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Accessibility to Maternal Health Services: Case Study of the Refugee Population in Hospitality Structure Filippiadas

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Abstract

Introduction: *Refugee asylum seekers have the right to free access to Public Health Facilities and are entitled to nursing and medical care. Pregnant refugees face a variety of linguistic, cultural, geographical, administrative, etc. barriers. Inadequate access to health services is a brake that affects all aspects of their lives.*

Purpose: *The present study investigates the accessibility of the refugee population of the Philippiada Community Center to obstetrical health services. The purpose is to make conclusions that will help in the evaluation of health services with the ultimate goals of identifying service deficiencies, introducing new applications and practices and improving the health services provided both for the refugees residing in the Greek area and for the health system itself. The social and political issues raised by this study are also highlighted.*

Materials and Methods: *The research was chosen to be qualitative, where individuals and phenomena are studied in their natural environment. It is characterized as a participatory observational study since the research team participated in the activities being studied trying to facilitate women's access to obstetric services. The research took place at the Refugee and Immigrant Reception Center from July 2020 to July 2021. The communication was made through certified cultural interpreters of the service/organization in two languages. Arabic and Farsi. The data collection method was (34) structured interviews that included eleven questions, categorized according to the type of accessibility studied (social, geographical and organizational). The results of the interviews were audio recorded and transcribed.*

Results: *All the women who participated in the survey chose a public hospital. This was an option that was 100% economical. Each respondent visited the doctor from only once to once a month with 50% visiting the hospital 2-3 times. Half of the women answered that they did not need more visits. The problems that most of them faced during the journey to the hospital were difficulties in transportation and the cost of it. The largest percentage (62%) say they did not have any problems with the use of the services. A large percentage (62%) believe that they were not confronted with racist behavior. 21% of women report offensive behavior by staff. Women faced various bureaucratic problems with their social security number, prescription and certificate of marital status. In the process of admission to childbirth, 65% reported various problems regarding the distance of the hospital from the place of residence and the cost of transportation. Women make very positive feedback on the support they received after pregnancy, and only two make negative feedback. The largest percentage of respondents (91%) recognize communication as the biggest obstacle and emphasize the need for a translator in every health service.*

Discussion: *The most important problems that arise regarding the accessibility of refugee women to health services are language, geographical and bureaucratic barriers. It is necessary to take the necessary measures in order to provide satisfactory maternal care within the geographical boundaries of the region without presenting the need to change the place with the accompanying problems that this entails. Health care providers must also recognize, respect and respond*

to the cultural beliefs and practices of the people they serve. This can be achieved through training programs both at the workplace (hospital, health center, etc.) and at the university (intercultural training). The most important issue that emerges from the literature and is confirmed by the research is the urgent need to provide interpretation services in the health system. Finally, the responsible bodies are required to do their utmost so that the already established mechanisms operate in an organized manner without delays and deficiencies to avoid bureaucratic problems as well as to establish new interventions that cover the geographical and linguistic needs of the population in order to provide refugees with an equal access to health services in general and obstetrics in particular.

Keywords: Refugees, Public Health, Maternal Health, Accessibility

Introduction

It is natural that the changes observed on an international scale turn health system in new directions, which are constantly evolving anyway, pushed by other processes. The need for changes also arises from the fundamental contradiction that characterizes the three basic values that must govern health systems, equality, quality and efficiency, which are fundamentally competitive with each other. Evaluation of health services is considered an integral part of the planning, organization and management of any health service or system. The Commission of the European Communities (Brussels 2001) in the context of a coordinated strategy for the modernization of social protection set three long-term objectives to ensure a high and sustainable level of health protection: Accessibility, Quality, Sustainability. Accessibility is a particularly important element of the first contact and is a condition of equality in care. Article 1 of the Geneva Convention defines exactly who a refugee is. With the Treaty of Lisbon signed in December 2007, it is foreseen that the European Union develops a common immigration policy with the aim of effective immigration management, the fair treatment of third country nationals residing permanently in the member states as well as the fight against illegal immigration and of human trafficking. At the same time and based on European policies, the government has established general rules for material reception conditions and medical care where it is stated that asylum seekers have the right to free access to Public Health Facilities and are entitled to nursing and medical care, including the necessary treatment for illnesses and the necessary psychiatric care, where required. Inadequate access to health services is a major barrier to the integration and inclusion of refugees which affects all aspects of life such as work and education. The barriers they face are continuous and include administrative barriers, long waits to receive services, fear of discrimination and prejudice, lack of proximity and information about the health system, and language or cross-cultural barriers. Recently, UNHCR highlighted that one of the most vulnerable groups in need of assistance, coordination and effective actions are migrant and refugee women, emphasizing pregnant and lactating women as well as adolescent girls who marry early and may bring their newborns with them. The impact of the COVID-19 pandemic on refugees has highlighted the need to intensify actions to facilitate their access to health services.

Theoretical Part

Health Systems

Definition of Health

According to the World Health Organization (WHO), health is the state of complete physical, mental and social well-being and not just the simple absence of disease or disability. Of course, the definition is broad enough to include social progress and well-being as components of the concept, thus recognizing that the long-term unemployed or those experiencing a state of poverty cannot be considered to be in perfect health. In addition, health is now officially recognized as a sector that is itself capable of leading to a process of social exclusion. This is of course when a person cannot access health care, i.e., health services, especially public health services, either because legal barriers prevent it or because it is not allowed in practice.

Health and social exclusion are also linked in another, inverse fashion. It has already been mentioned that the state of health and the ability to exercise the right to equal access to health services can fuel a process of social exclusion. Such a process, on the other hand, regardless of the factors that trigger it, is likely to affect the health of the person experiencing it and thus accelerate or worsen social exclusion. The mere fact, for example, that a long-term unemployed migrant lives in a shelter with poor sanitary conditions is enough to significantly increase the chances of getting sick. Illness for the socially excluded person can trigger a process of social exclusion, either at the level of accessibility to health services for treatment, or at the level of accessibility to another factor of social inclusion, such as the possibility of work [1].

Health is perceived as a public as well as a private good. Public goods are goods that are provided to everyone regardless of their economic situation, every citizen has the ability to consume them and the state has an active role in order to ensure the provision of the necessary health services to the entire population. Contrary to the perception that wants health to be a private good, health is produced and distributed according to the rules of the free market without government intervention [2].

Definition and Types of Health Systems

A system is a series of things connected or interdependent in such a way as to form a complex unit, i.e., a set consisting of individual subsets, structured in an orderly sequence and relationship according to some design and planning operation [2].

According to the World Health Organization, a health system is defined as conscious efforts whose primary purpose is to promote, restore and maintain health.

Each health system is an organized set of individual health services that work together to protect and promote the health of the population.

The main organizational characteristics that determine the form of the health system are the degree of parity, the extent of coverage, the type of services, the public-private sector relationship, the freedom of choice, the effectiveness and efficiency of the system.

Based on the way of financing, the way of production and distribution of health services, three basic types of health systems can be distinguished: the state which is financed by the state budget, the social security system (Bismarck) which is based on the existence of many different insurance funds and the private system which is financed by private health expenditure.

Most European countries have recently tended towards intermediate forms of mixed organization systems. The public sector, either as a national system or as social security coexists with the private sector while private medical services are increasingly being developed.

The health system in Greece falls into the category of mixed models, where the National Health System model coexists with the social security model with the parallel operation of a private model [3].

Welfare State

A welfare state is defined as a state that is committed to providing basic economic security to its citizens, protecting them in the event of unemployment, accident, illness and old age.

The term first appeared in the United Kingdom during World War II and has since been used more widely to describe welfare systems developed since the 19th century. Scholars of the term have attempted to classify countries into categories according to the role that the state, the market, and the family play in the well-being of the population. Looking at economic, political and ideological factors they also try to expand and present variations of already existing welfare states. These investigations are broadly interdisciplinary. Contemporary research examines the restructuring of the welfare state in the context of economic globalization and the pressure that has been placed on it by changes in family and racial roles [4].

Systems Development

It is natural that the changes observed on an international scale point towards new orientations and health systems, which are constantly evolving anyway, pushed by other processes. Health systems in developed countries are under significant pressure for change. The changing factors that affect the health systems are demographic, nosological, technological but also more broadly social and economic.

In terms of social changes, immigration and unemployment create increased needs without corresponding insurance contributions to health funds. Social inequalities are deepening as globalization and the new competitive environment push for low labor costs and cuts in social benefits thus shaking the foundations of the traditional welfare state [3].

For this reason, the Lisbon European Council in March 2000 recalled that social protection systems must be reformed in order to continue to offer quality health services [5].

Core Values and Directions

In addition to the above developments, the need for changes also arises from the fundamental contradiction that characterizes the three basic values that must govern health systems, equality, quality and efficiency, which are fundamentally competing values.

The aim of the 'Health for all in the 21st century' program of the World Health Organization is to make health an important priority, in all areas of policy, to strengthen social cohesion, and above all to reorient and modernize health services [3].

For Europeans, the existence of quality protection against the risk of illness and dependency is an essential asset that must be preserved and adapted to the challenges of our times [6].

After all, the European Parliament, the Council and the Commission issued in 2017 the 'European Pillar of Social Rights in 20 rules' where it is explicitly stated that everyone has the right to affordable and long-term health services of good quality, especially primary care [7].

The WHO has adopted some basic guidelines that should govern health systems internationally with the aim of increasing equity and efficiency of services. These guidelines (Charter of Ljubljana) state that health systems must:

- To be guided by the values of human dignity, equality, solidarity and professional ethics.
- Be people-centered, enabling individuals to influence health services and take ownership of health issues.
- To focus on quality without ignoring the cost-result relationship.
- To rely on sustainable financing.
- To provide universal coverage and equal access
- To be oriented towards primary health care [8].

