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

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**Abstract** (max 250)

***Background:*** In order to provide effective primary care for refugees and to develop interventions tailored to them, we must know their needs. Little is known of the health needs and experiences of recently arrived refugees and other migrants throughout their journey through Europe. We aimed to gain insight into their health needs, barriers in access and wishes regarding primary health care.

***Methods:*** In the spring of 2016, we conducted a qualitative, comparative case study in seven EU countries in a centre of first of arrival, two transit centres, two intermediate-, and two longer-stay first reception centres using a Participatory Learning and Action (PLA) research methodology. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. Transcripts and sessions reports were coded and thematically analysed by local researchers using the same format at all sites; data were synthesised and further analysed by two other researchers independently.

***Results:*** The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences, and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion.

***Conclusion:*** Health of refugees on the move in Europe is jeopardized by their bad living circumstances and barriers in access to healthcare. To address their needs, healthcare workers have to be trained in providing integrated, compassionate and cultural competent healthcare.

Keywords (Max. 5): Refugees, migrants, primary care, Participatory Research, PLA.

**Introduction**

In 2015, an unusual high number of migrants from Syria, Afghanistan and Iraq applied for asylum within the EU28 (1). Nearly all European countries were affected and faced the challenge to establish good quality and accessible healthcare for these migrants on the move . Primary Health Care (PHC) is the first point of entry to the healthcare system in most countries. PHC has the potential to respond adequately and at low costs to the health needs of a population, also migrants (2,3,4).

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

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

**Methods**

*Study design*

We conducted a qualitative, comparative case study in seven EU countries using Participatory Learning and Action (PLA) research methods for data generation and analysis. This methodology enables hard-to-reach groups to sharetheir knowledge (11). A PLA ‘mode of engagement’ is the essential attitudinal disposition a researcher adopts to promote participation by diverse stakeholder groups in dialogues that are ideally reciprocal, mutually respectful, co-operative and productive (12). PLA techniques are inclusive, user-friendly and democratic, generating and combining visual and verbal data. This encourages literate and non-literate stakeholders alike to participate. They are seen as ‘local experts’ who are uniquely knowledgeable about their own lives (12).

*Setting*

The fieldwork was carried out in refugee reception centres between February and March 2016. The local sites (see table 1) were chosen because they reflect the journey refugees make through Europe, differing in length of stay of the newly arriving refugees. We identified 4 types of centres. *Organization of and access to Primary Health Care services for the migrants differed between settings (see table1).*

1. “Hotspot centre” Lesbos, Greece, where the majority of refugees entered Europe by boat from Turkey.

2. Transit centres, Slavonski Brod in Croatia and Šentilj in Slovenia where refugees stayed at most a few days on their way to final destinations.

3. Intermediate-stay first reception centres: in Hungary, where, after the closing of the borders end of 2015, refugees were staying for months; and a temporary reception centre for 3000 refugees in the Netherlands.

4. “Long-term” reception centres in Italy and Austria where refugees stayed for a long period, after they applied for asylum or because they could not travel further.

---Table 1. Overview of the sites and fieldwork ---

*Recruitment*

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

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

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

*Data generation*

Before the start of the fieldwork, the local researchers from all sites involved participated in a two-day training to enhance quality and consistency of data generation and analysis across diverse settings.
 Data were gathered through PLA style flexible brainstorm discussions and in-depth interviews. This brainstorming method applies the ‘PLA-mode of engagement’ and uses materials adapted to the health literacy of participants giving ample opportunity to the participants to come up with their topics instead of using a fixed topic-list. This encourages interactive data generation (12, 14, 15). Each fieldwork session took approximately two hours.

During the sessions, all participants “posted” (using a picture or in writing on a post-it paper) their thoughts and explained them one at a time; the “posts” were categorised with the help of the researchers who acted as facilitators, and recorded on PLA charts following a pre-agreed template used by all sites. Topics for the discussion were brought up by the participants. In addition facilitators could use a predefined list of topics (see appendix 1) to ensure that all relevant aspects of health needs and barriers were covered. All PLA charts were digitalised by making a picture after each session and sessions were audio recorded and transcribed. In one group refugees refused audio recording. In that case, extensive field notes were taken.

*Data analysis*

We followed the principles of thematic analysis in qualitative research (16).

