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EUR-HUMAN project
WP3: Review of literature and expert knowledge

Deliverable 3.2. Final Synthesis

Understanding the factors that promote or hinder the implementation of health care interventions for refugees and others migrants in European health care settings

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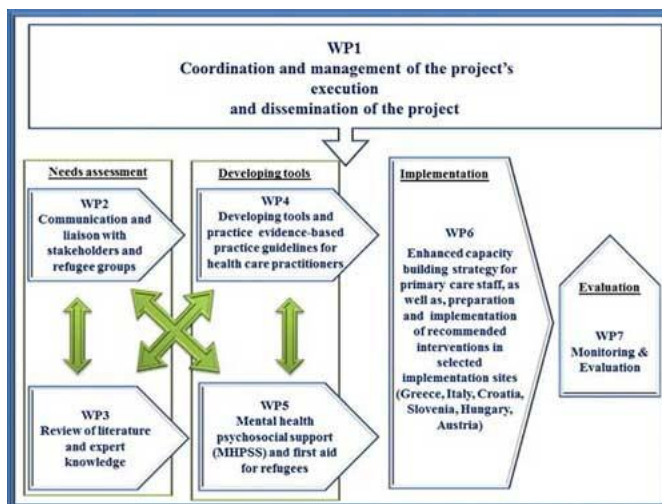
About this report

EUR-HUMAN

In January 2016, with the international refugee crisis in a critical phase, pressuring many European countries to develop policy and plans to better define their role in supporting refugees entering Europe, an international consortium led by University of Crete started the EU-funded EUR-HUMAN project: EUropean Refugees-HUMAN Movement and Advisory Network. The primary objective of the EUR-HUMAN project was to identify, design and implement interventions to improve primary health care delivery for refugees and other migrants¹ in Europe at hotspots, transit centres and longer stay first reception centres.

The work packages of EUR-HUMAN

The core of the EUR-HUMAN project consists of a set of interrelated work packages (WPs) with activities coordinated by different partners.



In the different WPs of EUR-HUMAN different types of information are collected, combined and discussed internationally, in order to be utilized to strengthen the local health care capacity at the sites that refugees and other migrants visit on their journey towards their country of destination. WP2 (coordinated by Radboudumc University) utilizes methodologies such as Participatory and Learning Action (PLA) to establish a

¹ Concerning the terminology: terms as refugees, migrants, asylum seekers, stateless persons have different meanings in different contexts. In this document the phrase "refugees and other migrants" is used, conform the Grant agreement.

democratic dialogue with national, regional and local stakeholders as well as with refugees themselves to access their needs, wishes and preferences. PLA sessions were carried out in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and The Netherlands) in the first half of 2016. In the same period *WP3* (coordinated by NIVEL) – the main subject of this report – accessed a diversity of data sources and experts to identify success factors and obstacles in the implementation of tools and interventions to optimize health care for refugees and other migrants in the European context. *WP5* (coordinated by University of Zagreb), among others, produced a report protocol for rapid assessment of mental health and psychosocial needs of refugees. Moreover, as part of *WP4*, the results of the review activities (*WP3*), the brokered dialogue with the stakeholders and refugees (*WP2*) and mental health protocol, were incorporated in an operational plan prepared by the general project coordinator of EUR-HUMAN (University of Crete). This comprehensive approach was discussed in an expert panel group in Athens (June 8-9).

These activities contributed to the development of guidance (e.g. documents, recommendations, training materials, tools) and to actually piloting this guidance on behalf of the provision of integrated and comprehensive person-centred primary care for refugees at the intervention site in hotspots, transit centres and longer stay first reception centres in *WP6* (coordinated by University of Vienna). The whole process is being monitored and evaluated by *WP7* (coordinated by European Forum for Primary Care).

Work package 3

The current report contains results from the third work package (*WP3*) of the project, produced between February and June, 2016. Information from a variety of data sources was accessed and analysed in order to learn more about the factors that play a role when implementing health care innovations for refugees and other migrants in Europe.

The report itself is based on Delivery 3.1 that was written in February and March, 2016 to provide early input for the other work packages of the EUR-HUMAN project. The initial document contained only the preliminary findings from the literature review. In Deliverable 3.2, additional information from an online survey and interviews from April to June is included. Importantly, the methodology section from Delivery 3.1 was extended (chapter 2). In chapter 3 we present the main findings. The overview provided offers a useful starting point for initiatives to implement health care interventions and measures on behalf of refugees and other migrants in complex settings in Europe. Chapter 4 contains the main conclusions and some limitations. In order to make the output of *WP3* as practical as possible a test version of an implementation checklist was drafted during the project and is included in this report (Appendix 6).

To keep the report readable, detailed information on the literature review, online survey and interviews is presented in appendices.

Chapter 1. Focus of work package 3

Objective

The general objective and structure of the EUR-HUMAN project have been briefly described on the pages 4 and 5 of this report. The objective of WP3 was to learn from literature and experts on measures and interventions and the factors that help or hinder their implementation in European health care settings.

The focus was on strategies to support the implementation of interventions and measures that:

- address one of the four refugee and migrant-related health domains of the EUR-HUMAN project: infectious diseases, mental health and psychosocial problems, women and reproductive health, and chronic illness;
- are feasible for local health actors and service providers;
- are cross-nationally (and inter-culturally) applicable within the EU;
- are useful in an international “refugee-chain perspective”;
- are based on the strongest available scientific evidence.

Questions

In a close dialogue with the EUR-HUMAN consortium, and based on feedback from international experts (including an expert on refugee and migrant health care guidelines), the following questions were formulated:

- (1) What factors help or hinder the implementation of health care interventions for refugees and other migrants in European settings?*
- (2) What recommendations are provided by the literature, experts and professionals to overcome these barriers and accommodate health care optimization?*

Chapter 2. Methods

2.1 Collection and analysis of information from three sources

The current situation regarding refugees and other migrants in EU is both dynamic and unprecedented. It was therefore decided to not only do a literature search, but also perform an online survey and interview several experts. When reading this rapport, it is important to emphasize that the timeframe to produce the Deliverable 3.1 and 3.2 was very narrow, and the topics (infectious diseases, mental health and psychosocial problems, women and reproductive health, and chronic illness) very broad. As a result, pragmatic choices had to be made regarding the three methods of data collection. Methodological choices are described in this chapter.

Framework for data extraction

To extract data from all three the sources in a systematic way, the implementation framework of Flottorp et al. (2012) was used as a starting point. The framework was gradually adjusted by adding or removing domains so that the framework would better help structure our findings. Seven domains were used to cluster the factors: Domain A. Legislation, protocols, guidelines, policies, Domain B. Individual professional factors, Domain C. Target population factors, Domain D. Professional interactions, Domain E. Incentives and resources, Domain F. Capacity for organizational change, and Domain G. Social and political circumstances. Next, 25 articles were selected to pilot the adjusted data-extraction framework. Main results from the three different data sources were grouped within the adjusted framework. This gave an overview of the different implementation variables one has to deal with when implementing health care interventions for refugees and other migrants. In chapter 3, the main variables are presented, so the reader has a good starting point when preparing to implement health care interventions. Details about the final framework are described in Appendix 5.

2.2 Literature review

Development of search strings

The search string contained two parts: 1) refugees and other migrants and 2) implementation within health care. Within the project group we developed the search string based on common words for refugees and migrants for the first block. Next, implementation search strings from a recent article on the implementation of health interventions (Chaudoir, Dugan & Barr 2013) were used. Search strings were shared among the EUR-HUMAN group and with an experienced librarian. Appendix 1 contains the search strings executed in the different databases.

Selection of articles

The search strings were entered in 6 databases (Appendix 1). In total, 5492 articles were found. After removing duplicate articles there remained a total of 3979 articles.

Selection based on title and abstract

Two researchers (MvV and DdB) independently checked all 3979 articles for abstract and title. Articles were excluded if:

- The abstract was missing
- The publication was not available through our institutional subscriptions
- The publication was written in another language than English or Dutch.
- Not applicable to specific target group of refugees and other migrants in similar (war related) refugee situations. (Asian, Latino specific, Mexicans at US border, immigrant students)
- The data was clearly outdated
- Interventions were aimed at lifestyle changes (e.g. smoking, exercise, diet etc.)
- Intervention was not aimed at one of the four health domains targeted within EUR-HUMAN (infectious disease, mental health, maternal health and chronic health condition).

Additionally, for each article, we checked for relevancy within a EU refugee context. This criterion was added because the output of WP3 had to be useful for health care providers in the context of the EU. For articles on implementation of health care for refugees and other migrants in Non-EU countries, two authors independently decided whether the content would be useful given the context of EUR-HUMAN the report. In case it was unclear from the title and abstract whether the article met the inclusion criteria, we decided to include the article for the full text screening selection. After discussion, consensus was reached on selecting 264 articles for full text screening.

Scientific quality of the articles

The articles were primarily qualitative, descriptive or mixed methods. According to Cochrane's standard of systematic reviews all articles would be labelled as weak. Standardized trails are merely impossible to do in refugee setting, so although the studies we found are of low scientific quality, they offered the best available evidence.

Selection based on full text

The 264 articles were grouped in five main themes and divided among the research team:

1. Mental health and psychosocial health (70 articles) (DdB)
2. Women, Maternal and Child health (48 articles) (MvV)
3. Communicable and Infectious diseases (75) (CB)
4. Non-communicable and Chronic diseases (11) (CB)
5. General/other implementation 63 (DdB, MvV, MD)

Due to time constraints no double checks of full texts was possible. Selection of full text was based on:

- The full-text contained information on refugees or other migrants
- The full-text contained information on implementation of health care
- The full-text contained information that was deemed relevant for health care providers in the EU
- Excluded when there was no clear method description, abstract only, poster presentation, when it concerned protocols or commentaries

2.3 Online survey

To supplement the literature and to provide more up-to-date and hands-on information on refugee care, an online survey was developed and disseminated among professionals and experts in Europe at the different work locations. Items were developed by the members of the review team and exchanged with the EUR-HUMAN group. The survey contained closed and open questions related to the type of health category, the nature of the experience, best practices, etc. (Appendix 2). Where possible, useful answers were categorized based on the type of country (either 'transfer' or 'destination') or the type of health care category. The first categorization was chosen because of presumable differences in context and challenges. The second categorization to see if there are differences in answers between different health topics, with the limitation that respondents could select more than one category – in that case it is impossible to make a distinction between health categories.

The survey targeted group consists out of two types of participants. On the one hand, people where approached who are involved in facilitating and coordinating the provision of health care for refugees and other migrant (e.g. policy makers, lawyers). On the other hand, the survey was disseminated among operational professionals and frontline workers with practical experience such as general practitioners and psychologists. The survey was explicitly targeted at participants with recent experience with issues, challenges and problems concerning refugees and other migrants in Europe - preferably related to local health care practices, but national and regional experiences were considered valuable as well. The survey link was shared via email with an introduction message and instructions on behalf of the EUR-HUMAN consortium. The survey link was accessible in March and April, 2016. Consortium partners assisted in disseminating the survey in their country. A reminder was sent out twice.

Data analysis

A total of 81 people completed the survey. Most of the participants view themselves as health care provider or health care professional (78%), the rest is involved in policy, management and organizational support (22%). Records of respondents that stopped after the first few questions on type of respondent, experience and country were removed from the file. The answers give a qualitative impression of what people with practical experience, at different European sites, consider relevant and of the issues

they are confronted with. The information from the survey as presented in this report was mildly edited to enhance readability, without changing the content. Information was anonymized where appropriate.

2.4 Expert interviews

Ten semi-structured interviews were held in May 2016 with professionals and experts, recommended by the EUR-HUMAN partners, about barriers and enablers for implementing care for refugees and other migrants. The majority of interviews were done by skype. One of the interviews was a written response and one interview was done face-to-face. The interviews took approximately 30 minutes and were conducted by four different researchers. The interviewees gave informed consent to record the interview. The interviews were transcribed and sent to the respondents for a final check.

The professionals had different fields of expertise, ranging from a professional within the municipal health authorities to a Public Health expert from Macedonia. The full list is available in Appendix 3.

The respondents were invited to talk about the implementation of migrant and refugee care. The topic list concerned items such as *Which role do you have concerning health care for refugees and/or migrants?* (Appendix 3).

Data analysis

The main topics of the interviews were analyzed in the light of the adjusted framework. Each interviewer selected relevant content from the interviews. The overarching analysis was done by one researcher.

Chapter 3. Overview of findings

3.1. Introduction

The literature review, online survey and the interviews generated a plethora of relevant information (detailed results per source can be found in Appendix 4). In this chapter the main findings are presented in a structured way, starting with an overview of findings from each data source (§3.2). Next, the findings are presented along the lines of the data extraction framework (Appendix 5) (§3.3).

3.2. Main findings from three sources

Literature review

This chapter presented a broad overview on the factors that help or hinder the optimization of health care services for refugees and other migrants. We highlight here the key lessons learned for implementation.

Guidelines, protocols, policy and legislation, need to be tailored to the context where health care is provided and match the local social reality. A problem is that guidelines are often based on stable circumstances, not chaotic emergency situations where prioritization is needed and the most immediate – often basic – needs are to be addressed first. Moreover, the guidelines need to be adjusted to the level of education of those who are implementing them (skilled professionals versus volunteers). Low awareness of guidelines, protocols, policy and legislation can be a barrier for implementation. This can be raised by providing training in guideline adherence. Restrictive legislation was identified as another significant barrier for refugees and other migrants in accessing health care and for professionals in trying to deliver care.

The included studies point at the necessity to invest in improving the knowledge, skills and attitudes of professionals, particularly in cultural competency and diversity. In many articles ‘lack of knowledge’ is recognized as an obstacle for the provision of high-quality health care (the nature of the knowledge differs between health category, ranging from trauma- and torture-related health complaints to female circumcision and vaccination). Knowledge about the specific target group (e.g. what are the most common health problems, risk factors), traditional health care practices and experiences with fleeing and asylum situation is important in the delivery of care to refugees and other migrants. Furthermore, it is important that those who implement services understand the need for those services and feel well equipped/able to deliver those services.

Other crucial competencies have to do with communication and interaction skills, concerning the contact with patients and with other professionals.

The interaction between professional and patient depends on trust. Building trust is both essential, and challenging given the limited time, language differences, frequent staff changes and scarce resources. The attitude and beliefs of patients and professionals can also hinder communication. Patients can feel a shame or stigmatized, particularly when sensitive issues such as reproductive health are to be discussed. Professionals can be insensitive to issues that are at stake for patients. When delivering care it is important to be aware of own cultural assumptions and beliefs and to be respectful to other cultural values. Searching for a middle ground between the patients traditional values and professional values can help overcome barriers in interaction.

Interpreter services are considered a priority when improving refugee and migrant care. It can increase early diagnosis, prevent miscommunication and misdiagnosis, establish trust and therefore increase quality of care and patient satisfaction. Implementation can however be challenging due to limited availability of adequate interpreters, confidentiality issues when a third party is involved in the consultation and logistically challenging in terms of getting translators at the location, high costs and limited time. Cultural mediators can help bridging the gap between services and patients. Although it is noted that resources are scarce, investment in these services is needed.

Patients' access to care is challenged by several barriers; legal barriers (eligibility), financial barriers (e.g. the inability to pay for health care), physical barriers (distance to the facilities) language barriers (including illiteracy), cultural barriers (acceptance of services, fear of stigmatisation or social repercussions when making use of services, cultural beliefs), lack of awareness (risk perception, not seeing the need for health services, unawareness about available services and their rights to health care), lack of knowledge, skills and attitude. To increase access patients firstly need to be aware of their rights to health care, availability of health care and how the health care system in the host country works. It helps when they know what they can expect in the country of arrival, even if temporary. Care delivery is more effective when patients have more general knowledge about healthy life-styles, about physical and mental well-being, illnesses and risks and reproductive health options. Informing and educating refugees and other migrants about the aforementioned topics would improve the acceptance and uptake of services. Furthermore, the infrastructure needs to change towards increasing access to care, e.g. available services within reach (mobile health services), rights to care, funding etc.

As health care provision is usually multidisciplinary, good interactions between professions, organizations, and authorities are a crucial condition for health care improvement.

Continuity of care is important for establishing a trustful relationship between practitioner and patients and also to assure follow-up of essential health care. A clear division of roles and responsibilities, good collaboration and coordination between is therefore key. Involving the patients' families, stakeholders, local communities and key

figures (e.g. from the government) in the host country would enable implementation. Clear agreements between the different parties involved, appointing persons that are responsible for keeping overview or for specific parts in the care chain, and overall commitment are enablers for implementation.

Especially, monitoring and evaluation in regards to health care needs of refugees and other migrants and health care service delivery is needed to optimize health care provision. This is clearly challenged in the dynamic fluid refugee movement over different locations. Systematic data collection is currently lacking and needs to be facilitated.

A lack of resources in terms of time, financial, human workforce, services and equipment are mentioned as prominent barriers for implementation.

Online survey

All major health categories of the EUR-HUMAN project are represented in the survey data. Individuals from each partner country participated.

Based on the survey data a coherent sketch could be made of the contexts where the respondents from different EU member states are involved in the provision of refugee health care. Respondents mention many success factors and obstacles for health care optimization efforts at European sites. Participants in the survey give many specific examples, at the level of professionals, the local health care organization, the tools, resources and knowledge needed to provide the right care, the capacity for change, but also regarding factors they can hardly influence in their social, political and legal environment. The text fragments provided by survey participant show that the different categories of implementation factors are actually strongly interrelated.

When a distinction is made in country groups, different patterns become visible. Transfer countries score different on the factors that help or hinder health care optimization than the countries where most of the asylum requests are submitted. This is probably linked to differences in the health care challenges the survey participants (mostly health care providers) are confronted with.