The European Union adopted these guidelines in 1996, but until 2007 they could not be fully implemented by most member states. However, efforts are being made to achieve these goals. Article 152 of the Treaty of Amsterdam states that 'the need for a high level of health protection should be considered in the planning and implementation of all actions and policies of the European Union'.

The Treaty of Nice in 2000, with the adoption of the Charter of Fundamental Rights, included the protection of health as one of the basic components of solidarity, i.e., as one of the six fundamental rights. In particular, it states that everyone is entitled to access to prevention and medical care, in accordance with the conditions of national laws and practices [9].

Health Services

Definition

A health service is either a procedure performed on a person for the prevention, diagnosis and treatment of a disease or a company or organization that provides these methods, distributes medicines or medical services. Any act aimed at the prevention, treatment and management of disease and the maintenance of physical or mental health and offered by health professionals is considered a health service.

These services can occur in a variety of work settings such as hospitals, clinics, dental offices, outpatient clinics, maternity wards, emergency clinics, home health services and paramedic centers [10].

Classification

In each health system, health services are classified into different categories, depending on the work they produce. In recent years,

with the development of prevention and more general medico-social care, in the context of new WHO strategies, classification into three categories has been established internationally: primary, secondary and tertiary [3].

Primary health care refers to services aimed at both the healthy and the sick population, aimed at prevention and care/treatment, and does not require hospitalization. It covers the local level and the services are provided by a general practitioner, from the health center or polyclinic [11].

Secondary includes hospital care provided by local, small or medium-sized hospitals where the main specialties (pathology, surgery, pediatrics, gynecology) and the main laboratories are usually located.

The secondary hospital usually covers a population of 50000-500000.

Tertiary includes hospital care provided by the largest of the large general hospitals. These include all the specialties and specialized departments that cover every need and make it possible to deal with any therapeutic problem. The tertiary level also includes university hospitals, which develop specialized educational and research activities, as well as special units such as breast centers, cardiac surgery centers, etc. [3].

Evaluation of Health Services

Evaluation of health services is considered an integral part of the planning, organization and management of any health service or system. By evaluating a health service, it is possible to identify any deficiencies or problems of the service and to address them. It also becomes possible to modify the operation of the service in the direction of achieving its predetermined goals and the introduction of new applications and practices in its operation.

The end result is the improvement of the health services provided and the rational distribution of human and financial resources. The basic evaluation criteria of health services and systems are equity, effectiveness and efficiency [12].

Equality-Accessibility

The Commission of the European Communities (Brussels 2001) in the context of a coordinated strategy for the modernization of social protection set three long-term objectives to ensure a high and sustainable level of health protection:

- Ability to access
- Quality
- Sustainability [13]

Accessibility is a particularly important element of the first contact and is a condition of equality in care. Achieving equality and justice aims to treat citizens fairly, so that everyone is treated equally according to his/her needs and health problems.

According to the World Health Organization health equity means equal access to the available health service for the same needs, equal rights and equal opportunities for all. Equity is the perspective of equal access and use of health services to the same quality of care, regardless of social, economic, racial, cultural and other criteria. The concept of equality extends to other factors that affect health, eg living conditions. Thus, a real and objective criterion of equality is the annihilation of differences in health indicators, such as infant or maternal mortality, between different population groups.

Equality has two dimensions, horizontal and vertical. Horizontality is achieved through the equal distribution of resources and services as well as the equal access and use of health services by the entire population. Vertical equity recognizes the need to individualize the needs of the population, which leads to different consumption of health products and services depending on individual needs.

In all countries, depending on the historical and political situation, it is observed that equality in access and consumption of health services is improved thanks to small or large interventions carried out by the state. These interventions vary depending on the type of health system, social policy, economic system and emergency needs, but always aim to maximize the usefulness of health services for users. In health systems governed by the laws of the market, significant inequalities are observed in the consumption of health services with results of greater benefit to the stronger socio-economic classes. In order to combat this inequality, methods of measuring health inequalities are used. As expected, health inequalities are a challenge for health policy and their measurement is crucial for evaluating the effectiveness of interventions. The evaluation should be continuous and based on regular health surveys where basic mortality and morbidity indicators as well as socio-economic indicators are assessed.

Accessibility, directly related to the critical issue of health equity, is defined as 'the number of people or the percentage of a specific population expected to use a health facility or service' and is divided into categories. We distinguish between social, geographic and organizational access. In the first category are included the obstacles created by social, religious, economic and cultural barriers, in the second the obstacles created by the distance between residence and service and in the last category those related to the way the services are organized and the working relationships of the medical staff.

The concept of accessibility differs from the concept of adequacy and concerns the ability to access services provided, regardless of their final provision or not. Accessibility concerns the user while adequacy concerns the producer. When existing services are provided to the entire population then provision is identified with accessibility. End. accessibility can be measured while the concept of access is general and abstract [3].

Quality

The concept of quality is used as a criterion that expresses the degree of patient satisfaction but also as an overall performance criterion that includes effectiveness, efficiency, accessibility to health services, patient satisfaction, scientific excellence and safety of care procedures.

According to according to the World Health Organization, quality is the provision of diagnostic and therapeutic procedures capable of ensuring the best possible result with the least iatrogenic risk, as well as the maximum possible satisfaction of the patient in terms of procedures, results and human contact

[14]. Objective criteria for quality assessment are the standards, guidelines and protocols in which many countries fall behind. The provision of quality medical care is a common requirement of all Europeans and is a central goal of public health [13].

Effectiveness

The effectiveness of a service or a health system is defined as the degree of achievement of the goals set by their design and planning. These goals concern many fields. In particular, effectiveness refers to the objectives related to the health outcomes of the population [3].

Efficiency

Efficiency is a criterion for evaluating a service or a health system in relation to the resources (financial, material, human) provided and used and is directly linked to the financial viability of a health system. Maximum efficiency is achieved when the best possible quality or maximum possible quantity is provided at the lowest possible cost [3].

If we consider the aging of the population that has been taking place in recent years, the increased cost of medical technologies and methods and the migration crisis of recent years, we realize that the medical care systems in the EU and in the candidate, countries face a challenge: they must achieve at the same time the triple goal of everyone's access to care, high quality level and financial sustainability of the systems.

In order to achieve these goals, the cooperation of all actors in the health system is of fundamental importance, be it public authorities, health professionals, social protection and supplementary insurance organizations, or users or their representatives. However, the different and often divergent rationales of these actors often make this cooperation difficult [13].

Refugee Health Policy

Geneva Convention

The Geneva Convention on the Status of Refugees was signed in the city of the same name in Switzerland on July 28, 1951 and ratified by Greece with Decree Law 3989/1959. A few years later the Convention was supplemented by the Protocol of 1967, which was ratified by Greece with A.N. 389/1968 and expanded the mandate of the High Commission as the problem of displaced populations spread throughout the world. Article 1 of the Convention defines exactly who a refugee is. Is a person who is outside his country of origin or place of residence, has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a certain social group or because of political beliefs, and because of the fear of persecution is unable or unwilling to receive protection of that country or return to it. The convention excludes persons who have committed crimes against peace, war crimes, crimes against humanity or a serious non-political crime outside the country of asylum. Also, a soldier cannot receive asylum [15].

This convention is important because it defines a series of fundamental human rights which should be at least equal to the freedoms enjoyed by foreign nationals of a country or in some cases also nationals [16]. It also recognizes the international scope of refugee crises and the importance of international cooperation, including the joint participation of states in solving the problem. Host countries are primarily responsible for the protection of refugees. Countries that have signed the 1951 Convention are obliged to abide by its terms. The United Nations High Commissioner for Refugees (UNHCR) maintains an observer role throughout the process, intervening if necessary to ensure that genuine refugees are granted asylum and are not forced to return to countries where their lives are at risk. The organization helps either through voluntary repatriation to their countries of origin or through relocation to host countries or other third countries.

Greek Legislation

Greece, a country that exported immigrants in the previous century, in the last two decades has been a host country for immigrants from Africa, Asia and the Balkans. Especially since 2013 with the war in Syria and the refugee crisis that was created, the need for a structured management of migration flows became evident. Law 3907/2011 therefore established the Asylum Service, the first independent structure in Greece, responsible for examining requests for international protection, which began operating in June 2013. The same law also established the Refugee Authority, which examines appeals against decisions of the Asylum Service rejecting applications for international protection, as well as the Reception and Identification Service, through which a system of initial reception and recording of the details and needs of those entering Greece without the legal formalities, including persons who wish to seek asylum.

Today, the operation of all three services is mainly regulated by law 4375/2016 and 4636/2019 and they are under the auspices of the Ministry of Immigration and Asylum [17].

The UNHCR cooperates with the competent Greek authorities and provides its assistance, thus contributing to the formation and operation of the country's asylum system. Its funding is based almost exclusively on voluntary contributions from governments, the United Nations, intergovernmental institutions and the private sector, and which funding is received by the Greek State to cover basic needs such as protection, housing, medical care, education, etc.

Rights for the Social Integration of Refugees in Health

With the Treaty of Lisbon signed in December 2007 and specifically based on Article 63a, it is foreseen that the European Union develops a common immigration policy with the aim of effective immigration management, the fair treatment of third country nationals residing permanently in the member states as well as combating illegal immigration and human trafficking [18]. Encouragement and support measures were also established which are referred to as European Policy Texts and include the basic principles of EU integration policy as well as the main measures/actions to implement this integration policy and dedicated EU funding to promote access in health services for people born outside the EU [19].

At the same time and based on European policies, the government has established general rules for material reception conditions and medical care where it is stated that asylum seekers have the right to free access to Public Health Facilities and are entitled to nursing and medical care, including the necessary treatment for diseases and the necessary psychiatric care, where required [20].

The Commission of the European Union, wanting to provide refugees with equal access and information regarding their rights, cooperates with various agencies and finances corresponding programs of prevention, education and facilitating access to health services.

