Preventive health care for refugee children in the Netherlands

A qualitative study to add refugees' perspectives

Chanine Brouwers

April 2019

Preventive health care for refugee children in the Netherlands

A qualitative study to add refugees' perspectives

Author

Chanine Brouwers (950524135080)

Supervisor

Dr. ir. H (Harro) Maat

Study

CPT-80836
MSc Health and Society
Wageningen University and Research

Cover photo

REUTERS/Sharif Karim (2013). Syrian refugee children play at a camp in Terbol in the Bekaa Valley. Retrieved 2019 February 2, from: https://www.reuters.com/news/picture/syrias-refugee-crisis-idUSRTX11RE5?slideId=786231624

ABSTRACT

Background: In recent years, the number of people forcibly displaced from their home worldwide has strongly increased. Children below 18 years of age constituted about half of the refugee population in 2017. Consequently, the Dutch health care system has to deal with an increasing number of refugee children, a vulnerable group with complex health needs. The aim of this research is to gain insight into how refugees experience the preventive health care for refugee children in the Netherlands and to what extent this matches their needs. **Method**: To answer the research question, qualitative research methods were used. Five semi-structured focus group discussions with 23 refugee parents and 8 unaccompanied minor refugees were carried out, as well as five semi-structured personal interviews with health care professionals. A salutogenic approach was used to identify stressors and Generalized Resistance Resources, in order to gain more in-depth knowledge and understanding of refugees' needs. **Results**: Four key themes were found in the experiences of the participants: (1) vaccinations by the JGZ, (2) perceived authority of health care professionals, (3) information provision, and (4) differences between health care in the Netherlands and the country of origin. Participants experienced multiple stressors in the context of health care, but the results also showed multiple resources to cope with these stressors. Overarching themes in participants' needs include (1) more extensive initial health assessment, (2) education in cultural differences at school, (3) attention to culture in health care, (4) parental support, (5) social support, and (6) information. **Conclusion**: Refugee children are confronted with many stressors before, during and after their flight to the Netherlands. However, focussing on the resources to cope and strengthening the Sense of Coherence may improve their health. More research is needed to better understand the health needs of this vulnerable group in order to plan and design preventive health care for refugee children more effectively and address their needs.

Key words:
Refugees, AMVs, preventive health care, Salutogenesis, stressors, Generalized Resistance Resources, Sense of Coherence.

ACKNOWLEDGEMENTS

Different people and organisations have contributed to this study. First of all, without many people, conducting the focus group discussions would not have been possible. I would like to thank the AZC Elderhoeve for helping us to conduct focus group discussions with their residents and their active involvement from the start of this research. I would also like to thank the KWV Apeldoornseweg for helping us to conduct a focus group discussion with AMVs, the Nidos Foundation for their approval to approach their pupils for participating in the study, and the interpreters for their great cooperation and enthusiasm.

Of course, I want to thank my supervisor Harro Maat for his supervision. Your feedback during our meetings over the months gave me new insights and kept me focussed. This study is linked to a PhD study of PhD student and paediatrician Albertine Baauw and will be used to develop the medical and psychosocial screening guideline for refugee children. I want to thank Albertine for sharing her knowledge with me, her infectious enthusiasm and her commitment to improve the health of all refugee children. Also, thanks to Sogol Fathi Afshar for the helpful conversations and brainstorm sessions throughout this study.

At last, though most importantly, my appreciation goes to all respondents of the FGDs and interviews who shared their stories and experiences. Without their time, effort and narratives, this study would not have been possible.

GLOSSARY

AMV	Alleenstaande minderjarige vreemdeling | Unaccompanied minor alien
AZC	Asielzoekerscentrum | Asylum Seekers' Centre
COA	Centraal Orgaan Asielzoekers | Central Agency for the Reception of Asylum Seekers
GGD	Gemeentelijke Gezondheidsdienst | Municipal Health Service
GGD GHOR	Gemeentelijke Gezondheidsdienst Geneeskundige Hulpverleningsorganisatie in de Regio | Municipal Health Service Medical Aid Organisation in the Region
GP	General Practitioner
GZA	Gezondheidszorg Asielzoekers | Health Care Asylum Seekers
IND	Immigratie- en Naturalisatiedienst | Immigration- and Naturalisation Service
JGZ	Jeugdgezondheidszorg | Youth Health Care department
KWV	Kleinschalige woonvoorziening | Small-scale Housing Facility
POH-GGZ	Praktijkondersteuner Huisarts Geestelijke Gezondheidszorg | GP Practice Assistant Mental Health Care
UNHCR	United Nations High Commission on Refugees

TABLE OF CONTENTS

Abstract iv

Acknowledgements v

Glossary vi

1. Introduction 1

1.1 Objective and research questions 3

2. Theoretical framework 4

2.1 The Salutogenic model of health 4

2.1.1 Stressors 5

2.1.2 Generalized Resistance Resources 6

2.1.3 Sense of Coherence 6

3. Methodology 8

3.1 Study design 8

3.2 Study population and sampling methods 8

3.3 Data collection 9

3.4 Data analysis 9

3.5 Methodological considerations 10

3.5.1 Practical preparation of the focus group discussions 10

3.5.2 Language and interpretation 10

3.5.3 Ethical considerations 11

4. Results 12

4.1 Experiences 12

4.1.1 Vaccinations by the JGZ 12

4.1.2 perceived authority of health care professionals 13

4.1.3 Information provision 15

4.1.4 Differences between health care in the Netherlands and the country of origin 17

4.1.5 Conclusion 18

4.2 Stressors 20

4.2.1 Cultural instability leading to parent-child conflict 20

4.2.2 Psychological problems 21

4.2.3 Limited social network 23

4.2.4 Conclusion 25
4.3 Generalized resistance resources 26
4.3.1 School 26
4.3.2 Traditional healing and home care 27
4.3.3 Knowledge 28
4.3.4 Conclusion 29
4.4 Needs 30
4.4.1 More extensive initial health assessment 30
4.4.2 Education in cultural differences at school 33
4.4.3 Attention to culture in health care 34
4.4.4 Parental support 35
4.4.4 Social support 35
4.4.5 Information 36
4.4.6 Conclusion 37

5. Discussion and conclusion 39
5.1 Discussion 39
5.2 Conclusion 42
5.3 Limitations 42
5.4 Suggestions for further research 42

References 44

Appendices 49
I. Study population 49
A. Focus group discussions 49
B. Interviews 50
II. Topic Guide 51
A. Focus group discussions 51
B. Interviews 53
III. Coding scheme 55

1. INTRODUCTION

In recent years, the number of people forcibly displaced from their homes worldwide has increased from 42.7 million in 2007 to 68.5 million in 2017. Children below 18 years of age constituted about half of the refugee population in 2017 (UNHCR, 2018). According to the Immigration- and Naturalisation Service (2018), the total asylum influx in the Netherlands counted 31.327 applications in 2017. Most of these asylum applications come from people from Syria (28%) and Eritrea (15%) (Immigratie- en Naturalisatie Dienst, 2018). As a result, the Dutch health care system has to deal with an increasing number of refugees, a group with complex health needs (Hunter, 2016).

A refugee is a person who has fled his or her country as a result of persecution, armed conflict or other forms of violence (UNHCR, 2018). Important to keep in mind is that the definition of the term refugee is used differently in the Netherlands, as the Dutch definition often includes asylum seekers, unaccompanied minor aliens (AMVs), status holders and undocumented individuals. Definitions of these terms are shown in Box 1. In this study, the various subcategories of forcibly displaced people will be subsumed under the general term refugee for simplicity.

Refugee	Someone who has fled his or her country of origin and is unable or unwilling to return due to a well-founded fear of persecution in his or her homeland. Reasons for persecution can be race, religion, political opinion or belonging to a certain group. A refugee cannot get protection against this prosecution in his own country.
Asylum seeker	Someone who has applied for asylum. In the Netherlands an asylum seeker can apply for asylum at the IND. This person obtains a residence permit when he or she is recognised as a refugee.
AMV	A child under 18 on arrival in the Netherlands, whose country of origin is outside the European Union and who travelled to the Netherlands without a parent or other person exercising authority over them.
Status holder	Someone who has a residence permit in the Netherlands.
Undocumented individual	An immigrant that stays in the Netherlands without having a residence permit.

Textbox 1: Definitions (UNHCR, 2018).

Forced displacement is a major child health issue worldwide. Migration can be a stressful event, regardless of the circumstances. However, refugees - unlike other migrants - have had to flee their home country to escape oppression and have been exposed to stressful events before, during and after migration. Consequently, physical as well as mental health problems are highly prevalent among refugee children (Fazel, Wheeler, & Danesh, 2005; Gerritsen et al., 2006; Laban, Gernaat, Komproe, Van Der Tweel, & De Jong, 2005). Available literature shows that refugee children have an increased risk for a variety of physical conditions, such as anaemia, hemoglobinopathies, hepatitis B, (latent) tuberculosis, intestinal parasites, malaria, the human immunodeficiency virus (HIV) infection, malnutrition, and micronutrient deficiencies (Marquardt, Krämer, Fischer, & Prüfer-Krämer, 2016; Yun et al., 2016). Furthermore, a study by Fazel and Stein (2002) shows increased levels of psychological morbidity among refugee children. Especially post-traumatic stress disorder (PTSD), anxiety with sleep disorders, and depression have a high prevalence among refugee children. A particularly vulnerable group within the group of refugee children are AMVs. This specific group is at a significantly higher risk for the

development of psychopathology compared to other refugee adolescents living with a family member, immigrants or Dutch adolescents (Bean, 2006).

Refugees have the right to access to basic health services in the Netherlands through the Health Care Asylum Seekers (GZA). The GZA organises the care provided at the reception centres of the Central Agency for the Reception of Asylum Seekers (COA). The GZA is the first point of contact for all refugees in the COA reception centres when it comes to medical care. A GP practice with a GP, a doctor's assistant, a nurse and a GP Practice Assistant Mental Health Care (POH-GGZ) is connected to a COA reception centre. They can signal problems among refugee children and parents and, when necessary, refer to youth care after consultation with the Youth Health Care Department (JGZ) (Pozzo, Bender, & Visser, 2018).

The Municipal Health Service (GGD) and JGZ institutions carry out the youth health care for underage refugees as defined in the basic package youth health care for asylum seeking children aged 0-18 years (GGD GHOR Nederland, 2017). This includes vaccinations according to the national vaccination programme, contact moments such as an intake by a JGZ nurse and medical examination by a JGZ doctor and periodic health examinations (Slinger, Peeters & Goosen, 2016). All refugee children are offered a medical intake at a COA reception centre by the JGZ within six weeks of arrival in the Netherlands (Hermans, Nutma, Oomen, & Van den Muijsenbergh, 2018). Parents and children are invited for a first intake via a letter or by telephone. This initial health assessment is a form of preventive health care and aims to evaluate the health status and psychological well-being of a child as well as to make an inventory of the vaccination status. If needed, additional vaccination(s) will be provided and children can be referred to a paediatrician, psychiatrist, or other specialist. Laboratory tests on nutritional status, infectious diseases and the existence of geographically determined diseases are not part of the preventive health care, although in some cases there may be reason to do so when children come from high-risk countries for certain diseases or have passes high-risk countries during their flight (Baauw et al., 2017).

Additionally, when refugee children arrive in the Netherlands, the GGD carries out the compulsory screening for active tuberculosis within the first six days of arrival. If necessary, further examination and treatment may follow (Hermans et al., 2018). Since 2015, a distinction has been made between refugees that come from low-risk countries (incidence <50 per 100.000) or high-risk countries (incidence >50 per 100.000) (De Vries, Van Rest, Meijer, Wolters, & Van Hest, 2016). Refugees coming from low risk countries, for example Syria, have been exempted from the tuberculosis examination due to low reported rates of active tuberculosis in these countries as well as the increasing number of arriving refugees, which overwhelmed the GGD's capacity to perform the examination (De Vries et al., 2016).

In summary, refugee children have an increased risk for developing a variety of physical health problems as well as mental distress and psychiatric disorders. The Dutch health care system plays a crucial role in the prevention and treatment of such health problems among refugee children in the Netherlands. However, for many health care institutions, ensuring the quality of care for this group is challenging, because of the complex health needs of this group (Hunter, 2016). Refugees may have different expectations from health care services and different understandings of health, illness and health care than health care professionals (Fazel, Reed, Panter-Brick, & Stein, 2012; Robertshaw, Dhesi, & Jones, 2017). Consequently, health care professionals face multiple challenges in delivering health care to refugee children (A. Baauw et al., 2018; Jensen, Norredam, Priebe, & Krasnik, 2013). Research from Baauw et al. (2018) has shown that paediatricians and youth health care doctors experience multiple barriers in providing health care to refugee children, including frequent relocations, unknown or incomplete medical history, poor handoffs of medical records leading to impaired communication between health care workers, low-health literacy of refugee children and their caretakers, and cultural

differences, with frequent relocations being the most frequently reported barrier impacting the delivery of health care to refugee children.

1.1 OBJECTIVE AND RESEARCH QUESTIONS

Refugee children are a particularly vulnerable group with an increased risk for developing a variety of physical health problems as well as mental distress and psychiatric disorders. The way in which the Dutch healthcare system is built up around refugee children leaves room for improvement and for many health care institutions, ensuring the quality of care for this group is challenging. Past research on the health care for refugee children in the Netherlands has been limited to the perspective of health care professionals, although a call to take the perspectives of refugees into account has been made in the past (Kotovics, Getzin, & Vo, 2018; Leh Hoon Chuah, Teng Tan, Yeo, & Legido-Quigley, 2018). It is crucial to understand the stories and experiences of refugees in responding to their needs. Refugees' experiences and needs in the context of health care can be understood through the lens of the salutogenic model of health, which is used to study the mechanisms whereby people manage to maintain their health while handling stressful situations (Antonovsky, 1979). Therefore, this study aims to examine refugees' experiences and needs in preventive health care for refugee children in the Netherlands, using a salutogenic perspective. The objective of this research is twofold; the first objective is to gain insight into the experiences of refugee parents and AMVs in preventive health care for refugee children. The second objective is to gain insight into the needs of refugee parents and AMVs in preventive health care for refugee children. In the textbox below (textbox 2), an overview of the research questions is shown.

Main research question	How do refugees experience the preventive health care for refugee children in the Netherlands and to what extent does this match their needs?
Sub research question 1	What are the experiences of refugees in preventive health care for refugee children in the Netherlands?
Sub research question 2	What are the needs of refugees in preventive health care for refugee children in the Netherlands?

Textbox 2: Overview of the research questions.

This study is linked to the PhD study of PhD student and paediatrician Albertine Baauw and will be used to develop the medical and psychosocial screening guideline for refugee children, along with another master student's thesis on the accessibility of health care for refugee children. The information obtained in this thesis can help to adjust the preventive health care for refugee children to their needs, in order to improve the health of these children.

This thesis starts with a theoretical framework, chapter 2, wherein the Salutogenic Model of Health is introduced. Hereafter, chapter 3 describes the methodology used for this research. After the methodology, chapter 4 describes the experiences of refugee parents and AMVs considering preventive health care for refugee children in the Netherlands. The Salutogenic Model of Health is used to explore stressors and resources that refugee children experience in the context of health care. Along with the personal stories of refugees, these stressors and resources provide insight into the needs of these children. Finally, the research questions will be answered in chapter 5, the discussion and conclusion. Literature references and appendices can be found at the end of this thesis.

2. THEORETICAL FRAMEWORK

The research questions of this thesis are inspired by the salutogenic perspective on health. This perspective enables me to pay attention to the factors that promote health and well-being among refugee children in the Netherlands. In the following section, the salutogenic model will be explained as well as three important concepts related to Salutogenesis; stressors, Generalized Resistance Resources (GGRs) and the Sense of Coherence (SOC).

2.1 THE SALUTOGENIC MODEL OF HEALTH

A health care professional's approach is often focused on diagnosing and treatment of diseases. Hereby, health care professionals are working from the presumed outcomes of illness and focus on disease origin and causes, using a pathogenic perspective. The pathogenic approach can be considered optimistic, as people are assumed to be healthy in the absence of disease. Under this assumption, there is no need to act in regard to one's health until some problem or disease occurs (Becker, Glascoff, & Felts, 2010). However, the World Health Organization (WHO) defines health as "a state complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006). In contrast to the pathogenic approach, using a salutogenic approach can help looking beyond disease at positive health outcomes. The salutogenic model of health considers health as a dynamic process rather than a state or condition. Salutogenesis, the study of health origin and causes, assumes people's ability to successfully cope with illness and allows for a focus on the factors that promote health. Instead of looking at health as an independent phenomenon, the salutogenic model conceptualises health as a movement in a continuum between total ill health (dis-ease) and total health (ease) and focuses on what moves people towards the ease end of the continuum (Antonovsky, 1996). This continuum is shown in figure 1. The assumption of Salutogenesis helps health care professionals to be proactive in providing care, as the focus is on creating a higher, new state of health than is currently being experienced (Antonovsky, 1996). This approach to health promotion states that more than just prevention efforts are necessary to reach the ease end of the health ease/dis-ease continuum (Becker, Glascoff, & Felts, 2010).

