gmail.com or by telephone at 6985076336 and Nefeli Roumelioti at nefeliroum@gmail.com or by telephone 6984 904646.

If you agree to participate, we are very interested to learn about your thoughts/ideas/challenges on what you are currently experiencing regarding your access to health care services.

By signing below I show that the researcher explained to me extensively the purpose of the study, clarified the study procedure and I agree to participate in this study.

Date:

Name of Participant in the Interview	Signature of Participant

Names of Researcher	Signature of Researcher

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