Ensuring that refugees and European citizens with a refugee background can participate and contribute is key to the future prosperity and cohesion of European societies. Successful integration can contribute to and address many challenges facing society today [19].

Problems in the Integration of Refugees in Health

As mentioned, for Europeans, access to medical care is a fundamental right, essential to human dignity, which must be guaranteed for all.

Access to health care and the provision of adequate replacement income are key goals of social security systems.

However, we observe that in all countries the overall state of health of individuals is linked to their social status, sometimes significantly, according to mortality data. This situation expresses an income deficiency that leads some people to limit the consumption of health care services, especially when a significant part of the cost is borne by the patients, for example, dental care, or when the health care system provides for the payment of costs by the patient and subsequently their reimbursement. However, it also reflects many other factors, such as living and housing conditions, quality of work, educational level and lifestyle and diet. Therefore, the challenges that lie in the access of disadvantaged groups and individuals to care, but also in the relations between the medical care system and other bodies fighting exclusion, are included among the "common objectives" for combating social exclusion set in the European Council of Nice and include immigrants/refugees.

The joint evaluation report of national action plans for social inclusion describes three broad categories of measures in this area:

- The development of prevention and training in health matters
- The improvement of access to care, with the enhanced provision of coverage, up to the provision of free care but also with better coordination between social and health services
- The implementation of measures aimed at the least favored groups [21].

Refugees are more likely to face unmet medical needs due to factors such as: lack of access or insufficient health security depending on the place of residence, lack of knowledge on how to approach services, economic factors, population living in areas with reduced access to quality health services, language barriers and lack of adaptation of national systems to the special needs of refugees.

Inadequate access to health services is a major barrier to the integration and inclusion of refugees which affects all aspects of life such as work and education. The barriers they face are continuous and include administrative barriers, long waits to receive services, fear of discrimination and prejudice, lack of proximity and information about the health system, and language or cross-cultural barriers.

Mental health is critical to the integration of refugees, who are more likely to develop mental illness and have greater access to mental health services due to the trauma they experienced in their country of origin and difficulties they faced on the refugee journey or in the country reception such as discrimination and isolation [19].

So, based on the previous, refugees have been recognized as a vulnerable group. But there is heterogeneity in the extent to which they are vulnerable to inadequate health care. Factors influencing vulnerability are socio-economic status, English language level, local political tactics, place of residence, marginalization as well as special status such as children, patients or pregnant women [22].

Recently, UNHCR highlighted that one of the most vulnerable groups in need of assistance, coordination and effective actions are all migrant and refugee women, emphasizing pregnant and lactating women as well as adolescent girls who marry early and may bear newborns with them [23].

Perinatal Health of Refugees

Perinatal Health

Perinatal health is the health of women during pregnancy, childbirth and delivery [24]. Perinatal health should prevent mortality and improve women's health. To do this, multiple actions are required. Healthy pregnancies include good nutrition of the woman, no infectious agents and are under treatment in case of chronic diseases. An obstetric emergency, of course, can also happen to a healthy pregnant woman. Its management means access to the affected woman. Obstetric services should include the ability to cross-fertilize and administer blood, perform caesarean sections in case of labor complications, administer antibiotics for infections, and manage preeclampsia and eclampsia. Antenatal care should improve the health of pregnant women and prepare them and their careers for emergencies. Pregnancy care is related to proper nutrition, monitoring of hemoglobin and trace elements levels, desired weight and treatment for communicable diseases. Postnatal care can be improved by aseptic procedures and good labor management. Facilities should include an operating room, anesthesia facility, blood and other intravenous fluids and drugs. Accessible care means distinguishing what has been problematic and reporting the short- and long-term consequences and assessing the causes considering the social structure, the environment, the health system or the hospital. The intervention goals must be clearly defined as well as the possible outcome [25].

Health promotion throughout pregnancy, labor and delivery is also vital. This includes proper nutrition, disease detection and prevention, ensuring access to reproductive health and supporting women who may be experiencing intense spousal violence [24].

In an ideal perinatal health system, all women would have access to medical care without restrictions and in partnership with financial, behavioral and social support.

A woman's health and well-being before pregnancy is critical to achieving a safe outcome for both her and her newborn. Access to health is essential during this time as it allows health provid-

ers to identify, treat and stabilize chronic conditions, recommend healthy behaviors and routines, and organize a healthy and desirable pregnancy. During pregnancy, women's needs for access to obstetrical health services increase. Prenatal care can reduce the risk of pregnancy complications for both mother and child. Postpartum women must take care to gain or regain their well-being.

At each stage of the care continuum, women in non-urban communities, face challenges and
barriers [26].

Inadequate access to obstetric health services can contribute to a host of negative outcomes including preterm birth, low birth weight, maternal mortality, severe maternal morbidity and increase the risk for postpartum depression. Poor or absent prenatal care may contribute to these outcomes [24].

Perirental Health and Refugees

Access to health as we said is a complex problem and includes the adequacy or availability of services, physical access and acceptability of services.

Social factors such as income, education, housing, food, transportation and social support are widely referred to as the social determinants of health and directly affect health, functioning and quality of life.

Refugees, as one of the most socially vulnerable groups, face additional obstacles such as inability to pay for services, uncertainty of where to go and for their transport, language barriers and lack of motivation to seek medical care. An additional problem is that refugees mostly reside in accommodation facilities located outside urban boundaries. Also, in the specific population and especially in women, reduced access to health services and worse obstetric outcomes have been observed. Fewer prenatal visits have also been observed. For these women, the absence of health insurance and reduced access to health services throughout the twenty-four hours, as well as the lack of social services, reduces the chances of receiving the necessary perinatal care during pregnancy.

Reduced access to high-quality obstetric health services in non-urban areas is the result of many factors such as the closure of gynecological and obstetric clinics, job cuts and other factors influenced by current social policy. These result in inequalities for rural women and their babies and a host of negative health outcomes as previously reported such as preterm birth and maternal mortality [29]. In both urban and rural areas there are persistent disparities in perinatal health including prenatal care, maternal mortality, and morbidity by race, ethnicity, and socioeconomic status. In addition to these parameters, it has been shown that women with a low educational level, illiteracy, unwanted pregnancies and lack of transport have been linked to a delayed start to their prenatal appointments.

Refugee women face additional challenges due to often lower language skills in the host country, weaker social networks and greater childcare and family responsibilities [26].

The WHO recommends at least 8 prenatal contacts with the respective health professional. The prenatal visit is key to detecting intrauterine growth retardation, detecting and managing preeclampsia, and detecting congenital or chromosomal abnormalities. Refugee women have a reduced attendance at obstetrical health services as reported by the WHO compared to the general population [27].

Also, research in the Greek area showed that refugee women are more likely to experience postpartum depression than Greek women, as well as that the quality and satisfaction with health care positively affects the lives of these women at various levels. The communication of these women with healthcare professionals has been shown to be the key to the satisfaction of the former [28].

Stronger actions are needed to strengthen the integration of refugee women. The impact of the COVID-19 pandemic on refugees has highlighted the need to intensify actions to facilitate their access to health services.

Research Part

Purpose

The present work studies the accessibility of the refugee population of the Philippiada Community Hospital to obstetrical health services. Accessibility as a term describes the equality which is also one of the evaluation criteria of health services between effectiveness and efficiency, as analyzed earlier. The purpose of this research is therefore to draw conclusions that will help in the evaluation of health services with the ultimate goals of identifying service deficiencies, introducing new applications and practices and improving the health services provided both for refugees residing in Greece, as well as and for the health system itself. The social and political issues raised by the present study are also highlighted.

Methodology

Research in health services is therefore mainly done to improve the services themselves. However, the emphasis placed on quantitative data in research places limitations on the subject of the research itself. The research was chosen to be qualitative, where individuals and phenomena in their natural environment are studied. The contribution of qualitative research to health services concerns two dimensions. The interpretation of the subjects' experiences and the cultural, historical and political conditions that influence the nature and provision of services.

Qualitative research is advantageous as it is considered to highlight many problematic issues without biasing the results of the researcher [3]. As an observational study, it is characterized as participatory as the research team participated in the activities being studied, trying to facilitate women's access to obstetric services.

The type of research chosen adds an anthropological perspective to the present study.

Disadvantages of Research

The main drawback of the research is that the results concern the residents of the specific Refugee and Migrant Center and while it is considered that generalization can be made within the certain living space, the generalization of the results for refugee women living in Greece is generally considered difficult and inappro-

priate if it is not combined with other data from other surveys concerning the same content.

Also, the answers to the questions may have been influenced by the social content of the contact between the researcher and the subjects.

Population's Sample

The research took place at the Refugee and Immigrant Reception Center from July 2020 to July 2021. Communication was done through certified cultural interpreters of the service/organization in two languages: Arabic and Farsi. The Arabic speaking population sample was 15 women of origin from Syria, Palestine and Iraq while the Farsi-speaking population sample was 18 women from Afghanistan. All the women belonged to the age group from 20 to 40 years old. 20.5% were primiparous, 14.7% of them were second-parous, 44.1% third-parous, 8.8% fourth-parous, 8.8% fifth-parous while there was also a sixth-parous (3%) They were also all women who had no accompanying medical problems at the onset of pregnancy.

The Resources Required

No resources were required to conduct the research.

Consent of Persons

All survey participants were informed that the survey is voluntary and that they are not obligated to participate for any reason. They were assured that they are not threatened or endangered in any way or for any reason by their participation in the research. They were also informed that they could terminate their participation in the study, either temporarily or completely, at any time they wished. Finally, they were assured that the survey was anonymous and that no personal information of any kind would be published.

Data Collection

The data collection method was structured interviews that included eleven questions, categorized according to the type of accessibility being studied (social, geographic and organizational).