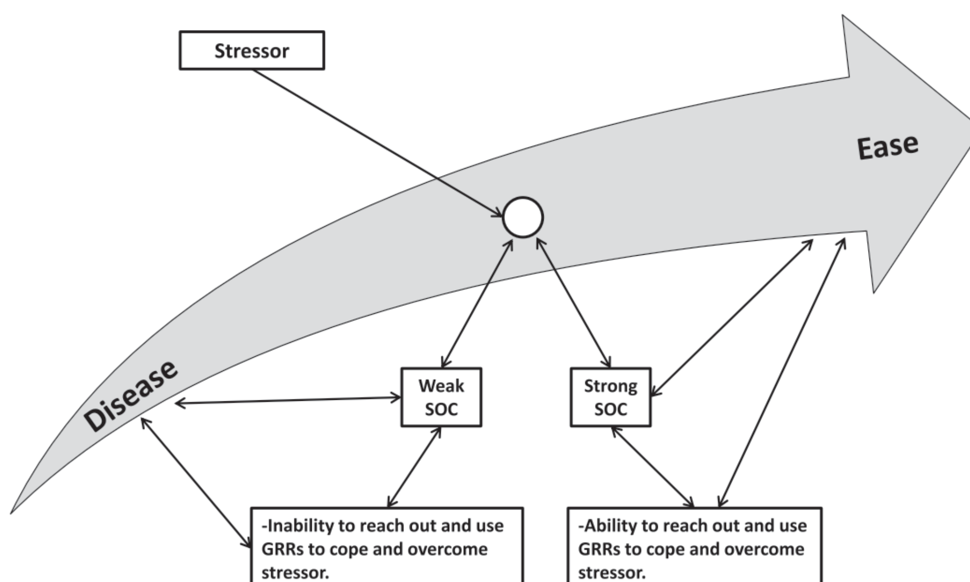

Figure 1. Overview of the ease-disease continuum in Salutogenesis (Swan, 2016).

Research on the role of Salutogenesis in preventive health care for refugee children is scarce. However, this perspective may provide insights into the role of life experiences in the health and well-being of refugee children and their needs in health care. Therefore, Salutogenesis will serve as a framework in this thesis for identifying stressors (see section 2.1.1) and Generalized Resistance Resources (GRRs) (see section 2.1.2) among refugee children in the context of health care and the needs that arise therefrom.

2.1.1 Stressors

Health is not a static state, but a continuous process that develops in the context of one's life. According to Antonovsky (1996), people are constantly exposed to changes and events in their lives that may be considered as stressors. The way in which people cope with these stressors, influences their outcome on the level of shifting on the ease-disease continuum. Stressors can appear as chronicle stressors, bigger life events or daily hassles and can be classified in two categories (Buch, 2006). Firstly, there are physical and biochemical stressors. These stressors put strain on our bodies. Examples are illness, hunger or environmental hazards such as bombings. Secondly, there are psychosocial stressors. These stressors are the events and circumstances that we interpret as unpleasant, for example a bereavement in the family or a social conflict.

Refugee children are exposed to stressors before, during and after their flight to the Netherlands. Research among recently resettled Iraqi and Kurdish refugees in Sweden has shown that life events, both in the country of origin and the country of resettlement, heavily contribute to the development of health and illness (Söndergaard, Ekblad, & Theorell, 2001). For example, violence experienced in the country of origin is a psychosocial stressor that may have serious health impacts (Kalt, Hossain, Kiss, & Zimmerman, 2013). Direct exposure to violence is a major risk factor for the development of psychopathology, including a post-traumatic stress disorder (PTSD) (Angel, Hjern, & Ingleby, 2001; Welling, Slaats-Willemse, Schers, & van de Laar, 2014). Available research among Sudanese refugees shows that social support plays a significant role in the prediction of mental health outcomes, particularly perceived social support from the same ethnic community (Schweitzer, Melville, Steel, & Lacherez, 2006). However, refugee children often suffer from the loss of family members and have left behind their homes and social network, which can cause severe loneliness. Besides the obvious presence of pre-migration stressors, studies have shown that post-migration stressors have a particularly significant impact on health decline among asylum seekers and refugees (Kirmayer et al., 2011; Schock, Rosner, & Knaevelsrud, 2015). For example, refugee children live in great uncertainty in a COA reception centre while awaiting for an unspecified period of time for the outcome of their application for residence in the Netherlands. Research from Laban, Gernaat, Komproe, Schreuders, and De Jong (2004) among Iraqi asylum seekers in the Netherlands has shown that the duration of the asylum procedure is an important risk for psychiatric problems. The way in which refugee children cope with these psychosocial stressors, influences the outcome of the stressor on the level of shifting on the ease-disease continuum.

In addition to the above, refugee children may have contracted a disease or an infection in their home country or in countries they have passed on their way to the Netherlands. In the country of a refugee's origin, other (infectious) diseases than in the Netherlands occur. Research in Germany has shown that 17.6% of 102 unaccompanied asylum-seeking adolescents aged 12-18 years suffered from iron deficiency anaemia (Marquardt, Krämer, Fischer, & Prüfer-Krämer, 2016). Reason for this may be nutritional deficiencies in the home country and/or during the flight. Other examples of physical and biochemical stressors that refugee children experience, are diseases such as hemoglobinopathies, hepatitis B, (latent) tuberculosis, intestinal parasites, malaria, the human immunodeficiency virus (HIV) infection, malnutrition, and micronutrient deficiencies (Marquardt, Krämer, Fischer, & Prüfer-Krämer, 2016; Yun et al., 2016). Although such stressors can temporarily reduce health, they can also in the longer term strengthen our capacity to manage stress (Eriksson, 2017). Stressful life events provide us

with the experiences that can be used in future, similar situations, and in that way strengthen the SOC (see 2.1.3) if successfully managed.

2.1.2 Generalized Resistance Resources

Part of the salutogenic model are the General Resistance Resources, which are elements that help people sense their life as coherent, structured, and understandable. GRRs can be defined as "phenomena that provide one with sets of life experiences characterized by consistency, participation in shaping outcomes and an underload-overload balance" (Antonovsky, 1987, p.19). These three types of life experiences are assumed to contribute to the development of the SOC. Consistent life experiences refer to the extent to which messages are clear and there is order and structure rather than chaos in one's environment. Such experiences provide the basis for the component comprehensibility of the SOC. Participation in shaping outcomes refers to the extent to which one has a significant part in deciding his or her fate. Participation in shaping outcomes is important for the SOC's meaningfulness component. The load balance refers to the extent to which one experiences underload or overload in the balance between the demands placed on one and the resources he or she possesses. Load balance is important for the manageability component of the SOC (Idan, Eriksson, & Al-yagon, 2017). GGRs comprise characteristics of a person, group or community that facilitate the ability to cope with stressors successfully and contribute to the level of Sense of Coherence (SOC) (Mittelmark & Bauer, 2017). They can be anything of help against stressors, such as knowledge, intelligence, money, coping strategies, self-esteem or social support (Idan, Eriksson, & Al-yagon, 2017).

2.1.3 Sense of Coherence

The Sense of Coherence refers to one's capacity to use the resources available. The stronger a person's SOC, the more likely that person is to be able to cope with stressful situations successfully. The SOC is defined as "a global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic feeling of confidence that 1) the stimuli from one's internal and external environments in the course of living are structured, predictable and explicable; 2) the resources are available to one to meet the demands posed by those stimuli; and 3) these demands are challenges, worthy of investment and engagement"(Antonovsky, 1987, p. 19). It consists of three interacting dimensions, namely comprehensibility (the ability to understand challenges), meaningfulness (the motivation to cope with challenges) and manageability (the belief that one has the resources to deal with challenges) (Eriksson & Lindström, 2005). Certain (repeated) life experiences build up ones SOC, which influences ones movement on the ease-disease continuum. The SOC helps a person to mobilise GRRs in the presence of psychosocial and physical or biochemical stressors. Mobilising GRRs may end with stressors avoided, defined as non-stressors, managed or overcome, leading to tension that is subsequently managed with success or leading to unsuccessfully managed tension (Mittelmark & Bauer, 2017). Migration may have great impact on one's SOC, due to a radical change in social-cultural influences and living conditions. Comprehensibility of the new culture, manageability of outcomes and the meaningfulness of one's life may be threatened, hindering the development of a strong SOC.

In conclusion, life experiences play a significant role in the development of the SOC and ones place on the ease-disease continuum. A salutogenic approach in this study provides insights into the mechanism whereby refugees manage to maintain their health while handling stressful situations and the role of their experiences in the context of health care. The salutogenic model therefore provides a theoretical lens through which refugees' experiences and needs in the health care setting will be

structured, analysed and understood in this thesis. Identification of stressors and GRRs allows for more in-depth knowledge and understanding of refugees' needs.

3. METHODOLOGY

The following chapter outlines the methodology used in this study. In the first section, the study design is presented. Hereafter, the study population and sampling methods are described. The third section describes the process of data collection and the fourth section describes the process of data analysis. Lastly, several methodological considerations are outlined

3.1 STUDY DESIGN

The aim of this research is to gain insight into how refugees experience the preventive health care for refugee children in the Netherlands and to what extent this matches their needs. To answer the research question, qualitative research methods were used, as qualitative methods are particularly suitable for exploring new topics or understanding complex issues (Hennink, Hutter, & Bailey, 2011). Five semi-structured focus group discussions (FGDs) with refugee parents and AMVs were carried out in order to gain more in-depth information on refugees' experiences with the preventive health care in the Netherlands and their needs. Open-ended questions were used so that the respondents could explain their underlying emotions and thoughts. This is an advantage of qualitative research in contrast to quantitative research (Hennink, Hutter, & Bailey, 2011). Each FGD was held in presence of a paediatrician, two master students - including myself - and a professional interpreter who translated between Dutch and the mother language of the participants. The other master student present at the FGDs did her research on the accessibility of health care for refugee children in the Netherlands, also as part of the PhD project, used to develop the medical and psychosocial screening guideline for refugee children. Therefore, part of the FGDs included open-ended questions on the topic of accessibility of health care, which was included in the analysis of this research.

Additionally, six health care professionals who work in the field of health care for refugee children were interviewed to gain better understanding of the context. In total, five interviews were conducted. One of these interviews was a double interview with two participants. The interviews were semi-structured and based on an interview-guide with open-ended questions. The purpose of the interviews was triangulation, collecting additional data, as well as to compare the results of the FGDs with the perspective of the professionals.

3.2 STUDY POPULATION AND SAMPLING METHODS

A total of 31 refugees participated in the FGDs. Among the participants were 23 refugee parents, with their number of children varying from 1 to 12. The other 8 participants were AMVs, who all fall under the custody of the Nidos Foundation (Foundation for Protection of Young Refugees; hereafter Nidos). Therefore, the Nidos guardians were asked for their permission to conduct a FGD with the AMVs. Participants of the FGDs were recruited in collaboration with AZC Elderhoeve in Arnhem and COA's small-scale housing facility (KWV) Apeldoornseweg in Arnhem. The group size of the FGDs varied between five and eight. Both written and oral information about the research was provided to the managers of the AZC and the KWV and to the AMVs guardians from Nidos. When the managers and guardians gave their permission for the FGDs, residents were informed about the research and an informed consent in their own language was shared among the residents. The residents could then show their interest to participate and fill in the informed consent. Among the participants were 9 different nationalities. Characteristics of the FGD participants are presented in appendix Ia.

Participants for the personal interviews were initially recruited in collaboration with PhD student and paediatrician Albertine Baauw. Additionally, the snowball technique was used to recruit participants for the last two interviews. Participants were approached via an e-mail and/or telephone, wherein they were informed about the purpose and set-up of the study. All participants received and

signed the informed consent. After the participants expressed an interest for the study, an appointment for the interview was made. Among the participants of the personal interviews were 4 health care professionals who work with refugee children on a daily or weekly basis and 2 health care professionals who work in health policy for refugee children. Characteristics of the interview participants can be found in appendix Ib.

3.3 DATA COLLECTION

Data from the refugees were collected during FGDs; information from the health care professionals was collected during personal interviews. The FGDs lasted approximately 90 minutes and took place in November and December 2018. The FGDs with refugee parents took place in the AZC Elderhoeve and the FGDs with AMVs took place in the KWV Apeldoornseweg. A topic guide with predefined topics and questions was developed beforehand by means of reviewing the literature, two training sessions on conducting qualitative research by the Royal Tropical Institute with multiple stakeholders present, and a pilot FGD during one of these training sessions in AZC Elderhoeve with three Syrian refugee fathers. The topic guide with the open-ended questions formed a guideline which allowed for a focus on relevant topics, but provided opportunities to deviate from the guide when appropriate as well, for example if a respondent were to contribute something that required further explanation or deepening. This provided a chance for new ideas to be initiated during the FGDs based on what the participants were saying. This way, respondents are encouraged to explain their perceptions on their own terms (Hennink, Hutter, & Bailey, 2011). When an important topic emerged during the FGDs, the topic guide for the following FGDs was adjusted. General topics for the FGDs included their experiences in preventive health care, their needs in preventive health care and the accessibility of health care services. This last topic was mainly for the thesis of the other master student, but was included when analysing the results. The topic guide for the FGDs can be found in appendix IIa.

The personal interviews lasted approximately 60 minutes and took place in January and February 2019. The interviews were conducted in Dutch. The first three interviews were conducted at the participant's work place and the subsequent two interviews were held by telephone. A topic guide with predefined topics and questions was developed for the personal interviews. This topic guide focused on the participant's opinion on preventive health care with regard to the experience they had in working with refugee children. Also, some results from the FGDs were raised to ask for the participant's view on these results and the participant's own experiences. The topic guide for the FGDs can be found in appendix IIb.

3.4 DATA ANALYSIS

Data analysis was done by thematic analysis in light of Antonovsky's salutogenic model of health. The first step of the analysis was to transcribe the audio-recorded conversations using verbatim style. To ensure anonymity, the participants were numbered. As the FGDs and interviews were conducted in Dutch, the recordings were transcribed in Dutch. However, the thematic coding was done in English. Prior to the analysis, each transcript was read several times in order to gain familiarity with the data. The transcripts were then coded with use of the coding program ATLAS.ti. Of the third FGD, no recording was available. Therefore, this FGD could not be transcribed and analysed using ATLAS.ti, but notes were made during the FGD that were used as additional information in the analysis.

During the first phase of the coding process, open coding, every part of the FGD was studied to decide what had been said exactly and to label each part with an adequate code. After coding of the data-set, multiple codes that combine were sorted to form overarching themes (appendix III). Themes were created based on high prevalence of the theme in the data and the importance of the theme in relation to the research question. The aim of this axial coding phase in the analysis is to obtain a sense of significance of the themes (Hennink, Hutter, & Bailey, 2011). The salutogenic model functioned as a

theoretical lens through which experiences and needs of refugees in the health care setting were structured, analysed and understood in this thesis. The codes that emerged after the first phase of data analysis were sorted into organising themes. A deductive approach was then used by which the themes from the previous phase were sorted based on the elements of the salutogenic model: stressors and GRRs. This way, deeper understanding of refugees' needs in preventive health care could be gained. Important to note is that the data analysis is not a linear process, but a movement back and forth throughout the phases (Braun & Clarke, 2006)

3.5 METHODOLOGICAL CONSIDERATIONS

Refugees are considered to be in a vulnerable position, due to pre-settlement trauma and postsettlement experiences (Eklöf, Hupli, & Leino-Kilpi, 2017). Furthermore, refugees may be reluctant to participate in a FGD or feel distrust as to how the information obtained in the FGDs will be used (Ogilvie, Burgess-Pinto, & Caufield, 2008). This raises various methodological points for attention to consider in this study. In the following section, practical preparation of the FGDs as well as language and interpretation and ethical considerations are discussed.

3.5.1 PRACTICAL PREPARATION OF THE FOCUS GROUP DISCUSSIONS

Organising focus group discussions with refugees can be challenging for several reasons. Shortly after their arrival in the Netherlands, refugees are asked to share their pre-settlement traumas with immigration authorities such as the IND in order to provide evidence of violence or persecution in their home country, which may increase lack of trust towards strangers (Eklöf, Hupli, & Leino-Kilpi, 2017). Therefore, in the beginning of the FGDs, it was emphasized again that the responses of the participants would remain confidential and no names would be included in the report. This was also explained in the informed consent. Furthermore, participants were asked to respect the privacy of other participants by not disclosing any content discussed during the FGDs.