The survey learns that the provision of health care services in transfer countries is chaotic, resources (staff, medication) are scarce, there is little time to address the many problems and health issues. NGOs play a more central role than in destination countries, sometimes resulting in frustration about the fact that organization have their own interests that can differ from what is needed at the sites. Regardless of the location of the respondent, and regardless of the health topic, cultural and language issues are recognized as crucial factors for refugee health care. In both country groups the decision-making by politicians, particularly the influence of right-wing politicians is considered a threat for refugee health care.

In general, improvement can be made in informing refugees and other migrants about the health care system of their host country, in the cooperation between health care providers from different organizations, in the interactions between governments at different levels, in giving a worthy future perspective, participation and development options to refugees, in reducing bureaucracy, in adopting a humane approach, and in establishing linkages with the local communities where refugees and migrants stay.

Particular documents and tools are recommended. However, most of the materials, guidelines and databases mentioned by the survey participants are general documents and other resources. The practical implementation of the suggested resources is likely to be affected by the same factors as identified by the survey participants.

Interviews

Ten interviews with professionals from different countries and organizations resulted in a wide range of insights and recommendations. Below, we summarise the most important elements and recommendations.

International collaboration and coordination, international networks in which information is shared and international consensus on policies is recommended to improve implementation of health care for refugees and other migrants in Europe. The respondents addressed the importance of improving the local infrastructure to handle the large influx of refugees.

It is argued that the living conditions are very important for the health outcome. Poor living conditions at reception in the countries currently result in refugees getting ill. Treating migrants the same as the host population, in terms of housing, employment and health services could help prevent the development of mental health problems. On the one hand special services for refugees and migrants, such as mobile clinics, can increase access to services. On the other hand these separate services might result in those services not becoming part of the regular health care provision. Instead of looking at differences between ethnic groups and organizing health care accordingly, it is suggested to look at what different groups have in common and adjust health care services towards that end. For example, illiteracy or low social-economic capital. Which could also prevent stigmatization of migrant groups.

Lack of prioritization of certain health issues can result in health services being unavailable. In this regard preventative measures are explicitly mentioned.

Politics are seen as a major barrier for implementation. Lack of political will to address the health issues and needs of refugees and other migrants result in services being absent or inaccessible for these groups, or NGOs taking over the responsibility of providing care. Constantly changing political realities result in problems with adapting services to these new circumstances in time. Entitlement and the right to care is mentioned as a crucial barrier in providing and accessing care for these groups.

Especially, when transit countries turn into destination countries entitlement for the long term becomes an important issue to discuss.

Lack of resources is addressed as an important barrier. Specifically, financial resources, available translation, interpretation and mediation services. In this regard is suggested that resource poor countries could increase collaboration with resource full countries.

At organizational level different implementation factors were identified. Lack of data regarding the health needs of refugees is mentioned as an important barrier. This is challenged by refugees trying to avoid registration or hiding their health problems because of fear of losing the right to travel to their destination country.

Unpredictability regarding the numbers of refugees makes it difficult for organizations to plan ahead. Better coordination and organization between the different parties involved would enable implementation. Involving stakeholders, including the local government, in implementation is important for creating social support.

To establish continuity of care information exchange is required. Currently fragmentation of health care and the fact that refugees are not staying in one place is challenging. There is a need for a workable information system that is not bound to one place. Respondents spoke about a medical passport. Refugees could however resist using the passport, because of fear that it would trouble them in reaching their destination country. Therefore it is important to inform the target group about the benefits and risks of using the passport. Lastly, it is argued that merely the transfer of data will not help the continuity of care because follow-up care needs to be available and acceptable by patients.

Providing culturally sensitive care is considered important. Taking into account language capabilities and cultural beliefs that might form obstacles in practice. Cultural mediators could help adjust health services to needs of refugees or other migrants. Multilingual, multicultural and interdisciplinary teams (including psychosocial practitioners) are suggested to increase the quality of care. Language and cultural barriers could be easier overcome, it could increase the acceptance of care, reduce diagnostic mistakes and the threshold for patients reaching out for psychological help is lower.

To enable the interaction between professionals and patients it is suggested to invest in interpreter services, cultural mediators and provide translated information.

Refugees and other migrants can experience multiple barriers in accessing care. Financial barriers, physical distance to facilities and cultural barriers. Fears of not reaching destination countries can result in avoidance of care. Informing and educating about health, how the health care system works, how they could get access to care and regarding their rights to health care is seen as essential for improving the uptake and access to care.

It is suggested to increase knowledge regarding the health care needs of refugees and develop cultural competency by providing training to health care professionals. In developing training for professionals stakeholders need to be involved.

Lastly, it is argued for more research to enable providing evidence based interventions and measures for refugees and other migrants.

3.3. Main findings categorized along the domains of the data extraction framework: barriers and enablers/improvement strategies

Hereafter the main findings are categorized along the seven domains of the data extraction framework (Appendix 5). In different tables information from the literature review, the online survey and the expert interviews is summarized. Each table contains an overview of barriers (left column) and enablers or improvement strategies (right column).

Domain A. Legislation, protocols, guidelines, policies

Barriers	Enablers/ strategies to improve implementation
<ul style="list-style-type: none"> • <u>Unavailability</u> of useful guidelines. • <u>Complexity</u> of guidelines and <u>newness</u> of a guideline. • <u>Adherence</u> to guidelines can be low when the guidelines are considered inappropriate for the target population. For example, when professionals are providing care to patients that are not entitled to it. • <u>A lack of protocols and policies or restrictive legislation</u> can result in the absence of certain services. For example, the treatment of STIs, rape, abortion and HIV. • <u>Weak institutionalisation</u> of policies can also be a barrier for implementation. 	<ul style="list-style-type: none"> • See if already existing guidelines can be <u>simplified, clarified or adjusted</u>. • <u>Summaries</u> of guidelines can also help implementation. • <u>Adjust guidelines to the circumstances</u> in which they are used and to the specific target group. For example, instead of stable practices unstable practices, different health priorities and scarce resources. • <u>Adjust guidelines to level of education</u> of the implementers. Are they untrained, professionals or volunteers? • Make the guidelines more <u>culturally sensitive</u>. • Develop clear guidelines about the following <u>unaddressed topics</u>: entitlement of different migrant groups, about best practices on cross-cultural communication, or the usage of interpreters, or about working with the health surveillance system. • <u>Engage stakeholders</u> in the development of guidelines (e.g. Ministry of Health to increase acceptability). • <u>Accessibility of guidelines</u>. This could be enabled by making guidelines available on the internet. • <u>Government</u> can help to ensure feasibility of policies.

Domain B. Individual professional factors

Barriers	Enablers/ strategies to improve implementation
<ul style="list-style-type: none"> • Their <u>lack of knowledge and awareness</u> regarding supportive policies, protocols and legislation or available services can result in under usage of services. • The lack of access to the <u>medical history</u> of patients makes it difficult to provide accurate (follow-up) care. • The <u>high workload, complex situations</u> in which patients are in need of care but not entitled to it, bureaucracy, fear of stigmatizing patients, and limited support by authorities. • <u>Cultural norms</u> regarding the provision of certain services can be a barrier for implementation (for example, resulting in professionals not providing condoms to unmarried women). • <u>Not seeing the need</u> for certain services. • The <u>fear of losing one's licence</u> when providing care to undocumented migrants. • <u>Time constraints</u>. • <u>Language difficulties</u>. • <u>Attitude</u> can hinder when it is negative, discriminative, arrogant or xenophobe. 	<ul style="list-style-type: none"> • Make professional <u>aware of the need</u> for providing services. • Knowing about <u>specific issues for the target group</u> could enhance practice <ul style="list-style-type: none"> ○ understanding their needs ○ cultural issues ○ traditional health practices and beliefs ○ common health problems ○ barriers for accessing care (e.g. entitlement) ○ refugee related issues (fleeing experience, current accommodation, status etc.) ○ risk factors and treatment effects for different ethnic groups. • <u>Training</u> of professionals is an important factor for enabling implementation <ul style="list-style-type: none"> ○ Training about above mentioned target group issues ○ Improving cultural competency and awareness of own cultural assumptions ○ Developing skills to negotiate sensitive issues with patients ○ Develop skills for building a trustful relationship with patients ○ Developing an appropriate attitude. Changing attitudes can help implementation: being flexible, creative, supportive, feeling responsible and having patience. • <u>Involve stakeholders</u> in the development of training for professionals . • Make use of <u>multidisciplinary teams</u> (including psychosocial practitioners) and professionals with a diversity of backgrounds, could reduce language and cultural barriers, increase the acceptance of care, reduce diagnostic mistakes and reduce the barrier for reaching out for psychosocial help. • <u>Actively reach out to patients</u> and provide information to patients, to improve acceptance and uptake of services of patients. • <u>Involve the family</u> of patients in care when this is expected (for example with pregnancy).

Domain C. Target population factors

Barriers	Enablers/ strategies to improve implementation
<ul style="list-style-type: none"> • <u>Complex medical and social histories</u> of refugees and other migrants. • <u>Limited knowledge</u> about disease, illness and healthy practices, low awareness of health risks, available services and their rights to health care and how the health system in the host country works. • Limited understanding of <u>language, illiteracy and low educational level</u>. • Different <u>norm and belief systems</u> regarding health practices and health services. • A <u>passive attitude</u> towards treatment. • <u>Legal restrictions</u> (e.g. entitlement issues), distance to the health care facility and lack of transport, inability to cover health care use, lack of required documents and long waiting times can be a barrier in obtaining care. • <u>Lack of trust</u> in health care professionals • Patients seeing health care professionals as migration <u>authority figures</u>, resulting in hiding symptoms, feelings of discrimination, fear of deportation or citizenship refusal, or reluctant to discuss sensitive issues such as HIV. • <u>Fear of being shamed</u> upon when making use of services, fear of stigmatisation or social repercussions from the <u>community</u>. • <u>Lack of privacy</u> when making use of health services. • <u>Lack of a supportive environment</u> to make use of health care services could hinder the uptake of services. 	<ul style="list-style-type: none"> • Providing group <u>training</u> of making use of educational campaigns about the topics mentioned under 'barriers' could increase the acceptability and uptake of the health services. It could guide their expectations of health care. <u>A group approach</u>, in which patients can share their problems, could also increase the social network of patients. • Training material needs to be <u>adjusted to level of understanding</u> of patients. Translated material and interpreters could also lower language barriers. • Professionals need to take into account that patients can have <u>certain expectations</u> that can become a barrier when these are not addressed. For example, that the husband or family is involved in care, or that the health care provider is of similar gender or they expect to be told what to do instead of informed decision making. • <u>Actively involve refugees in development of care</u>. To increase quality, acceptability and effectiveness of services. • Ability to make use of <u>childcare</u> during appointments and <u>flexible walk-in sessions</u> would enable patients to come to appointments.

Domain D. Professional interactions

	Barriers	Enablers/ strategies to improve implementation
Patient-professional interaction	<ul style="list-style-type: none"> • <u>Language and communication difficulties</u> is one of the most prominent barrier in delivering care to refugees and migrants. • Language and <u>cultural differences</u>, differences in norms and beliefs. • lack of a <u>trusting relationship</u> • <u>time</u> constraints. 	<ul style="list-style-type: none"> • <u>Develop trust</u> and increase patient compliance by involving family, use shared language, use neutral words when discussing sensitive topics, and by being culturally sensitive. • <u>Longer consultation time</u> would enable practice, especially when making use of interpreter services. • Provide <u>translated information</u> to reduce language barriers.
Interpreters cultural mediators	<ul style="list-style-type: none"> • <u>Informal interpreters</u>, such as family of community members can involve <u>difficulties</u> with confidentiality, fear of gossip, not being familiar with medical vocabulary and withholding information. • <u>Formal interpreter services barriers</u>: limited availability of adequate interpreters, confidentiality issues when a third party is involved in the consultation and logistically challenging in terms of getting translators at the location, high costs and limited time. 	<ul style="list-style-type: none"> • Be aware that the <u>dynamic changes</u> when interpreters are involved in the interaction. • <u>Formal interpreter services</u> are considered a priority when improving refugee and migrant care (Pottie 201). It can increase early diagnosis, prevent miscommunication and misdiagnosis, establish trust and therefore increase the quality of care and patients satisfaction with care. • Making use of <u>phone (or skype)</u> can reduce some of these barriers. • <u>Cultural mediators</u> can help bridging the gap between services and patients. They could help adjust the health services to the needs of refugees and other migrants. Although it is noted that resources are scarce, these services need more investment.
Continuity of care	<ul style="list-style-type: none"> • Continuity of care is difficult due to <u>mobility</u> of the target population and uncertainty of how long people are there to stay. • Lack of adequate <u>information exchange</u> on different organisational levels and between countries. • <u>Divergent referral practices</u> between EU countries and insufficient patient registration • Limited <u>available information for professionals</u> about how referral of patients need to be arranged. • <u>Lack of coordination</u> between the many different professionals and services involved. 	<ul style="list-style-type: none"> • A <u>medical passport</u> could help information exchange. However, refugees could resist using the passport because of fear that the document would hinder them in reaching their destination country. Therefore it is essential to inform the target population about the risks and benefits of using the medical passport. • Not only transfer of data is needed, <u>follow-up care needs to be available and acceptable</u> for patients. • A well-functioning <u>referral system</u> is essential for follow-up. • Good <u>collaboration</u> is needed. Among others, between reception facilities and health sector to enable tracking refugees in the system and facilitate access to care. • <u>Continuity of staff</u> and interpreters is essential for building trust with patients. • Other strategies mentioned; minimizing the <u>amount of referrals</u> and making someone (for example a casemanager) <u>responsible</u> for keeping overview within the referral system.

Domain E. Incentives and resources

Barriers	Enablers/ strategies to improve implementation
<ul style="list-style-type: none"> A lack of resources in terms of time, financial, human workforce, services and equipment are mentioned as prominent barriers for implementation. 	<ul style="list-style-type: none"> Resource poor countries could increase <u>collaboration</u> with resource full countries to enable implementation.

Domain F. Capacity for organisational change

	Barriers	Enablers/ strategies to improve implementation
Monitoring and evaluation	<ul style="list-style-type: none"> Monitoring of refugees and migrant needs is extra. challenged by refugees trying to <u>avoid registration or hiding</u> their health problems because of fear of losing the right to travel to their destination country. <u>Systematic data collection</u> is currently lacking. 	<ul style="list-style-type: none"> Monitoring and evaluation in regards to health care needs of refugees and other migrants and health care service delivery is <u>needed to optimize health care provision</u>. To be able to evaluate health service performance, establish quality assurance systems, patient compliance evaluation, cost-efficacy and cost-benefit analysis and develop a strong evidence base. Systematic data collection needs to be <u>facilitated</u> in terms of financial resources, appropriate data collection systems, expertise and time. Coordination is essential. <u>More research</u> is needed for developing evidence-based interventions and measures for refugees and other migrants.
Coordination of care		<ul style="list-style-type: none"> A <u>clear division</u> of roles and responsibilities Effective coordination by appointing a <u>leading agency or focal point</u>. <u>Involvement of stakeholders</u>, such as migrant groups, could optimise migrant friendly care. <u>Collaboration</u> between partner organisations.
Integration of care		<ul style="list-style-type: none"> It is recommended to <u>mainstream migrant care</u>, to reduce stigmatisation and establish acceptance of care. On the one hand separate services, such as NGOs delivering care to refugees or specialized mobile health units can increase access to care, on the other hand these can result in those services not becoming part of the regular health care provision. The <u>integration of different sectors</u> is seen as important for improving refugee and migrant care. Among others the integration of psychiatric and social services. Some authors and interviewees see mental problems as by product of social problems (literature and interviews). (and mental care as part of regular care?). Integrating reproductive health services into primary

		<p>care services.</p> <ul style="list-style-type: none"> • The <u>integration</u> of HIV testing into routine care can be improved by normalising this in guidelines. • <u>Commitment</u> of different stakeholders and clear agreements between them is essential • <u>Evidence based advocacy</u> could help establish the integration of care.
Prioritisation and authorisation	<ul style="list-style-type: none"> • <u>A lack of prioritisation and authorisation</u> are resulting in the unavailability of certain health services. 	<ul style="list-style-type: none"> •

Domain G. Social and political circumstances

Barriers	Enablers/ strategies to improve implementation
<ul style="list-style-type: none"> • Politics are seen as a major barrier for implementation. <u>Lack of political will</u> to address the health issues and needs of refugees and other migrants result in services being absent or inaccessible for these groups, or NGOs taking over the responsibility of providing care. Possibly resulting in segregated services. • Constantly <u>changing political realities</u> result in problems with adapting services to these new circumstances in time. Therefore, take into account that circumstances change over time and improve the local infrastructure to be able to respond to the large influx of refugees and adjust interventions and measures. • <u>Entitlement and the right to care</u> is mentioned as a crucial barrier in providing and accessing care for these groups. Especially, when transit countries turn into destination countries entitlement for the long term becomes an important issue to discuss. • <u>Living conditions</u> of refugees and other migrants need to be improved. Poor living conditions at reception in the countries currently result in refugees getting ill. Treating migrants the same as the host population, in terms of housing, employment and health services could help prevent the development mental health problems. 	<ul style="list-style-type: none"> • Collaborate and coordinate on an international level. Realise <u>international networks</u> in which information is shared and international consensus on policies is at the centre. • <u>Involve stakeholders</u>, including the government in implementation in order to create social support. • At the community level things can be done to enable implementation. Cultural norms and beliefs in the community and a lack of information about available services can prevent refugees and other migrants from making use of health services. <u>Actively reaching out</u> to the communities and capacity building efforts are essential for implementation and making sustainable change. <u>Community involvement</u> can reduce barriers in the provision and uptake of health services. • <u>Advocacy</u> efforts toward the goal of creating a climate in which health care services can be optimised for refugees and other migrants can enable implementation. • Instead of looking at differences between ethnic groups and organizing health care accordingly, it is suggested to <u>look at what different groups have in common</u> and adjust health care services towards that end. For example, illiteracy or low social-economic capital. Which could also prevent stigmatization of migrant groups.