Interviews in qualitative research provide the opportunity to study the patient's point of view and his attitude towards the research object. Questions 1, 2, 4, 7, 10, 11 falls under the first category of social access considering social, economic and cultural/religious barriers. Questions 3, 5, 9 falls under the category of geographical access and the distance between service and home, while questions 6, 8, 9 falls under the category of organizational access, i.e., the barriers faced by women due to the way services and work are organized staff relations. Questions often include all three categories without clear dividing lines between them.

The results of the interviews were audio recorded and transcribed.

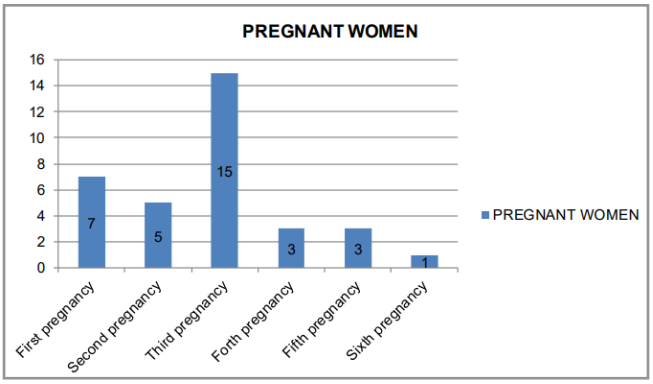
Interview Questions

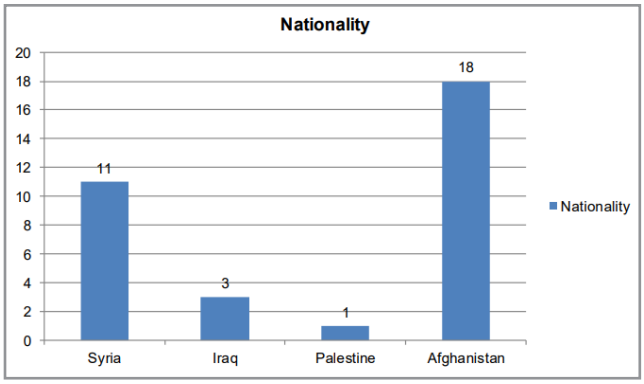
1. Did you choose a private or public maternity hospital?
2. What criteria were used to make your selection?
3. How often did you visit the hospital?
4. Do you think you need to see your doctor more often?
5. Have you ever faced any problem during your transfer to the hospital? If so, what kind?
6. Have you ever had a problem with any services you used?
7. Do you think you were treated differently because of your country of origin?
8. What bureaucratic problems did you face? What were the causes?
9. How easy was the induction process? What problems were encountered?
10. How receptive were health professionals to helping you with post-pregnancy counseling and support?
11. What would you like to change in the system to make the hospital more affordable?

The questions can be answered in any way the respondent wishes, who can answer either one word at a time or expand his answer as much as he likes on details that seem important to him and are worded in as simple and understandable a way as possible.

Results

Population Sample



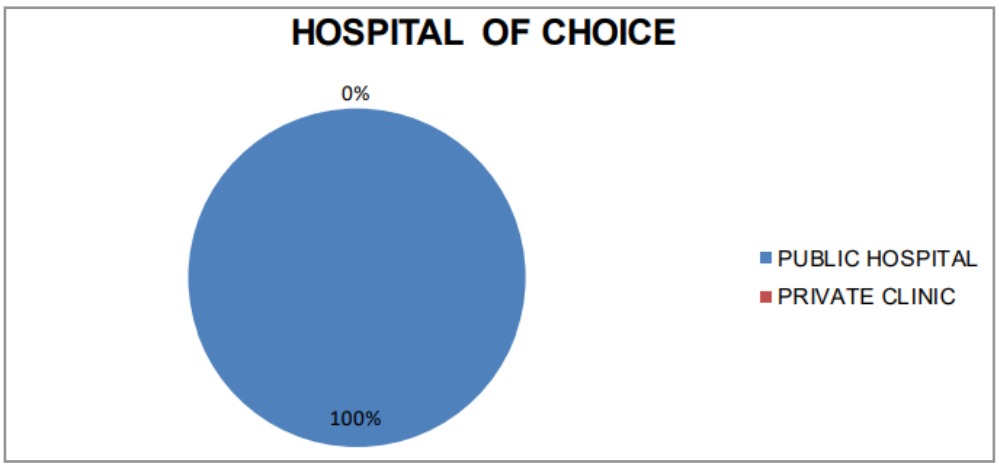


All the women belonged to the age group of 20 to 40 years.

The Choice of Hospital

One of the most important questions respondents are asked to answer is whether they chose a private or public hospital and why. All women who participated in the survey chose a public hospital.

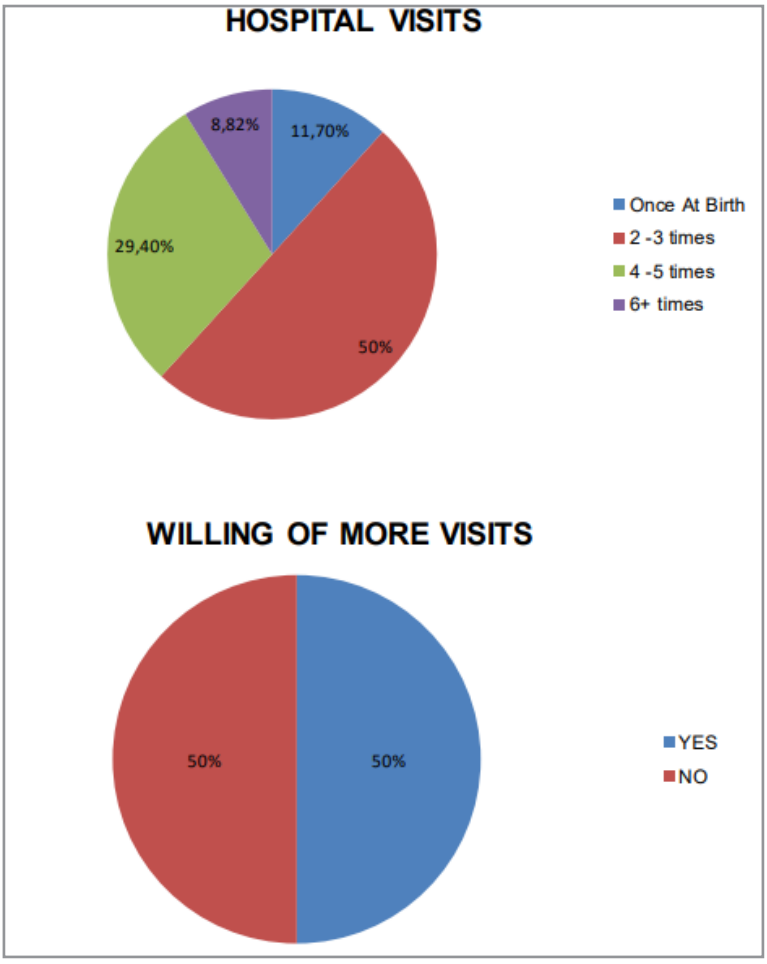
This was an option that was overwhelmingly economical (100%). Most women said they could not afford the cost of a private hospital. Several felt they had no choice because they were refugees. Therefore, choosing a public hospital was a forced choice for all of them.



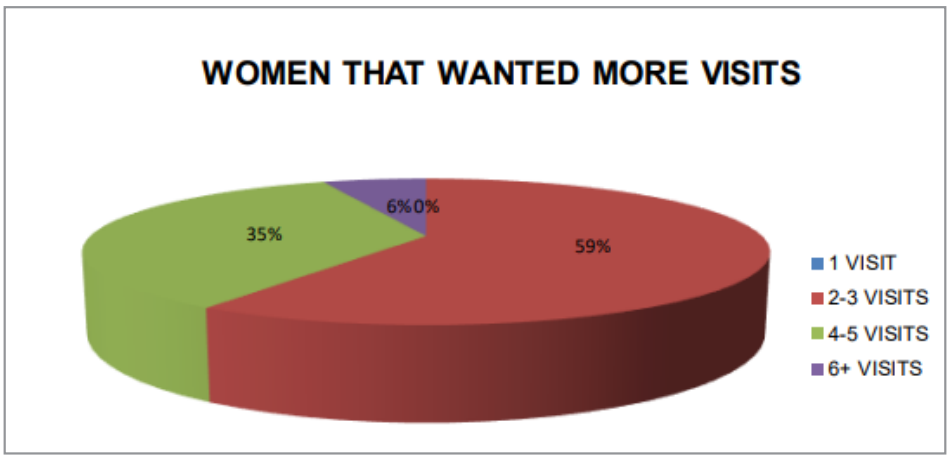
The Frequency of Visits

In this question, women were asked how many times they had visited the doctor before giving birth and whether they needed more visits.

At this point it appears that there was no system by which they visited the doctor. Each respondent visited the doctor with a different frequency than the others. Responses ranged from once and that was at birth, to once a month.



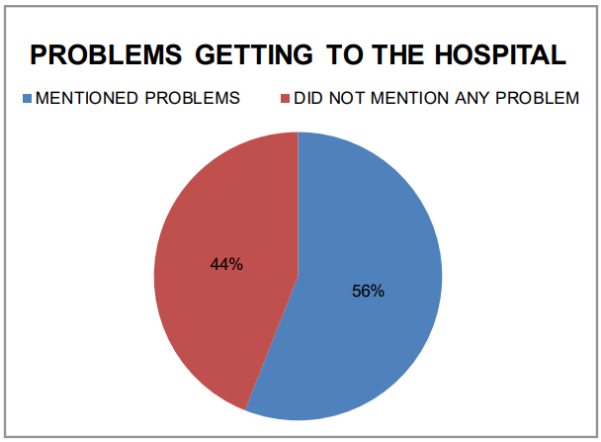
Half of the women reported not needing more visits than they needed. The other half think they wanted to make more hospital visits but couldn't. In these cases, the women mention as the main reason they wanted to see the doctor again the anxiety they felt and discomfort or complications caused by the pregnancy. It was observed that the 17 women who reported the need for more visits already belonged to the groups of visits 2-3 times (59%), 3-5 times (35%) during pregnancy and 1 of them had visited the hospital more than 6 times. (6%).