Even with careful planning, the number of participants as well as the composition of the focus group may change last minute. Reason for this may be the different concept of time or priorities in different cultures (Birks, Chapman, & Francis, 2007), even when participants have agreed to participate and signed the informed consent. Therefore, the researchers realised that flexibility with group size was needed and we needed to be ready to conduct the FGDs with fewer or more participants than planned. In order to prevent that the group size of the focus group discussions would deviate from six participants as much as possible, the FGDs were planned at the residential location of the participants at a time that was most suitable for the participants, to avoid them being distracted by the need to be elsewhere. In this study, six participants were invited for each FGD. However, the group size varied from five to eight participants.

To ensure that participants understood the questions asked during the FGDs, a pilot FGD was held prior to the first FGD in AZC Elderhoeve. During this pilot FGD, three Syrian refugee fathers were present, as well as a paediatrician, two master students - including myself - and an interpreter. This FGD lasted approximately 30 minutes and included some of the questions from the topic guide. Afterwards, the participants were asked for feedback on the FGD. This pilot FGD gave the researchers the opportunity to practice with conducting a FGD and to improve the topic guide.

3.5.2 LANGUAGE AND INTERPRETATION

Another methodological point for attention to be addressed in this study is different languages used. First of all, the participants of the FGDs generally did not speak Dutch. Therefore, a professional interpreter was present during the FGDs to translate between Dutch and the mother language of the

participants. This made it difficult for the researchers to follow what was happening and what was being said during the FGDs. Also, an interpreter uses his or her own interpretation in translating, which may influence the results of the FGDs.

Furthermore, as both the FGDs and the interviews were conducted in Dutch, the audio-recorded conversations were transcribed in Dutch, but the transcriptions were analysed and coded in English. Even with careful translation, ensuring that concepts are understood the same way across cultures can be challenging. Using verbatim style while transcribing, I have used my own unavoidable interpretation of the recordings. For the results to deviate as little as possible from the original answers of the participants of the FGDs, many citations are used in this thesis, that were translated as literally as possible.

3.5.3 Ethical considerations

The Medical Ethical Committee of Rijnstate Hospital Arnhem approved the study. All participants in both the FGDs and the interviews participated voluntary. An informed consent form was provided prior to the FGDs and the interviews which had to be read and signed. The informed consent was made available in the mother language of the participants of the FGDs and in English for the participants of the interviews. Also, prior to the distribution of the informed consent among the AMVs, Nidos was asked for their informed consent. Anonymity was ensured at the beginning of the FGDs and the participants were asked whether they agreed that the FGD or interview would be audio recorded. Citations of the participants are being used in the results section of this thesis and any identifying information has been removed in order to guarantee the participants' privacy.

4. RESULTS

This section presents the results of the FGDs with AMVs and refugee parents. Based on the topic guide, open-ended questions were asked about how the participants have experienced certain events and what their needs are regarding preventive health care provided to refugee children in the Netherlands. Firstly, experiences in the health care setting that were discussed by the participants are presented. Then, the identified stressors and Generalized Resistance Resources are described and, lastly, the needs are outlined that participants indicated in the context of preventive health care for refugee children in the Netherlands. These needs primarily arise from what the participants explicitly indicated as their needs in health care. Additionally, the identified stressors and Generalized Resistance Resources either supported the needs expressed by the participants or led to additional needs that participants did not explicitly mention. Therefore, the themes described under 'Experiences', 'Stressors', 'Generalized Resistance Resources' and 'Needs' are generally interconnected and closely related to each other. The personal interviews with health care professionals are used to reflect upon the stories of the refugees and to compare the results of the FGDs with the perspective of the professionals. Anonymous citations are given for illustration.

4.1 EXPERIENCES

There was a wide variety of participants' experiences with preventive health care in different FGDs. However, a number of themes was recurrent in the experiences of participants within different groups, including (1) vaccinations by the JGZ, (2) perceived authority of health care professionals, (3) information provision, and (4) differences in health care between the Netherlands and the country of origin. Although participants were asked about their experiences with preventive health care for refugee children in the Netherlands, multiple stories that the participants shared were about curative health care, health care provided to adults or elderly, or health general. However, these stories are still included below when they contained relevant information to reflect upon the preventive health care for refugee children.

4.1.1 Vaccinations by the JGZ

After explaining to the participants of the FGDs what preventive health care for refugee children in the Netherlands includes, the participants were asked about their experiences. Most participants, both AMVs and parents, could well remember vaccinations being given to them or their children.

> *"Regarding vaccinations, when we came to the Netherlands, they started vaccinations after three months. And they just gave the vaccinations regularly until… The last vaccination was two years ago. Three vaccinations, and they've received a yellow booklet with the names of the vaccinations and stamps. The doctor has given the vaccinations, and what kind of vaccinations, and it's all stamped."*
>
> (Father of 2 children, from Iraq)

Most participants were pleased with the vaccinations that were provided by the JGZ. Mainly parents showed their satisfaction during the FGDs. The reason for their satisfaction was the improvement of the immune system of their children as well as the prevention of diseases. A Syrian mother indicated a specific vaccination for her daughter with which she was very pleased, namely the vaccination for cervical cancer. The other participants of that FGD agreed that that specific vaccination is a very good

vaccination for cancer prevention among girls. However, one participant was dissatisfied with the care by the JGZ regarding vaccinations. The son of this mother from Kuwait had not received any vaccination since their arrival in the Netherlands 11 months earlier, unlike the other children that did receive vaccinations in Ter Apel.

> *"My son has a disability. So far, he has not received any vaccination. Every time they say 'yes we will send back...'. But we don't hear anything back. While he may be the only one that really needs it."*
>
> (Mother of 3 children, from Kuwait)

Among the AMVs, the ones who received vaccinations did remember, but did not discuss any specific experiences other than that they simply had received injections, some hurt, and some did not. Interesting however is that some participants of this FGD notified us of the fact that they did not receive any vaccination, because they did not show up or were not present at the vaccination moments. After some more questioning, a 16-year-old AMV, who had been diagnosed with tuberculosis, explained why:

> *"They have asked me too, to get myself vaccinated, but I'm taking medication and they tell me that I also need vaccinations... I haven't done that yet. [...] No, I want to wait. Because the medication is a lot and I don't want another vaccination at the same time. I think that that would be too much for me."*
>
> (16-year-old boy, from Eritrea)

The personal interviews showed that all participating health care professionals were very satisfied with the vaccination programme for refugee children in the Netherlands. The importance of vaccinations was often emphasized, as was their satisfaction with the Dutch vaccination programme. However, only one participant, a paediatric haematologist, also emphasized the importance of understanding the resistance of refugees towards these vaccinations.

> *"I also think that we, paediatricians in general, we think that vaccinations are very important. But then again, I think we come back to that very first part... Understanding of what is the resistance in other people. There may sometimes be thoughts that we could not have thought of beforehand. Because we just have a very different upbringing and very different habits. I think that's important to explain."*
>
> (Paediatric haematologist)

4.1.2 PERCEIVED AUTHORITY OF HEALTH CARE PROFESSIONALS

In two FGDs with parents, multiple participants shared stories that showed that health care professionals have little authority in their perception. With authority here is meant being competent and able to instruct others to perform actions, to the benefit of earned recognition, education and position. Some participants experienced feelings of mistrust towards health care professionals or their competences and stated not to have followed the doctor's or nurse's advice. This was particularly evident with regard to nurses. Among refugee parents, nurses and assistants have less authority than doctors. This becomes evident from the following citation:

> *"In the GP practice, there is a nurse. And a nurse is not a doctor… The problem that we often encounter here is that the doctor's assistant or nurse sometimes understands what we want, and sometimes they don't understand us at all. And sometimes they decide for themselves whether you should go see a doctor or not. And then we don't feel helped. In general, the trust in a doctor is much higher than in a nurse, because a nurse simply remains an assistant. A doctor is something different for us. The trust in a doctor is higher than in an assistant."*
>
> (Father of 4 children, from Syria)

In parents' experiences, a nurse does not have sufficient competence to provide care for psychological complaints or disorders. Parents indicated a need for mental health care and a Syrian father specifically stated that a nurse was not competent enough. *"We also need someone here who is specialised in mental health or in psychological complaints or disorders. Not a nurse"*, he stated.

What also emerged during several FGDs with both parents and AMVs, was that refugees overall did not consider the vaccinations given by the JGZ as part of health care. While being asked about their experiences in preventive health care, participants mainly discussed the curative health care, instead of preventive health care and for example the JGZ or the GGD. An AMV stated during the FGD that he had no experience with health care, although he had received a test for tuberculosis as well as two vaccinations by the JGZ.

> *"When we arrived here, we were examined. We had a control, a check, but I've never made use of health care. I've never asked for a doctor or been to the hospital, so I don't know, I have no experience."*
>
> (16-year-old boy, from Eritrea)

In the personal interviews with health care professionals, the authority of health care professionals perceived by refugees was also discussed. Although refugee parents indicated a need for mental health care and stated that a nurse is not sufficiently competent, a JGZ nurse stated that she specifically asks questions to the child or the family to explore possible mental health problems in the child:

> *"I actually ask more about how they sleep… Does it take a long time for them to fall asleep? Can they sleep well? Do they have any nightmares? What about bedwetting? Do they bite their nails? Because, there may be some stress or mental health problems behind their behaviour."*
>
> (JGZ nurse)

In specific, a GP had experienced a situation wherein she noticed that she had no authority in the perception of a refugee visiting her consultation hour. However, the GP also explained that she feels like refugees accept her as a GP quite quickly, despite the little authority she might have to refugees in the first instance.

> *"Yesterday, a man visited my consultation. He stayed seated when I asked him to come with me. 'We are waiting for the doctor', he answered. Yes, I am the doctor, I said. Such a young girl, who knows nothing, you know [laughter]… Yes, at one point he will come with me, but it is different than what they are used to, you can see that. But they also accept it very quickly. Like, we are here now and this is probably the way it goes and we just have to accept this."*
>
> (GP)

This GP also mentioned that she does not see many parents during her consultations who bring up psychological problems. A few times, she received questions about bedwetting or nightmares whereby the children woke up crying, but refugee parents do not come to her with questions about the mental health or psychological problems of their children. The reason she proposed for this, was that refugees might think that a GP cannot offer much regarding mental health. However, "*If I were really honest*", she said, "*I actually do not really know what I could offer. So they come to me mainly for physical things*".

4.1.3 Information provision

When discussing participants' experiences with preventive health care, in three FGDs - including the FGD with AMVs - the topic of information provision in health care came to light. Although both positive and negative experiences were shared about the (amount of) information that the participants received in a various situations, more negative than positive experiences were expressed. Participants who said to have received sufficient information had more positive experiences with health care services in the Netherlands compared to those who said to have received insufficient information. For example, a Syrian mother of four children was very pleased with the care she received during her delivery in the Netherlands. "*In general, it is really good. I gave birth in one of the hospitals and that was really good. My child was well cared for, so in general I had no problems at all*", she explained. When she was asked how the information provision was then, and whether she knew what was going to happen, her answer was as follows: "*Yes, more than enough. Very nice. Exactly like in our country*".

The context of the experiences that participants discussed about information provision varied greatly. For example, whereas some participants discussed the provision of information regarding the diseases for which they or their children were vaccinated, other participants discussed the provision of information regarding the Dutch health care system. In general, participants attached great importance to information provision of health care professionals, for example during treatment, as well as general information about diseases and the health care system in the Netherlands. A Syrian mother expressed the importance of information provision about diseases and health:

> *"We have no information… Little information about certain diseases. About the spread of diseases. About general health. Information is very important. We also want to know, what kind of diseases are here in the Netherlands? How do we prevent that? What can we do about it? We do not know that."*
>
> (Mother of 4 children, from Syria)

An AMV from Eritrea who has been in the Netherlands for 7 months, shared an experience of going to his doctor's appointment after receiving an invitation letter. In his experience, he did not have enough information to locate the doctor and, as a result, he intended to return home when on his way.

> *"I'm new here, I don't know where to be. I get a paper… 'You can go' [to the doctor]. Not just here, also at the previous location… 'Yes, go yourself'. I do not speak the language, I do not know how to go there… Last time, I went [to the doctor], but I couldn't find it. I wanted to return, but by chance I found Tigrinya speaking compatriots. They brought me there and showed me where I needed to be and so I was able to go for that examination. But why…? They say you should go and see a doctor, but why don't they take you there? Why do they not bring you?"*
>
> (16-year-old boy, from Eritrea)

During personal interviews with health care professionals, the provision of information to refugees and the access to information for refugees were also widely discussed. Health care professionals indicated that refugees often have (too) little information to be able to make proper use of health care services. They had various ideas and suggestions about factors that influence the ability of refugees to obtain information. Factors that were mentioned by the interview participants were access to the internet, memory of diagnosis or care use in the country of origin, social contacts in the neighbourhood, level of education and intelligence level. Also, a JGZ nurse mentioned that she encounters challenges in providing information to refugees. "*Some people are really not familiar with the health care system, while some people are. That they really know what to do and where to be*", she explained. However, this participant mentioned that these differences are also evident among Dutch people.

During a personal interview with a manager JGZ and a regional coordinator for the health of status holders, the participants indicated that information provision regarding vaccinations is very well organised in the Netherlands. Prior to a vaccination moment at a KWV, someone would have visited the KWV with an interpreter to give an explanation about the vaccinations, why vaccinations are provided and how that is organised. The supervisors of the KWV are also present and well informed, according to the participants of this interview. "*It is simply a process of informing and informing*", the regional coordinator for the health of status holders stated.

A paediatric haematologist explained how she gives information to her patients, using the interpreter telephone. However, sometimes the interpreter telephone is insufficient, for example for one of her patients who is illiterate. In such cases, she also uses pictures to support the information she provides.

> *"I need the interpreter. I'm not just going to give an explanation. Unfortunately, I find that my fellow caregivers still do that too often, an explanation in Dutch or some broken English because 'oh mister probably understands a little bit of English'. And then you notice later that the information did not reach the patient. So I'm a big fan of the interpreter telephone. […] But if you don't speak the language and you're also illiterate… Just going to the X-ray department? She just cannot find the way in the hospital.*
>
> (Paediatric haematologist)

Several health care professionals also mentioned that they do not know exactly how or by whom refugees receive the initial general information about the Dutch health care system. It was unclear to them who is responsible for providing this information and when or where this information is provided to refugees. However, three interview participants mentioned the important role of the COA herein. They discussed how the COA informs the residents of the AZC not only about general information by organising presentations, but also helps the refugees in remembering their appointments and encouraging them to go to their appointments with, for example, the JGZ. Furthermore, multiple health care professionals indicated that the information that refugees receive may be too much for them to either understand or remember, and therefore the information provided does not reach the refugees.

> *"I don't know exactly how that goes… is that explained by GZA? Maybe it's a lot of information too, for refugees. I don't know that, how it starts, how it's arranged."*
>
> (JGZ nurse)

> *"I don't know… They probably tell in the AZC. But then again, the question remains to what extent all this information reaches the refugees."*
>
> (GP GZA)

As regard to logistical information about, for example, a doctor's appointment, a JGZ doctor mentioned that refugees receive many letters which they might not understand or remember. "*You have to be proactive. If I have a list of children, I am not going to wait for them to come. I can wait forever. They have so many letters. I just go to their room and say 11 o'clock appointment, make sure you are on time*", he explained. This was also mentioned by a JGZ nurse, who stated to proactively approach refugees to remind them of their appointment with the JGZ.

4.1.4 Differences between health care in the Netherlands and the country of origin

In all FGDs, differences between the health care system in the Netherlands and the country of origin that refugees experienced were discussed. Especially experiences in the context of differences in access to medication and treatment were discussed, as well as the long waiting time they experience compared to what they were used to in their country of origin, mostly due the Dutch referral system. Although the differences discussed were not all regarding preventive health care, it was a much recurring topic during the FGDs and may provide new insights that are important for preventive healthcare, and therefore will be discussed.

In all FGDs, with exception of the FGD with AMVs, participants discussed differences in access to medication, in particular access to antibiotics. They were used to very easily obtain antibiotics in their country of origin, where, for example, antibiotics were available in pharmacies without needing any prescription. Although multiple participants mentioned that they have to get used to the limited accessibility of antibiotics in the Netherlands, all participants who discussed this agreed that it is better to limit the use of it.

> *"When my children are ill, I know that they don't like going to the doctor, just paracetamol and water… We have missed that in our countries, because in our countries we are used to antibiotics. It is very good that we are now going to learn to only take paracetamol and water and fewer antibiotics. […] In our country, antibiotics are available in the pharmacy. If you go into the pharmacy and you say 'I want antibiotics', you'll get antibiotics. Also injections and everything, so you don't need a prescription. Even if a child enters a pharmacy, you will get antibiotics, so that's not good. It is actually better not to give antibiotics, because your body will get used to building its own resistance."*
>
> (Father of 4 children, from Syria)

Furthermore, two participants from Syria were very agitated about the waiting time in the Netherlands and the possibility of receiving non-drug treatment. One participant, father of 7 children and suffering from hernia, explained that his back ached due to hernia. In Syria, he was receiving physiotherapy. In the Netherlands, the doctor gave him medication, namely tramadol. According to the participant, the doctor did not try to examine or solve the problem of his hernia by, for example, offering physiotherapy.