Chapter 4. Discussion

The objective of WP3 was, firstly to establish a comprehensive overview of factors that could help or hinder the implementation of interventions and measures aimed at improving refugee and migrant health care. Secondly, to formulate recommendations to overcome these barriers and optimize health care implementation. Information was collected using three methods: a systematic search of literature databases, an online survey among health care experts and practitioners at various sites in Europe, and interviews with experts. The data collection and analysis took place from February to May 2016.

Coherent overview of barriers and enablers

Both the objectives of WP3 were presented as questions in the first chapter. In our view both questions could be addressed in a satisfactory way based on the collected material. In the previous chapter many different barriers or enablers were described with a more extensive and detailed description in Appendix 4. Many examples of relevant factors could be identified and verified based on other data sources. Regardless of the health care domain, country setting or migrant target group these factors play a decisive role during initiatives to improve health care for refugees and other migrants. The factors covered each of the seven domains of the heuristic framework used during the analysis (Appendix 5), which is logical because in the end the domains are connected. When problems, for instance, are not recognized at a higher level of scale where resources are allocated and capacity is assigned, it is logical that professional staff and certain parts of equipment or medication are unavailable at local sites. When local practitioners are confronted with large numbers of specific target groups for the first time, and are fully occupied with health provision, it is not strange that particular skills and competencies are underdeveloped and that there is limited time for education or training. Furthermore, international guidelines commonly reflect the result of a systematic data collection and weighing of evidence with the objective to provide the best guidance thinkable, yet general recommendations often are not written with all the potential, highly specific target groups with cultural differences in mind. These considerations are only a few thoughts that remind us of the complexity of our main theme.

The need to make it more practical

This brings us to another issue. Since the report contributes to our understanding and awareness of factors that influence refugee health care optimization efforts in the European Union, the contents of this report is relevant for a broad audience in different countries. In order to further maximize the impact a next step is needed. A great deal of the information is written down in general terms by the original authors and probably not as instructive as it could be. Although we considered it important to be as specific as possible while extracting the data, we were at the same time reluctant with interpretations and avoided speculation about the specific practical implications of

general lessons we found in the collected materials. Particular practical tools, training materials and checklists we encountered during the review activities were handed over to WP4 of the EUR-HUMAN project. However, in our view, the next step requires something more. Since we are aware of the large amount of material collected and presented in this report, and the limited amount of time available for policy-makers, health care planners, managers, consultants and health care professionals, we consider it necessary to make information as displayed in this report available as practical and well-dosed as possible. There are undoubtedly numerous methods to do this. In Appendix 6 of this report we added a test version of “ATOMiC”, an implementation checklist that can be seen as a simplified series of issues health care professionals, managers, policy-makers, implementation advisors can consider in relation to a particular improvement idea (ATOMiC is part of the e-learning module develop in WP6). By carefully contemplating the factors they can, in an early phase, identify issues that require special attention when proceeding, or might even warrant timely reconsideration. We recommend the further development and testing of instruments like these. Since implementation factors are context-specific, and the context of the refugee crisis is continuously changing, it is necessary to evaluate and reevaluate whether proposed factors are still at play.

Strength and weaknesses

As the findings of the review are largely in line with the findings in the interviews and the surveys, we consider it likely that we managed to catch the essence of facilitators and barriers. Also, the EUR-HUMAN consortium, consisting of GPs and other professionals with a wide range of specialities read and commented on different versions of the manuscript. Therefore, we feel that it is valid to use our findings as input for improving the implementation of interventions and other measures for refugees and other migrants.

Obviously, the work presented in this report has its limitations. The review was conducted under time pressure. The selection of articles was done in a practical and quick manner. Regarding the full text, each researcher selected articles for their thematic area. It is possible that relevant articles were missed. The chosen focus on relevancy for the EU situation resulted in selecting articles that were mainly about short stay instead of long stay situations. Furthermore, we recognise that our target group demarcation was arbitrary, but necessary to be able to grasp key issues for the current EU refugee crisis. Moreover, we sometimes included articles for their practical findings on how to overcome barriers, even though they took place in very different contexts, for example in refugee camps in Africa. When selecting full texts, and when subtracting data from the article into the data framework, there was no time to perform a double check. Since the identification and extraction of enablers and barriers were assessed by different reviewers (per theme), the risk of reviewer bias, cannot be ruled out. It should be noted that relevant enablers and barriers were not always directly extractable from the examined studies; in a number of cases they were implied, e.g. in the form of study limitations. Barriers and enablers were identified and categorized under different

themes and subthemes. Also, since we were looking for concrete recommendations and valuable contextual information to improve implementation, we tended to include information that was not only in the result section of articles, but also in the discussion sections where other relevant literature was discussed in relation to the findings. Often, these sections were not directly supported by the data presented in the article.

The survey made it possible to collect information from a diversity of experts with different backgrounds, with recent field knowledge and experience with delivering health care to the target group of the EUR-HUMAN project. Also, it provided an opportunity to collect grey literature. Despite its added value to the literature review, a couple of limitations should be mentioned. The survey participants represent a convenience sample with a limited sample size. It is unclear whether the collected data are representative and findings are generalizable. The fact that the survey was in English, which is not the native language of most of the participants, might be of influence on the validity of the responses. We cannot out-rule the possibility that survey items were interpreted differently by the respondents in different countries. The open answering categories were probably not the most optimal way to collect narrative information about the factors that helped or hindered the optimization of health care services for refugees and migrants, especially for participants who filled out the questionnaire on a relatively small mobile device. Since, we could not interview everyone and this was the second best option to gather this type of data. On the other hand, to our knowledge the online survey is the most recent and systematic approach to collect information from a variety of sites simultaneously.

Finally, some remarks concerning the interviews. Working with four different researchers, with different backgrounds and focal areas, who interview experts and extract data is not ideal and might contribute to selectiveness of responses. Nevertheless, the literature, survey and the interviews resulted in different types of findings that, taken together, enabled us to sketch a broad picture of the factors that might help or hinder the implementation of measures and interventions to enhance health care for refugees and other migrants in local European settings in the context of a massive influx.

Appendix 1. Search terms

PsychINFO

1#

diffusion of innovation.ab. OR diffusion of innovations.ab. OR information dissemination.sh. OR dissemination.ab. OR disseminate.ab. OR disseminating.ab. OR effectiveness in research.ab. OR health plan implementation.ab. OR implement.ab. OR implementation.ab. OR implementing.ab. OR knowledge to action.ab. OR knowledge transfer.ab. OR knowledge translation.ab. OR research to practice.ab. OR scale up.ab. OR scaling up.ab. OR research utilisation.ab. OR research utilization.ab. OR technology transfer.ab. OR translational research.ab. OR practice guidelines as topic.ab. OR practice guideline.ab. OR practice guidelines.ab. OR evidence-based medicine.ab.

29.02.2016

Time 15h27

Hits 120504

AND

2#

refugees.sh. OR refugee.ab. OR asylum seeker.ab. OR asylum seekers.ab. OR conflict survivor.ab. OR conflict survivors.ab. OR immigrant.ab. OR immigrants.ab. OR migrant.ab. OR migrant.ab.

29.02.2016

hits 26089

time 15:28

combined 1# AND #2

29.02.2016

time 15h 29

861 results

Sociological Abstracts

#1

SU(refugees) OR AB, TI(refugee) OR AB, TI(refug*) OR AB, TI("asylum seeker") OR AB, TI("asylum seekers") OR AB, TI("conflict survivor") OR AB, TI("conflict survivors") OR AB, TI(immigrant) OR AB, TI(immigrants) OR AB, TI(migrant) OR AB, TI(migrants)

Date 26.02.2016

Time 17:08

Hits 47,662

#2

AB, TI("diffusion of innovation") OR AB, TI("diffusion of innovations") OR SU(information dissemination) OR AB, TI(dissemination) OR AB, TI(disseminate) OR AB, TI(disseminating) OR AB, TI("effectiveness in research") OR SU(health plan implementation) OR AB, TI(implement) OR AB, TI(implementation) OR AB, TI(implementing) OR AB, TI("knowledge to action") OR AB, TI(knowledge transfer) OR AB, TI("knowledge translation") OR AB, TI("research to practice") OR AB, TI("scale up") OR AB, TI("scaling up") OR AB, TI("research utilisation") OR AB, TI("research utilization") OR AB, TI("technology transfer") OR AB, TI("translational research") OR SU(practice guidelines as topic) OR AB, TI("practice guideline") OR AB, TI("practice guidelines") OR AB, TI("evidence-based medicine")

Date 26.02.2016

Time 17:11

Hits 30,981

Combined #1 and #2

Date 26.02.2016

Time 17:13

Hits 995

Cochrane

1#

Ti,ab,key words: refugee OR refug* OR "asylum seeker" OR "asylum seekers" OR "conflict survivor" OR "conflict survivors" OR immigrant OR immigrants OR migrant OR migrants
OR Refugees mesh

Date 26.02.2016

Time 16:42

Hits 610

AND

2# (OR everywhere)

MeSH health plan implementation

MeSH information dissemination

MeSH Practice guidelines as topic

Ti,ab,key words "diffusion of innovation" OR "diffusion of innovations" OR dissemination OR disseminate OR disseminating OR "effectiveness in research" OR implement OR implementation OR implementing OR "knowledge to action" OR "knowledge transfer" OR "knowledge translation" OR "research to practice" OR "scale up" OR "Scaling up" OR "research utilisation" OR "research utilization" OR "technology transfer" OR "translational research" OR "practice guideline" OR "practice guidelines" OR "evidence-based medicine"

Date 26.02.2016

Time 16:46

Hits 22989

Combined: #1 AND #2

Date: 26.02.2016

Time 16:49

Hits: 66 (1 cochrane review, 62 trials, 3 economic evaluations)

Pilots

su(refugees) OR AB,TI(refugee) OR AB,TI(refug*) OR AB,TI("asylum seeker") OR AB,TI("asylum seekers") OR AB,TI("conflict survivor") OR AB,TI("conflict survivors") OR AB,TI(immigrant) OR AB,TI(immigrants) OR AB,TI(migrant) OR AB,TI(migrants)

date 26.02.2016

time 15:48

Hits 2,472

AND

#2

AB,TI("diffusion of innovation") OR AB,TI("diffusion of innovations") OR su(information dissemination) OR AB,TI(dissemination) OR AB,TI(disseminate) OR AB,TI(disseminating) OR AB,TI("effectiveness in research") OR su(health plan implementation) OR AB,TI(implement) OR AB,TI(implementation) OR AB,TI(implementing) OR AB,TI("knowledge to action") OR AB,TI(knowledge transfer) OR AB,TI("knowledge translation") OR AB,TI("research to practice") OR AB,TI("scale up") OR AB,TI("scaling up") OR AB,TI("research utilisation") OR AB,TI("research utilization") OR AB,TI("technology transfer") OR AB,TI("translational research") OR su(practice

guidelines as topic) OR AB, TI("practice guideline") OR AB, TI("practice guidelines") OR AB, TI("evidence-based medicine")

Date 26.02.2016

Time 16:03

Hits 1219

Combined #1 and #2

16:04

Hits: 64 results

PubMed

#1

MeSH Terms	refugees	OR
Title/abstract	refugee	OR
Title/abstract	refug*	OR
Title/abstract	"Asylum seeker"	OR
Title/abstract	"Asylum seekers"	OR
Title/abstract	"conflict survivor"	OR
Title/abstract	"conflict survivors"	OR
Title/abstract	migrant	OR
Title/abstract	migrants	OR
Title/abstract	immigrant	OR
Title/abstract	immigrants	OR

Date 26.02.2016

Time 15:28

Hits 42698

#2

Title/abstract	"diffusion of innovation"
Title/abstract	"diffusion of innovations"
MeSH Terms	"information dissemination"
Title/abstract	dissemination
Title/abstract	disseminate
Title/abstract	disseminating
Title/abstract	"effectiveness in research"
MeSH Terms	health plan implementation
Title/abstract	implement
Title/abstract	implementation
Title/abstract	implementing
Title/abstract	"knowledge to action"
Title/abstract	"knowledge transfer"

Title/abstract	"knowledge translation"
Title/abstract	"research to practice"
Title/abstract	"scale up"
Title/abstract	"Scaling up"
Title/abstract	"research utilisation"
Title/abstract	"research utilization"
Title/abstract	"technology transfer"
Title/abstract	"translational research"
MeSH Terms	practice guidelines as topic
Title/abstract	"practice guideline"
Title/abstract	"practice guidelines"
Title/abstract	"evidence-based medicine"

Date 26.02.2016
Time 14:09
Hits 386258

Combined #1 AND #2
Date: 26.02.2016
Time 15:29
Hits 1417

Embase

1#

Typing

'refugee'/exp OR refugees:ab,ti OR refug*:ab,ti OR "asylum seeker":ab,ti OR "asylum seekers":ab,ti OR "conflict survivor":ab,ti OR "conflict survivors":ab,ti OR immigrant:ab,ti OR immigrants:ab,ti OR migrant:ab,ti OR migrants:ab,ti
Select: with abstract

In code:

'refugee'/exp OR refugees:ab,ti OR refug*:ab,ti OR 'asylum seeker':ab,ti OR 'asylum seekers':ab,ti OR 'conflict survivor':ab,ti OR 'conflict survivors':ab,ti OR immigrant:ab,ti OR immigrants:ab,ti OR migrant:ab,ti OR migrants:ab,ti AND [abstracts]/lim

Date: 26.02.2016
Time: 15:17
Hits: 37,833

#2

2#

Typing:

"Diffusion of innovation":ab,ti OR "Diffusion of innovations":ab,ti OR 'information dissemination'/exp OR dissemination:ab,ti OR disseminate:ab,ti OR disseminating:ab,ti OR "effectiveness in research":ab,ti OR 'health plan implementation'/exp OR implement:ab,ti OR implementation:ab,ti OR implementing:ab,ti OR "knowledge to action":ab,ti OR "knowledge transfer":ab,ti OR "knowledge translation":ab,ti OR "research to practice":ab,ti OR "scale up":ab,ti OR "scaling up":ab,ti OR "research utilisation":ab,ti OR "research utilization":ab,ti OR "technology transfer":ab,ti OR "translational research":ab,ti OR 'practice guidelines as topic'/exp OR "practice guideline":ab,ti OR "practice guidelines":ab,ti OR "evidence-based medicine":ab,ti

Select: with abstract

In code:

'diffusion of innovation':ab,ti OR 'diffusion of innovations':ab,ti OR 'information dissemination'/exp OR dissemination:ab,ti OR disseminate:ab,ti OR disseminating:ab,ti OR 'effectiveness in research':ab,ti OR 'health plan implementation'/exp OR implement:ab,ti OR implementation:ab,ti OR implementing:ab,ti OR 'knowledge to action':ab,ti OR 'knowledge transfer':ab,ti OR 'knowledge translation':ab,ti OR 'research to practice':ab,ti OR 'scale up':ab,ti OR 'scaling up':ab,ti OR 'research utilisation':ab,ti OR 'research utilization':ab,ti OR 'technology transfer':ab,ti OR 'translational research':ab,ti OR 'practice guidelines as topic'/exp OR 'practice guideline':ab,ti OR 'practice guidelines':ab,ti OR 'evidence-based medicine':ab,ti AND [abstracts]/lim

Date: 26.02.2016

Time 15:54

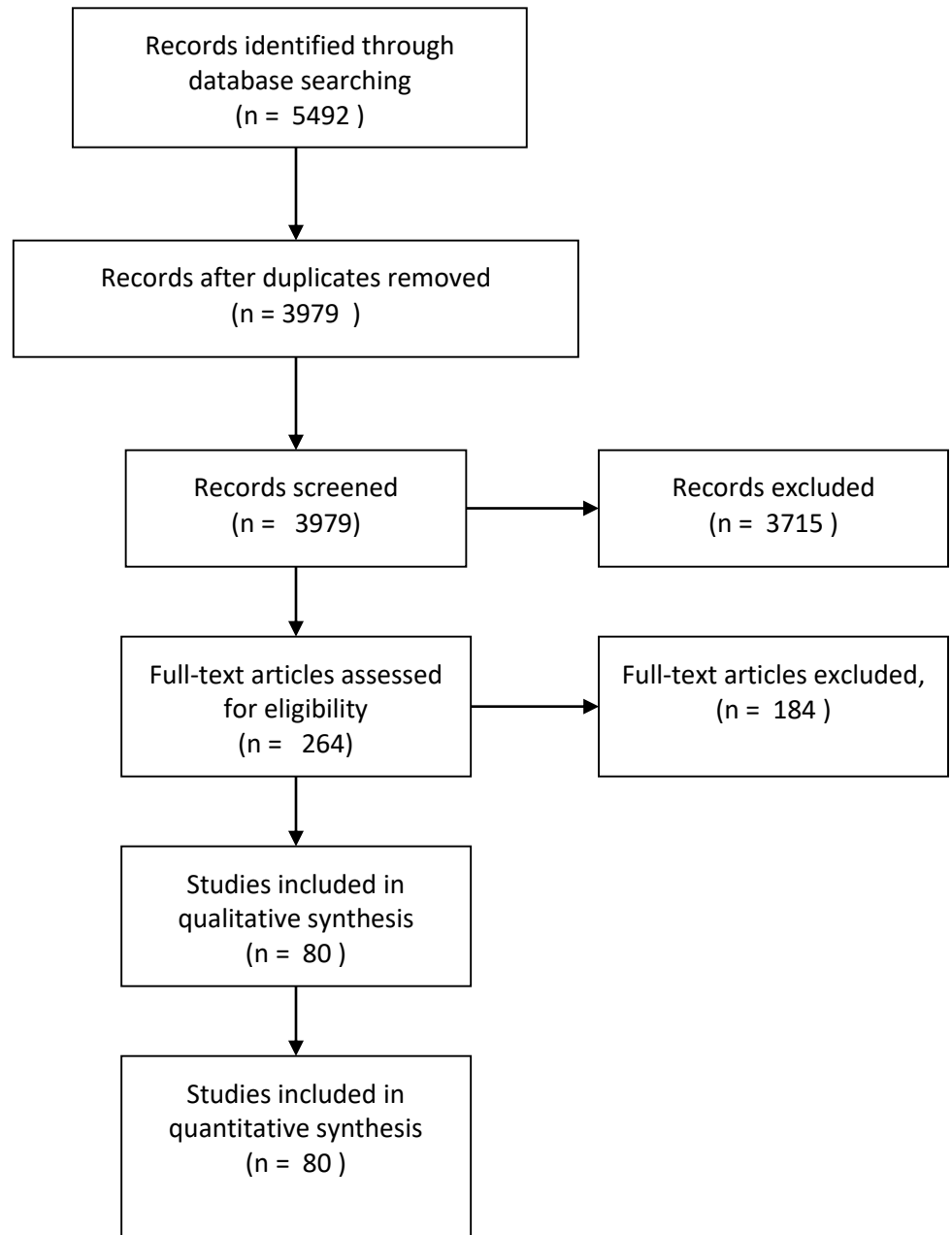
Hits 569,572

Date 26.02.2016

Time 15:56

Combined: 2116

PRISMA Flow Diagram



Appendix 2. Survey items

EUR-HUMAN SURVEY

This survey is part of the project '717319/ EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020). A primary objective of the EUR-HUMAN project is to identify, design and assess interventions to improve primary health care delivery for refugees and migrants with a focus on vulnerable groups. For more information <http://eur-human.uoc.gr/>

PURPOSE OF THIS STUDY

With this survey we seek to collect information on the practical implementation of measures and interventions to promote the health of refugees and migrants within Europe.