The most common deterrent cited as a barrier to more frequent visits was difficulty of movement and communication as well as other parameters such as situation of the pandemic and what will leave the rest of the children.

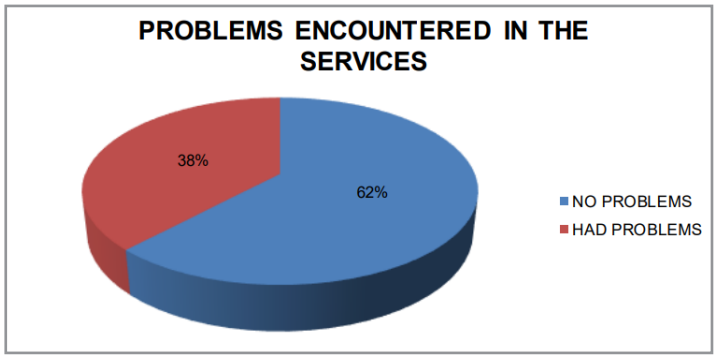
Problems on the Way to the Hospital

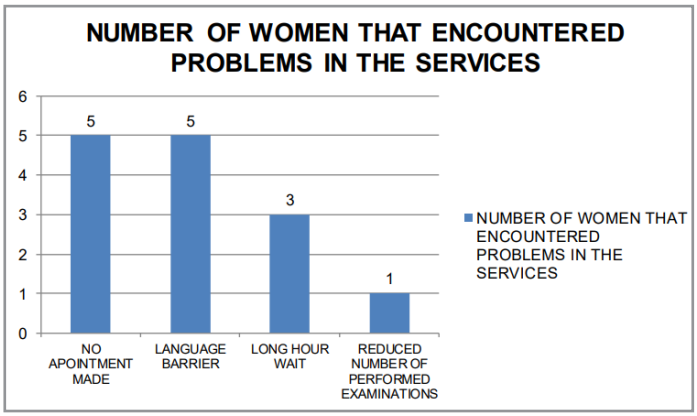
44% of the women surveyed said they had no problem going to the hospital. The problems that most faced were related to difficulties in transportation and its cost. They reported that the bus did not always serve at the expected times, the inability to communicate with the driver, the cold, the financial and physical strain, the long wait. The general difficulty they faced with commuting appeared to these women as a nuisance.



Problems Encountered in the Services

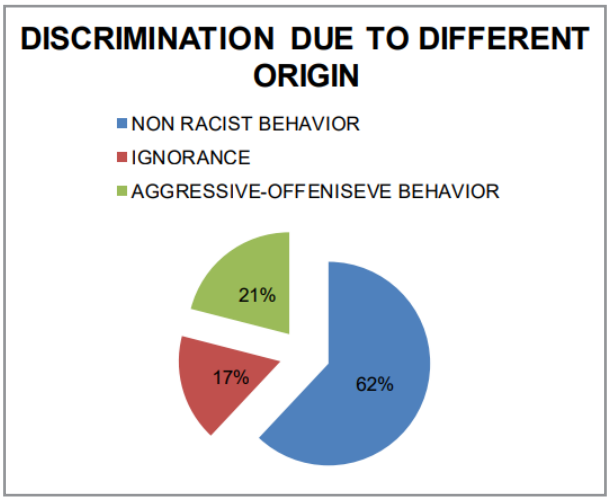
The largest percentage (62%) declares that they did not face any problems. A smaller percentage (38%) who faced some problems initially mentions the difficulty in communication as the most important problem but also the non-fulfillment of appointments due to workload and pandemic. A smaller percentage mentions followed by the tedious waiting and the reduced number of examinations.





Dealing with Disqualification Due to Different Origins

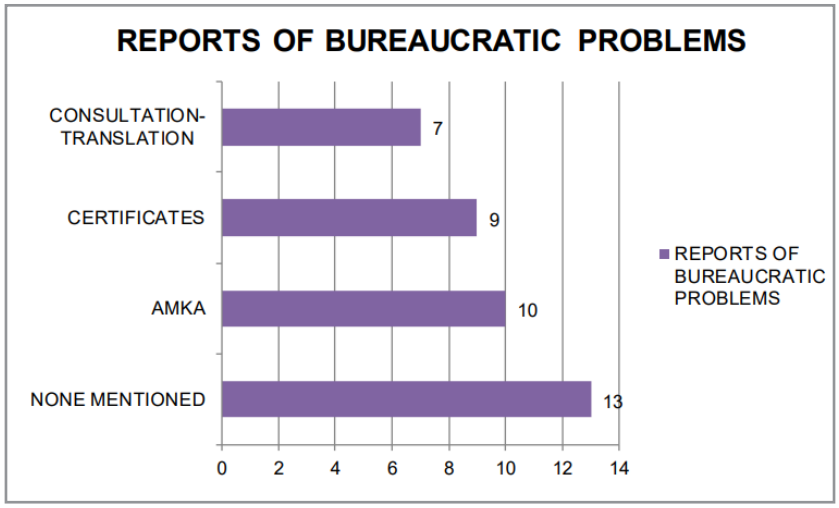
A large percentage (62%) considers that they did not encounter racist behavior. However, some women report aggressive or offensive behavior from doctors and nurses (21%). Some women also report that there was indifference towards them and consider that an important problem in this direction was the impossibility of proper communication and the fact that they were refugees (17%).



It was observed that 76% of women who reported no service problems also reported no staff behavior problems in contrast to 62% of women who reported service problems and received racist or indifferent behavior.

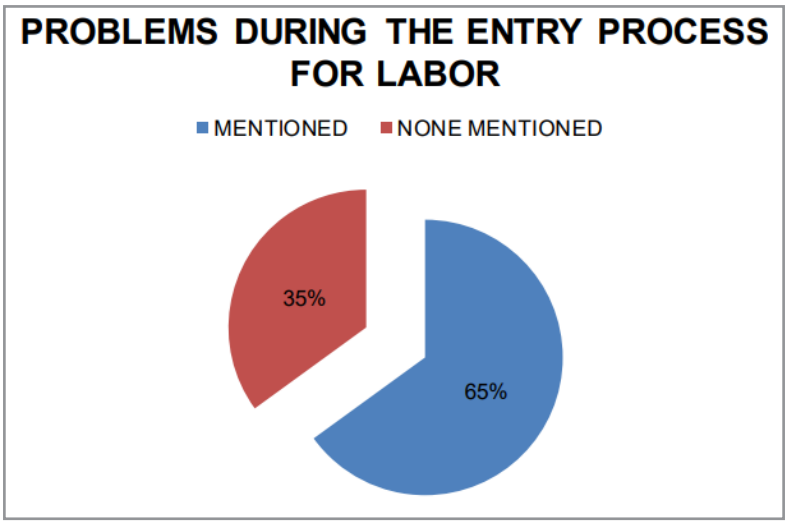
Dealing with Bureaucratic Problems

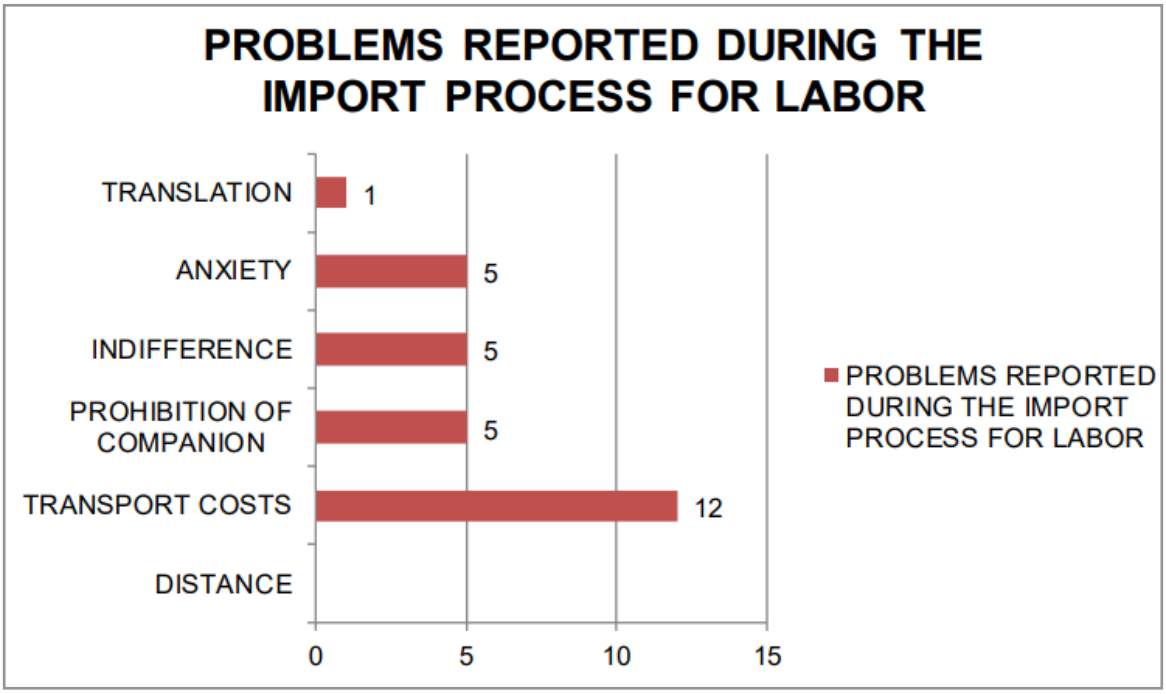
Overall, women faced various problems of a bureaucratic nature. About 30% of them had problems with their social security number and prescription. 26% stated that their marriage certificates were invalid because they were not officially translated creating problems in identifying children. They also mentioned the registration numbers and marital status certificates among the documents that caused them various bureaucratic problems. While 20% of women again mention the issue of communication as a key problem.