> *"[…] Tramadol does soothe the pain for a while, but the problem remains. Maybe I need surgery, but not tramadol. I am afraid of surgery, but still. But physiotherapy, or exercise, look at the problem, but no medication. […] In Syria, I've had physiotherapy with certain exercises. So I try to do these exercises in my room and I stopped taking tramadol".*
>
> (Father of 7 children, from Syria)

Another participant had the feeling that non-drug treatment for refugees was often postponed in the Netherlands and medication was given instead. In his story, it was unclear with whom or what kind of health professional he had this experience. However, he mentioned the GZA as an organisation that postpones treatment, in his experience, until refugees are granted a status and a house in the municipality.

> *"I got the feeling that here, they just wanted to give paracetamol and they just want you to move to a house in the municipality and get a doctor or something there. But they do not want to do anything. Everything is treated with paracetamol and a sip of water. […] I also get the feeling that we are put later, later and later by the GZA, because they say 'yes they will get a house [in the municipality].' And they do not give actual treatment. It is just wait and see, postpone until we get a house".*
>
> (Father of 4 children, from Syria)

Furthermore, in all FGDs with parents, long waiting time in the Netherlands was mentioned as a barrier in the access to health care in the Netherlands. Participants expressed their dissatisfaction about the long waiting time compared to what they are used to in their country of origin. Even when a Syrian mother explained that she was very satisfied with how her son was treated when he broke his fingers, she asked why it takes such a long time to receive health care and why there is a procedure of going from one doctor to another. A Syrian father explained that in Syria, there is direct access to a doctor 24 hours a day and that in every village or area there is a doctor available. This is something that the participants appreciated very much about the health care in their country of origin. This Syrian father also expressed that he found it remarkable that in the Netherlands there is a GP, not a specialist to go to directly, as they were used to. In two FGDs with parents, the participants also stressed that the time that a GP is present at the AZC is too little. Participants discussed the long waiting time to receive care in the AZC as a result, compared to their country of origin, where there was a doctors' practice close by and open to access 24 hours a day, according to the participants.

The health care system in the Netherlands obviously differs from the health care system in the Middle East, as multiple parents as well as health care professionals mentioned. Supporting refugees' experiences with a different health care system than they are used to, a paediatric haematologist discussed how refugees often come to the emergency department right away, instead of visiting a GP first.

> *"We of course have such a different health care system than elsewhere. Of course, they [refugees] always come to the emergency department in the hospital and so on. But no, first go to the GP. Or if you have a referral, you will be helped faster. That's just different from how they are used to."*
>
> (Paediatric haematologist)

4.1.5. Conclusion

All in all, both positive and negative experiences with health care in the Netherlands were reported during the FGDs. Although not all experiences were regarding preventive health care for refugee children, four overarching themes were identified in participants' experiences. Firstly, parents were positive about the vaccinations provided to their children. AMVs did not share specific experiences about being vaccinate, although some did notify us of the fact that they did not receive any vaccinations because they did not show up or were not present at the vaccination moments, as they did not like getting injections or thought it was too much next to their medication.

Participants also discussed experiences that showed that the health care professionals have little authority in their perception, in particular with regard to nurses. Parents indicated a nurse had insufficient competence to provide mental health care. However, a JGZ nurse stated that she does explore possible mental health problems among refugee children. Although multiple health care professionals shared experiences of their little authority perceived by refugees, according to a GP, refugees do accept health care professionals very quickly.

Participants discussed that they receive (too) little information, for example about diseases and health. The participants attached great importance to information. Health care professionals stated that refugees sometimes lack knowledge on such topics, although they also discussed that refugees may receive a lot of information. The information provided may be too much or too difficult to refugees to either understand or remember, and therefore the information does not reach the refugees. Additionally, for some health care professionals, it was also unclear by whom, when and where information was provided to refugees on such topics.

Lastly, participants discussed differences that they experience between the health care system in the Netherlands and in their country of origin. Although the limited use of and access to antibiotics was considered rather positive, the access to non-drug treatment, the long waiting time and the Dutch referral system resulted in dissatisfaction in the experiences of refugees.

4.2 STRESSORS

Refugee children are constantly exposed to changes and events in their lives that may be considered as stressors. They may occur in the form of chronical stressors, bigger life events or daily hassles. Not only before and during their flight, but also when living in the Netherlands. When analysing the transcriptions of the FGDs, multiple stressors were identified. The stressors were divided into three overarching themes: (1) Cultural instability leading to parent-child conflict, (2) psychological problems, and (3) limited social network.

4.2.1 CULTURAL INSTABILITY LEADING TO PARENT-CHILD CONFLICT

Much recurring topics during the FGDs with refugee parents were cultural change and cultural instability, particularly present in the different cultural context of school and parenting that refugee children encounter. In three of the FGDs with parents, the participants shared experiences in the context of upbringing in which they indicated difficulties raising their children in a different culture than their children encounter at school. While parents try to maintain more of their own culture, children quickly encounter the Dutch culture at school. In parents' experiences, these cultural differences lead to cultural instability and in turn to parent-child conflicts. "*Our children have come here and suddenly they live in a different culture. Everything is allowed… It's a different environment. So we notice that our children become a bit naughty, also against the parents*", explained a father of 2 children from Iraq. Multiple parents shared experiences of conflicts between them and their child(ren). Parents felt like they had no control over their children. According to the parents, their children learn about Dutch culture and their rights at school, but not about their duties.

> *"They [school] gave them their rights. 'In the Netherlands, you have the right to this and that, and this is not allowed and the parents are not allowed to do this and that'. But on the other hand, they haven't told them what their duties are. What do you have to oblige? 'You cannot do this to your parents or you cannot tell them this'. So actually, the children become stronger for themselves, but they no longer have respect for their parents. Children must understand that you must listen to what your father and mother say. You don't just call the police unless you really are abused. Let children understand their rights, but also their duties.".*
>
> (Father of 4 children, from Syria)

A father from Syria mentioned the difference in culture as the collectivistic culture in their country of origin compared to the individualistic culture in the Netherlands. He stated that Western norms and values differ from Syrian norms and values and that there needs to be attention to cultural differences. In that way, people with a different culture living in the Netherlands would be able to find balance in their lives.

> *"[…] Because it is now about people with a different culture living here. But they also need to find balance in their lives. So there really needs to be attention to cultural differences. We have our norms and values, which do not change when our country has changed."*
>
> (Father of 7 children, from Syria)

When discussing cultural differences in the personal interviews, a GP explained why she thinks that parents have concerns in the upbringing of their children. According to her, besides the fact that children encounter a different culture at school than in the upbringing of their parents, they also have to deal with the new, Dutch culture in the AZC, with the COA consisting of a Dutch team. Moreover,

when young parents are struggling with themselves, it makes it harder for them to have an eye for the children.

> *"What I hear is that there are many concerns in parenting. But of course it's also… The COA is a Dutch team with Dutch norms and values, like, children are raised in this way. So I notice that culture is very different, which is difficult sometimes. And often it's also parents who just leave their children be, and cannot be consistent and just don't know how to handle it. Or young mothers who are struggling so much with themselves that they just don't have an eye for the children. You see that. But they are now very open to advice or help, or things like that"*
>
> (GP GZA)

Additionally, a JGZ nurse and a JGZ doctor mentioned that they experience differences between Dutch children and refugee children due to their different cultural background. Although there was not much further elaboration on this topic from participants of the interviews, the JGZ doctor explained that parents often join their children to an appointment with the JGZ nurse or doctor and always ask many questions. Whereas Dutch children are more direct and independent, refugee children let their parents speak more. "*Naturally, they come from a completely different culture. Last Friday, I asked a 12- or 13-year-old child if he would like to get vaccinated. The child did not answer, the father did. The child has to do what the father says, that's different culture. You see, Dutch children are a bit more direct and independent*", the JGZ doctor explained. However, a paediatric haematologist mentioned that refugee children actually speak more than their parents during a doctor's appointment, as they often speak the Dutch language sooner and better than their parents, which may also result in an imbalance in the family. The same was brought up by a manager JGZ and a regional coordinator for the health of status holders. They suggested that the fact that refugee children often learn the Dutch language and integrate in Dutch culture easier and faster than their parents, may result in ignorance and frustration between refugee children and their parents. They also explained how cultural change may influence the process of family reunification among AMVs. "*Initially, AMVs really want family reunification, so that the family members in their country of origin can come to the Netherlands. But when it comes to that, they actually start to hesitate and don't want it anymore, because they think like… We are free here and we have our own life here. And then our parents will come and they will take that away from us*", the manager JGZ stated.

4.2.2 Psychological problems

When discussing the health of refugee children, multiple participants mentioned that their children, or themselves in case of the AMVs, experience psychological problems. In four out of five FGDs, this topic was widely discussed by the participants. During the FGDs with Arab fathers, with Arab mothers and fathers, with Afghan and Iranian mothers and fathers, and with AMVs, multiple participants raised the topic of psychological problems. The FGD wherein the topic of psychological problems was not discussed, was the FGD with Arab mothers only.

A father from Iraq who has been in the Netherlands for three years, explained that he has a 13-year-old son with psychological problems. For example, he wakes up at night with nightmares. A few years ago, their asylum application was refused by the IND and the family was not allowed to stay in the Netherlands. This father told that suddenly at 6 o'clock in the morning, the police came into their room in the AZC and the family was brought to the detention centre for refused asylum seekers in Zeist. Because of this situation, the psychological well-being of his son worsened, he became more afraid and more unstable. This father could not understand why his family, in particular his son with psychological problems, was treated this way, even while the COA knew about the situation of his son. He was very

worried about the psychological well-being of his son and he was very upset while describing this experience. In addition, he explained that he works as a driver and brings the children from the AZC to school. "*Half of these children have psychological problems. Even more than half*", he stated.

Furthermore, multiple AMVs reported that they experience stress. For a 16-year-old amv from Eritrea, this was not a reason to go and see a doctor, but actually prevented him from seeing a doctor. He refused to come out of bed for a check-up, because of the stress he was experiencing and the things that he has experienced in Libya.

> *"In Weert, they've told me to go to the doctor for a check-up. I just went to bed, I refused. One more time, I refused. The third time, they brought me themselves. And that has to do with… I have a lot of stress. I don't want to talk to people about it, but I've been through a lot of things in Libya. So if I have to go somewhere, I get stressed. Then I think back to what I experiences in Libya. So, I cannot do it alone".*
>
> (16-year-old boy, from Eritrea)

AMVs also discussed that they experience great uncertainty about their future as a result of not having a residence permit in the Netherlands. This in turn led to stress and demotivation in school.

> *"If you don't have a residence permit, that's the only thing you're thinking about. You get stress. It's also dangerous, you can also think dangerous things. But also at school you can't do your best. Because, why would you? Because you don't even know whether you will live here further or not. At school, you don't think 'I'm going to do my best, I'm going to school', because you don't know whether you can stay here or not. If you've learned the language, you're doing you best… Tomorrow they can say 'Well, you may leave'. So if you don't know whether you can stay, then you don't find it important to do your best".*
>
> (16-year-old boy, from Eritrea)

Two other AMVs however, did not necessarily perceive the uncertainty about their future as a form of stress. One AMV from Eritrea simply referred to it as "*thinking about the future*, *but not stress*". Another participant called it a dark spot in his mind:

> *"For me, my future is… Uncertain future. That is a dark spot for me in my mind. I think about that, but I do not call it stress."*
>
> (16-year-old boy, from Eritrea)

The AMVs did not try to do anything to reduce their stress themselves. "*I just walk away from it. It doesn't matter to me*", stated a 16-year-old AMV. When discussing about the health care provided to AMVs regarding psychological problems and stress, AMVs stated that they were never asked about their stressful situation, or never talked about it.

> *"Nobody is asking us about the stress situation. They don't know that, because we suffer from it and then we just go on with it, so yeah, we don't talk about it openly. We keep that to ourselves. So they don't ask for it, and thus nothing is done with it."*
>
> (16-year-old boy, from Eritrea)

A 15-year-old AMV from Eritrea added that there are many more things that they do not talk about, because they are trying to forget. "[…] *But there's much more than this, we don't tell everything*", he mentioned at the end of the FGD. However, refugee parents talked more openly about the mental health of their children during the FGDs. Multiple parents had children who struggled with anxiety, nightmares or bedwetting. A Syrian father mentioned that their children have been through war and bombings. They might have experienced the death of a family member, which is not easy to forget. When their children hear an airplane flying over, they run to their father. "*Unconsciously, they go to their father, only because of the sound of an airplane. They have not forgotten that. Only a sound scares them*", mentioned a Syrian father. This father also mentioned that children may be afraid of water, and thus afraid to swim, when they have travelled by boat, and that psychological well-being needs to be a priority. "*Anxiety, depression, homesickness… We first need to be treated psychologically to come to rest*", he stated.

These psychological problems were also discussed during personal interviews with health care professionals. In all five interviews, participants brought up psychological problems among refugee children. A GP mentioned that she sees refugee children during her consultation hours who have issues with nightmares or bedwetting. However, other than that, she mainly deals with more medical issues, she mentioned. In contrast, a JGZ nurse stated that she specifically asks refugee children and parents about sleep, nightmares, bedwetting, or nail biting, to gain insight into children's psychological well-being. She explained that such issues are generally more present among refugee children than Dutch children. However, according to this nurse, when talking with refugee parents about such issues, parents often laugh or feel embarrassed.

Other issues that were mentioned by health care professionals, were refugee children being traumatised as a result of war, bombings, or the death of their relatives, sometimes in front of their own eyes. During the interview with a manager JGZ and a regional coordinator for the health of status holders, the participants explained how this can impact refugee children's school performance. "*Extreme reactions of anxiety, dropping out of school, or being unable to concentrate*" were mentioned as possible consequences of psychological problems among refugee children. However, mental health care provided to refugee children mostly remained undiscussed. Although multiple refugee parents expressed their concerns about the psychological well-being of their children and the priority of mental health care, not all health care professionals shared this priority. During one of the interviews, the participants explicitly stated that the psychological health of refugee children has less priority than the physical health. This will be further discussed under the needs in section 4.4.1.

4.2.3 Limited social network

Another stressor that arose from the stories of the participants during the FGDs, was a limited social network. When fleeing and leaving behind their country of origin, refugees are also leaving behind the social network in their country of origin. Building up a new social network in the Netherlands may be very challenging when being relocated from one AZC to another. Additionally, multiple parents stated that their children have little social contact with other children, because they spend a lot of time on digital devices.

> *"I would prefer my child to go out and play, play soccer, play with his hands, do something. We find it very unfortunate that they are on the iPad 24 hours a day and are only focused on these digital things. They have no communication with the outside world."*
>
> (Father of 3 children, from Syria)

Another parent in that FGD, a Syrian mother of four children, did not completely agree with this statement and indicated that the AZC offers many possibilities for their children to play and join activities with other children. However, the father in question added that, even if there are enough opportunities for their children, their children do not join these activities. "*They leave school at 3 o'clock in the afternoon and go digital. They all play one game. This is autism. Children now have autism with these digital devices*", he stated. To this, the mother suggested to let the children play educational games, instead of fighting games in which the children had to shoot people. However, all parents agreed that it is best for their children to play outside with other children, rather than playing on their own on a digital device.

A limited social network was also reflected in the stories of the AMVs. Contact with family members or friends can be an important source of support. However, the stories of AMVs showed that they can reach their parents poorly, if at all. This has consequences for the work of health care professionals, as they have little or no knowledge about an AMVs medical history, except for some vague memories of the AMV. AMVs in general do not have their vaccination papers from their country of origin with them and may not be able to contact their parents to ask about their vaccination status, as the following citation shows:

> *"I never asked if it [vaccination papers] is still there or not… I don't know whether I've been vaccinated or not, because I can't reach my parents well, so I don't know…"*
>
> (16-year-old boy, from Eritrea)

Additionally, an AMVs experience with visiting the doctor (as cited earlier under section 4.1.3, Information provision), showed that not only a lack of information, but also the absence of compatriots speaking the same language, or anybody who could come with him to show him the way, led him to wanting to return back home and skip his doctor's appointment. He received a letter with an invitation for a doctor's appointment, but did not know where to go. During the FGD, he asked why nobody came with him, or why nobody brought him there.

This topic was also raised by two health care professionals during personal interviews. Firstly, a GP explained that retrieving medical history is more difficult for her when it considers AMVs from Eritrea, as she mostly retrieves medical history though the parents, which is not possible in case of AMVs. However, she also mentioned that AMVs are quite well able to explain their complaints and they can well express what is going on. The reason she proposed for this, is that AMVs form a close group, in which they can ask each other for advice and support.