This survey collects data in addition to a systematic review of literature and expert knowledge.

To maximize the potential impact of the outcomes of the EUR-HUMAN project we want to learn from your most recent, practical experiences.

INSTRUCTIONS

The survey contains closed and open questions.

Please answer as many questions as you can. Be as specific as possible, preferably by giving examples.

Your input will be anonymized and only be reported at an aggregated level.

QUESTIONS

1. How would you describe your primary role in the health care for refugees or migrants?

- ☐ Policy, management, organizational support
- ☐ Provision of health care/health care professional

2. In which country/countries do you work with/for refugees or migrants?

3. If possible, please mention particular sites:

4. In which way/stadium do you have experience with health care for refugees or migrants? (please describe) (if applicable, please make an estimation of how long each experience lasted)

	Arrival	Transit	Longstay	How long did your experience last?	N/A
Experience 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
Experience 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
Experience 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
Experience 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>

5. In which domains do you have experience? (multiple answers are accepted)

☐ Infectious diseases

☐ Mental health and emotional maltreatment

☐ Chronic and non-communicable diseases

☐ Health of women and children

☐ Other, please specify

6. Which best practices/good examples do you know on prevention, screening and intervention regarding the indicated domains? (please describe shortly and, if

available, add written information or a hyperlink to the method)

	Practices	N/A
Best practice/good example: prevention	<input type="text"/>	<input type="radio"/>
Best practice/good example: screening	<input type="text"/>	<input type="radio"/>
Best practice/good example: intervention	<input type="text"/>	<input type="radio"/>
Best practice/good example: other	<input type="text"/>	<input type="radio"/>

7. Are you aware of any trainings/online courses for health care workers, people working with refugees and also volunteers?

☐

No

☐

Yes, please specify...

8. Have you attended any training/online course with regards to health care for refugees?

☐

No

☐

Yes, please specify...

9. In general, which factors help the implementation of health care measures and interventions in your local setting? (multiple answers are accepted)

☐

Characteristics of health care measure or intervention

☐

Characteristics of health care providers

☐

Characteristics of refugee/migrant population

☐

Professional interactions

☐

Incentives and resources

☐

Local capacity for organisational change

☐

Particular social, political and legal factors

☐

Other, please specify

☐

None of the above

10. Please explain:

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

Professional interactions

Incentives and resources

Local capacity for organisational change

Particular social, political and legal factors

Other factors

Extraction based on: 9. *In general, which factors help the implementation of health care measures and interventions in your local setting? (multiple answers are accepted)*

11. In general, which factors hinder the implementation of health care measures and interventions in your local setting? (multiple answers are accepted)

☐

Characteristics of health care measure or intervention

☐

Characteristics of health care providers

☐

Characteristics of refugee/migrant population

☐

Professional interactions

☐

Incentives and resources

☐

Local capacity for organisational change

☐

Particular social, political and legal factors

☐

Other, please specify

☐

None of the above

12. Please explain:

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

Professional interactions

Incentives and resources

Local capacity for organisational change

Particular social, political and legal factors

Other factors

Extraction based on: 11. *In general, which factors hinder the implementation of health care measures and interventions in your local setting? (multiple answers are accepted)*

- 13. Please make a top 3 of the most important condition for the implementation of health care measures and interventions in your local setting (1 = most important, 2 = second, etc.)**

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

Professional interactions

Incentives and resources

Local capacity for organisational change

Particular social, political and legal factors

Available time for access

Other determinants, namely

- Which local/national documents are in your view valuable for the optimization of**
*** 14. refugee health care in Europe? (e.g. names of local/national guidelines, studies, websites, other resources; no language restriction)**

Document

Document

Document

Document

- 15. Below you can share extra information (experiences, considerations) in relation to**

improving refugee and migrant health care in Europe.

Your responses have been registered!

Thank you for taking the time to complete the survey, your input is valuable to us.



**Co-funded by
the Health Programme
of the European Union**

This survey is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020).

The content of this survey represents the views of the author only and is his/her sole responsibility; it can not be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Appendix 3: Experts and topic list for interview

- 1) Professional within the municipal public health authorities, GGD, in the Netherlands. Shares experience with resettled or newly arrived refugees and other migrants in the Netherlands.
- 2) Professional at International Organization for Migration (IOM). Shares experience with training health care professionals and other workers such as coast guard/law enforcers.
- 3) Doctor and researcher regarding migrant care. Concerned with research and development of evidence based guidelines for migrant care .
- 4) Professor migrant care Europe
- 5) Representative of the European Public Health Association (EUPHA)
- 6) Public Health expert from Macedonia. Practitioner, independent consultant in the field of family medicine
- 7) Practitioner & representative of the Ministry of Health in Malta
- 8) Professional at management level Medicine Sans Frontiere (MSF) Greece. Shares MSF experience with implementing health care in Greece for refugees
- 9) Academic professional in regard to reproductive health care and women's health for migrants in Greece. Shares experience with educating migrants about sexual and reproductive health care
- 10) Dutch professor specialized in primary care for migrants. Shares research experience regarding prevention interventions for migrants in the Netherlands

The respondents were invited to talk about the implementation of migrant and refugee care. The topic list concerned the following:

1. Which role do you have concerning health care for refugees and/or migrants?
2. What is, to your opinion, most important for a successful organization of refugee and migrant health care in the European setting?
3. Which structures are meaningful and promising?
4. What are the biggest challenges? Specifically, for transit countries and for long term settlement countries?
5. What factors, are essential for helping implementation of health care measures for refugees and other migrants in Europe?
6. Which barriers for implementation need to be addressed first for successfully implementing health care measures for refugees and other migrants in Europe?
7. Could you recommend specific health care interventions that would be feasible in the current context of the refugee crisis? (think about prevention, screening, therapy, clinical interventions etc.)

Appendix 4. Detailed description of results

4.1 Literature review

4.1.1 Introduction

In appendix 4.1, the detailed results of the literature review are presented for the four health care categories: mental health/psychosocial care (§4.1.2), women, maternal and childcare (§4.1.3), infectious diseases (§4.1.4), and chronic and non-communicable diseases (§4.1.5). Additionally, several publications were identified that contained relevant but could not be assigned to one of the four health care categories: general health and implementation studies (§4.1.6).

4.1.2 Mental health/psychosocial care

Selection of articles

A total of 70 articles was selected on the basis of their abstract and title. 9 articles were not available. 1 article was in French and one in German. 41 articles did not involve specific information on implementation.

Quality of the articles

The content and context of the 15 articles that were included based on a full-text analysis differed. Many articles were framed as offering practical information on implementation. Often, no methodology section was provided.

Topics of the articles

4 studies focused on EU countries (Dardenne 2007, Kieft 2008, Watters 2014, Brugha 2014). Kieft and Dardenne focused on resettlement refugees. Most actual information on the EU hotspots comes from Brugha and Watters. Other articles are more general in that

Guidelines, protocols, policy and legislation

Many guidelines do not have specific information on care for refugees (e.g. Mollica 2004, Brugha 2014). Miller (2008) advises to make guidelines that reflect the priorities of the community, and that prevention should be preferred over treatment. Guidelines can be modified by integrating them with local values and beliefs (Miller 2008). Regarding the implementation of the MH guideline in Jordan, the language and layout was not beneficial for professionals. It was only deemed useful for policy makers (Horn 2008). Proctor 2006 warns that you cannot copy assessment tools from guideline because the translated assessment tools become new measures, that need to be re-validated.

Professional level

Improving knowledge, skills or attitude of professionals in the field of mental health is deemed an important barrier/enabler in most of the articles (Proctor 2006, Foster 2001, Miller 2004, Mollica 2004, proctor 2005, Darndenne 2007, Kieft 2008, Brugha 2014, Hinton 2014). Most importantly, professionals need to be trained in cultural competency and diversity (Brugha 2014). Building trust is also mentioned as an important skill, and Proctor (2006) gives concrete advice. The concept of western therapies cannot be implemented unchanged. Elicit the asylum seekers explanatory model of mental distress. MH pros should be trained to develop a mutual understanding of each other's explanatory model of stress (Proctor 2006). They need to be made aware of protocols for interpreting trauma focused PTSD (Dardenne 2007). There is a need to be up to date on the actual and continuously changing political situation of both the country of origin as of the country of arrival (Brugha 2014). Mollica (2004) states that all frontline workers need to be trained in basic mental health principles and stresses the necessity of a relief program for mental health workers themselves. Forster (2001) argues that professionals should be aware that psychiatric diagnoses in bilingual patients can differ per language.

Patient factors: lack of trust/fear of stigma

Refugees can have a lack of trust in (mental) health care (Proctor 2006, Saechao 2012). Often they have no mental health programs in their own country (Saechao 2012), and are unfamiliar with the possibilities that mental care offers. They fear to lose control, or to be hospitalized (Proctor 2006). They fear being shamed upon by the community if they seek health for mental problems (Proctor 2006). When developing a program for refugees, it is of importance to actually identify the needs of the patients, and to adopt the program accordingly (Brugha, Sachao, Kieft, Hinto, Proctor - Years).

Accessibility of care

Several studies argue that for migrants services are geographically (Hinton 2014, Kieft 2008, Brugha 2014) or financially (Saechao, 2016) inaccessible. This limits the initial contact with mental health care providers, as the continuity of care. Actions that build resilience over time are deemed important. This can only be accomplished if continuity of care is ensured (Proctor 2006).

Professional interactions

There is a well identified need to more actively involve the refugee in the development of MH care (Mollica, 2004, Proctor 2005, Brugha 2014) Hinton 2014 argues that time should be spent to better match patients with the care providers and to increase the positive expectancy of mental health care . They argue that patients are more likely to benefit from mental health care if they have a good "click" with the professional and if they think that mental health care will help.

Interpreter services

Working with interpreters is not simply hiring translators. Interpreters play an important role in the triad professional-patient-interaction. Transfer and counter transfer reactions not only occur between patient and professionals, but within the triad. The therapist needs to be constantly aware of this process and has to reflect on this together with the interpreter after the treatment session. Dardenne (2007) offers the most practical advice on how to explain CBT to interpreters. They refer to a booklet which might help interpreters understand CBT for trauma related therapy : Understanding your reactions to trauma (Herbert 2002).

Continuity of care

To improve continuity of care, the distance between community care and formal care should be limited (Kieft 2008). Therapists should ask patients about the history of care they received, and to actively address barriers the patient experiences to access care (Hinton 2014). Proctor (2006) argues that it is important to focus on treatment elements that build resilience over time.

Care for children

Some specific remarks were made regarding mental health care for children. Proctor states that education is vital for the mental health of children. Focus should be on the reduction for drug therapy in children. Children's trauma is highly influenced by the way in which their parents dealt with the migration stress (Foster 2001). One study in Yugoslavia found that a specific youth club, with a focus on dealing with trauma helped children rebuild their trust (Ispanovic 2003). Findings on mental wellbeing were mixed however. Internal and external services for children should closely work together to optimize mental health care. (Proctor 2006)

Organizational change: integration of care

Several authors stress the need for psychiatric services and social services to work together (Proctor 2006, Hinton 2014, Brugha 2014). Patients are often more helped by concrete solutions for their social problems than for treatment of their mental health problems, as they are often the by-product of their social problems (Miller 2004, Hinton 2014, Brugha 2014).

Community

Related, enabling the community to play a preventive role in mental health care is argued to be more important than to offer a single intervention (Miller 2004). In a case study in Jordan, one of the barriers for the implementation of mental health was the lack of a community to support the interventions (Horn, 2008). Mollica (2004) identified the mobilization of community to restore normal life to be an important enabler of mental health for refugees. Non-health services and volunteer groups can also add to the care provided by professionals (Proctor 2006). It is however also important to monitor the quality of care provided by community (Mollica 2004 Horn, 2008). Training a community to provide basic psychological help is also recommended (Mollica 2004).

Monitoring

Hinton (2014) and Mollica (2004) propose that the monitoring of provided care from the start of the services are important enablers for mental health.

Funding

Funding of mental health initiatives is often short term (Horn 2008). This makes it difficult to train staff before the implementation of an intervention can begin (Horn 2008, Hinton 2014). Mollica (2004) indicate that resources should be used to build a Mental Health system of local primary care provides or even traditional healers. It is argued to integrate mental health initiatives in regular mental health care (Proctor 2006, Mollica 2004).

4.1.3 Women, maternal and childcare

Selection of articles

50 articles were selected on the basis of their abstract and title. 35 articles concerned women's, maternal and reproductive health and fifteen concerned child health. Three articles were unavailable and eight lacked full text. Three articles were excluded because of language (not written in English or Dutch). Seven articles were excluded because they did not concern barriers or enabling factors for implementation. Five articles were excluded because they were either too subjective, concerned a protocol or commentary. 11 articles were excluded because the research concerned a different context (emergency, crisis, non EU) or different target group.

Based on an assessment of full texts, 13 articles were included.

Quality of articles

Most articles (6) concern mixed methods; primarily a combination of qualitative interviews, surveys and a literature review. Three articles used qualitative methods, such as interviews or focus groups. Two were unsystematic literature reviews, such as state-of-art reviews. Two other articles were descriptive studies on policy and practice.

Description of the articles

The selected articles range from being published in year 2001 to 2015. The researches took place in different countries. Only four took place in a European context: one at the Balkans (Macadonia and Albania), one in Sweden and two in the Netherlands. Furthermore, two articles were situated in Switzerland, one in multiple countries in Sub-Saharan Africa (developmental context), two in Australia, one in the United States, one in Jordan (upper middle income country) and one research is conducted primarily in low-and middle income countries and, lastly, one that is speaking about emergency settings and is not bound to a specific location.

The researches took place at different sites; Refugee camps, in communities, at the patients' homes, specialized clinics, and hospitals. It involved differed target groups;

primarily refugee and migrant women and children, but also refugees and other migrants in general. The selection involves a wide variety of topics.

Selection of articles women, maternal and child care

Author	Main topic	design	Country of study & setting
Boerleider, 2014	Boerleider (2014) looks into strategies from maternity care assistants (MCA) to cope with issues encountered when providing postnatal care to non-western women in the Netherlands. The objective is to make postnatal care more culturally competent and culturally tailored. MCAs are responsible for monitoring the health of mother and baby at home and reporting to midwives and helping/instructing mothers in taking care of the babies at home	qualitative. 15 interviews	The Netherlands (high income country), home setting
Borrel, 2001	Borrel (2001) addresses factors that influence adherence to best practice guidelines and policy concerning infant feeding in the case of the Balkan Crisis	Descriptive study. analysis of practice and policy.	the Balkans (Macadonia and Albania), refugee camps
Byrskog, 2015	Byrskog (2015) explores how antenatal care midwives in Sweden deal with Somali Born refugees that are suspected to be exposed to violence. Specifically, barriers and facilitators in counselling violence and well-being.	qualitative 17 interviews with staff	Sweden. Antenatal care clinics
Casey, 2015	Casey (2015) looks into the availability, quality and utilization of reproductive health (RH) services and access barriers in three different countries in Sub-Saharan Africa. RH services such as abortion care, contraceptives, clinical management of rape, HIV and STIs.	cross-sectional mixed methods study: FDGs, questionnaires and HFAs	3 countries in Sub-Saharan Africa. Burkina Faso, DRC and South Sudan. different settings. 28 health facilities in Burkina Faso, 25 in DRC and 9 in South Sudan. Primarily in UNHCR-refugee camps and community settings
Correa-Vales, 2012	Correa-Vales (2012) explores key elements that characterize a best practice model of maternity care for women from refugee backgrounds. As part of a project in which clinical service delivery, social work and interpreting services are central.	mixed methods. literature review, consultations with key stakeholders, chart audit of hospital use, surveys among patients and hospital staff	Brisbane, Australia, maternity hospital

Goosen, 2010	Goosen (2010) looks into patients' health care needs, risk factors and outcomes in regards to pregnancy among pregnant asylum seekers in the Netherlands and other Western countries.	literature study of empirical studies (state-of-art review)	the netherlands and other western countries
Hearst, 2013	Hearst (2013) provides an introduction to the practice of female genital cutting (FGC) guidelines for primary care physicians. Specifically, how they can discuss FGC with their patients.	Semi-structured interviews with staff and review of international literature	US, primary care
Jaeger, 2013	Jaeger (2013) identifies hospital-based care needs of pediatric migrants (PMs) and good service approaches for this target group	Semi-structured interviews with staff and review of peer-reviewed international literature	Switzerland, hospital
Krausse, 2015	Krausse (2015) evaluates the implementation of the Minimum Initial Service Package guideline (MISP) for Syrian refugees in Jordan. "The MISP is a coordinated set of priority RH services designed for the onset of an emergency to prevent excess morbidity and mortality, particularly among women and girls"	3 methods: Key informant interviews (KIIs), health facility assessment (HFAs), focus group discussions (FDGs)	Jordan (upper middle income country), two refugee sites; Zaatri Camp (164,365 refugees) and Irbid City (47,087 refugees)
Moss, 2013	Moss (2013) explores the effectiveness of guidelines for care for children in complex emergencies.	rapid review and surveys among staff from international relief organisations	complex emergency setting, not bound to specific location
Thierfelder, 2005	Thierfelder (2005) looks into the experiences from women and health care professionals with Swiss gynecological/obstetrical care in regard to Female Genital Mutilation (FGM).	focusgroups with 29 women and telephone interviews with 37 health care professionals	Switzerland, Swiss health services
Tran, 2015	Tran (2015) tries to gain inside in the overall state of organizational capacity to deliver reproductive health care in humanitarian settings. Among others he addresses The Minimum Initial Service Package for reproductive health (MISP), the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM), and the Inter-Agency Reproductive Health Kits.	descriptive study	primarily low-and middle income countries. humanitarian setting. camp based, rural and urban settings

Woodland, 2010	Woodland (2010) develops a framework for good practices to promote improved access, equity and quality of care in service delivery for newly arrived refugee children.	state-of-art review	Australia, health care system level
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Even though this review takes into account a wide variety of interventions and measurements that take place in different contexts, which clearly challenges the generalizability of the results, lessons can be learned and similar barriers and enabling factors can be identified.