The Induction Process for Childbirth

To the very important question about the admission procedure for childbirth and the problems they encountered in this particular case, the minority of respondents answered that they did not encounter any problems (35%). 65%, i.e. 22 women, reported various problems that were not related to the childbirth process, but to other practical problems.



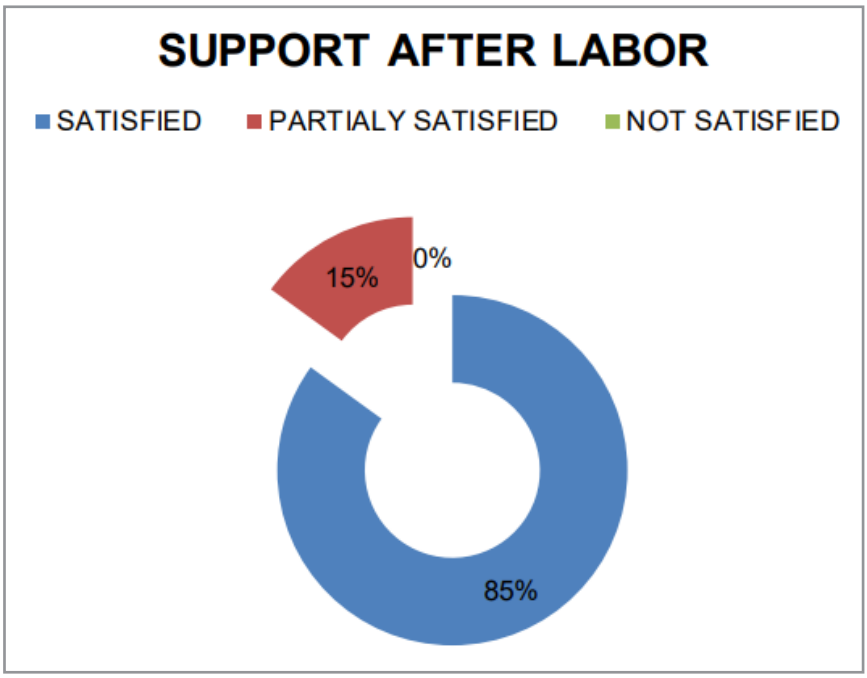


Most of the women had to move to another city to give birth because of the bureaucratic problem that arose regarding the identification of her child. Many of them reported that the hospital was relatively far away and this created problems with their transportation on that particular day, such as anxiety about whether they would arrive on time, whether there would be a way of transportation, and the cost of transportation. Another five women mentioned the fact that they faced many difficulties on that particular day because they were alone due to the pandemic but also in terms of communication when they finally arrived at the hospital because while they wanted to ask and say things they could not be understood by the staff.

Counseling and Support After Pregnancy

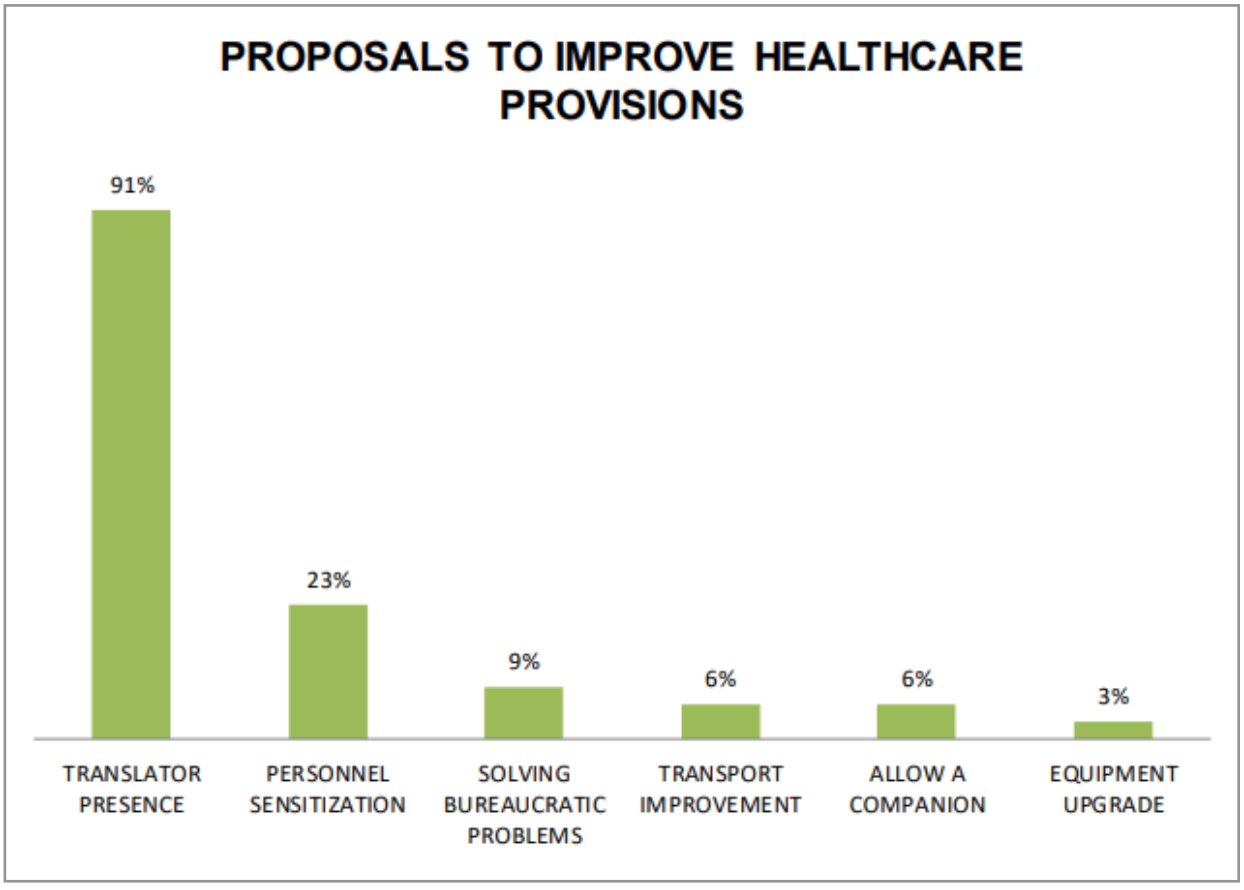
On the issue of postpartum counseling and support, only two women make a negative comment. One says that various things she was told were not right for her, while the second reports rude behavior from clinic staff. Two more women report that staff were willing to help but had little time.

All other women comment very positively on both the counseling and support they received after pregnancy. They report that they were helped by the experts who explained many things to them and many of them report that they had a lot of help.



Suggestions for Improvement

The largest percentage of respondents recognizes communication as the biggest obstacle and emphasizes the need to have a translator in every health service. Refugees also requested that staff be more informed and aware of their population and that the state ensure that the social security number works and that there is a common policy on the issue of document recognition. Some also highlighted the issue of improving transportation so that they have direct access to the hospital and are provided with the possibility of being accompanied by a familiar person. Finally, a woman emphasized the need to equip hospitals with new medical equipment.



Conclusions

One of the very important issues related to pregnancy, namely the choice of the maternity hospital, is an issue in which immigrants have no choice. The survey shows that the absolute majority cannot cope with the demands of a private maternity hospital and therefore prefer the public option.

The World Health Organization recommends a minimum of 8 visits to reduce perinatal mortality and morbidity [34]. From the present research, it is clear that most refugee women do not follow the standard obstetric follow-up and do not make the required number of obstetric visits. Their answers vary from a single visit to complete childbirth to once a month, which proves that they do not follow a follow-up pattern but they visit the doctor only when they feel discomfort or if something worries them. Exactly half did not think they should go more times to the doctor and this percentage is identical to the women who had fewer visits while the other half who wanted to see the doctor more often had already made more visits relative to the rest. In conclusion, it seems that women who make more visits experience stress or have health problems and want even closer monitoring.

However, it was not easy for them to go to the doctor as often as they would like because of their financial situation, the difficulty they faced with transportation, the ignorance of the routes, the inability to communicate with the bus driver, the prevalence of bad weather conditions, the fear of the pandemic and other social problems such as where they would leave their children. Regarding the provision of health services, most women state that they are satisfied with the quality of the services they received. A very important thing reported by those who say they experienced problems was fatigue due to the waiting time in some cases when they visited the hospital. The problem of communication with staff is a problem that is often mentioned in various situations as well as in the issue of service delivery.

Based on staff behavior the majority of respondents have not experienced any kind of racist behavior related to their origin. However, isolated incidents of rude behavior by a nurse are reported, as well as the case where a doctor yelled at them. In a few cases, they name certain healthcare professionals who are indifferent to them and believe that this attitude is due to the fact that they come from a foreign country.

Also, refugee women who arrived at the hospital faced a number of bureaucratic problems related to marital status certificates, Social Security Number and marriage certificates. The number of documents they brought were not translated into Greek and there was no institutional framework to offer them the possibility of translating official documents. The result was that the documents were not recognized by the Greek Public Health System and the parents could not recognize the children. them. The major problem arising from the precarious operation of the Social Security Number was the inability to prescribe.

Additionally, regarding the issue of admission for childbirth, the vast majority state that they did not face any serious problems. All the women state that they did not face any problems due to the birthing process. Some problems faced by some of them were related to the difficulty of getting to the hospital, the cost of transportation, but also to the fact that they had to go to the hospital alone, without someone familiar to them, which is stressful for them and also for the prevents them from communicating effectively.