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

*Ethical approval*

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

**Results**

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

--- Table 2. Overview of respondent characteristics ---

*Health needs*

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

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

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

--- table 3. Overview of mentioned health problems ---

*Barriers in accessing healthcare*

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

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

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

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

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

 “*There is no psychological care here. It is very important, more than medication. Especially for the children. The longer there is no psychological care, the problems become even bigger”* (Male, 50, Syria, intermediate, Netherlands)

However, fear of stigmatisation played an important role.

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

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

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

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

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

*“… we did not get any documentation of the treatment we received…”* **(**Male, 26, Syria, intermediate, Hungary)

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

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

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

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

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

*Wishes*

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

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

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

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

**Discussion**

*Main findings*

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

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

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

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

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

*Strengths and limitations*

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

*Impact of the study*

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

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

*Conclusions*

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

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**Conflicts of interest**: ‘none declared’

**Keypoints**

* Refugees on the move in 7 European countries suffer mainly from health problems related to their journey and bad living circumstances, from pregnancy related problems and from mental health problems.
* They also face important barriers in accessing good quality healthcare due to time pressure, linguistic and cultural differences, and lack of continuity of care.
* They wish for more information on legal procedures and on the organisation of healthcare, for better continuity of care and above all for compassionate, cultural competent health care providers.
* In order to achieve health equity and secure the access to good quality healthcare for refugees and other migrants on the move through Europe joint efforts from policy and practice are needed. Policy makers in the countries involved should guarantee the availability of sufficient manpower and services; healthcare professionals need to provide compassionate, cultural sensitive care tailored to the needs of the migrants at stake. The development and implementation of guidances and training can support them in this.

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**Table 1. overview of sites and fieldwork.**

|  |  |  |  |
| --- | --- | --- | --- |
| Site and Country | Type | Primary Health Care | # participants and# sessions |
| General strength of PHC systema  | PHC available for migrants at the site | PHCBarriers in accessb |
| Moria Lesvos Greece | Hotspot | Weak yes 2,4  | 20 – 5 |
| ŠentiljSlovenia | Transit | Strong yes 1,4 | 19 -14 |
| Slavonski BrodCroatia | Transit | Unknown yes 1,4 | 25 -5 |
| BicskeHungary | Intermediate | Weak yes 4 | 32 -6 |
| Heumensoord NijmegenThe Netherlands | Intermediate | Strong yes 4 | 8 -3 |
| Villa Pepi and Villa ImmacolataItaly | Long-term  | Medium yes 1,3,4 | 11- 4 |
| ViennaAustria | Long-term | Weak noc 1,3,4 | 8 -6  |

**a From** Kringos D, Boerma W, Bourgueil Y, Cartier T, Dedeu T, Hasvold T, Hutchinson A, Lember M, Oleszczyk M, Pavlic DR, Svab I, Tedeschi P, Wilm S, Wilson A, Windak A, Van der Zee J, Groenewegen P. The strength of primary care in Europe: an international comparative study. British Journal of General Practice 2013; 63:e742-e50. (12)

b 1 = migrants have limited time to attend services

 2 = access limited by time pressure and lack of manpower

 3 = access hampered by finances

 4 = access hampered by linguistic and cultural differences

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

**Table 2 characteristics respondents**

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

**Table 3. overview of mentioned health problems**

|  |  |
| --- | --- |
| Main health problem | Specific health issue  |
| Disabilities and injuries | *violence related wounds**burns**frostbites**broken bones**sprained ankles* *pain in back and legs**blisters**hypothermia* |
| Mental health problems | *trauma related distress**depression**insomnia**fatigue**anxiety**uncertainty* *disorientation* |
| Pregnancy related issues | *dehydration**no medical examinations**lack of privacy**lack of facilities* *lack of healthy food*  |
| Infectious diseases | *common cold**flu**respiratory infections**urogenital infections**eye infections**scabies* |
| Gastro intestinal problems and dehydration | *diarrhoea**viral gastroenteritis**vomiting**dehydration* |
| **Dental problems** |  |

Appendix 1. Topiclist



**TOPIC LIST fieldwork WP2**

**Topic list for PLA moderated sessions with refugees and other migrants, to get insight into their views and experiences on health problems, healthcare needs and needs for social care / mental support.**

The topic list consist of 2 parts: **Topic #1** and **Topic #2**

**Single sessions:**

For the single sessions you can use the questions of **topic #1** of the topic list. The emphasis should be on question 2 and 3. But question 1 is a good starting point for the discussion.

If after a few sessions you have the idea that you have heard ‘everything’ on topic #1, you can choose to start a group with **topic#2.** Try to have at least one group where **topic #2** is discussed.