Guidelines, protocols, policy and legislation

Six articles mentioned the (un)availability of guidelines as a factor for implementation. Some studies found that the absence of a guideline resulted in difficulties with the improvement of care (Jaeger 2013, Thierfelder 2005, Tran 2015). Even when guidelines are available, they need to be applicable to the specific situation in which they are used. Moss 2013 noted that most guidelines concerning childhood diseases were based on stable practices instead of complex emergencies (Moss 2013). In emergency settings different health care problems have priority and different resources are available. Moreover, an infrastructure to implement guidelines in emergency settings is often missing (Moss 2013). Krause (2015) addresses the importance of an infrastructure as well. Furthermore, guidelines need to be adjusted to the level of education of the implementers. Moss (2013) states that guidelines concerning childcare are often aimed at trained professionals, whereas in complex emergencies a range of lower skilled health-care workers are involved. The guidelines also need to be adjusted to the target group, otherwise this can cause difficulty with implementation (Byrskog 2015). For guidelines to be adopted by professionals it is important to create societal support. Moss (2013) explains different ways to establish this. It is, for example, helpful to engage stakeholders in the development of guidelines and important that national authorities, such as the Ministry of Health, adopt the guidelines. International agencies should support this by disseminating the guidelines among international relief organizations. Another strategy is to adjust the already existent local guidelines, which could also strengthen national capacity to deal with health care problems (Moss 2013). The newness and complexity of the guidelines can also be a barrier for implementation (Tran 2015).

Available protocols and policies can enable implementation. Krause (2015) illustrated how a lack of national protocols on the treatment of Sexual Transmitted Infections (STIs) and the clinical management of rape can result in the absence of these services. They also found that available HIV policies indeed helped practice. Woodland (2010) refers to policies that address a wider range of health determinants, such as housing, as beneficial for health outcomes. Restrictive national policies can form a barrier for implementation. Anti-Retroviral Treatment (ART) for HIV is for example unavailable outside hospitals in the Democratic Republic of the Congo (DRC) due to policy barriers (Casey 2015). Weak

institutionalization of policies within agencies can also form an obstacle for implementation (Borrel 2001). Health care practices can be enabled when policies are implemented. For example, the enactment of a female circumcision policy in a maternity hospital enhances staff to cope with circumcised women. (Correa-Valles 2012). According to Jaeger (2013), the government has a role in the implementation of policies concerning Migrant Friendly Hospitals (MFH). They need to ensure feasibility of policies and monitor possible side-effects.

Professional level: knowledge, awareness and skills

Nine out of thirteen authors named knowledge as a factor for implementation. Limited knowledge among the staff could be a barrier for implementation. Borrel (2001) noticed this among staff of different organizational levels that were concerned with infant feeding. Thierfelder (2005) noticed a lack of experience with Female Genital Mutilation among health care professionals. Casey (2015) speaks about ‘a lack of critical reproductive health knowledge’. Health care professionals lacked knowledge regarding supportive policies, protocols and legislation. For example, they thought that abortion was unauthorized, while this was not the case (Casey 2015). Professionals could also lack knowledge about the availability of services, resulting in under usage. For example, service providers had insufficient knowledge about the availability of services for rape survivors (Krausse 2015). Another important issue, mentioned by Borrel (2001), is the lack of knowledge regarding risks that are involved with certain policies. Resource managers and others that were involved with commodity storage did not know much about the risks involved with the distribution of baby milk products. This resulted in unexpected high costs for handling expired baby products (Borrel 2001).

Improving the knowledge of staff can enable implementation. Six authors mentioned ‘knowledge’ as a beneficial factor. Byrskog (2015) names experience, intuitive knowledge and a theoretical foundation as beneficial for implementation. Correa-Vales (2012) and Goosen (2010) both mention the importance of specific knowledge regarding the target group. Knowing about cultural aspects such as female circumcision and traditional birthing practices, health problems such as schistosomiasis, psychosocial issues resulting from torture and trauma, and refugee related issues such as fleeing experiences, asylum procedures, asylum centre conditions and regulation in regard to health care. Goosen (2010) states that professionals also need to be knowledgeable about risk factors and treatment effects for different ethnic groups (Goosen 2010). According to Moss (2013) knowledge about the local epidemiology is important (Moss 2013). Knowledge about culturally sensitive approaches to discuss health is required (Hearst 2013, Thierfelder 2005). Experience with Female Genital Mutilation and knowledge, not only about the clinical part but also the cultural context, enables the provision of culturally sensitive care (Thierfelder 2005, Hearst 2013).

Four authors mentioned (lack of) ‘awareness’ as a factor for implementation. Unawareness of guidelines, procedures and policies were mentioned as a barrier (Borrel 2001). Lack of awareness of the situation and of available services is addressed by Casey

(2015). Thierfelder (2005) names the unawareness of psychosexual needs of women in regards to Female Genital Mutilation (Thierfelder 2005). Raising awareness among relevant implementing partners can benefit the application of guidelines in practice (Borrel 2001). Goosen (2010) discusses the importance of cultural awareness, e.g. how culture influences individual behaviour and thoughts and awareness of own assumptions and stereotyping. In sum, awareness raising could enable implementation.

Skills are mentioned by four authors as a factor for implementation. When looking at 'competency' and 'capacity' of staff, which are broader terms, this number is larger, namely seven. As a barrier Casey (2015) points at weak clinical competence, poor decision making and 'interpersonal skills' (e.g. communication and teamwork). Skilled staff is seen as an enabler for implementation (Casey 2015, Krausse 2015). Goosen (2010) and Byrskog (2015) specifically mentioned skills to handle language and cultural barriers. Byrskog states that having developed these skills increase the possibilities of overcoming social distances between patient and professionals (Byrskog 2015). Goosen (2010) refers to skills concerning 'cultural competency', e.g. 'how to inform patients, make use of tols, identify and fulfil needs of patients and the ability to adjust to new circumstances'. Byrskog (2015) speaks about 'interpersonal competence', meaning the ability to build a trustful relationship with patients. She states it can be established by making use of words that are part of the patient's language.

Professional level: attitude, beliefs and cultural factors

Ten of the thirteen authors mention attitude, beliefs and cultural factors of professionals as a factor for implementation.

Correa-Vales (2012) sees limited cultural competence of staff as a barrier. Difference in culture, cultural beliefs and norms can become cultural barriers in implementation. This can result in staff avoiding discussing certain sensitive topics with patients and not providing certain services, such as family planning. For example, not providing condoms or emergency contraception or screening on STIs for unmarried women (Casey 2015, Krausse 2015). Jaeger (2013) speaks about cultural differences in understanding and acceptance of disease, particularly disability, chronic or somatic problems. Borrel (2001) illustrates how staff beliefs can become an obstacle. Staff thought that traumatized women were unable to breastfeed that resulted in changed traditional values among women and created dependency on baby products (Borrel 2001). Furthermore, the attitude of staff regarding infant-feeding products, namely seeing these as similar to other humanitarian aid products, hindered adequate implementation (Borrel 2001). Goosen (2010) suggest a proactive approach of staff, to reach out to pregnant asylum seekers that are missing out on care or not coming to appointments.

Attitudes of staff can also enable implementation. Boerleider (2014) illustrates how 'being flexible' and 'being creative' enhances practices. The first is about finding a compromise between foreign cultural practices and protocols when this does not pose health risks for the patients. The second entails improvisation and having a practical

attitude in case there are limited financial resources or no available interpreters to assist communication. Byrskog (2015) sees having patience with the patients as beneficial for practice. Both Goosens (2010) and Byrskog (2015) advise to focus on the individual patient; a person centered approach. Specifically, a focus on social and psychosocial needs of the individual patients and enhancing “positive coping factors, strength and resilience” (Goosen 2010). Correa-Vales (2012) suggests staff to be culturally sensitive by involving the family of patients during labor and delivery. Moreover, she suggests to not only focus on beliefs and values in order to be culturally sensitive, because that has the risk of stereotyping, but to focus on a broader understanding of culture (Correa-Vales 2012). Being aware of own attitude towards other cultures and being receptive to other cultures is suggested to improve implementation (Casey 2015, Goosen 2010, Thierfelder 2005) Avoiding stigmatization can enable implementation (Jaeger 2013), as well as addressing provider biases (Casey 2015). According to Woodland (2010), culturally and linguistically sensitive services can improve “access, equity, health literacy communication, patient safety and quality of service provision”. Furthermore, Woodland suggests professionals to be appreciative of the client’s culture because this “can provide clinically useful insights into the cultural/religious practices, dietary practices and health beliefs. This assists the clinician to tailor information regarding diagnosis and treatment and thus, to maximize the families' understanding and adherence” (Woodland 2010:564).

Professional level: expectation of outcome, motivation, self-efficacy and staff incentives

Expectations of outcome and staff-incentives are not mentioned as a factor for implementation. Motivation is mentioned four times and self-efficacy by three authors. Not seeing the need to provide (alternative) services are named in two articles. Borrel (2001) explains how the widespread availability of infant-feeding products acted as a barrier for searching for alternatives in regard to infant feeding. Casey (2015) illustrates how a lack of family planning services were result of professionals not seeing the need to provide these services. Krausse (2015) states that a highly dedicated staff facilitated MISP implementation. According to Jaeger (2013) the willingness of professionals to recognize and address needs of patients are dependent of the following: “information, feasibility, values, experiences, the migrant population served and the level of acculturation efforts expected from the migrant population” (Jaeger 2013). Therefore, it is essential to address these issues when using motivation as an enabling factor for implementation.

Self-efficacy is defined by Flottorp (2013) as “the targeted health care professionals’ self-perceived competence or confidence in their abilities”. Professionals can experience feelings of insecurity. For example, when recommendations do not fit well with the target groups background (Byrskog 2015). Or professionals worrying about cultural or language misunderstandings that can result in poor health outcomes (Jaeger 2013). Casey (2015) illustrates that there can be a difference in perception of professionals in regards to actual and perceived quality of RH services. They were convinced providing

adequate services, whereas the minimum quality standards of RH services were actually lacking.

Professional level: perceived barriers and other factors

One important perceived barrier mentioned by Casey (2015) is the lack of authorisation. Providers felt restricted in the delivery of RH services, whereas they were actually authorised. Furthermore, professionals can perceive time constraints and language barriers as hindering implementation (Jaeger 2013). In regards to FGM, women sometimes need their husbands to give permission for undergoing certain health procedures. Thierfelder speaks about the lack of communication about FGM between sexual partners as a barrier. They argue it could be beneficial to involve men and facilitate discussion between the partners about FGM (Thierfelder 2005).

Provision of training and information

Nine out of thirteen articles mention training of staff as a factor for implementation. Borrel (2001) and Casey (2015) mention a lack of trained staff as a barrier for implementation. Moss (2013) speaks about professionals needing to be 'properly trained'. Specifically, training of cultural competency is recommended (Goosen 2010, Jaeger 2013, Woodland 2010). Jaeger states that this training also needs to be adapted to the target group, in his case paediatric migrants (Jaeger 2013). Training in different areas is seen as helpful for implementation; training about policy and guidelines (Borrel 2001) clinical, social and cognitive skills (Casey 2015), knowledge in regards to reproductive health, health systems, humanitarian principles, ethics and accountability (Casey 2015) and concerning Pediatric Migrant Health (Jaeger 2013) and capacity building in regard to FGM (Thierfelder 2005) and for all those involved in the supply chain (Casey 2015) and development of expertise (Woodland 2010). Trainings prior to the onset of an emergency, in regards to policies and guidelines (Borrel 2001) and Krausse (2015) mentioned prior MISP trainings. Krausse (2015) sees the need for training about 'the use and need of contraceptives and emergency contraception' (e.g. how to use, where to obtain). Tran (2015) advises to make use of the already existent materials, because "developing yourself is resource consuming and needs to be thoroughly planned and evaluated". (Tran 2015)

Patient factors

Providing health care to female refugees can be extra challenging due to their complex medical and social histories, among others female circumcision (Correa-Vales 2012). Byrskog (2015) identified this complexity as a barrier for determining violence among patients. In regards to maternal care, Goosen (2010) identifies the following risk factors: "low quality of general health, undernutrition, FGM, lack of knowledge concerning health and health care, limited social networks, seeking care in a late stadium and refusing caesarean option" (Goosen 2010). Woodland identifies the following issues for refugee children: "immunisation coverage, nutritional deficiencies, growth and developmental issues, poor dental health, communicable diseases incl. tuberculosis, hepatitis b & parasitic infections, interrupted education, multiple language transitions.

Mental health conditions such as PTSD, anxiety and depression” (Woodland 2010) When providing health care to these groups these complexities need to be taken into account.

Patient level: knowledge, awareness and skills

Four authors name patients’ knowledge of as a factor for implementation. Casey (2015) mentioned low knowledge about condom use and Krausse (2015) low knowledge about where condoms can be obtained Casey also noticed limited knowledge about HIV and STIs among young women (Casey 2015). Goosen points at limited understanding of language and illiteracy, a lack of knowledge concerning the body and pregnancy, unfamiliarity with the Dutch health care system and with the need for maternity care and youth health care (Goosen 2010). Furthermore, Krausse (2015) noticed that women's knowledge was limited about the availability of services for rape survivors and for family planning services and a lack of knowledge on how medical care could prevent health consequences. Jaeger (2013) recommends group training to increase understanding of diseases among patient groups.

Three authors mentioned awareness as a factor for implementation. Casey (2015) notices a lack of awareness of reproductive health services, which can result in under usage of these services. Therefore he recommends raising awareness of available services. Byrskog (2015) speaks about awareness raising of rights and support among women. According to Hearst (2013), women need to be educated about the legal consequences of FGC to enable protection of women and their daughters. Skills are not mentioned as a factor for implementation, although the already mentioned ‘condoms use’ could also be regarded as part of a skill set.

Patient level: attitude, beliefs and cultural factors

Eight authors mention attitude, beliefs and cultural factors of patients as a factor for implementation. Cultural factors that have to do with patient- professional interactions are discussed under ‘patient-professional interaction’. A different norm system can function as a barrier. Byrskog (2015) shows that this is the case for disclosing violence. A lack of trust can also play a role (Casey 2015, Byrskog). Casey (2015) specifically mentions a lack of trust in confidentiality of professionals and quality of services. A fear of gossip (Byrskog 2015), stigmatization (Krausse 2015) or social repercussions (Krausse, Casey 2015) can be a barrier for seeking care. Patients can have the tendency to comply to socio-cultural norms and therefore not seek care (Casey 2015). Especially for reproductive health services, since this is a sensitive topic. The beliefs of women about FGC can be a barrier in providing care (Hearst 2013). Furthermore, Borrel (2001) illustrates how traditional values among patients can change due to health interventions. He illustrates how traditional values in regard to breastfeeding changed due to the baby products that were offered as a preferred method for breastfeeding. Patients can have cultural preferences in how they would like birthing practices to take place. For example having a traditional midwife (Thierfelder 2005) or family present (Correa-Vales 2012) or only female practitioners or translators (Krausse 2015, Correa-

Vales 2012). When not taking these preferences into account, these can become barriers in implementation.

Patient level: expectation of outcome, motivation, self-efficacy, patient incentives

Only one author mentioned the expectation of outcome as a factor for implementation. According to Borrel (2001), the expectations of women altered due to the large distribution of infant feeding products and they became more dependent on these products. One author mentioned motivation of patients as a factor for implementation. According to Casey (2015), patients did not know why they should seek care. Using educational campaigns to inform patients or health providers actively reaching out to patients could overcome this barrier (Casey 2015). Self-efficacy is not mentioned as a factor for implementation. Four authors mentioned patient incentives as a factor for implementation. Moss (2013) sees accessibility of health-care facilities as an enabling factor. The distance to the facility and lack of transport are seen as barriers for accessing health services (Woodland 2010, Casey 2015, Correa-Vales 2012). Long waiting times on the day of the appointments were also experienced as a barrier (Correa-Vales 2012, Krausse 2015). Therefore, Correa-Vales (2012) recommends using 'time management strategies' to reduce waiting times for appointments. Furthermore, patients preferred longer consultation time to discuss their issues with providers (Thierfelder 2005). Longer time for consultations when interpreters are used (Correa-Vales 2015, Jaeger 2013) and the ability to make use of childcare during the appointments could enable practice (Correa-Vales 2012). Financial constraints (Woodland 2010, Krausse 2015) and a lack of appropriate medicines (Krausse 2015) were perceived as barriers. (Specifically, Krausse (2015) identified a problem with the need of a UNHCR registration card to receive free health care services outside refugee camps). The gender of the provider or interpreter can be perceived as a barrier for patients. Correa-Vales (2012) identified the age and gender of interpreters as a barrier for patients. Krausse (2015) notices that patients preferred female staff and suffered from a lack of privacy when making use of services. Furthermore, a negative attitude of patients towards the services or service providers can also form a barrier for using services (Krausse 2015, Thierfelder 2005). According to Moss (2013) the effectiveness of guidelines are dependent on e.g. the health seeking behaviour of patients. Active patient involvement in health services could increase quality, acceptability and effectiveness of services according to Woodland (2010). He recommends developing strategies to make the inclusion culturally competent. In order to create support it is important that the participants are representative for the refugee group (Woodland 2010). Furthermore, patients' needs need to be taken into account (Jaeger 2013, Thierfelder 2005). Jaeger (2013) sees a 'receptive environment in which privacy is secured, hospital staff has a welcoming approach and respect for the clients culture and where is also taken care of the family of patients', as an enabling factor for realizing migrant friendly care. In regards to FGM in combination with pregnancy, Thierfelder (2005) identified a list of needs. (please see table 3).