All women had significant help after childbirth and are very satisfied to a very large extent. The only two women who recorded a negative comment referred to certain details explained to them by the staff which they felt were incorrect, and the fact, as the second woman states, that some people did not behave properly.

Discussion - Suggestions

As can be seen from the above, the most important problems regarding the accessibility of refugee women to health services are linguistic, geographical, cultural and bureaucratic. In terms of geographical barriers and the movement of refugees, accommodation facilities must provide continuous care for all patients and be able to provide transport if needed especially for obstetric and other emergencies. The transfer of pregnant and lactating women between different health units, when deemed necessary, is an important part of rural medicine and an integrated perinatal health system. The cooperating hospitals and other health structures must accept these movements and the obstetric care system of each region must support the needs of each place and time. It is necessary to take the necessary measures in order to provide satisfactory obstetric care within the geographical borders of the region without presenting the need to change the place with the effects this brings to the recipients of health services. It is certain that an extensive study of the conditions and obtaining information about each refugee structure is needed in order to build an action plan that will offer direct access to the appropriate health structure for each patient and each pregnant woman. In this effort, the study of other health systems that have treated similar population groups and the adoption of successful practices and tools with the aim of optimal perinatal care of refugees and the prevention of maternal and neonatal mortality and morbidity is also considered useful [29]. The women themselves should be informed by the health professionals about the value of prevention and the necessary obstetric follow-up, so that they do not visit the doctor only in case of discomfort or discomfort, as can be seen from this research.

Regarding cultural barriers, since culture is largely "unconscious" and strongly influences health and illness, health care providers must recognize, respect, and respond to the cultural beliefs and practices of the people they serve. Health care personnel who understand people's cultural values and beliefs are better able to share and provide culturally acceptable care.

Therefore, the modern social reality, the impact of culture and civilization on daily life and the need to provide effective and quality health care to the population make it necessary for health professionals to adapt to today's multicultural society. A key element for the adaptation of health professionals to the multicultural environment is cultural competence. This term describes the health worker's ability to respond to the needs of populations and individuals who may have a culture or cultural context different from the dominant one. When it comes to caring for vulnerable refugee women, a holistic approach needs to be adopted that considers the wider context and experiences of women in countries of origin, in travel and in their current living space and how these experiences may have affected their physical and

their mental health. It is therefore important for the health professional to build a relationship of trust and to explain how the procedures take place in the country of residence as they may differ from the procedures in the place of origin. It is also noted that continuity of care is very important for vulnerable refugee women.

The health worker should:

- To respect the different language, values and customs of a social group.
- To know the key points of the person's cultural context and to be willing to explore the beliefs and prejudices that distinguish them.
- Integrate the person's culture into the delivery of care and be open to different ways of integrating the patient into their treatment.
- To develop and implement personalized practices adapted to the socio-cultural environment of each individual.
- To have social skills such as patience, lack of selfishness and rejection, respect, willingness to change and learn [31]

The literature shows that women's quality of life is affected by satisfaction with health services and the quality of care. With this in mind all healthcare professionals who provide care must be informed and aware and detect at an early-stage, women whose psychological health is vulnerable. In this way they can develop interventions to promote mental health in the perinatal period and refer them to a specialist. This can be achieved through training programs both in the workplace (hospital, health center, etc.) and through their basic training.

From the above it becomes clear that the purpose of education should be to prepare students of medicine, nursing and other health professions for the development of intercultural competence, i.e. the ability to function effectively within the context of a specific culture. This requires adapting their curriculum, which should include the principles and theories of intercultural medicine and nursing. Therefore, students should be adequately prepared in order to acquire the ability to provide holistic care to individuals from different cultural groups. At the same time, they must assume that it is extremely important to respect and accept the different beliefs of individuals from different cultures, even if these may not be compatible with their own [32].

In terms of bureaucratic barriers, women also seem to have faced a number of problems related to marital status certificates, Social Security Number, prescription drugs and inability to understand procedures.

The main demand for them is to have a translator in every hospital and health structure that asks for help. An important if not the most important issue that emerges from the literature and is confirmed by the research is the urgent need to provide interpretation services in the health system [33]. Overcoming language barriers is a necessary step in managing health problems. A study by Vinder et all (2012) highlighted the importance of cultural compatibility between the translator and the refugee woman. Trust, commitment to care, and disclosure of sensitive issues are improved when the caregiver understands the woman's cultural background, including health and mental health issues. This understanding comes through training but also through essential discussion with the woman with respect for her and her preferences regarding the proposed methods.

Although the behavior of the staff plays a large role in women's satisfaction with health care, the problems that arise with the shortage of translators in hospitals, Social Security Number, translations of certificates or recognitions of children, and financial problems are issues that do not directly affect health professionals but the entire state mechanism that, although there are guidelines from International and European Conferences, many times the services of the Ministry of Immigration seem to be under-functioning, exhibiting long delays or not preventing situations, thus creating large issues in the daily lives of refugee women. An example is the Social Security Registration Number, which although in theory every refugee residing in the reception centers is entitled to have in order to be given medicines and to have easy access to hospitals, many times it is not recognized by the system, with the result that they either pay for the medicines or not be able to get them if they are prescription only. Regarding the identification of the children, many times the refugees had lost their family status certificates during the journey and the hospitals without it registered the child in the name of the mother, creating a problem in the asylum process and long legal procedures for the identification of the father. The translation of the certificates is not planned to be done by some service, costing dearly to the already financially burdened refugees. In addition, each refugee is entitled to a certain amount of monthly living allowance, which has long delays or may be cut off due to bureaucratic omissions. It is therefore required of the Ministry and its mechanisms to address the obstacles in order for the already established mechanisms to operate in an organized manner without delays and deficiencies as well as to establish new interventions that cover the geographical and linguistic needs of the population. Cooperation between the Ministry of Immigration and the Ministry of Health is needed. The responsible bodies must therefore do their utmost to minimize these malfunctions with the aim of providing refugees with equal access to overall health and obstetric services.

Acknowledgments

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ANNEX

Interview 1: RT

1. Public.
2. Because we don't have enough money to pay for private.
3. 1 time in 3 months.
4. No. It was ok.
5. Every time I had to go to the hospital, I felt weak.
6. No .
7. Yes. Sometimes they didn't care about me and my pain.
8. No. I didn't have any big problem.
9. It was ok.
10. They treated me very well.
11. I wish every hospital had a translator because communication was very difficult.

Interview 2.ZS

1. Public.
2. Because of money and because I am a refugee.
3. I visited the hospital when I found out I was pregnant and after five months again because I had high blood pressure and diabetes where I stayed for two weeks as well as the last month of pregnancy.
4. Yes, I think I should have seen him more often for various health problems I had.
5. Yes. There was the problem of translation and my limbs felt frozen.
6. No, I didn't have a problem.
7. Some of the doctors were not interested in us because we were refugees.
8. When we entered the hospital, we could not understand anything.

9. The problem of the distance, the cost of transportation, the company because due to COVID I was alone and the behavior of the nurse.
10. It was ok.
11. To be a translator in every hospital we go to.

Interview 3: BH

1. Public.
2. Cost and because I am a refugee.
3. In nine months, I went twice.
4. No .
5. I didn't have any problem.
6. I had no problem.
7. No, I don't think so.
8. I didn't face any problems.
9. There was the problem of the distance and the cost of transportation, they refused to accept me and sent me to another hospital I don't know why.
10. They helped me a lot.
11. I hope the doctors care more about us and that there is a translator in every hospital.

Interview 4.HH

1. Public.
2. Because of cost and because I am a refugee.
3. During my pregnancy I went twice.
4. No .
5. I had no .
6. I had no .
7. No .
8. I had no problem.
9. I had the distance, the cost and the doctors were not interested in us.
10. It was ok.
11. There should be a translator in every hospital.

Interview 5: SB

1. Public .
2. Because of money.
3. In nine months, I went four or five times.
4. Yes.
5. There was a problem with the cost and the translation.
6. I didn't have any problem.
7. No .
8. Yes. The marriage certificate was not recognized because it was not translated to register my child.
9. There was the problem of the cost of transportation.
10. They were very good and explained many things to me.
11. I would like there to be a translator and to be accepted more in the hospital because we might go and be kicked out.

Interview 6: MA

1. Public .
2. Because I had no money.
3. I went once when I wasn't feeling well and when I gave birth.
4. Yes, but due to COVID it was difficult.
5. I had a problem with moving.
6. No .
7. No .
8. With the child's statement and with AMKA because he was not working.
9. I had no problem.
10. It was ok.
11. I wish every hospital we go to had a translator so that we could understand more and that AMKA was working because now for months we couldn't write medicines or take them.

Interview 7: FS

1. Public .
2. The money .
3. Not very often .
4. Yes.
5. The hospital did not have good access to the place where I lived and the public transport.
6. No .
7. No .
8. Problem with AMKA and papers.
9. I was very anxious but after I arrived everything was fine.
10. They treated me very well and gave me a lot of information that I didn't know.
11. I would like a translator and a better connection between the hospital and where I live.

Interview 8:SS

1. Public.
2. The money .
3. About once every two months for a check and for problems that have occurred
4. Yes, because I didn't feel well often.
5. I could not agree on the stops and where to get off.
6. Sometimes we went to the hospital and waited and they turned us away because the doctor wasn't there or he couldn't make it or we didn't have a translator.
7. Yes. Sometimes the doctors were shouting and we didn't understand what they were saying or they didn't care about us, I don't know why. Some were very good.
8. I had no problem.
9. I had no problem.
10. They helped me, yes.
11. I wish there was a translator.

Interview 9: AH

1. Public.
2. For the money.
3. I went 3 times because I felt weak and had stomach pain and once when I went to give birth.
4. No .
5. Yes, the transportation to get back was expensive.
6. Sometimes they didn't serve us and we left.
7. Some were good some not interested.
8. I had a problem with the drugs.
9. Yes, I was worried about the distance if I would be able to go and how it would be.
10. I didn't have any problem.
11. I wish they would care more about us and accept the baby's name.