> *"[…] And that is because they are quite close to each other. Because of this, in my opinion, they also ask each other, like 'how do you deal with this or how do you deal with that?'. So I do have the idea that they find protection within their group."*
>
> (GP GZA)

Furthermore, during the interview with a manager JGZ and a regional coordinator for the health of status holders, it was discussed how psychological complaints are very much individually dependent; Psychological well-being of an AMV with no parents close by may be completely different from a refugee family that can find support in each other. Additionally, during this interview, the regional coordinator for the health of status holders explained how the upbringing of children changes when the social community changes:

"You see in particular among Eritrean women that raising their children have been given a completely different setting in Dutch society than in the country of origin. The whole social network that they had there, because of the community they lived in, where their children were raised by each other and with each other, is now gone."

(Regional coordinator for the health of status holders)

4.2.4 Conclusion

Parents indicated that the change from one culture from their country of origin - a collectivistic culture - to another culture in the Netherlands - an individualistic culture - leads to cultural instability and in turn to conflicts between parents and their children. According to the parents, this is especially due to the different culture that their children encounter at school compared to home. Health care professionals also mentioned parents struggling with themselves as well as the Dutch culture in an AZC as causes of parent-child conflicts.

Furthermore, according to refugee parents, their children have been exposed to many events in their country of origin and during their flight to the Netherlands, resulting in many of their children struggling with psychological problems. AMVs reported that they experience stress, due to experiences in their country of origin, but also due to the great uncertainty about their future in the Netherlands. AMVs stated to be less motivated in doing their best at school, as their application for residence in the Netherlands could be rejected at any time. This may negatively affect the meaningfulness component of the SOC. However, they reported that they were never asked about or talked about their stress. During personal interviews, this stressor was supported by multiple health care professionals, although just one of the interview participants, the JGZ nurse, stated to explore psychological problems among refugee children in her work as a nurse.

Lastly, refugees have a limited social network. According to parents, their children spend much of their time on digital devices instead of playing outside with other children. Moreover, the frequent relocations between AZC make it challenging for refugee children to build up a social network. Additionally, AMVs can poorly, if at all, reach their parents. This is hampering the work of health care professionals, as they have little or no knowledge about the medical history of the AMV.

The presence of such stressors creates tension. As a consequence, people shift in their position on the ease-disease continuum. When overcoming the stressor, one shifts towards the ease-end, while shifting towards the disease-end when one fails to do so. However, the consequences of stressors can only be understood when we understand the coping process. Therefore, in the following section (4.3), the available resources for the participants to deal with stressors are presented.

4.3 GENERALIZED RESISTANCE RESOURCES

The following section presents the available resources within refugee children or their environment to deal with stressors. These GRRs facilitate coherent life experiences and SOC, which in turn is assumed to sustain health. Although a large number of GRRs were coded in the transcriptions after analysing the transcriptions of the FGDs, three overarching themes were found, including (1) school, (2) traditional healing and home care, and (3) knowledge. These GRRs were identified based on recurring topics or an explicit importance from the participants.

4.3.1 School

Besides the fact that the different culture that children encounter at school was perceived as a stressor by multiple refugee parents, school can also function as a resource in the life of refugee children. In the first FGD with Arab fathers, the participants were rather negative in their stories about school. School was mainly experienced as a stressor due to the cultural differences between school and parenting. However, in the second FGD with Arab mothers and the third FGD with Afghan and Iranian fathers and mothers, school was rather experienced as a resource. This was because of the role schools can have in recognising problems or diseases among the school going children. A Syrian mother was very pleased by the attention of the school to the health of her child:

> *"At school, my son… He drank lots of water. So at school they noticed and they've asked me… 'We want to do an examination for him, we're afraid of hepatitis'. So they did a blood test, but luckily it was all good."*
>
> (Mother from Syria)

Additionally, school has an important role in educating refugee children, for example about cultural differences and sex education, according to refugee parents. During the FGDs, multiple parents expressed the importance of teaching children at school about differences in culture. This will be further discussed under the needs in section 4.4.2. Furthermore, a Syrian mother of 4 children brought up the topic of sex education in the FGD with Arab mothers and fathers. A Syrian father indicated that sex education was taught at school at a later age in their country of origin, namely 15 or 16 years old. The same applied to homosexuality. A Syrian father explained that this is called "*deviant behaviour*" in their culture, but their children do learn about it at school. Education about these themes does exist in their country of origin, but the explanation is different and the age at which it is taught is higher. Other parents commented on this that they understand that it is taught earlier here in the Netherlands.

> *"Nowadays, in the Middle East or in Arab countries, attention is paid to these themes at an earlier age too, because the world is also changing. So maybe what was not allowed a few years ago, has now changed and is allowed now. It's different here in the Netherlands, so maybe we were a bit behind, especially on these themes. […] It is better to give this information to them instead of that they get wrong information themselves."*
>
> (Father of 1 child , from Syria)

Additionally, school can bring structure into the lives of refugee children, enhancing their SOC. This was evident from the stories of both parents and AMVs. "*Upbringing is for the parents*", a Syrian mother of four children stated, "*but learning and structure is for school*". School was brought up AMVs very often. They mainly discussed how the uncertainty in their life about a residence permit negatively affected their performances in school. Because they did not have a residence permit, they could less well

concentrate and did less well in school. They also discussed the fact that the opening hours of the kitchen in their KWV were not as desired, which resulted in not being able to have breakfast before going to school. Although there was confusion about the opening hours of the kitchen, the AMVs all agreed with the fact that they could not properly concentrate at school as they were constantly hungry. Without explicitly expressing the importance of school as a daily activity for them, school seemed to be an important form of structure in their lives.

During personal interviews with health care professionals, school was incidentally mentioned by three of the six participants. Both a paediatrician haematologist and a GP mentioned the role of school in recognising problems or diseases as well as accelerating the integration process of refugee children and hereby improving their mental health. "*School is a different environment with a different culture*", explained the GP, "*and if you talk about that, in my opinion, children integrate much faster. They find their way in the Netherlands easier and let things go much better. And I think we cannot do that by wanting to treat psychological problems, because sometimes, they are really very stuck*". Furthermore, a regional coordinator for the health of status holders explained that signalling health problems is done in collaboration with the JGZ, primary health care facilities, and school. School herein is a very low threshold way to give advice not only to refugee parents, but also to teachers in how to deal with psychological problems without referrals or health care programmes, according to the regional coordinator for the health of status holders.

4.3.2 Traditional healing and home care

In two FGDs, traditional healing and home care were brought up by refugee parents. Traditional healing in this context refers to health practices, approaches, knowledge and beliefs of the participants that are used to treat illness. This, together with home care, appeared to be a coping strategy of multiple parents when their children are ill. A Syrian mother told about her son who got ill in the central reception centre in Ter Apel. He had a very high fever and she described what steps she took when she realised that her son was ill. She explained that she called the doctor who had prescribed a recipe for paracetamol suppositories. However, what she did next was trying to relieve the fever by use of "*Arabic traditional medicine*", such as water with vinegar, or water with ginger and herbs. During another FGD with Arab mothers and fathers, a father came up himself with a question about traditional healing to the paediatrician present at that FGD. While discussing their experiences with health care in the Netherlands, he brought up the following question to ask for the paediatrician's opinion on this.

> *"What do you think of alternative healing? The herbal healing, or what do we call it? The traditional medicine, what do you think of that? Do you believe in that? Instead of medication, do you believe in… I don't know, herbs? Do you believe in that?"*
>
> (Father of 3 children, from Syria)

Without answering his question, but instead asking him how he did that in his country of origin, the father continued that they had their own way of treating a child with fever in their country of origin. *"When a child has a fever, we immediately make a washcloth with cold water, and certain substances, and then it gets better. Without paracetamol or… And that very strong cough, that dry cough, I use ginger and honey for that"*, he explained. To this, another father in the group stated that this is very common to do and this is common knowledge. However, the other father answered: "*Some people do not. When a child is coughing or has a fever, they run to the GP, although they can just cure it at home*". A mother in this group then added how, in their country of origin, parents deal with illness of their children and only visit a doctor when traditional healing has no effect:

"Definitely, we all do that. If our children are ill, we don't go to the hospital or to the doctor straight away, but we use other means like cold water or herbs. We do. But if the child doesn't respond to this traditional medicine and the fever keeps going up and doesn't drop, the we go to the doctor."

(Mother of 4 children, from Syria)

Although traditional healing was not brought up by any of the health care professionals themselves during the personal interviews, this topic was raised sometimes by the researchers and briefly discussed during the interview with a GP. She explained that in her opinion, when patients question traditional healing, we should certainly consider it. Especially regarding Eritrean refugees, she noticed that they do more with herbs.

"I always ask about what they've already done themselves and then sometimes stories come out and I think: 'Okay, interesting' [laughter]. But yes, I think that there should be room for that [traditional medicine]. And if I think that something really needs treatment, then I say so, and then they do that too."

(GP GZA)

4.3.3 Knowledge

A number of participants, especially parents, indicated that having knowledge about, for example diseases common in the Netherlands and the Dutch health care system is crucial for them in order to make good use of the available health care. The experiences of parents and AMVs already showed that parents and AMVs often feel that they have (too) little information and knowledge about such topics. Next to this, AMVs expressed the importance to them of having knowledge about their own state of health, which is evident from the very first answer to the first question of what their experiences were with preventive health care in the Netherlands:

"First, we obviously must know what our state of health is, in order to let you know what our experience with that is."

(16-year-old boy, from Eritrea)

After further explaining what preventive health care includes and that we would like to know their experiences with preventive health care in the Netherlands, the AMVs discussed whether they have ever been ill or been to a doctor in the Netherlands. An Eritrean AMV then explained that he had visited the doctor several times here in the Netherlands and that he had been diagnosed with tuberculosis. He was asked how he had experienced this and how it felt that he had been diagnosed with tuberculosis, to which he replied the following:

"That's the reason why I've been there [the doctor] so many times. To know what I was suffering from. So of course I am happy that it has been found."

(16-year-old boy, from Eritrea)

Among to the AMVs, having the knowledge that you are diagnosed with a disease was preferred above having no knowledge about your state of health at all. Another 16-year-old AMV from Eritrea also mentioned that it is important to know if you are suffering from an infectious disease, in order to prevent infecting others with it.

Although knowledge was not specifically mentioned as a resource by health care professionals during the personal interviews, both a JGZ doctor and a GP did mention that the refugees who visit their consultation hours in the AZC always have a lot to ask. The JGZ doctor explained that in general, parents join their children to an appointment and always ask him many questions. Furthermore, the GP explained that this is especially the case when there is a (telephone) interpreter present too.

> *"I also have the feeling that they [refugees] really want to know everything. And that is because there is an interpreter and they can explain everything well. Then I have the idea that they also ask a lot."*
>
> (GP GZA)

4.3.4 Conclusion

Several GRRs that can help refugee children sense their life as coherent, structured, and understandable can be derived from the results of the FGDs. Firstly, school was identified as a GRR. School brings structure into the lives of refugee children, as became evident during the FGDs with AMVs. This may contribute to the comprehensibility component of the SOC - the ability to understand challenges – and, this way, help in managing or overcoming stressors. Additionally, school can have a role in recognising problems or diseases among school going children and in educating children, while accelerating the integration process of refugee children and hereby improve their mental health. School can also be a low-threshold source of information to both refugee parents and teachers in how to deal with psychological problems among refugee children.

Additionally, a GRR that emerged from the results of the FGDs with refugee parents, was traditional healing and home care. Several parents indicated that when their child is ill, they try to cure this at home first. They used traditional remedies instead of doctor's prescriptions for paracetamol suppositories. This was considered as common knowledge by the participants, as they were used to in their country of origin. This may contribute to the manageability component of the SOC; the belief that one has the resources to deal with challenges. Using traditional healing and home care gave participants the feeling that the stressors they faced (e.g. an ill son) was manageable.

Lastly, an important GRR that emerged from the results of the FGDs with both parents and AMVs was knowledge. Having knowledge about diseases or the Dutch health care system appeared to be important to the participants in order to make good use of the available health care services. Also, knowledge about one's own state of health appeared to be an important GRR among AMVs, contributing to the comprehensibility component of the SOC.

4.4 NEEDS

Participants of the FGDs were asked what they needed with regard to preventive health care (for their children). In the following section, their needs are presented. In addition, salutogenesis provides a framework to understand what is needed to move towards optimal health. Therefore, this section describes the needs that were not directly mentioned by the participants, but arose from the stressors and GRRs as presented in the sections above. Important to note is that participants of the FGDs also expressed a need regarding curative health care, namely the need for access to specialised care without a referral. However, as this need is regarding curative health care, and the research question in this thesis is regarding preventive health care, access to specialised care without referral will not be further discussed.

4.4.1 More extensive initial health assessment

In all five FGDs, areas for improvement of the initial health assessment were discussed, based on the participants' needs. The two main needs that arose from the FGDs, were screening for common diseases from the country of origin in the initial health assessment, for example by blood research, and attention to psychological problems in the initial health assessment. These needs will be discussed below.

Screening for common diseases

Multiple parents and AMVs indicated a need for the screening of several diseases that refugee children are currently not being screened for when entering the Netherlands. Diseases that were mentioned by parents were cholera, avian flu, anaemia, micronutrient deficiencies, hepatitis, thalassemia, but also post-traumatic stress disorder (PTSD). Diseases mentioned by AMVs were scabies, anaemia and "*diseases as a consequence of thirst and hunger*". Although two parents from Syria mentioned that such a screening is not essential, because in general their children receive the necessary vaccinations in the country of origin, some parents also discussed the fact that children may be born during the journey from their country of origin to the Netherlands and, that way, do not receive any vaccination nor screening. Furthermore, a Syrian father stated that periodic examinations are very important in preventive health care, every three or six months for example. Another Syrian mother and father agreed with this statement and emphasized the importance of periodic examinations after the first screening for common diseases, as some diseases might come up in a later stage.

> *"[…] Perhaps periodic examinations for the children, every 3 or 6 months. […] Because it is possible that they have aberrant diseases, or something that appears to occur after years. […] A general assessment. Perhaps they've brought diseases with them from abroad that only occurs after 1 or 2 years. We don't know exactly what, but general examination on general health."*
>
> (Father of 4 children, from Syria)

Parents also discussed for which groups, that are extra vulnerable, screening is extra important. Refugees who have come from warzones or who have been in prison in their country of origin or during their flight, were considered as an extra vulnerable group by refugee parents.

> *"Screening for people from Syria or people who come from a warzone. Ask them, "who was in prison there?". Because in prison they have different kind of diseases. Then they have to pay attention. Especially among the people who were in prison, do extensive research, because they have diseases that would not normally occur, in a normal situation."*
>
> (Father of 4 children, from Syria)

The group with Afghan and Iranian parents mentioned AMVs as an extra vulnerable group. Not only the fact that they have come without parents or guardians would make them vulnerable, but also the route and sort of transport they have used to flee were said to affect their health status and should be given priority.

When discussing this topic during the FGD with AMVs, the participants particularly mentioned that they feel the need for screening in order to know what their state of health is. A 16-year-old amv from Eritrea explained that he had visited the doctor several times, as he was coughing blood and really wanted to know what was wrong with him. Another 16-year-old AMV from Eritrea, stated that besides a test for tuberculosis, he was never physically examined. However, he had also never felt ill. "*So, if I've never had an examination, and I've never been ill, how can I know for sure that I don't have any disease? In order to be able to say that you are healthy, you must have had an examination, a screening, to exclude any diseases*", he stated. Assuming a disease is found during such an examination, for example by doing blood research, this AMV stated to prefer knowing that he has a disease rather than not knowing what his state of health is; Not just for himself, but also to prevent infecting others.

> *"Then that's just the way it is. When you're ill… It has happened to you, you must know. What do you mean, you can't just keep procrastinating not wanting to know, while you do suffer from, you know… And besides, you also must be careful not to infect others."*
>
> (16-year-old boy, from Eritrea)

This AMV specifically mentioned that he would not mind giving blood at all for a blood research to screen on common diseases. However, not all AMVs were willing to participate in such an examination. A 17-year-old AMV from Sudan explained that he does not like medication or injections, nor giving blood for research. "*Because they are going to use up my blood completely*", he stated. Another 16-year-old AMV from Eritrea explained that he does not want to give blood for screening or receive injections next to his medication for tuberculosis.