Patient level: provision of training and information

Nine of the authors mentioned the provision of training or information for patients as a factor for implementation. Providing health information could “improve acceptance of services and the uptake of positive health behaviours” (Krausse 2015). Most authors agree that educating and informing patients would enable practice. Different forms are recommended. Educational campaigns (Casey 2015). A group approach to exchange information, experiences and also expand social contacts (Jaeger 2013, Goosen 2010, Byrskog 2015, Thierfelder 2005, Woodland 2010). Jaeger (2013) recommends groups training to increase understanding of diseases. Goosen (2010) talks about networks of pregnant women in asylum seeker centers to exchange experiences and increase knowledge. Thierfelder (2005) about self-help groups in which sexuality, pregnancy and delivery can be openly discussed. Byrskog (2015) about parent-group education to e.g. increase awareness of rights (Byrskog 2015). Furthermore, Casey (2015) recommends an active outreach by health providers (Casey 2015). According to Boerleider (2014) and Goosen (2010) it is important to educate patients about the maternity system in the host country. This could lower access barriers (Boerleider 2014). Furthermore Boerleider (2015) recommends to educate about what health care practices benefit health or pose health risks.

In regards to FGM, Thierfelder (2005) argues that patients need to be provided with “information about options regarding defibulation and include the patient in the decision of how to proceed after delivery.” (Thierfelder 2005)

Professionals need to be careful with the use of generic education materials, because these could be inappropriate for the specific target group (Woodland 2010). It is important to take the patients’ specific circumstances, e.g. literacy level or knowledge barriers, into account when developing educational material (Woodland 2010, Goosen 2010). According to Woodland (2010) refugee networks could help finding and sharing appropriate educational resources. Furthermore, it is important that patients can understand information in their own language. Therefore it is helpful when the information is translated to the language of patients (Correa-Vales 2012, Jaeger 2013). Language barriers could also be overcome by using interpreters (Correa-Vales 2012). This will be discussed later.

Professional interactions: patient-professional interactions

Six authors discussed patient-professional interactions as a factor for implementation. Language barriers and cultural differences were named (Byrskog 2015, Jaeger 2013, Thierfelder 2005). Byrskog (2015) explains that social distance between patient and provider could be a result of differences in norms. Time constraints are also a barrier for patient- professional interactions (Jaeger 2013). According to Thierfelder (2005), the following issues can result in patients avoiding talking about FGM: “The main reason was the language barrier, cultural, gender related and social reasons, an inappropriate setting and time constraints (Thierfelder 2005).

Patient-professional interactions can be enabled by different factors. For example, by building a trustful relationship (Boerleider 2014, Byrskog 2015). There are different strategies mentioned to accomplish this. Boerleider (2014) states that it is important to involve the family in maternity care and by “showing respect, understanding and interest in their culture”(Boerleider 2014). Byrskog (2015) recommends to create a shared language by using a few words from the patient’s own language. Hearst (2013) argues that it is important to use the right words to discuss FGC. He states that ‘circumcision’ is the most neutral and appropriate term. Furthermore, translated information could enable the patient-professional interaction and prevent potential problems and expenses (Jaeger 2013). Hearst (2013) noticed that patients prefer a proactive and open approach from health providers when discussing FCG problems. In regards to professionals communicating with pediatric patients, parents or other relatives are also involved, which could complicate the interaction (Jaeger 2013). To enhance patient-professional interactions Correa-Vales (2012) recommends to appoint officers that “can form a bridge between service providers and patients. They make sure that patients receive culturally sensitive information about the care, resources and improve cultural sensitivity among the staff” (Correa-Vales 2012). Lastly, as discussed earlier in more detail in chapter (professionals) professionals can use some approaches to enhance the interaction. For example, to have patience, take time and to develop skills for intercultural communication (Byrskog 2015). Making use of interpreters could also enhance communication between patients and professionals. In the next paragraph interpreter services will be discussed.

Interpreter services

Adequate interpreting services are essential when language is a barrier in providing health care to refugees and other migrants (Goosen 2010). According to Woodland (2010) this is the ‘cornerstone of good clinical practice’ and should be routine practice. Correa-Vales (2012) argues that adequate interpreting services mean that the age and gender of the interpreter are adjusted to the patients’ needs. For example, patients could prefer female or experienced interpreters. Furthermore, patients can be worried about the confidentiality (Woodland 2010) To reduce this barrier Woodland (2010) argues to make use of telephone interpreters. Jaeger (2013) also recommends to use interpreter services by phone to immediately tackle language barriers. However, Byrskog (2015) warns that this phones service poses the ‘risk of misunderstanding or loss of nuance’. Preferring interpreter services over the patients’ social network for translation could be argued to enable safeguarding confidentiality and reducing the patients’ fear of gossip (Byrskog 2015). Patients can feel embarrassed when needing to discuss private health problems with interpreters (Hears 2013). Interpreters could also feel embarrassed. Therefore, Hearst (2013) recommends to “formulate questions regarding FMG in a way in which it is normalized as part of the health history of the women”. Moreover, interpreters can have emotional difficulties when faced with patients’ problems. Therefore it is recommended by Jaeger (2013) to provide emotional support, such as debriefings before and after the consultation. Lastly, familiarity of the

interpreter with the medical vocabulary could benefit the interpreter services (Jaeger 2013).

Organizational level: incentives & resources

The (un)availability of resources as a factor for implementation is mentioned by 11 articles. According to Flottorp (2013), resources can be seen in terms of time, financial, human, services and equipment. Incentives on the organizational level are only named by three authors.

Six authors mention time as a factor for implementation. Time constraints or a lack of time are experienced as a barrier (Borrel 2001, Casey 2015, Jaeger 2013, Thierfelder 2005) Extra time is required for consultation and assessment. Byrskog (2015) argues that time is required for professionals to reach out to marginalized women. Woodland (2010) recommends to allocate resources to gain additional time. Financial resources are mentioned by seven authors. Jaeger (2013) speaks about ‘financial constraints’ and Krausse (2015) in terms of ‘insufficient funding’. Sufficient and sustained funding could enable implementation (Casey 2015, Moss 2013, Krausse 2015) Tran (2015) points at how the growing investment in reproductive health services could benefit implementation. Woodland (2010) argues for resources to ‘address the costs involved in providing comprehensive care’.

In the literature there is not always a clear distinction between available human resources and services. Therefore these categories are put together in this analysis. For example when Goosen (2010) talks about the availability of professional translators. This is a service as well as a human resource. Seven authors mention (un)available human resources or services as a factor for implementation. Krausse (2015) speaks about “limited human resource capacity” and “limited primary health clinics in refugee camps”(Krausse 2015). Borrel (2001) and Krause (2015) both address the needs for skilled human resources. Borrel (2001) notices how a lack of capacity of partner organizations formed a barrier in implementation. Goosen (2010), Correa-Vales (2012) and Jaeger (2013) talk about the (un)availability of interpreting services. The availability of these services can benefit implementation (Goosen 2010, Jaeger 2013).Correa-Vales (2012) notices limited availability of these services. Tran (2015) addresses the importance of continuing investment in human resources for the implementation of reproductive health services in humanitarian settings.

Four authors name the (un)availability of equipment as a factor for implementation. Notably, this is only mentioned in researches that took place in a humanitarian setting. Krausse (2015), Casey (2015) and Tran (2015) mention a lack or stock-out of reproductive health supplies. Krause also mentioned a lack of basic necessities. Specifically, supplies regarding menstrual hygiene, STIs and HIV. Casey (2015) points at a lack of drugs as primary barrier and a lack of equipment. Moreover, Tran (2015) addresses also the troubles with “delays in obtaining or distributing Interagency RH Kits, difficulty in sourcing RH supplies, delay in identifying suppliers for RH commodities [...]”

(Tran 2015) Available supplies could enable implementation (Krausse 2015, Moss 2013). Krausse (2015) specifically mentioned “accessible and stocked blood banks” as needed in practice. Moss (2013) addresses the need for “adequate and appropriate drug supplies”.

In addition to Flottorps account of resources, Jaeger (2013) provides two other accounts. Jaeger (2013) argues that the diversity of backgrounds of professionals and their motivation should be recognized as a resource for implementation. He argues that these could “reduce language and cultural barriers” (Jaeger 2013).

Only two authors mention incentives at the organizational level as a factor for implementation. Borrel (2001) explains how the high costs involved with correcting mistakes resulted in inaction of stakeholders involved. Casey (2015) argues that supportive supervision can “help providers improve and maintain acquired skills and knowledge and address gaps in service provision” (Casey 2015).

Monitoring and evaluation

Six authors mention monitoring and evaluation as a factor of implementation. Borrel (2001) speaks about the ‘absence of a monitoring system’ and ‘lack of control mechanisms’ and Casey (2015) about a ‘weak monitoring and evaluation system’ and ‘poor availability of utilization data’. Monitoring could increase accountability and would make it possible to identify ‘weak points in application of policy’ (Borrel 2001). Different enabling factors are mentioned to optimize monitoring and evaluation. According to Casey (2015) it is important that “key data are collected in facility registers so staff can monitor progress”. Furthermore, he argues that a ‘comprehensive logistical audit’ is being done. With this he means “evaluation of policy and protocols, budgetary constraints, forecast accuracy, storage conditions, and staff capacity” (Casey 2015). Tran (2015) argues for an accountability mechanism to be in place for reproductive health in humanitarian settings. Krausse (2015) emphasizes that ‘monitoring of access to resources needs to continue even if the humanitarian situation changes’. In order to establish Migrant Friendly Hospitals Jaeger (2013) recommends to regularly evaluate migrant friendliness and to revise infrastructure and services regularly. Woodland (2010) argues that standardized and consistent data collection is needed. “Standardized and consistent data collection across health services, which requires specific funding support, would allow monitoring of the health of refugee children at a population level and would serve to guide service provision”.”(Woodland 2010:565)

Division of roles and responsibilities and coordination

Seven authors mentioned roles and responsibilities or coordination as a factor for implementation. Borrel (2001) saw this as a barrier in regards to the practice of infant feeding. Borrel mentioned unclear roles and a “strong sectoral divisions and poor communication between health and (non-)food agencies” as a barrier for effective coordination. Woodland (2010) sees inter -sectoral collaboration as essential for realizing screening routines for pediatric refugees. Furthermore, collaboration within

and between agencies is also important (Woodland 2010). According to Tran (2015) 'formal partnerships' and 'interagency coordination' are key elements in successful implementation and remain areas for improvement. In this regard Goosen (2010) talks about 'collective responsibility'. Casey (2015) addresses the problem of 'poor supply chain management' and the need for improved 'logistics management information systems' for reproductive health service delivery.

Funding can be a barrier in effective coordination. For example, Borrel (2001) illustrates how an NGO's ability to coordinate activities of partner organizations was limited due to indirect funding arrangements. To increase collaboration, Casey (2015) and Borrel (2001) advise humanitarian organization to actively reach out to partner organizations. According to Borrel (2001) these organizations need to take responsibility for increasing awareness of policies and capacity building of partner organizations. Jaeger (2013) advises to actively involve stakeholders, such as migrant groups, when establishing migrant friendly care. Only Borrel (2001) mentioned poor communication between stakeholders as a barrier.

Both Borrel (2001) and Krausse (2001) address leadership of an agency, one that takes responsibility for coordination, as an enabling factor. Borrel (2001) in regards to infant feeding practices and Krausse (2015) in regards to reproductive health coordination within the health sector. Tran (2015) argues that coordination can be improved by appointing a 'reproductive health focal point'.

Another enabling factor is the recognition of roles. According to Moss "the role of community health workers and volunteers should be recognized and defined, even when trained health care workers are present" (Moss 2013:61). Lastly, Jaeger (2013) recommends to identify a 'reference team' that exists of staff from different levels in the organization that would take responsibility in ensuring implementation.

In the next paragraph collaboration in relation to continuity and integration of care will be discussed.

Integration of care/continuity of care and staff

The continuity and integration of care and staff are mentioned as a factor for implementation by seven authors. Woodland (2010) argues for a 'holistic approach' in which physical, developmental and psychological care are integrated. According to Casey (2015) 'barriers for seeking pregnancy care could be reduced by integrating reproductive health services into primary health care services'.

To accomplish an integrated approach different strategies are provided. Goosen (2010) emphasizes that clear agreements need to be made in the health care supply chain. Woodland (2010) argues that the "fragmentation between services across providers of physical health, child development, mental health and torture and trauma need to be reduced." (Woodland 2010:564) Krausse (2015) argues that commitment of different

stakeholder is important for integrating reproductive health care (for example MOH and NGOs). Furthermore, Casey (2015) argues that 'evidence-based advocacy could help to integrate reproductive health commodity security into national policies and programs'.

Good collaboration is important for safeguarding continuity of care (Goosen 2010). Improved collaboration between the reception facilities and health sector is desirable, because this would enable to track refugees in the system and facilitate access to care (Goosen 2010, Woodland 2010). Continuity of care could be established by appointing a case manager that would be responsible for keeping the overview within the referral system (Goosen 2010). Furthermore, Goosen (2010) recommends to minimize the amount of referrals for pregnant asylum seekers to safeguard continuity of care.

Byrskog (2015) and Correa-Vales (2012) mention the importance of continuity of care for building a trustful relationship between professionals and patients. According to Correa-Vales (2012) "continuity of carer increases women satisfaction, trust and confidence and improves communication and enhances women's sense of control and ability to make informed decisions" (Correa-Vales 2012). For this not only the continuity of health staff, but also continuity of interpreters is important (Correa-Vales 2012)

Woodland (2010) addresses the difficulty for general practitioners of coordinating care across primary and tertiary services. She advises to build linkages and to link general practitioners with refugee health services to overcome this barrier. Refugee health nurses could effectively assist with the coordination (Woodland 2010). Another enabling strategy Woodland (2010) mentions is to have "specialist clinics linking multiple sub-specialists" (2010:562) Furthermore, Woodland sees the need for "coordination of care across screening providers and medical specialists in the initial period, and routine transfer to primary care for ongoing management" to enable the provision of pediatric care (Woodland 2010)

Lastly, Jaeger (2013) argues for providing 'mainstream solutions' which do not differ between migrant or non-migrant which could reduce stigmatization and establish acceptance of care.

Authority of change and prioritization

Three authors name 'authority of change' as a factor. Borrel (2001) argues that "change depends on the ability of representatives to influence attitudes and actions within their own agencies" (Borrel 2001) Jaeger (2013) addresses the issue of "acknowledgement of the staffs' migrant friendly efforts that can result in the need for extra consultation time"(Jaeger 2013). Casey (2015) explains about health care providers that felt a lack of authorization in regards to the delivery of reproductive healths services. These examples illustrate a top-down structure that could enable or obstruct implementation of care.

Prioritization is addressed as a factor for implementation by four authors. Krausse (2015) sees the lack of prioritization of preventing sexual violence resulting in the

absence of measures taken in this regard. Tran (2015) argues that reproductive health services are 'not sufficiently prioritized'. He specifically mentioned the following services: "abortion related services, permanent methods of contraception, cervical cancer screening and treatment" (Tran 2015). As enabling factor for implementation Krausse (2015) sees 'the willingness' to address reproductive health issues and Tran (2015) the "commitment given to reproductive health in humanitarian settings by institutions". Casey (2015) sees the importance of the ministry of health and international humanitarian organizations to prioritize comprehensive abortion care and commodity management and security in crisis-affected settings. Byrskog (2015) addresses the prioritization given by employers to develop intercultural communication skills of staff.

Other factors

Both Woodland (2010) and Hearst (2013) see advocacy as enabling factor for improving pediatric care. Jaeger (2013) advises organizations to look for more innovative approaches, which is similar to the recommendation of Boerleider (2014) on the individuals level for professionals to be more creative.

Social context

As part of the social context the following factors are named: cultural factors, community factors, the scale of the problem, the infrastructure, timing and the socio-political context.

Cultural factors on the community level can play a role for implementing health care. Both Krausse (2015) and Casey (2015) address this as a barrier. Cultural norms and fear of social repercussions can prevent patients from making use of services. Using family planning methods can be culturally sensitive issue (Krausse 2015, Casey 2015). Casey (2015) gives the example of communities having problems with providing contraceptives to adolescents because of their fear of increasing sexuality outside marriage. Other examples named are: stigmatization of people with HIV, negative attitudes towards women using family planning methods, abortion or rape survivors (Casey 2015). Furthermore, a lack of information within the communities regarding the need for services can also be a barrier (Krausse 2015). Casey (2015) recommends 'meaningful community participation and engagement' to overcome these barriers and increase societal support in regards to reproductive health care.