**Multiple sessions:**

If a group has multiple sessions, start the 1th sessions with **topic #1.** The emphasis should be on question 2 and 3. But question 1 is a good starting point of the discussion.

In the 2nd and 3th session you can use **topic #2.**

**Sessions with NGO’s and other stakeholders:**

You can use the same topics.

**Important remarks for the sessions:**

* Guidance has been circulated separately on how to facilitate the discussion, and how to achieve a PLA ‘mode of engagement’, as well as practical issues as collecting informed consent, audiotaping , data storage etc.
* Very important during each session is attention for ground rules, atmosphere, safety, giving every participant equal opportunity to speak, noting discomfort or anxiety as well as limitations in reading and/or speaking the communal language (as will be discussed during the training).
* Know exactly what you can offer them in terms of acute access to care, to social support, in reward, etc. Make sure you have some contacts with local healthcare / social / psychological workers in case there is an acute need for help.
* Very sensitive topics (like sexual abuse) often can be better addressed by asking if anyone has heard of such a thing, instead of if anyone has experienced this.

**Topiclist**

Note: These are the topics we think are relevant to address – however there has to be room for topics the refugees themselves come up with!

**Topics #1**

1.What are the main health problems you have experienced so far in your life - at home or during your journey to Europe?

*If participants do not mention the following conditions themselves, then please ask if they know people with these conditions:*

*- Chronic diseases*

*- Other diseases (focus on communicable diseases)*

*- Mental disorders*

*- Childhood diseases*

*- Pregnancy related issues*

*- Disabilities / Injuries*

2. What experiences do you have with healthcare during your journey / in this centre?

What barriers did you encounter if you wanted to see a doctor or if you needed medication?

*If participants do not mention any experiences or barriers, you can help them with the following topics*

*- administrative and financial hurdles?*

*- language?*

*- cultural/religious barriers?*

*- lack of facilities?*

*- lack of continuous health care*

3. What care would you appreciate for the health problems mentioned before these problems?

*To help participants think about all issues, it could be helpful to specify after an introductory broad question ( e.g. what healthcare facilities do refugees like you need?)*

*what is needed in relation with:*

* *Acute illness (infections and others)*
* *Injuries*
* *Chronic diseases management and medications' provision*
* *Illness in Children*
* *mother and child care ( pregnancy care, delivery and problems with newborns)*
* *Do you want a medical first aid kit for during your journey? If so, what should be in it?*
* *Stress, anxiety: other mental disorder?*
	+ *Example questions: we know you all have suffered a lot. And we know many people feel very stressed, or have to think a lot. Sometimes they cannot sleep at all, or are very frightened. Or the cry the whole day. Or just are numb and sad. Or very easily irritated and angry. Do you recognize this? What do these people need, right now on their journey, and when they have reached their final destination?*
* *Sexual and gender based violence : this topic should be addressed only if there is a really confidential atmosphere in the group, and as last questions*
	+ *Example questions: we know very bad things happen with women in the war, or during the flight. If you have ever heard of such an awful thing, what do you think these women would need? With whom should they speak about this?*

*And the same kind of questions related to torture.*

Related to the kind of services they need, it is important to get information on the following questions:

* What do you need to access care
* How do you get information on access – what kind of information would you want?
* How would you want to deal with language barrier?
* Preference for predictable and coordinated visiting schedule of clinics?
* Where do they find support when they do not feel well mentally? Where do they go to?
* If people have severe mental health problems: do they have access to mental health care facilities? Can they find the way? Would they go there if they had complaints?

**Topics #2**

1. Health information system
* *Do you want the doctors elsewhere to know your medical history?*
	+ *How could this be achieved?*
* *Do you posses any paper or electronic personal health records?*
	+ *Medical cards or booklets containing medical history*
	+ *Vaccinations booklet*
* *What do you think of a personal health record (show the IOM example)*
1. Competencies of healthcare workers and previous experiences in healthcare
* *What are your preferences and expectations in relation to the care services?*
* *Sufficient patient-doctor time*
* *Active involvement in the decision of the therapeutic scheme*
* *Physicians showing understanding and compassion*
* *What was your experience with the healthcare services in your country?*
* *First point of contact in case of a health problem*
* *Accessibility of healthcare services (eg. geographical barriers, insurance policy, private or public healthcare services etc)*
* *Continuity of healthcare (eg. general practitioner, family physician or other physician)*
* *Health information sources (eg. healthcare professionals, family, friends, media etc)*