This topic was also discussed during personal interviews with health care professionals. Overall, opinions about the necessity and effectiveness of a more extensive health screening programme were divided. A paediatric haematologist explained how she finds it feeling crooked not to do extra screening for a group of children you know is at risk. "*We do that for our own, say, cheese heads. Although we know in advance that a Dutch child will not have sickle cell disease. Yet it is cost-benefit. That's how it works with a screening programme. But for the group that is notably more at-risk, we don't do it*", this paediatric haematologist stated. When discussing this topic with a GP working for GZA, the GP asked herself, "*what are the risks of this group really? And how far should we go?*". However, when screening would be beneficial, the GP suggested that this would be a task for politicians at first, and could be executed by the GGD, being a form of preventive health care. The importance of really knowing the risks of this group was also expressed by a manager JGZ during one of the personal interviews. She mentioned that a more extensive health screening, by adding blood research to screen on common diseases from the country of origin, could be very beneficial, "*but then one has to look very carefully what is the country*

of origin from a child and which diseases occur there". Diseases that were mentioned during this personal interview were hepatitis, HIV and blood diseases. However, a more extensive health screening programme entails high costs, as mentioned multiple times during the personal interviews. This was a reason for the participants not to support laboratory tests in the initial health assessment for refugee children. Another reason not to, was the fact that adding screening for common diseases from the country of origin is medicalising, according to a manager JGZ.

> *"[...] But I think that is medicalising. Of course you don't try to medicalize, because we don't do that in the Netherlands. And you want people to know that it should not be medicalising or normalising. If you are going to examine a child in the hospital for youth health care, you will medicalize again. So you actually want to handle that very carefully"*
>
> (Manager JGZ)

Attention to psychological problems

When discussing participants' needs in preventive health care, in three FGDs (Arab fathers, Arab mothers and fathers and Afghan and Iranian mothers and fathers) participants particularly expressed a need for attention to psychological complaints and disorders in the initial health assessment. Early detection of psychological problems can prevent later mental disorders and referrals to youth care of youth mental health care. Parents also discussed that there is no doctor available that is specialised in psychological problems in the AZC, although they do feel the need for that. A Syrian father explained why he thinks that it is so important to give attention to psychological well-being of refugee children as soon as possible after arrival in the Netherlands:

> *"If they [Dutch health care professionals] start screening and treatment for psychological complaints or disorders, that is also good for the Netherlands. Because these children are going to grow up here, they are going to live here. So if they grow up with these problems, then we don't have a safe environment either, also for the Netherlands. It is very important to screen and treat this. Why? When a child is 7 years old, and you treat him now, he will be fine. But if you only do that when he is 18 years old, he already shows difficult behaviour. Maybe he will do something bad."*
>
> (Father of 7 children, from Syria)

AMVs did not specifically express a need for attention to psychological problems. However, regarding the stressors among AMVs, there may also be a need in this group. Multiple AMVs indicated that they experience stress, but that they never talk about this and were never asked about this. A 16-year-old AMV from Eritrea explained that health care professionals do not ask about stress because they do not know about their stress, which is because the AMVs are dealing with stress without talking about it openly and "*just go on with it*". When this group was asked whether they would like to talk about their stress, another 16-year-old AMV from Eritrea answered "*No, you are health care professionals, right? Isn't that what you are about*?". However, although several AMVs indicated that they do not talk about their stress and that they do feel healthy, when asking the AMVs what they think is 'health', a 16-year-old AMV from Eritrea answered that health is both mentally and physically. "*If you don't have a cold, but you do have stress, you are not yet healthy*", he stated.

When discussing a possible need for more attention to psychological problems in the initial health assessment during the personal interviews, five out of the six participants gave no priority to this in preventive health care. Although the importance of psychological well-being of refugee children was

discussed and acknowledged by all six participants, only the JGZ nurse stated that she particularly gives attention to psychological well-being of a child. A manager JGZ explained why the initial health assessment for refugee children is mainly medical:

> *"It is very broad social medical, but the medical side is of course the most important. Because in first instance, psychosocial problems, of course, do not come up immediately. They have fled, they have a flight history and that is just that for the moment. That doesn't really have priority, or someone has to be really psychotic or something like that. But otherwise, that is something when they come to rest, often when that have a residence permit eh. That they have a status and that they suddenly discover 'oh well I am sitting here somewhere without family' and that it comes out much more. But I also think, because language is a problem and whatsoever, that you really do look more medical or paramedical."*
>
> (Manager JGZ)

Furthermore, there seemed to be some confusion among the participants of the personal interviews about who signals psychological problems, who to refer to, and/or who provides mental health care. For example, a GP working for GZA mentioned that she does not often see refugees visiting her consultation hour with psychological problems or questions about mental health, and that she also does not really know what she could offer for mental health problems. However, a JGZ doctor stated that "*psychological problems often have already been signalised by the COA, who then refers to the GP*".

4.4.2 Education in cultural differences at school

During two of the FGDs with refugee parents, participants expressed an explicit need for attention to cultural differences. After some further questioning about this topic, parents suggested that their children should learn about cultural differences at school, about differing norms and values, and about their rights, but also about their duties. This need was not only indicated by parents directly, but also emerged from stressors and GRRs. Cultural instability was identified as a stressor, leading to parent-child conflict. According to refugee parents, attention to cultural differences would bring balance into their lives and facilitate parenting in a new, different culture. Furthermore, school was identified as a GRR, as school can have a role in signalling diseases among refugee children as well as educating refugee children.

In section 4.2.1 (cultural instability leading to parent-child conflict) was already discussed that parents experience the change from a collectivistic culture to an individualistic culture in the Netherlands as a challenge. An Iraqi father expressed the need for education in cultural differences, in order for their children to learn and understand how they should cope with cultural change and differences between their country of origin and the Netherlands.

> *"The children have come here and suddenly they live in a different culture. Everything is allowed… it's a different environment. So we notice that our children become a bit naughty, also against the parents. We also want someone to teach the children, how do you deal with different cultures? It is a new country."*
>
> (Father of 2 children, from Iraq)

A Syrian father also stressed the importance for their children to maintain their own norms and values and to participate in the society, without their children interacting with the parents in an uncivilised way. This father suggested that their children need to learn about the difference in culture by explaining

them, "*This is how we do it here, and that is how you do it there. And you don't have to adapt, but just know that it is different here*". Thus, refugee parents felt the need for their children to *integrate* in the Dutch culture, rather than *assimilate* to the Dutch culture.

Although educating cultural differences at school was not brought up by any participant in the personal interviews, the general importance of school in improving the health of refugee children was discussed. In three interviews, participants mentioned the importance of school for refugee children, because of the role school can have in recognising diseases among refugee children, but also in educating and advising refugee parents and teachers to help children cope with complaints and diseases to limit referrals to health care.

4.4.3 Attention to culture in health care

Although multiple parents indicated a need for attention to culture in health care during the FGDs, they did not elaborate much further on this need. Traditional healing and home care was identified as a GRR and confirms the need for attention to culture in health care. Furthermore, this need was evidently reflected in the personal interviews with health care professionals. Several health care professionals mentioned the importance of being open to and having knowledge about the cultural background of refugees. In this regard, it is more about being open to culture and customs of refugees than knowing the cultural differences, and therefore this need is described as attention to culture rather than attention to cultural differences in health care. For example, a paediatric haematologist explained that she can try anything to convince a refugee patient of following her advice, but if church is really important to that patient and the priest says no, it will not happen. It is therefore important to have some cultural background information, without forming prejudices or assumptions beforehand. A GP mentioned during the personal interview, that it is very important for health care professionals to stay curious and willing to learn about the patient, without having cultural prejudices.

All four health care professionals that work with refugee children directly (a paediatric haematologist, a GP working for GZA, a JGZ doctor and a JGZ nurse) mentioned that they have a special interest in refugee children and their cultures. For example, the paediatric haematologist explained during the personal interview that she deepens herself in this particular group and in culture by reading books about it. She also mentioned that health care professionals naturally stick to their Dutch habit that they think is good health care, while knowing that traditional remedies are still being used.

> *"One of my families turned out to have a Yazidi background. And then I just read a book about it, that way. […] And we know for example that there is a large group of Ghanaian people living in Amsterdam and thus a lot of Ghanaian people come to our clinic. We know that the church is very important to them. And then we give them advice and they'll be like 'yes, yes, yes doctor'. It's always 'yes', 'nice' and 'good'. But then they actually want confirmation from someone from the church. If he says no, we can say no matter what, but it will not happen. […] So sometimes it can help to ask them to bring that person from church who is so important. To see whether you can enter into that dialogue in that way. But we naturally stick to our Dutch habit that we think we think is good health care, knowing that herbs and things like that are of course still used. […] It does not mean that what we don't know is not good."*
>
> (Paediatric Haematologist)

4.4.4 PARENTAL SUPPORT

In one of the FGDs with refugee parents, a Syrian father expressed a need for parental support in the upbringing of their children in a different culture. His need was shared by a number of other parents of the FGD with Arab fathers. In other FGDs with parents, this need was not explicitly mentioned. However, in two FGDs with parents, participants did mention difficulties in parenting. Although this need is regarding the parents themselves instead of their children, the upbringing by parents plays a crucial role in the physical and psychological health of their children and therefore is discussed in this section.

Parents indicated to experience difficulties in the upbringing of their children. Specifically raising their children in a different culture than their children encounter at school is, according to parents, leading to conflicts between them and their children. As discussed in section 4.2.1, parents indicated that their children learn about Dutch culture and their rights at school, but not about their duties. A Syrian father also explained that when he does something that is normal in parenting in Syria, but not normal in parenting in the Netherlands, that does not necessarily mean that he is a bad parent:

> *"We are good parents. Don't think that we didn't raise them properly, we love our children. We must keep control over them. So if I grab my child's hand like that, that doesn't mean that I have to go to 'Veilig Thuis'. You see, it's different. And because things are different in the Netherlands, that does not mean that what we are doing is incorrect. And they [the Dutch] must understand that."*
>
> (Father of 4 children, from Syria)

Parents also indicated to find it difficult to talk with their children about experiences from the war. Multiple parents indicated that their children have traumatic experiences, they have experienced war and saw horrible things, like the death of a family member, which will not be easy for them to forget. In two FGDs with parents as well as in the FGD with AMVs, the participants stated that they are trying to forget what happened before and/or during their flight. A Syrian mother stated that she sees that when it comes to war, parents should not discuss that again with their children. "*We let them live in the present. That has been, so think about now. If we keep talking about that, what we have experienced and the war and everything that has been destroyed, that is not good*", she stated.

Health care professionals indicated to know about a need from refugee parents for parental support in the upbringing of their children. Although specific challenges in parenting were not mentioned by the interview participants, a GP suggested that the presence of a pedagogue or parenting coach could be very useful in an AZC to focus on children and parenting. In another interview, a regional coordinator for the health of status holders mentioned Eritrean mothers as a group with specific needs in parental support, as Eritrean children were raised by each other and with each other in the Eritrean community, which they have lost after fleeing to the Netherlands. This also confirms a need for social support, which is discussed in the following section.

4.4.4 SOCIAL SUPPORT

When fleeing and leaving behind their country of origin, refugees are also leaving behind the social network in their country of origin. This became apparent during both the FGDs with refugee parents and the FGD with AMVs. Although none of the participants in the FGDs mentioned a particular need for social support, from the stressors that were identified can be derived that refugee children (and their parents) may have a need for social support.

As mentioned in section 4.2.3 (limited social network), refugee parents expressed their concerns about the limited social contact that their children have with other children, because they spend a lot of time on digital devices. Parents preferred their children playing outside with other children in the AZC. Furthermore, parents of the FGD with Afghan and Iranian mothers and fathers indicated that the group of refugees who have come to the Netherlands without parents or guardians, thus the AMVs, is an extra vulnerable group and should be given priority. The fact that they do not have their parents close by and that they can poorly, if at all, reach their parents, means that the need for social support is even more crucial.

During the FGD with AMVs, the participants did not particularly indicate a need for social support. However, a 16-year-old amv from Eritrea did mention that he could not find the way to his doctor's appointment, because he was new and did not know where to be, did not speak the language, and thus could not find his way. "*Why don't they take you there? Why don't they bring you*?", he asked. Moreover, this boy explained that he was suffering from a lot of stress, because of the things that he had experienced in Libya, and specifically stated that he "*cannot do it alone*".

Additionally, although none of the participants of the personal interviews explicitly expressed that refugees need social support, health care professionals suggested several times that social support is beneficial for the health of refugee children. For example, a GP mentioned in a personal interview that she feels like AMVs form a quite close group, which is beneficial for their health as they can ask each other for advice and support. "T*hey also ask each other, like 'how do you deal with this or how do you deal with that?'. So I do have the idea that they find protection within their group*", she explained.

4.4.5 Information

A much recurring topic when discussing the needs of refugee children in preventive health care, was the need for information. Besides being explicitly expressed by the participants of the FGDs, this need emerged from participants' experiences (section 4.1.3, information provision) and Generalized Resistance Resources (section 4.3.3, knowledge). From participants' experiences, it appeared that AMVs and refugee parents have the feeling that they often have (too) little information about, for example, diseases, vaccinations, the health care system, cultural differences, but also about logistical things such as the way to the doctor. Due to the lack of knowledge and information, they also had many questions to the researchers about such topics during the FGDs. Trying not to give an answer to these questions, but instead asking them how they came to these questions and with whom they could discuss these, a Syrian father answered that he had a doctor's appointment the next day, but that he only had 10 minutes to talk with the doctor, which he stated to be too little. "*You don't have anybody to talk with about this. So what are you going to do with the questions that remain?*", he then said.

In section 4.3.3, knowledge was identified as a GRR, which is assumed to sustain health. AMVs expressed the need to know about their state of health. As discussed in section 4.4.1, a more extensive initial health assessment could give the necessary information about the health status of refugee children in order to fulfil this need. Furthermore, by providing information, refugee children and parents can obtain the knowledge necessary on a wide range of topics in health care. Hereby, it is particularly important that refugees actually understand and absorb this information. When discussing how information could best be provided to the participants, both parents and AMVs expressed how they appreciated the form of the FGD, in which they were able to share their experiences and opinions and had the possibility to ask questions in presence of an interpreter, who translated everything clearly for them. During the FGD with AMVs was discussed how the participants thought that an initial health assessment for refugee children in the Netherlands should be arranged; Where, by whom and when this should be done and how information should be provided about this. To this, an AMV from Eritrea stated the following:

> *"When someone is here, they should tell that something like that is possible. Just tell, so that people know that it exists. [...] So like now, like you [interpreter] are now interpreting for us. Tell, with an interpreter, what is possible. Telling, and also understanding what that means."*
>
> (16-year-old boy, from Eritrea)

The need for information was also widely discussed during the personal interviews with health care professionals. A regional coordinator for the health of status holders mentioned that repetition of information is key. She stated that information best comes across when repeating information during each contact moment that JGZ nurses and JGZ doctors have with refugee children. "*Repeating what you do, for who you work, how it works and who they can consult. So in that way, you can just try to familiarise them with a piece of information and prevention*", she explained. Another example that this participant gave to provide information, was through social media. She mentioned the Facebook pages, managed by Pharos (Dutch Centre of Expertise in Health Disparities) "Syriërs gezond" (Syrians healthy) and "Eritreeërs gezond" (Eritreans healthy), that provide a lot of information in Dutch as well as Arabic and Tigrinya, about health, health insurance and mental health.

4.4.6 Conclusion

Multiple needs in preventive health care for refugee children were indicated by refugee parents and AMVs during the FGDs, and emerged from the stressors and GRRs. Firstly, the need for a more extensive health assessment was discussed. In the initial health assessment, currently including vaccinations according to the national vaccination programme, an intake by a JGZ nurse and a medical examination by a JGZ doctor and periodic health examinations, could be extended by including a screening for common diseases in the form of laboratory tests. Although this need was indicated by multiple parents and AMVs, not all participants of the FGDs supported the inclusion of laboratory tests. Health care professionals questioned the necessity and effectiveness of such a screening programme, whereby it is important to research who is really at risk, and what these risks are. Furthermore, although refugee parents indicated a need for attention to psychological problems in the initial health assessment, most health care professionals prioritised a more medical focus.

Secondly, education in cultural differences at school was indicated as a need by refugee parents. According to refugee parents, their children should learn about cultural differences at school for them to *integrate* in the Dutch culture, rather than *assimilate* to the Dutch culture. Thus, parents want to see their children maintaining the culture of origin while adopting the new culture context, instead of adopting the new culture context to the disadvantage of that of origin. Parents' need for education in cultural differences at school was not discussed by health care professionals, although the important role of school in the health of refugee children was mentioned. According to health care professionals, school can recognise diseases among refugee children as well as educate and advise parents and teachers. Besides education in cultural differences, recognising diseases and educating and advising parents and teachers, school also plays a crucial role in the lives of refugee children as it brings structure into their lives as well as provides social support gained from friendships and teachers. This way, school contributes to the comprehensibility and manageability component of the SOC.

Thirdly, refugee parents indicated a need for attention to culture in health care. This need can partially be explained by the GRR traditional healing and home care. Refugees may have tried to treat illness with other coping mechanisms before visiting the doctor and may have interests and motives that health care professionals may not expect. It is therefore important to have some cultural background information, without forming prejudices or making assumptions beforehand. Health care

professionals emphasized the importance of being open to and having knowledge about the cultural background of refugees.