Only two authors address the 'scale of the problem' as a factor for implementation. Borrel (2001) noticed that the large amount of infant feeding products can result in problems for the monitoring of the usage of it. Krausse (2015) experienced that the high influx of refugees can become a barrier for implementing health care. A pre-existing infrastructure is seen as an enabling factor for implementation (Krausse 2015, Moss 2013) Krausse (2015) names timing as a factor as well. The crisis occurred before the 'MISP contingency plan' was implemented. Lastly, only Jaeger (2013) names the socio-political context as a barrier for implementation. Although other authors also mention a

lack of policies or prioritization of certain health problems and services, which was discussed earlier.

4.1.4 Infectious diseases

Study selection

Based on the title and abstract, literature search yielded 69 potentially eligible studies for this cluster. Twenty-nine articles published between 2000 and 2015 were considered as suitable for inclusion. Primary reasons for exclusion were: lack of focus on the European situation, lack of information regarding enablers and barriers for the implementation of health care practice and article language other than English, Dutch, French, Greek. Articles on interventions or reviews that did not meet the primary inclusion criteria but provided information that could be implemented in European settings, especially in relation to Syrian refugees and health outcomes under-investigated in the literature, were considered as relevant.

Study characteristics and quality

The present findings for the infectious disease cluster are based on 29 studies. The vast majority of them concerned (at least to some extent) EU countries as setting. Only one study exclusively focused on Syrian refugees and was performed in Jordan (Cookson et al., 2015). Most of the included papers focused on tuberculosis and hepatitis as health outcome of primary investigation. The primary target group was (but not restricted to) refugees and immigrants from several (non-western) countries. Time-frame varied from before-arrival at the setting to long-term settlement. There was no restriction regarding basic demographic characteristics (age, gender) of the target groups in most of the examined studies. Among the involved parties were (inter)national expert networks, national and international (health) organizations (WHO, UN, Centre for Disease Prevention), Ministries, local authorities and health care providers. Most of them were reviews (n=7) and or solely descriptive in nature (n=12) and therefore the assessment of the quality of the provided evidence on the basis of established schemes (Gouweloos et al., 2014) was, in many cases, a challenging task and was generally estimated as moderate to weak.

Legislation, protocol, guidelines, policies

Guideline factors may act as barriers when there is lack of established international guidelines on screening among migrant groups, taking into account also the differences between countries receiving immigrants/refugees, the number of people arriving and their specific status (e.g refugees, economic migrants). (Fella et al., 2013; Kärki et al., 2014). Many local health authorities do not follow national guidelines for screening infectious diseases and have developed their own screening protocols (Pareek et al., 2011). In terms of treatment interventions, for instance, in the case of, usage of a single, specific diagnostic test (instead of multiple) might increase compliance (Pareek et al., 2011). Lack of a broadly accepted treatment protocol and guidelines for

disaggregating data collection comprise additional barriers (Riccardo et al., 2012; Cookson et al., 2015).

Quality guidelines and protocols and also policies on screening and immunization practices adapted to the needs of different professional and patient groups are missing (Moro et al., 2005; Manirankunda et al., 2012; Levi et al., 2014; Bechini et al., 2015; Cookson et al., 2015). Manirankunda et al. (2012) argue that the fact that some diseases (e.g HIV) are treated differently in the guidelines compared to other chronic diseases could discourage integration of testing into routine care because of patient (perceived) stigmatization. They also emphasize the importance of the development of supporting policies, with the participation of stakeholders, that encourage “normalization” of HIV testing. In addition to clinical factors, social and environmental aspects should be integrated in the health practice guidelines and documents in general, to facilitate implementation (Almasio et al., 2011). For example, the practice of sending invitations for health screening in the language of the host country makes make participation of newly arrived immigrants difficult (Kalengayi et al., 2015). Furthermore, the restrictive migration law that limits the entitlement of some categories of migrants only to ‘care that cannot be postponed’ is, among other things, an ethical dilemma (Kalengayi et al., 2015).

Lack of clarity of relevant documents also play a hindering role, when for instance recommendations are ambiguous (Breuss et al., 2002; Mulder et al., 2012) and/or when guidelines do not specify where exactly patients should be referred to (Harstad et al., 2009). Therefore there is need for simple and clear guidelines designed to facilitate physicians and patients in taking decisions (Harstad et al., 2009; Riccardo et al., 2012) which will be actively promoted among those who are to follow them (Bechini et al., 2015). Availability of summaries within guidelines can also be a helpful addition (Bechini et al., 2015)

Broad and easy accessibility of guidelines is important for health care implementation (Fala et al., 2013) and the use of internet-based guidelines for physicians seems to be a promising enabler (Mueller et al., 2014).

Individual health professional factors

Health care providers do not sufficiently adhere to the national or international (WHO) guidelines and national policies, often because they provide care for patients that are not entitled to it (Breuss et al., 2002; Harstad et al., 2009; Manirankunda et al., 2012; Mulder et al., 2012; Levi et al., 2014). Among the documented reasons were concerns about individuals’ well-being & conflict between individual health care standpoint versus population health perspective (Mulder et al., 2012). Health care professionals also perceive their working environment as stressful and complex (Kalengayi et al., 2015) and feel they have limited support by the authorities (Moro et al., 2015). In addition, there is high workload in specialized clinics (Harstad et al., 2009). In terms of conditions such as HIV, lack of information for migrant groups, fear of

stigmatizing patients discourages GPs from performing provider-initiated testing and counseling, especially in undocumented patients. (Manirankunda et al., 2012). Physicians also feel uncertainty about whether test results would be returned (Manirankunda et al., 2012).

In terms of knowledge and expertise, limited knowledge and understanding of culturally diverse patients and their health problems (Moro et al., 2005; Harstad et al., 2009; Kalengayi et al., 2015) and also lack of skills, training and expertise (Moro et al., 2005; Kalengayi et al., 2015; Storberg et al., 2015) , especially in discussing sensitive issues such as sexual health (Manirankunda et al., 2012), pose as major barriers. Furthermore, health care staff is not always willing to adapt to the new needs (Storberg et al., 2015). Lack of awareness of the current practices (e.g for vaccination) for migrants from endemic regions has been identified as an additional hindering factor (Levi et al., 2014). Training programmes on infectious diseases are not widely available for all involved professional groups, especially for those outside secondary care. Limited guidance can also be a reason for inadequate referral of patients (Bechini et al., 2015).

Appropriate training of health care providers would help professionals deal with the focus groups and provide efficient information to patients regarding their disease and treatment (Almasio et al., 2011; Manirankunda et al., 2012; Mulder et al., 2012; Levi et al., 2014). Dissemination of guidelines to less experienced clinicians (Bechini et al., 2015) is also a positive aspects towards implementation.

Individual patient factors

One's attitude towards disease is often related to one's culture (Riccardo et al., 2012; Fuller et al., 2013) and therefore migrants can have a different cultural conception of health and illness compared to Western societies (Harstad et al., 2009; Almasio et al., 2011).

Several patient-related barriers were identified in the literature related to cultural factors, attitudes and beliefs. These were: Not complying with intervention guidelines (Breuss et al., 2002), poor adherence to medication (Cookson et al., 2015), negative predisposition towards and poor adherence to treatment (Padovese et al., 2003; Meynard et al., 2012) and tendency to minimize their symptoms or denial of their health problems (Manirankunda et al., 2012). Sociocultural differences can also influence patient expectations regarding health assessment (Kalengayi et al., 2015). There could be contrary views between patients and nurses on medical screening or treatment due to patients' high expectations or demands; it is often the case that asylum seekers question restrictive migration laws (e.g interventions applied only in high risk groups) (Kalengayi et al., 2015). Furthermore, migrants and refugees sometimes mistakenly see health care professionals as migration authority figures; they feel discriminated and often try to hide their symptoms in fear of deportation or citizenship refusal and are reluctant to discuss sensitive health issues such as HIV or their sexuality (Dara et al., 2012; Campbell et al., 2015; Kalengayi et al., 2015).

Among the major hindering factors were language barriers (Pandovese et al., 2003; Harstad et al., 2009; Almasio et al., 2011; Dara et al., 2012; Riccardo et al., 2012; Fuller et al., 2013; Bechini et al., 2015; Kalengayi et al., 2015), patients' low educational level and/or awareness of/knowledge about their health problem (Almasio et al., 2011; Meynard et al., 2012; Bechini et al., 2015), and a lack of understanding of how the health care system in the host country works (Bechini et al., 2015). Communication with newly arrived migrants, and those coming from rural regions might even be more challenging (Manirankunda et al., 2012).

One of the priorities should be to obtain patients' personal commitment to the screening/treatment process and the building of trust in health care services (Liratsopulos et al., 2000; Mendelsohn et al., 2012; Riccardo et al., 2012). This could be achieved with the availability of clear and concise information regarding the guidelines among mobile communities (Riccardo et al., 2012; Bechini et al., 2015) and health education to patients (e.g through the dissemination of multilingual information booklets). Moreover, provision of transcultural counselling by multidisciplinary teams consisted of infectious disease experts, cultural mediators, psychologists, toxicologists and ethno-psychiatrists can enhance patient motivation and bridge communication gaps (Almasio et al., 2011).

Patient factors that limit accessibility to health care services and medication are also crucial for implementation. These mainly concern legal and policy restrictions especially for undocumented immigrants (Almasio et al., 2011; Riccardo et al., 2012; Falla et al., 2013; Fuller et al., 2013; Napoli et al., 2015), difficulties in gaining a long-term settlement in the host country and inability to cover health care use and/or associated transport costs (Mendelsohn et al., 2012; Riccardo et al., 2012; Fuller et al., 2013). In terms of the latter, distance is an obstacle to screening for the patients as well as for the professionals (Kalengayi et al., 2015). The initiation of interventions would be facilitated by free patient access to primary care (El-Hamad et al., 2014)

Other characteristics of migrant groups that act as barriers are the mobility of asylum seekers without reporting or informing authorities about their new address (Harstad et al., 2009), older age and immunocompromised health status (Padovese et al., 2003; Moro et al., 2005). In addition, high comorbidity levels among patient groups requires additional costly interventions (Cookson et al., 2015) and can reduce adherence, especially when it comes to mental disorders (Almasio et al., 2011). Nevertheless, intervention implementation is facilitated and associated costs are lower when screening infectious diseases such as tuberculosis is targeted only to patients coming from intermediate to high endemic areas (McNerney et al., 2011; Pareek et al., 2011; El-Hamad et al., 2014); in this case, patient characteristics are acting as enablers. Restriction of interventions to the age groups where the benefit of treatment is expected to be larger can also contribute to lower intervention costs (Breuss et al., 2002).

Professional interactions

Communication between immigrants/refugees and health care professionals can be challenging because of language barriers and cultural differences (Padovese et al., 2003; Manirankunda et al., 2012; Campbell et al., 2015). The involvement of interpreters and especially cultural mediators can help overcome linguistic and cultural obstacles (Almasio et al., 2011). However, there is often limited access to interpreters (Harstad et al., 2009) and working with them is currently not without limitations as reported by Kalengayi et al., (2015): It is time consuming, there are only interpreters for certain languages, access is often restricted to telephone communication, in many cases there is limited-time to use the interpreter and it is also difficult to find interpreters who know the appropriate dialect within a language, gender, or country of origin. Furthermore, some interpreters can be unprofessional or have little knowledge of medical terms (Kalengayi et al., 2015).

Communication at organizational level among different national services and also cross-border communication with other health programs is often problematic, even between member states of the WHO European region, and can hinder implementation (Moro et al., 2005; Cookson et al., 2015; Dara et al., 2012 Kalengayi et al., 2015). More specifically, the health information flow between administrative levels is often not proportional to the increased mobility of asylum seekers and there is also lack of adequate information exchange between asylum seeker centres and primary or secondary health care (Harstad et al., 2009). Inconsistencies have also been observed in the official discourses and daily practice of nurses (Kalengayi et al., 2015).

Proposed enablers are the simplification of organization and coordination between authorities, closer communication between different levels of health care (Harstad et al., 2009), intensive collaboration between policy makers and health care providers (Mulder et al., 2012) and better collaboration between health care management and staff on the implementation of the guidelines (Storberg et al., 2015)

Referral practices are also highly divergent between EU countries (Falla et al., 2013).and a major barrier regarding continuity of care is insufficient patient registration. Harstad et al.(2009) pinpointed that asylum seekers do not have a personal identifier and systems managing follow-up screening data are mixed. Additionally, disease incidence is not possible to be assessed at certain times after arrival; dates for assessment or referral are often incorrect or unfilled in the provided forms (Harstad et al., 2009). Lack of continuity of care is distinctly observed for tuberculosis patients when they move to another country, even within the Schengen area (Dara et al., 2012). In addition, when immigrant/refugee groups are internally displaced may result in delayed treatment (Cookson et al., 2015). There is often uncertainty about how long the asylum seekers would stay in the country, which is a burden in the referral process (Harstad et al., 2009).

Incentives and resources

Availability of financial resources at both individual patient and host-country level was identified as a major barrier for implementing health care practice. Representative examples are difficulties for national prevention and treatment interventions in securing a funding source that is stable over time (Cookson et al., 2015), lack of financial resources in general practice regarding provider-initiated screening strategies (Manirankunda et al., 2012) and financial problems of refugees and immigrants (Padovese et al., 2003; Almasio et al., 2011). Short-term therapeutic interventions, especially for cases that subjects are difficult to be treated, could be among the potential solutions to improve cost effectiveness of implemented programmes, in addition to patient adherence (Almasio et al., 2011). Individually adapted catch-up immunization plans, e.g. focusing on groups of adolescents and young adults regardless of origin or gender could also be a facilitating factor, to prevent unnecessary and unsafe interventions such as vaccination (Meynard et al., 2012).

Health care infrastructure in terms of availability of human resources and services prevents implementation of optimal care (Storberg et al., 2015). Lack of dedicated specialized services (Moro et al., 2005), insufficient number of public health nurses (Moro et al., 2005) and limited time availability for the adequate provision of services by GPs (Manirankunda et al., 2012) constitute primary obstacles. Moreover, there is large between-country heterogeneity in the legal framework regarding access to health care (Dara et al., 2012).

Increase in clinic capacity, expenditure on medicines and virology services (Hudson et al., 2014) as well as the employment and support of multidisciplinary teams of professionals (Padovese et al., 2003; Fuller et al., 2013) including liaison psychiatrists (Hudson et al., 2014), clinic social workers (Meynard et al., 2012) and transcultural mediators (Fuller et al., 2013) to interpret patients' (health) behavior and facilitate access to migrant community services. Adequate financial compensation and free-of-charge vaccination for high-risk groups have also been suggested as motivational enablers for health care professionals and patients respectively (Levi et al., 2014).

Furthermore, there is often no access or provision of little information to the health providers and authorities in the countries of transit, destination and return regarding the (health) status of risk groups, while local authorities are often not able to provide medical records for patients who had moved elsewhere (Harstad et al., 2009).

Capacity for organizational change

Enablers related to monitoring and evaluation are highly important towards the enhancement of health care implementation for high risk groups, such as the collection of disaggregating data to monitor and evaluate health service performance in mobile populations (Riccardo et al., 2012), the establishment of quality assurance systems (Harstad et al., 2009), patient compliance evaluation and cost-efficacy and cost-benefit analysis (Almasio et al., 2011).

Coordination and division of roles comprises a challenging domain which is closely related to the existing models for treatment and host country legislation (Napoli et al., 2015) and insufficiencies of health systems to deal with cross-border disease control (Dara et al., 2012). Moro et al. (2005) have highlighted the limited capacity for integration of care due to the provision of care in multifunctional units instead of dedicated clinics; implementation can be hindered when patients are treated by several different health professionals in different organizational settings (Moro et al., 2005). Kalengay et al., (2015) also argued that the involvement of many people and services is often not well-coordinated and that delays the process. Lewis et al. (2012), suggested that a direct general practice-based screening approach would be easier to implement and ensure higher patient adherence.

Commitment and knowledge on every level of the health care system as well as political will are crucial factors to facilitate implementation (Storberg et al., 2015), . Sharing responsibilities with staff from other migrant-serving agencies (Kalengayi et al., 2015) and clear definition of responsibilities and better utilization of available expertise (Moro et al., 2005).

Social context

Social stigma and discrimination and limited awareness at the community level towards the target groups and their health problems as well as lack of support within patients' family environment should also be considered as important hindering factors to the implementation of health care strategies (Harstad et al., 2009; Almasio et al., 2011; Dara et al., 2012; Kärki et al., 2014; Bechini et al., 2015; Cookson et al., 2015). Lack of a supportive system in combination with poverty conditions can also result in extreme situations such as involvement in local illegal activities (Padovese et al., 2013).

The evaluation of immigrants'/refugees' social needs and encouragement of family support could substantially contribute to adherence to therapy (Almasio et al., 2011; Mendelsohn et al., 2012), while the organization of outreach and education activities in community support groups could further enhance motivation (Almasio et al., 2011).

The cultural appropriateness of guidelines and health assessment comprise additional enablers relevant to the social context, through the development of guidelines on cultural competence (Fuller et al., 2013) and use of culturally sensitive/minimally intrusive and engaging screening measures explained to the participants in their native language (Liratsopoulos et al., 2000; Campbell et al., 2015).

4.1.5 Chronic and non-communicable diseases

Study selection

Based on the title and abstract, literature search yielded 11 potentially eligible studies for this cluster.

Seven recently published articles (2006-2015) were considered as suitable for inclusion. Primary reasons for exclusion were: lack of focus on the European situation, lack of information regarding enablers and barriers for the implementation of health care practice and article language other than English, Dutch,. Interventions or reviews that did not meet the primary inclusion criteria but provided information that could be implemented in European settings were considered as relevant.

Study characteristics and quality

Among the eligible studies, 3 were performed in the EU, while 4 merely concerned literature reviews or study protocols. The examined publications focused on diverse chronic conditions as outcome of primary investigation, among them cardiovascular problems, diabetes and cancer. In most of the studies, the primary target group was adult immigrants/refugees with (the prospect of) a long-term settlement. Among the involved parties in the implementation of the proposed health strategies, were national expert societies, health care providers, local authorities, policy makers and researchers. Since most of the publications included in this evaluation concern (non-systematic) reviews and study protocols, their quality was generally estimated as weak based on previously published criteria (Gouweloos et al., 2014).