Interview 10:

1. Public .
2. Because I am a refugee and for the money.
3. When I went to give birth.
4. No .

5. No .
6. I didn't have any problem.
7. I didn't have any problem.
8. When we were in the hospital, we didn't understand anything.
9. Yes, the cost of transportation and the distance. Also, when I got there they didn't accept me and I turned back.
10. They were very helpful.
11. I would like to have a translator in every hospital and not be alone.

Interview 11:AS

1. Public .
2. For the money.
3. About once a month.
4. No .
5. Yes, because I didn't know where to go and how to explain to them sometimes. When you came along, I didn't have a problem.
6. No .
7. Accordingly.
8. I didn't have any problem.
9. I had the problem of transportation, if we didn't catch the bus and translation.
10. The girls were very helpful and explained many details to me.
11. I wanted there to be a translator in the hospital.

Interview 12: DK

1. Public .
2. Because of money.
3. I went when I went to give birth.
4. No .
5. I didn't have any problem.
6. No .
7. No .
8. I had a problem with AMKA and the translation.
9. I had no problem.
10. Everyone was fine and explained a lot to us.
11. I would like them to pay more attention to us because I felt that because we were refugees they didn't care that much.

Interview 13:FA

1. Public .
2. We had no choice.
3. I went 3-4 times to see if the baby is okay.
4. Yes, but due to COVID we couldn't.
5. Yes, sometimes we went for no reason and the doctor didn't see us.
6. Other than that, nothing else.
7. No .
8. Yes, the marriage certificate was not recognized.
9. I was worried if everything would go well, but there was no problem.
10. They were very good.
11. It would have been easier to go to the hospital.

Interview14: SA

1. Public .
2. Money.
3. 2-3 times during pregnancy.
4. Yes.
5. Transportation and cost.
6. Translation and coordination.
7. No .
8. AMKA was not recognized, agreement.
9. I had no problem.
10. Everyone was fine.
11. Translator.

Interview 15: DA

1. Public .
2. Money.
3. 1 time every 2 months approximately.
4. No .
5. No .
6. No .
7. I had no problem.
8. I had no problem.
9. I had no problem.
10. They helped me with everything I needed.
11. I would like every hospital to have a translator.

Interview 16: DK

1. Public .
2. Money, because I'm a refugee.
3. Not very often .
4. Yes.
5. Yes, transport, cost, distance, translation.
6. Translation.
7. Some doctors were not interested and shouted.
8. With the AMKA, the papers and the translation.
9. The cost of transportation and the distance because I had to go and give birth in Ioannina as the marriage certificate was not recognized in Arta and the child would be in my name-unrecognized.
10. They were very helpful.
11. There should be a translator in all hospitals.

Interview 17:WH

1. Public .
2. Money.
3. I went twice.
4. Yes.
5. No .
6. I didn't have any problem.
7. No .
8. Problem with the identification of the child - Marriage certificate.
9. The hospital was far away.
10. They give me a lot of information.
11. Have a translator.

Interview 18:HH

1. Public .
2. Money.
3. 2-3 times.
4. No .
5. Sometimes the cost of transportation.
6. No .
7. No .
8. Yes, with the translation of the marital status certificate.

9. No, I didn't have a problem.
10. They were very well behaved.
11. There should be a translator and they should care more about us.

Interview 19:RM

1. Public .
2. The private one was very expensive.
3. About once a month.
4. Yes, but due to COVID it was difficult.
5. The bus was tiring and it was cold.
6. No .
7. No .
8. At first, AMKA did not work and I paid for the medicines.
9. I didn't have any problem.
10. They were very good and I had no problems.
11. I would like to have a translator and not have a problem with papers.

Interview 20:MM

1. Public .
2. Money.
3. 1 time per quarter.
4. No .
5. No .
6. Sometimes we waited there all day.
7. I don't know, sometimes they didn't understand us. E.g. I was asking for a female gynecologist and they told us that it is not possible even if we don't want to leave.
8. I had no problem.
9. I had no problem.
10. They helped me a lot.
11. I would like a translator because communication was difficult.

Interview 21: ZK

1. Public .
2. Because we don't have money and papers.
3. 4 times.
4. No .
5. There was no taxi, we didn't understand the language on the bus.
6. Language was a barrier..
7. No, as in all, maybe with more care.
8. I had a problem with the TIN and AMKA.
9. I didn't have any problem.
10. When they had time, they explained to me what I wanted.
11. I would like to have a translator in the hospital who knows my language.

Interview 22: DK

1. Public .
2. Because we had no money, we were very difficult.
3. 1 time in the first trimester and 3-4 times towards the end.
4. Yes, because I felt weak and sick.
5. No, I didn't have a problem.
6. I had no problem.
7. Yes, many times I felt that they don't care about me.
8. I didn't have any big problem.
9. Yes, I had to go alone and when I arrived, I didn't understand anything.
10. All the girls were very nice, only one nurse was rude.
11. I would like every hospital we go to have a translator and good machines.

Interview 23:SS

1. Public .
2. Money.
3. 2 times .
4. No .
5. I had no problem.
6. No .
7. No .
8. I had no .
9. The cost of transportation was a problem.
10. Yes, I had no problem.
11. There should be a translator and we don't go and get kicked out.

Interview 24:PP

1. Public .
2. Money and because I am a refugee.
3. 3 times and 2 times I was hospitalized because I vomited.
4. I wanted to go often because I wasn't feeling well.
5. The cost of transportation.
6. Sometimes I went and they kicked me out.
7. Yes, some doctors didn't care because I'm a refugee.
8. It was very difficult to agree.
9. The stress, the money for the transport and the distance ..
10. Yes, they were very helpful.
11. I would like to have a translator.

Interview 25:MS

1. Public .
2. Money.
3. 2 times, 1 time at the beginning and 1 when I gave birth.
4. No .
5. When there was no bus, it was a problem.
6. No, I didn't have a problem.
7. No .
8. When we were in the hospital, we didn't understand anything.
9. I didn't have any serious problem.
10. Most of them yes. The behavior of some was not good.
11. Have a translator.

Interview 26:MB

1. Public .
2. Money.
3. Almost once a month.
4. No .
5. Usually, I didn't have a problem.
6. Sometimes I couldn't do the exams I wanted.
7. A nurse was very rude.
8. Problem with the AMKA and the family status certificate.
9. The cost of transportation.
10. Yes, they explained many things to me.
11. Every hospital should have a translator because now many times they didn't have one and they kicked us out.

Interview 27:AF

1. Public .
2. I had no other choice.
3. When I gave birth.
4. No, I didn't have a problem.
5. No, when I gave birth, I called EKAV.
6. No .
7. No .
8. I had no problem.
9. No, I didn't have a problem.
10. It was fine.
11. Have a translator who speaks my language.

Interview 28:KK

1. Public .
2. Money.
3. 1 time and 1 to give birth.
4. Yes, because I was worried if the baby is okay.
5. There was a problem with leaving my other children.
6. There was often a problem of communication.
7. Most were very kind.
8. I had a problem with the papers and how to write medicines.
9. I had a problem because I couldn't have anyone with me.
10. Yes, they were very helpful.
11. I wish they behaved better, explained more things to us and we could get along.

Interview 29:CW

1. Public .
2. Money.
3. 3-4 times because I wasn't feeling well.
4. Yes, because I felt weak.
5. When I was about to go, I felt dizzy and tired.
6. We had to wait for many hours and we were getting tired.
7. Yeah, I think they weren't that interested in my situation.
8. No, I didn't have a problem.
9. The hospital was far and I had no way to go.
10. I didn't have any problem.
11. I would like to have a translator and hospitals to accept us more.

Interview 30:AA

1. Public .
2. Because we are refugees and we don't have papers.
3. In 9 months, I went 4 times.
4. No, it was fine.
5. No .
6. No .
7. No, although sometimes we didn't get along.
8. I had no problems.
9. I didn't have a problem; I was just stressed.
10. Yes, although some of the things they said were wrong.
11. I would like there to be a better agreement because now we waited a long time and once the doctor was absent and they kicked us out.

Interview 31: WK

1. Public .
2. For the money.
3. I went 1 time because I vomited and then I went again because I had abdominal pain and weakness.
4. Yes, because I didn't feel well often.
5. Yes, many times we were very late at the hospital and the bus was leaving.
6. No .
7. No .
8. I didn't have any problem.
9. Yes, the cost of transportation and the distance.
10. They explained many things to me.
11. I would like to have a translator in every hospital.

Interview 32: AW

1. Public .
2. Because I had no other choice.
3. I went 1 time before I gave birth and 1 time when I gave birth.
4. Yes, but because of the pandemic I couldn't.
5. No .
6. They wouldn't accept me because of COVID.
7. No, it was fine.
8. I had a problem because I couldn't understand anything.
9. I was alone because of COVID.
10. Not when they had time to help me.
11. I wish I could have had an escort because I was alone in the hospital and the translator was not there every day.

Interview 33: LM

1. Public .
2. Because I had no money.
3. I went 3-4 times because I wanted to see the baby if he is ok.
4. Yes, but due to COVID it was not easy.
5. No .
6. No, but I waited many hours.
7. Sometimes I didn't understand anything and I was scared by their behavior.
8. The marriage certificate was not recognized so that I could recognize my child.
9. There was the problem of distance and cost of transportation.
10. No, I didn't have a problem.
11. Yes, I would like them to care more about us and to have a translator.

Interview 34:KL

1. Public .
2. Because I had no money.
3. I went when I was about to give birth.
4. No .
5. No .
6. No .
7. No, I didn't.
8. I didn't have any problem.
9. There was the problem that I was alone due to COVID.
10. It was ok.
11. Yes, I would like to have a translator in every hospital.

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