Furthermore, parental support was indicated as a need by refugee parents. Although this need is not regarding refugee children in preventive health care, parenting does play a crucial role in the upbringing and the health of a child. Refugee parents encountered challenges in raising their children in a different culture than their children encounter at school, which is, according to parents, leading to conflicts between them and their children. Parents felt that they were found to be bad parents when they did not comply with Dutch parenting habits. The need for parental support was confirmed by health care professionals. Parental support contributes to the manageability component of the SOC, offering parents support in developing adequate resources to manage demands in the upbringing of their children.

Another need that emerged from stressors and resources, was social support. Although social support was not explicitly mentioned by the participants, parents expressed their concerns about the limited social contact that their children have with other children in the AZC, as they spend much of their time on digital devices. Refugees have a limited social network after they have fled and left behind their country of origin as well as their social network and AMVs were seen as an extra vulnerable group, as they do not have their parents close by. This need was not brought up by health care professionals, although social support was mentioned as being beneficial for the health of refugee children.

Lastly, both refugee parents and AMVs expressed a need for information. This need was supported by the GRR knowledge, contributing to the comprehensibility component of the SOC. A prerequisite to be able to cope with stressful situations successfully is that one can to some extent understand the situation. Refugee parents and AMVs stated that they have (too) little information, for example about diseases, vaccinations, the health care system, but also about logistical things such as the way to the doctor. When providing information, it is particularly important that refugees actually understand and absorb this information. Information should be orderly, coherent, clear and structured. When discussing with the participants how this could best be done, both parents and AMVs expressed how they appreciated the form of a FGD for obtaining information. Health care professionals confirmed this need and mentioned that repetition of information is key. Another way for refugees to obtain information was suggested to be through social media.

5. DISCUSSION AND CONCLUSION

In the following chapter, the results will be interpreted in light of existing literature. Previous research may clarify or contradict with the results of this thesis. Afterwards, a conclusion is given, limitations of this study are discussed and recommendations for future research are outlined.

5.1 DISCUSSION

Participants brought up a variety of experiences with health care and shared many personal stories. Overall, four overarching themes were found in the experiences of the participants, including vaccinations by the JGZ, perceived authority of health care professionals, information provision, and differences between health care in the Netherlands and the country of origin. Remarkably, the participants of this study hardly shared any specific experience with the JGZ, who provides preventive health care for refugee children in the Netherlands, other than vaccinations being given. AMVs even stated to have no experience with health care at all, when they did have received vaccinations and a tuberculosis examination, which is performed by the JGZ. These results may indicate that refugees do not consciously experience or remember the intake and medical examination during the contact moments with a JGZ nurse and a JGZ doctor. Engaging with a new health care system can be challenging, especially when cultural and linguistic differences are present. Refugees may have insufficient knowledge about the Dutch health care system to understand the role of the JGZ in preventive health care for refugee children in the Netherlands. This idea is supported by a Swedisch cross-sectional study of Wångdahl, Lytsy, Mårtensson and Westerling (2015) among asylum seekers, which found that a considerable proportion of the participants experienced that they received little health care information and that the quality of communication was low during health examinations for asylum seekers. Similarly, the current study found that information provision is a key prerequisite for refugees in having positive experiences with health care. This may be depending however on refugees' level of health literacy (the ability to engage with and understand information in a way that promotes good health), as having inadequate health literacy is associated with the experience of not receiving new knowledge or receiving help with health problems, compared to adequate health literacy (Wångdahl, Lytsy, Mårtensson, & Westerling, 2015).

Another important finding of this study is that health care professionals have little authority in refugees' perspective. Participants indicated that they did not always follow the doctor's or nurse's advice and experienced feelings of mistrust towards health care professionals or their competences, particularly with regard to nurses. Without authority or power from health care professionals, a message or communication may not be respected or trusted by a patient. The different roles that health care professionals have in the country of origin may lead to distrust in the competence of health care professionals in the Netherlands. However, these results should be interpreted with caution, as an authoritative communication style of the health care professional has also been found to act as a barrier to the use of health services among ethnic minorities. Approaching an ethnic minority patient in a confrontational way can result in shame and discomfort, for example when the health care professional routinely refers to non-compliance of the patient (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). The low perceived authority of health care professionals by participants in this study may be explained by the unfamiliar power distribution between health care professionals and refugees. Power distance is what Hofstede, Hofstede and Minkov (2010) defined as "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally. Institutions are the basic elements of society, such as the family, the school, and the community; organizations are the places where people work". In many Arab countries, power distance is very strong, whereas the Netherlands score rather low on power distance (Hofstede,

Hofstede, & Minkov, 2010). In countries where power distance is strong, patients speak less, patient-doctor roles are more fixed and patient expectations regarding the medical encounter are more uniform compared to countries with a smaller power distance (Meeuwesen, van den Brink-Muinen, & Hofstede, 2009).

This study used a salutogenic approach to examine refugees' experiences and needs in preventive health care. Stressors and GRRs were identified to allow for more in-depth knowledge and understanding of refugees' needs. Overall, six key themes in the needs of participants were identified, including a more extensive initial health assessment, education in cultural differences at school, attention to culture in health care, parental support, social support, and information. The results of this thesis showed a need for a more extensive initial health assessment for refugee children upon arrival in the Netherlands, including a screening for common diseases by the use of laboratory tests and more attention to psychological problems. Regarding psychological problems, for many Eritreans there is a taboo on recognizing mental health issues. Such issues are seen as a threat to family honour and may be attributed to supernatural powers. A solution is therefore sought in medicine or ritual cleansing and expulsion (Ferrier, Kahmann, & Massink, 2017). However, the Eritrean sample of AMVs in the current study openly discussed suffering from stress and having negative thoughts, due to experiences in their country of origin, but moreover because of the great uncertainty about their future in the Netherlands. In line with these results, research from Sleijpen, Van Es, Te Brake, and Mooren (2017) found that Eritrean refugees suffer from many psychosocial complaints, such as stress, worry, insomnia and bad dreams. Among AMVs in their study, the symptoms were also expressed in feeling sick, problems with concentration at school and difficulty in regulating emotions. When experiencing too much stress, they stay in bed (Sleijpen, Van Es, Te Brake, & Mooren, 2017), as was mentioned by an AMV in the current study. As regards the SOC, refugee children have little participation in shaping the outcome of their application for residence in the Netherlands and must wait for an unspecified period of time. The decision of whether their future will be in the Netherlands, in their country of origin, or in another unknown place, is in hands of the IND. This may threaten the development of a sense of meaningfulness and thus the building a SOC.

Parents in the current study stressed the importance for their children to maintain their own norms and values while participating in Dutch society. This refers to a process of integration, what Berry and Sabatier (2011) describe as a situation "when there is both a wish to maintain one's heritage culture, and also to participate in the larger society", rather than assimilation; a situation "when individuals express a preference for not maintaining their heritage culture and to participate in the larger society" (Berry & Sabatier, 2011). Maintaining the native culture is an important prerequisite for integration and has been found to facilitate adjustment during resettlement (Braun-Lewensohn & Al-Sayed, 2018). Moreover, a study of Benz, Bull, Mittelmark and Vaandrager (2014), wherein a synopsis of Antonovsky's work in the area of culture in Salutogenesis is provided, showed that Antonovsky not only addressed culture as a source of stress, but also as a key source of GRRs. An important aspect of GRRs is cultural stability. Cultural stability as well as the ability to adapt to cultural norms is a factor in the building of a strong SOC and contributing to well-being (Antonovsky, 1987; Antonovsky, 1979). According to refugee parents in the current study, their children learn about the Dutch norms and values and about their rights at school, but not about their duties or their native culture, resulting in a cultural imbalance and in turn parent-child conflicts. In many refugee families, manners at home may be very different compared to those at school. This cultural imbalance leads to difficulties in upbringing. Upbringing can be extra challenging for parents in a migration context (Distelbrink, Pels, Jansma, & Van der Gaag, 2012). In the new country of residence, many non-western migrants, for example, are confronted with a different (parenting) culture and with norms, values and customs that deviate from what they were used to in their country of origin (Bucx & Roos, 2015). Children may adapt more quickly, make new

contacts and come into contact with other norms and values than in their home country, which may conflict with that of the parents and lead to stress in the family, as was found in a sample of Chilean and Middle Eastern refugees in Sweden (Hjern, Jeppson, & Angel, 1998). Building on to these results, the current study identified a need among refugee parents for parental support and for their children to be educated in cultural differences at school, in order for their children to be stimulated to maintain their native culture while adapting to Dutch cultural norms.

Social support is widely acknowledged as a post-migration protective factor for the mental health of refugees (Mina Fazel, Reed, Panter-brick, & Stein, 2012; Haker et al., 2016; Kovacev & Shute, 2004; Oppedal & Idsoe, 2015). Research from Kovacev and Shute (2004) showed that the availability of social support facilitates successful psychosocial adaption of refugee children. Supporting these results, the current study found a need for social support for the health of refugee children. Refugee parents participating in the FGDs of this study pointed out AMVs as an extra vulnerable group, as they do not have their parents close by. For this group, it may be extra relevant to increase social support. The frequent relocations between COA reception centres impedes social contact and building up a social network. Moreover, children may feel like making new friends is not worthwhile, impeding the meaningfulness component of the SOC. One way to increase the access to social support for refugees would be to ensure the development of reception centre and school environments where refugees can stay for a longer time and feel able to seek support from family, fellow residents and compatriots, but also from staff, as a way to deal with stress. In particular, enhancing the mutual social support among compatriots deserves attention, as research among unaccompanied Sudanese refugee minors showed that Sudanese children living in a group home or foster care without other Sudanese people were more likely to have PTSD than those in foster care with other Sudanese people (other fostered children or foster family) (Geltman, Grant-Knight, Ellis, & Landgraf, 2008). On the policy level, government and policy makers should consider to limit the frequent relocations of refugee children, in order to give them a more stable community, which is one of the most important criteria for the development of SOC, as the stability of the community helps to perceive the world around them as predictable and manageable (Sagy & Braun-Lewensohn, 2009; Antonovsky, 1987).

Lastly, both refugee parents and AMVs indicated a need for information. Many refugees originate from low- or middle-income countries, where the health care system is very different to that of the Netherlands. Understanding how the Dutch health system works was found to be a challenge for refugees and this information gap needs to be addressed. These results are supported by a systematic review (Hadgkiss & Renzaho, 2014) which showed that refugees in the majority of the studies included had difficulties in navigating the health care system. Lack of provision of health service information upon arrival was found as one of the barriers to accessing health care. Similar results were found by Loenen et al. (2018), who found that refugees and health care workers received insufficient information about the organisation and location of health care services, and lack of information was one of the biggest barriers in health care (Loenen et al., 2017). When providing information, it is particularly important that refugees can understand and absorb this information. When discussing with the participants in the current study how this could best be done, both parents and AMVs expressed how they appreciated the form of the FGD for obtaining information. This way, they were able to share their experiences and opinions with each other and they had the possibility to ask questions in presence of an interpreter, who translated everything clearly for them, and professionals, who could answer their questions.

5.2 CONCLUSION

The aim of this study was to gain insight into how refugees experience the preventive health care for refugee children in the Netherlands and to what extent this matches their needs. The salutogenic model functioned as a theoretical lens, focussing on how the participants move towards health despite the challenges they face, to gain more in-depth knowledge and understanding of refugees' needs. The results showed that participants experienced multiple stressors in the context of health care. More importantly, this study indicated resources within refugees and their environment to cope with stressors and help sense their life as coherent, structured, and understandable, such as school, which is assumed to sustain health. Overall, this thesis identified refugees' needs and has highlighted the importance of strengthing the SOC among refugee children, in order to enable them to cope with the variety of stressful situations they experience and to reduce the threat that migration may pose to experiencing consistency, load balance and meaningfulness. Despite the extremely high numbers of people seeking asylum, little research has been done to better understand the health needs of this vulnerable group. More research is needed to plan and design preventive health care for refugee children more effectively and address their needs.

5.3 LIMITATIONS

There were several limitations to this study, which should be acknowledged. Firstly, refugees are not a homogeneous group of people, and have differing understanding and expectations of health care. Every individual is unique and may have different experiences, understandings and expectations. The sample of this study is limited, as is the diversity in the participants' background and place of residence in the Netherlands. Also, the inclusion of one FGD with AMVs in this study was limited, compared to four FGDs with refugee parents. Furthermore, there was no recording of the FGD with Afghan and Iranian parents, thus only notes of this FGD were used as additional results in the data analysis. Therefore, generalising the results to a broader population is difficult. A more balanced research sample would be beneficial to heterogeneity. However, this is a trade-off that must be made while choosing for either quantitative or qualitative research methods. Choosing for qualitative research methods was necessary to gain detailed understanding of underlying reasons, beliefs and motivations.

Secondly, the FGDs were all held with use of an interpreter, which may have influenced the reliability of the results. Despite explicit instructions to translate as literally as possible, the interpreter may have chosen words that altered the messages of the respondents and it is not known how accurate the interpretation was. Moreover, even with careful translation, ensuring that concepts are understood the same way across cultures can be challenging. During this research, I have used my own inevitable interpretation, which influenced the outcomes of this research.

This study is part of the PhD research and will be used to develop the guideline health care for refugee children, together with another master student's thesis on the accessibility of health care for refugee children. Therefore, part of the FGDs included open-ended questions on the topic of accessibility of health care, which is included in the analysis of this research. As a result, access to care may have received relatively much attention in the current study and there was limited time during the FGDs to focus on experiences and needs in preventive health care. However, although this may have influenced the results, it also helped to gain better understanding of participants' expectations and experiences of health and health care.

5.4 SUGGESTIONS FOR FURTHER RESEARCH

The current research was cross-sectional, meaning that the FGDs and interviews were only held at one point in time. Respondents answered from their current situation and their needs in that specific

moment, although these can change over time. It could be valuable to examine whether refugees' experiences and their needs change over time and, if so, how this changes over the time they have been in the Netherlands. Future research could examine this by the use of longitudinal research.

Secondly, further research on high-risk groups among refugees and their specific risks are required in order to examine the necessity and effectiveness of a more extensive screening programme, wherein, for example, laboratory tests on nutritional status, infectious diseases and the existence of geographically determined diseases are included. Additionally, a pilot screening programme could be implemented in order to gain insight into the cost-effectiveness of a certain screening programme.

Using a salutogenic approach, stressors and GRRs in the context of health care were identified in this study. Through application of GRRs, the tension caused by stressors being transformed into stress and illness can be prevented. Investing in a resource-strengthening approach, focussed on using, improving and maintaining the resources available, will empower refugees to deal with everyday life stressors and improve their SOC, which in turn leads to better health. It would be interesting for future research to examine the possible effect of a resource-strengthening approach in preventive health care.

REFERENCES

Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion 1. *Health Promotion International*, *11*(1), 11–18.

Baauw, A., Rosiek, S., Slattery, B., Chinapaw, M., van Hensbroek, M. B., van Goudoever, J. B., & Kist-van Holthe, J. (2018). Pediatrician-experienced barriers in the medical care for refugee children in the Netherlands. *European Journal of Pediatrics*.

Bean, T. M. (2006). *Assessing the psychological distress and mental healthcare needs of unaccompanied refugee minors in the Netherlands*. Leiden University.

Becker, C. M., Glascoff, M. A., & Felts, M. (2010). Salutogenesis 30 Years Later: Where do we go from here? *International Electronic Journal of Health Education*, *13*, 25–32.

Birks, M. J., Chapman, Y., & Francis, K. (2007). Breaching the Wall: Interviewing People From Other Cultures. *Journal of Transcultural Nursing*, *18*(2), 150–156.

Braun-Lewensohn, O., & Al-Sayed, K. (2018). Syrian adolescent refugees: How do they cope during their stay in refugee camps? *Frontiers in Psychology*, *9*, 1–10.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Buch, B. (2006). *Salutogenesis and Shamanism*. Department of Health Psychology and Health Education University of Flensburg. Master's Thesis.

Bucx, F., & Roos, S. De. (2015). *Opvoeden in niet-westerse migrantengezinnen. Een terugblik en verkenning*. Sociaal en Cultureel Planbureau, Den Haag.

De Vries, G., Van Rest, J., Meijer, W., Wolters, B., & Van Hest, R. (2016). Low yield of screening asylum seekers from countries with a tuberculosis incidence of <50 per 100000 population. *European Respiratory Journal*, *47*(6), 1870–1872.

Distelbrink, M., Pels, T., Jansma, A., & Van der Gaag, R. (2012). *Ouderschap versterken: Literatuurstudie over opvoeding in migrantengezinnen en de relatie met preventieve voorzieningen*. *Verwey-Jonker Instituut*.

Eklöf, N., Hupli, M., & Leino-Kilpi, H. (2017). Planning focus group interviews with asylum seekers: Factors related to the researcher, interpreter and asylum seekers. *Nursing Inquiry*, *24*(4), 1–8.

Eriksson, M. (2017). The Sense of Coherence in the Salutogenic Model of Health. In *The Handbook of Salutogenesis* (pp. 91–96). Springer International Publishing.

Eriksson, M., & Lindström, B. (2005). Validity of Antonovsky's sense of coherence scale: A systematic review. *Journal of Epidemiology and Community Health*, *59*(6), 460–466.

Fazel, M., Reed, R. V, Panter-brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, *379*, 266–

282.

Fazel, M., & Stein, A. L. (2002). The mental health of refugee children. *Arch Dis Child*, *87*(5), 366–370.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, *365*, 1309–1314.

Ferrier, J., Kahmann, M., & Massink, L. (2017). "Jullie Nederlanders hebben voor alles een systeem". Handreiking voor ondersteuning van Eritrese nieuwkomers bij hun integratie. *Kennisplatform Integratie & Samenleving*.

Geltman, P. L., Grant-Knight, W., Ellis, H., & Landgraf, J. L. (2008). The '"Lost Boys"' of Sudan: Use of Health Services and Functional Health Outcomes of Unaccompanied Refugee Minors Resettled in the U.S. *Journal of Immigrant and Minority Health*, *10*, 389–396.

Gerritsen, A. A. M., Bramsen, I., Devillé, W., van Willigen, L. H. M., Hovens, J. E., & van der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, *41*(1), 18–26.

GGD GHOR Nederland. (2017). *Basispakket JGZ Asielzoekerskinderen 0-18 jaar*.

Hadgkiss, E. J., & Renzaho, A. M. N. (2014). The physical health status , service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature, *38*, 142–159.

Haker, F., van den Muijsenbergh, M., Torensma, M., van Berkum, M., Smulders, E., Looman, B., … van Bokhoven, R. (2016). Kennissynthese gezondheid van nieuwkomende vluchtelingen en indicaties voor zorg , preventie en ondersteuning, 90.

Hermans, B., Nutma, N., Oomen, T., & Van den Muijsenbergh, M. (2018). *Factsheet Asielzoekers en Gezondheidszorg.*

Hjern, A., Jeppson, O., & Angel, B. (1998). Political violence, family stress and mental health of refugee children in exile. *Scandinavian Journal of Public Health*, *26*(1), 18–25.

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and Organizations: Software of the Mind*.

Hunter, P. (2016). The refugee crisis challenges national health care systems. *EMBO Reports*, *17*(4), 492–495.

Idan, O., Eriksson, M., & Al-yagon, M. (2017). The Salutogenic Model: The Role of Generalized Resistance Resources. *Springer International Publishing*, 57-69.

Immigratie- en Naturalisatie Dienst (2018). *Asylum Trends: Monthly Report on Asylum Applications in The Netherlands*.

Jones, D., & Gill, P. S. (1998). Refugees and primary care: tackling the inequalities. British Medical Journal, *317*, 1444–1446.

Kalt, A., Hossain, M., Kiss, L., & Zimmerman, C. (2013). Asylum seekers, violence and health: A systematic review of research in high-income host countries. *American Journal of Public Health*,

103(3).

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., … Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, *183*(12), 959–967.

Kotovics, F., Getzin, A., & Vo, T. (2018). Challenges of Refugee Health Care: Perspectives of Medical Interpreters, Case Managers, and Pharmacists. *Journal of Patient-Centered Research and Reviews*, *5*(1), 28–35.

Kovacev, L., & Shute, R. (2004). Acculturation and social support in relation to psychosocial adjustment of adolescent refugees resettled in Australia, *28*(3), 259–267.

Laban, C. J., Gernaat, H. B. P. E., Komproe, I. H., Schreuders, B. A., & De Jong, J. T. V. M. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *Journal of Nervous and Mental Disease*, *192*(12), 843–851.

Laban, C. J., Gernaat, H. B. P. E., Komproe, I. H., Van Der Tweel, I., & De Jong, J. T. V. M. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease*, *193*(12), 825–832.

Leh Hoon Chuah, F., Teng Tan, S., Yeo, J., & Legido-Quigley, H. (2018). The health needs and access barriers among refugees and asylum-seekers in Malaysia : a qualitative study. *International Journal for Equity in Health*, *17*, 1–15.

Loenen, T. Van, Muijsenbergh, M. Van Den, Hofmeester, M., Dowrick, C., Ginneken, N. Van, Mechili, E. A., … Lionis, C. (2017). Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes. *European Journal of Public Health, 28*(1), 82–87.

Marquardt, L., Krämer, A., Fischer, F., & Prüfer-Krämer, L. (2016). Health status and disease burden of unaccompanied asylum-seeking adolescents in Bielefeld, Germany: cross-sectional pilot study. *Tropical Medicine and International Health*, *21*(2), 210–218.

Meeuwesen, L., van den Brink-Muinen, A., & Hofstede, G. (2009). Can dimensions of national culture predict cross-national differences in medical communication? *Patient Education and Counseling*, *75*(1), 58–66.

Mittelmark, M. B., & Bauer, G. F. (2017). The Meanings of Salutogenesis. In *The Handbook of Salutogenesis* (pp. 7–13). Springer International Publishing.

Ogilvie, L. D., Burgess-Pinto, E., & Caufield, C. (2008). Challenges and Approaches to Newcomer Health Research. *Journal of Transcultural Nursing*, *19*(1), 64–73.

Oppedal, B., & Idsoe, T. (2015). The role of social support in the acculturation and mental health of unaccompanied minor asylum seekers. *Scandinavian Journal of Psychology*, *56*, 230–211.

Pozzo, M., Bender, D., & Visser, W. (2018). Leefomstandigheden van kinderen in asielzoekerscentra en

gezinslocaties, 82.
Robertshaw, L., Dhesi, S., & Jones, L. L. (2017). Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: A systematic review and thematic synthesis of qualitative research. *British Medical Journal*, *7*(8), 1–18.
Sagy, S., & Braun-Lewensohn, O. (2009). Adolescents under rocket fire: When are coping resources significant in reducing emotional distress? *Global Health Promotion*, *16*(4), 5–15.
Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: a review. *Family Practice*, *23*(3), 325–348. 3
Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatized asylum seekers. *European Journal of Psychotraumatology*, *6*, 1–9.
Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma , post-migration living difficulties , and social support as predictors of psychological adjustment in resettled Sudanese refugees, *40*(2), 179–187.
Sleijpen, M., Van Es, C., Te Brake, H., & Mooren, T. (2017). *Alleenstaande minderjarigen uit Eritrea in Nederland*.
Söndergaard, H. P., Ekblad, S., & Theorell, T. (2001). Self-reported life event patterns and their relation to health among recently resettled Iraqi and Kurdish refugees in Sweden. *Journal of Nervous and Mental Disease*, *189*(12), 838–845.
Swan, E. (2016). *Understanding healthful eating from a salutogenic perspective*. Wageningen University.
UNHCR (2018). *Global Trends: Forced Displacement in 2017*. Retrieved 2019 January 19, from: https://www.unhcr.org/5b27be547.pdf
UNHCR (2018). *Begrippenlijst*. Retrieved 2018 May 30, from: https://www.unhcr.org/nl/media/begrippenlijst/.
Wångdahl, J., Lytsy, P., Mårtensson, L., & Westerling, R. (2015). Health literacy and refugees' experiences of the health examination for asylum seekers - A Swedish cross-sectional study Health behavior, health promotion and society. *BMC Public Health*, *15*(1).
Welling, R., Slaats-Willemse, D., Schers, H., & van de Laar, F. (2014). Psychische problematiek bij kinderen en jongeren. *Huisarts En Wetenschap*, *57*(12).
WHO (2006). Constitution of the World Health Organization. Retrieved 2018 September 19, from: www.who.int/governance/eb/who_constitution_en.pdf.
Yun, K., Matheson, J., Payton, C., Scott, K. C., Stone, B. L., Song, L., … Mamo, B. (2016). Health profiles of newly arrived refugee children in the United States, 2006-2012. *American Journal of Public Health*, *106*(1), 128–135.

APPENDICES

I. STUDY POPULATION

A. Focus group discussions

	Nationality	Sex	Children	Age	Type	Time in the Netherlands (range)
1	Iraq	Male	2	-	Parent	7 months to 3 years
2	Syria	Male	8	-	Parent	
3	Kuwait	Male	3	-	Parent	
4	Syria	Male	4	-	Parent	
5	Syria	Male	7	-	Parent	
6	Syria	Male	4	-	Parent	
7	Palestine/Syria	Female	12	-	Parent	
8	Iraq	Female	2	-	Parent	
9	Jordan	Female	3	-	Parent	
10	Kuwait	Female	3	-	Parent	
11	Syria	Female	7	-	Parent	
12	Syria	Female	4	-	Parent	
13	Syria	Male	1	-	Parent	
14	Syria	Male	4	-	Parent	
15	Syria	Female	4	-	Parent	
16	Syria	Female	4	-	Parent	
17	Syria	Male	3	-	Parent	
18	Iran	Female	4	-	Parent	
19	Afghanistan	Male	6	-	Parent	
20	Afghanistan	Female	5	-	Parent	
21	Afghanistan	Female	3	-	Parent	
22	Afghanistan	Female	4	-	Parent	
23	Iran	Male	4	-	Parent	
24	Eritrea	Male	-	15	AMV	7 months to 14 months
25	Eritrea	Male	-	16	AMV	
26	Guinee	Male	-	17	AMV	
27	Eritrea	Male	-	16	AMV	
28	Eritrea	Male	-	16	AMV	
29	Eritrea	Male	-	16	AMV	
30	Sudan	Male	-	16	AMV	
31	Sudan	Male	-	17	AMV	

B. INTERVIEWS

	Function	Date of the interview
1	Paediatric Haematologist	11-01-2019
2	GP at GZA	25-01-2019
3	Manager JGZ Regional coordinator for the health of status holders	04-02-2019
4	JGZ nurse 4-18 year olds	12-02-2019
5	JGZ doctor 0-18 year olds	25-02-2019

II. TOPIC GUIDE

A. Focus group discussions

Introductie onderzoek en uitleg preventieve zorg + rol JGZ in Nederland

Thema	Vragen:	Tijd	Notes
Experiences in preventive health care (*Chanine*)	a. Wat kunt u zich herinneren van de preventieve zorg in Nederland? • Contactmoment met JGZ. • Jeugdverpleegkundige intake/ lichamelijk onderzoek jeugdarts/vaccinaties. • Was u als ouder daarbij? Waar/wanneer was dat? • Informatieverschaffing/kennis: Was het duidelijk voor u wat er gebeurde/kreeg u voldoende uitleg/kon u vragen stellen? b. Wat heeft u als positief ervaren bij dit contact met een jeugdarts/jeugdverpleegkundige? • En wat als minder positief? • Bijv. Taal, uitleg/informatievoorziening, soort vaccinaties, follow-up, etc.	20 min	
Needs in preventive health care (*Chanine*)	a. Wat verwachtte u van de Nederlandse preventieve gezondheidszorg (voor uw kind)? • Verwachting aan vaccinaties. • Verwachting aan testen voor ziekten uit land van afkomst (welke ziekten). • Verwachting aan zorg voor psychische gezondheid. b. Wat vindt u van de aandacht voor fysieke gezondheid in het nieuwkomersonderzoek? • Voldoende/onvoldoende. • Hoe zou dit verbeterd kunnen worden? c. Wat vindt u van de aandacht voor psychische gezondheid in het nieuwkomersonderzoek? • Voldoende/onvoldoende. • Hoe zou dit verbeterd kunnen worden?	30 min	**Anemie, hemoglobinopathie, hepatitis B en C, HIV, (latente) tuberculose, parasitaire infecties*

	d. In uw land van herkomst komen andere ziektes voor dan hier in Nederland, bijvoorbeeld *. Hier wordt u(w kind) niet standaard op getest bij binnenkomst in Nederland. Wat vindt u hiervan? • Is dit nodig? Waarom wel/niet? Welke ziekten? e. Wat herinnert u zich van de preventieve zorg in uw thuisland? • Hoe verschilt deze vorm van preventieve zorg met die in Nederland? • Wat vindt u van dit verschil? f. Hoe zou u graag willen dat het nieuwkomersonderzoek door de jeugdverpleegkundige en jeugdarts op het AZC, (een intake, lichamelijk onderzoek en een vaccinatieplan), eruit ziet? g. Wat betekent voor u "gezondheid"?		

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

Heeft u nog iets toe te voegen/heeft u nog vragen?

Participanten bedanken voor deelname.

B. Interviews

Introductie onderzoek

1. *Algemeen*

- Wat is uw rol/wat houdt uw baan in?

2. *Preventieve gezondheidszorg (Chanine)*

Korte uitleg preventieve gezondheidszorg en rol van JGZ.

- Wat vindt u van het huidige nieuwkomersonderzoek?
    - De ziektes waarvoor gevaccineerd wordt.
    - Aandacht voor fysieke en voor psychische gezondheid.
    - Informatievoorziening hieromheen.
- Vluchtelingen kinderen kunnen andere gezondheidsbehoeften hebben dan Nederlandse kinderen wat betreft de gezondheidszorg. Kunt u vertellen wat in uw ervaring de behoeften van vluchtelingenkinderen zijn?
    - Volledigheid/omvattendheid nieuwkomersonderzoek→ Denkt u dat het nieuwkomersonderzoek aansluit op de gezondheidsbehoeften van vluchtelingenkinderen?
    - Ervaringen en behoeften die uit FGD zijn gekomen voorleggen en vragen naar herkenning.
- In het land van herkomst komen andere ziektes voor dan hier in Nederland (bijv. anemie, hemoglobinopathie, hepatitis B en C, HIV, (latente) tuberculose, parasitaire infecties). Vluchtelingenkinderen worden hier niet preventief op getest bij binnenkomst in Nederland. Wat vindt u hiervan?
    - Voordelen?
    - Nadelen?
- Hoe zou u de preventieve zorg/het nieuwkomersonderzoek voor vluchtelingenkinderen graag willen zien in Nederland?

3. *Accessibility (Sogol)*

Ability to Perceive

- Wat voor kennis heeft u over de achtergrond van uw patiënten?
- Wat weten vluchtelingenouders/kinderen/AMVs over het gezondheidssysteem en het recht op gezondheidszorg?

Ability to Seek

- Hoe kunnen ze toegang krijgen tot de zorg die u ze verleent?
- In hoeverre ervaart u dat taal, cultuur en religie van invloed zijn op de zorg die u verleent?
    - Hoe gaat u hiermee om?
    - Hoe denkt u dat dit kan worden verbeterd?

Ability to Reach

- Wat kunt u vertellen over de hulp die vluchtelingen krijgen om uw zorg te bereiken in de vorm van transport/taal?

Ability to Pay

- In hoeverre zijn vluchtelingen op de hoogte van hun zorgverzekering en eigen risico?
- In hoeverre komt het voor dat vluchtelingen voor transport, medicatie of aanvullende medische hulp moeten bijbetalen?

Ability to Engage

- Heeft u het idee dat uw patiënten u voldoende begrijpen tijdens uw consult?
    - Zo ja, hoe handelt u tot zij u begrijpen? Zo nee, waar ligt dit aan?
- Waar denkt u dat behoefte aan is om vluchtelingenkinderen optimale zorg te verlenen vanuit uw rol?
- Heeft u suggesties ter verbetering voor de toegang van zorg voor vluchtelingkinderen?

Heeft u nog iets toe te voegen/heeft u nog vragen?

Participant bedanken voor deelname.

III. CODING SCHEME

1. EXPERIENCES	
Overarching categories	**Open coding phase**
Vaccinations by the JGZ	• Vaccinations
Perceived authority of health care professionals	• Distrust in health professionals • Noncompliance
Differences between health care in the Netherlands and the country of origin	• Antibiotics • Paracetamol and water • Referral system • Long waiting time • Direct access to specialised care
Information provision	• Information on diseases • Information on health care system • Information on vaccinations • Information in general
2. STRESSORS	
Cultural instability leading to parent-child conflict	• Parent-child conflict • Cultural change • Cultural differences in upbringing • Child abuse
Psychological problems	• Nightmares • Bedwetting • Anxiety • Uncertainty about the future • Stress • War
Limited social network	• Digital devices • Unable to reach parents • Absence of compatriots • Relocation
3. GENERALIZED RESISTANCE RESOURCES	
School	• Influence of school • Unable to concentrate in school • Hungry at school
Traditional healing and home care	• Traditional medicine
Knowledge	• Information on diseases • Information on health care system • Information on vaccinations • Information in general • Knowing about health status
4. NEEDS	
More extensive initial health assessment	• Screening • Laboratory testing • Attention to psychological problems
Education in cultural differences at school	• Influence of school

	• Cultural differences in school • Norms and values • School in general
Social support	• Digital devices • Unable to reach parents • Absence of compatriots • Relocations • Activities in COA reception centre
Information	• Information on diseases • Information on health care system • Information on vaccinations • Information in general • Knowing about health status