Legislation, protocol, guidelines, policies

Most of the eligible studies did not provide explicit information in terms of enabling and hindering factors. Nevertheless, two papers argued in favor of the development of evidence-based guidelines (Saha et al., 2013) and simple screening protocols (Venturelli et al., 2014) as enablers of applicability, effectiveness and patient compliance.

Individual health professional factors

Remennick (2006) reported aspects such as arrogance or brusqueness of medical staff as a hindering factor for the participation of immigrant and minority women in preventive health care and specifically in breast cancer screening. Therefore, more active involvement and support of health care staff (Van de Vijver et al., 2015) could be important enablers. Provision of cultural competence training (Remennick, 2006) and training on the enhancement of collaboration between doctors and interpreters could ensure culturally effective communication between patients and health care providers (Butow et al., 2012).

Individual patient factors

Patient factors were the most frequently identified barriers and enablers for the implementation of health care strategies relevant to chronic non-communicable diseases. The most important barriers were related to cultural, religious and lifestyle beliefs (Modesti et al., 2014; Van de Vijver et al., 2015), attitude towards social relationships, perceptions on health and disease (Caperchione et al., 2009) and passive attitude towards treatment (van de Vijver et al., 2015). The latter was often related to

denial of susceptibility and the belief that treatment is futile, which can trigger avoidance behavior towards health care (Remennick, 2006).

Fear of disease/treatment or of being abandoned by family/partner after a positive diagnosis, subservient status within the family/social environment and dependence on the partner were barriers mostly identified among women (Remennick, 2006). Involving men in screening strategies could be a motivational enabler, since in some societies, women would not visit a clinic without their husband's permission (Remennick, 2006). Additional enablers can be the provision of training addressing healthy behaviours (Caperchione et al., 2009) and encouraging participation in health care interventions of people with similar cultural background (Caperchione et al., 2009). Similarities between different target groups (e.g in terms of lifestyle, risk factors, socio-economic status) were also considered a facilitating factor towards the application of previously tested interventions on different settings and populations (van de Vijver et al., 2015).

A major hindering factor was poor literacy in both new (host country) and native languages (Remennick, 2006; Butow et al., 2012). Lack of basic knowledge about disease treatment (Remennick, 2006) and difficulty understanding and making use of the health care system (Remennick, 2006; Butow et al., 2012) were important knowledge barriers as well.

Individual expectations can also act as hindering factor. Patients are often not comfortable with the Western approaches of informed decision making; they expect to be told what to do because of the lack of confidence in making decisions regarding their health (Butow et al., 2012).

Obstacles related to the accessibility of services and refugee specific issues were also identified in the relevant literature, such as long distance to a screening facility (Remennick, 2006), limited accessibility to treatment (Van de Vijver et al., 2015), lack of or limited health insurance and inability to take sick leave to participate in the screening program (Remennick, 2006).

Professional interactions

After pointing out that the gap between migrants' and doctors' conceptualization of illness and treatment can act as a barrier, Butow et al., (2012) highlighted the role of interpreters as a facilitating factor of the interaction between minority groups and medical professionals. Interpreters' role is not restricted within the boundaries of mere translation but should aim to the establishment of a "cultural bridge" between patients and health care providers; for example, by explaining biomedical terminology on diseases and treatment to patients in a simple manner or by explaining to the doctor the possible cultural origins of a patient's illness beliefs.

Furthermore, the development of a cooperative network involving physicians, nurses and patients and/or their families, enables a high level of patient compliance (Venturelli et al., 2014)

Incentives & resources

Various facets of incentives and resources seem to play a major role in the implementation of health interventions. More specifically, patients' financial problems, making them often unable to pay for health care (Remennick, 2006; Caperchione et al., 2009) as well as lack of registry data and clinical databases to study the clinical profile of the target groups (Modesti et al., 2014) pose as considerable obstacles. Lack of transportation to health facilities constitutes an additional barrier related to the provision of services (Remennick, 2006).

Regarding financial resources for public health strategies, employment of cost-effective interventions is highly important (Caperchione et al., 2009; Venturelli et al., 2014). According to Saha et al., (2013) an implementable intervention should be adapted to and make effective use of existing resources in primary health care and the community.

In terms of human resources, lack of female providers can have a negative impact on the compliance of women to screening interventions, while the recruitment of minority health care professionals could enhance outreach (Remennick, 2006).

Capacity for organizational change

In terms of prioritization, it has been suggested that informed decision-making is required before implementation of a population-level intervention (Saha et al., 2013). In terms of monitoring and evaluation, early screening (before the onset of clinical symptoms), would facilitate the implementation of measures that may decrease disease deterioration and mortality rates (Verurelli et al., 2014).

Social context

An unfavourable social context that enables social exclusion and isolation of patients may have an adverse impact on the implementation of prevention and treatment strategies (Modesti et al., 2014). Opposite outcomes are expected when the (local) community is supportive and actively involved (van de Vijver et al., 2015).

Regarding cultural appropriateness of guidelines and measures, culturally sensitive health care practice guidelines and, when applicable, interventions adapted to patients' cultural norms, beliefs and traditions facilitate acceptance and consequently their implementation (Caperchione et al., 2009; Saha et al., 2013; Modesti et al., 2014).

4.1.6 General health and implementation studies

Selection of articles

58 articles are selected on the basis of their abstract and title. 9 articles were not available. 1 article was in Spanish and one in German. The other 36 articles either did not focus on barriers and enablers for implementation, or were situated in a different context (non-EU countries, resettlement countries etc.).

Quality of the articles

12 articles were included based on a full-text assessment. The content and context of the articles differed. Many articles were framed as offering practical information on implementation. Often, no methodology section was provided.

Topics of the articles

6 studies focused on EU countries (O'Reilly-deBrun 2015, Dauvrin 2014, Hollings 2012, Mladovsky 2012, Ekblad 2012, Priebe 2011). Many articles are on skills, knowledge and attitude of professionals (e.g. O'Reilly-deBrun 2015, Pottie 2014, Dauvrin 2014). For example: The article of Bennet specifically focuses on how to set up a monitoring system in acute setting. With regards to hand hygiene promotion in the context of humanitarian emergencies Vujcic et al. (2014) researched facilitators and barriers for implementation by interviewing experts on the matter. O'Reilly-DeBrun (2015) conducted a participatory learning and action project in which ideas of migrants and other stakeholders on guidelines for communication among professionals and migrants are explored. De Brun (2015) assessed several guidelines and training initiatives supporting communication with migrant target groups in different European countries in the context of the RESTORE project.

Author	Main topic	Design	Example of advice	Country of study
Hacker 2015	literature review of peer reviewed literature(between narrative and systematic)	Review	Discriminatory practices within health care itself is problem	NA
De Brun 2015	Guidelines and training initiatives that support communication in cross-cultural primary-care settings	Appraising implementability using Normalization Process Theory (NPT)	NPT is applicable to apprais implementatibility, most of the materials assessed did not involve migrants as stakeholders	The Netherlands, Ireland, England, Scotland, Greece, Austria
O'Reilly-deBrun 2015	Development of guideline to improve cross-cultural communication	Qualitative case study	There is a difference between the usefulness of interpreters and their acceptability of	Ireland

			best practice	
Pottie 2014	Prioritizing of innovative strategies to improve care for refugees	delphi consensus among professionals	1)language interpretation, 2)comprehensive interdisciplinary care, and 3) evidence-based guidelines.	Canada
Dauvrin 2014	Adaptation of health care for migrants by pros or migrants?	questionnaire among 569 health care pros	Health care pros do not feel responsible to adapt to cultural diversity	Belgium
Vujcic 2014	hand hygiene promotion in the context of humanitarian emergencies	Interviewing experts.	practical barriers to overcome in regards to hand hygiene promotion	humanitarian emergency context
Hollings 2012	Capacity building at EU borders	in-depth situation analysis(desk review, retrospective data, surveys, checklists, field visits	Linkages between health and border management remains troublesome	Hungary, Poland, Slovakia
Mladovsky 2012	Good practices in migrant health	literature review	Mobile health services are important ways to improve access to care	EU
Ekblad 2012	Training refugees in health care delivery	Survey among 629 refugees	Refugees were very pleased to be given the training	Sweden
Priebe 2011	Examples of good practice for health care in migrants	Structured interviews	Difficult to arrange care for migrants without health coverage	16 EU countries
Johnson 2008	Experiences of GPs with initial care for refugees	experiences of 12 GPs	GPs lack knowledge and resources to provide initial care for refugees	Australia
Bennet 2000	Surveillance and monitoring in acute situation	evaluation of health surveillance and monitoring	Health monitoring should have central role in refugee care	Australia

Quality of articles

The selection contains several surveys and interviews among professionals (Johnson 2008, Priebe 2011, Dauvrin 2014, Pottie 2014) and one among refugees (Ekblad 2012). The other designs were literature searches (Mladovsky 2012, Hacker 2015) or case study evaluations of health surveillance and monitoring (Bennet 2000, Hollings 2012, Blum 2014, O'Reilly-deBrun 2015).

Guidelines, protocols, policy and legislation

Several authors name guidelines as a factor for implementation. According to Priebe (2011) migrant health care could be improved when clear guidelines on care entitlements of different groups of migrants would exist. Furthermore, Pottie (2014) argues for the need of making guidelines more culturally sensitive. O'Reilly DeBrun (2015) addresses the importance of including best practices on cross-cultural communication and the involvement of interpreters to national guidelines. The need for a working health surveillance system should also be formalized in guidelines, according to Bennet (2000).

Hollings (2012) addresses the lack of procedures to support vulnerable groups (e.g. minors, pregnant women) as a barrier. Furthermore, she argues for the need for “available response plans on preparedness to react in health-related emergencies”.

Priebe (2011) argues for appropriate policies and protocols, because these could facilitate organizational flexibility. Hacker (2015) identifies policies and legislation as a barrier for implementation. She illustrates that national policies are currently resulting in exclusion of undocumented immigrants for health care. For example, they are denied access to insurance (Hacker 2015). Mladovsky (2012), Hacker (2015) and Priebe (2011) argue for improvement of legal entitlements for migrants in regards to access to services. Furthermore, Hacker (2015) argues for ‘legislation that would enable delaying deportation until treatment is completed’ and “immigration reform that would grant legal status to undocumented immigrants” (Hacker 2015). Hacker (2015) sees the need for advocacy for policy change. Hacker provides two other suggestions to improve access to health care: “special insurance programs for undocumented immigrants or full insurance benefits to employees regardless of their status” and a “state-funded-insurance or low-cost insurance plan” (Hacker 2015). In regards to access to services Priebe (2011) identifies the problem of lack of access to the medical history of the patient, resulting in uncertainties regarding whether the patient has previously been vaccinated, experienced health problems or allergies.

De Brun (2015) assessed several guidelines and training initiatives supporting communication with migrant target groups in different European countries in the context. The findings from this study, conducted under the umbrella of the RESTORE project, point at a need to initiate meaningful engagement of migrants in the development of guidelines and training materials. The authors recommend a European-based professional standard for development and assessment of cross-cultural communication resources.

In regards to handwashing practices Vujcic (2014) identified a knowledge gap regarding effective measures in the developmental context. Furthermore, standards that are tailored to the specific context are missing. There is insufficient knowledge regarding the uptake and acceptability of handwashing equipment by the target group.

Specifically, a lack of knowledge regarding barriers and motivators for handwashing. Due to this, targets for prevalence of handwashing practices are missing (Vujcic 2014)

According to Hollings (2012) it is not the lack of international health regulations, but the actual implementation of these regulations as a barrier for health care at the borders.

Professional level: knowledge, awareness and skills

Dauvrin (2014), O'Reilly DeBrun (2015) and Johnson 2008 identified the lack of GP knowledge on several aspects, such as language, previous health assessments, and the multiple and complex nature of refugee health conditions as barriers for health. In regards to health care at countries' borders, Hollings (2012) identified limited understanding of health risks among border personnel, resulting in anxiety toward disease transmission. Furthermore, limited knowledge of "vaccines or personal protective equipment among staff of checkpoints and detention centers" (Hollings 2012). In regards to handwashing promotion, Vujcic (2014) identifies a lack of understanding on best practices and knowledge about usage or acceptability of handwashing facilities.

A lack of awareness is identified as barrier for implementation. Hacker (2015) noticed this regarding policies and law on health care access for undocumented immigrants. Hollings (2012) points at the unfamiliarity of staff with international health regulations and "unawareness of provisions in place for victims of trafficking, even when such where provided for by national law". (Hollings 2012)

Vujcic (2014) addresses alack of skills among professionals in regards to handwashing practices. Hollings (2012) points as the lack of necessary skills regarding first aid among border guards. In Australia, GPs were afraid that if it became known that they offered good care for refugees, they would be overwhelmed by new refugee patients (Johnson 2008).

Finally, the success of a training of refugees on health delivery let the authors to argue that a renewed focus on communication and pedagogic skills, instead of just cultural training, should be considered for health care professionals assisting asylum seekers (Ekblad 2012).

Professional level: attitude, beliefs and cultural factors

Cultural competency is seen as an important factor for implementation (Hacker 2015, Priebe 2011, Hollings 2012, Mladovsky 2012). Limited cultural competency of professionals is identified as a barrier (Hacker 2015, Priebe 2011). Priebe (2011) identifies the problem of staff trying to be culturally sensitive, but actually treating migrants by ethnic group which could result in 'cultural expectations exceeding the migrants' individual preferences'. With regards to being culturally sensitive, Mladovsky (2012) and (Priebe 2011) argue that migrant staff could enable practice by 'increasing awareness of migrants rights', "assist with understanding culture and language issues",

and increase patients' satisfaction with care. Priebe (2011) argues that implementation would be enabled if staff would know more about patients' cultural and religious practices.

Attitude and beliefs of professionals are also identified as a barrier for practice. Hollings (2012) points at 'unsubstantiated fears of disease transmission by migrants' among border personnel. Priebe (2011) addresses negative attitudes such as 'discrimination' and 'xenophobia'. Also, Hollings (2012) addresses the importance of fighting prejudice and cultural taboos among staff. Furthermore, prioritization could also be a barrier in practice. For example, some professionals felt that there were other matters, such as legal and socioeconomic problems, more important than focusing on health issues (Priebe 2011). Priebe (2011) sees trying to change the attitudes as 'most challenging' but really important for implementation.

The extent to which professionals feel responsible can be a factor for implementation. Dauvin (2014) identified differences in where responsibilities were placed for adaption. When it came to adaption to cultural preferences, patients were seen as responsible. In regards adaption to enable direct communication professionals felt responsible.

Professional level: expectation of outcome, motivation, self-efficacy and staff incentives

Expectation of outcome, self-efficacy and staff incentives are not mentioned as a factor. In regards to motivation, Priebe (2011) argues that professionals need to be interested in order to take part in trainings.

Professional level: perceived barriers and other factors

Several barriers are perceived by staff for implementations. For example, Hacker (2015) addresses the problem of not providing care to undocumented migrants resulting from practitioner's fear of losing their license or facing criminal charges when offering care to undocumented migrants. Also the bureaucracy that comes with providing care to undocumented migrants is perceived as 'complex' and a barrier for implementation (Hacker 2015). In regards to border personnel Hollings (2012) points at the heavy workload, 'irregular work schedules' and mentally challenging situations as barriers in practice. Moreover, discussing these issues was not supported (Hollings 2012).

Provision of training and information

Training is considered an important factor for implementation (Pottie 2010, O'Reilly DeBrun 2016, Hacker 2015, Hollings 2012, Priebe 2011, Mladovsky 2012, Eckblad 2012). A lack of training is addressed by Hollings (2012) in regards to border guards. They need "refresher courses on first aid" and training on other health issues. Furthermore, health professionals need migrant specific training and training regarding "occupational health of border personnel" (Hollings 2012). The importance of training on cultural competence and awareness is addressed by Priebe (2011) and Mladovsky (2012). In this regard the following issues are mentioned: "migrant specific diseases, cultural

understandings of illness and treatment, and information about cultural and religious taboos” (Priebe 2011). Mladovsky (2012) argues for the need to make cultural competence part of basic education, as part of this he sees the following: “developing skills in intercultural communication, attitudes of respect and openness, and relevant knowledge, and awareness of their own culture and implicit assumptions”(Mladovsky 2012). Priebe (2011) and Hacker (2015) both see the need for training on legal matters concerning migrant health care. Furthermore, training on understanding the needs of immigrants (Hacker 2015) and on migrant health care rights (Priebe 2011). Lastly, Priebe (2011) addresses the importance of education about how to gain funding for treating undocumented migrants and what is considered a life threatening condition. Next to training Pottie (2014) also identifies mentorship of professionals as important for improving migrant care.

Patient factors: knowledge, awareness and skills

Knowledge of the target group is identified as a factor for implementation by five authors. A lack of knowledge could become a barrier for implementation. Vujcic (2014) identifies a lack of understanding concerning disease transmission in regards to handwashing practices among camp residents. Priebe (2011) addresses the difficulty with establishing a diagnosis and adherence to treatment and recommendations due to different understandings of illness and treatment by patients. Mladovsky (2012), Hacker (2015) and Priebe (2011) address the limited knowledge regarding the health system of the host country as a barrier. Which could result in “under usage of resources and services and different expectations of roles of doctors, and could also result in feelings of mistrust and uncertainty among migrants” (Priebe 2011). Another difficulty is the limited language proficiency of patients (Mladovsky 2012) and ‘inability of communicate’ (Hacker 2015) in the host country. Furthermore, Hacker (2015) addresses the lack of awareness regarding right to health care among undocumented migrants.

Patient factors: attitude, beliefs and cultural factors

Mladovsky (2012), Hacker (2015) and Priebe (2011) address cultural barriers. Patients having ‘cultural discomfort’ with how communication takes place in the host country (Hacker 2015). Priebe (2011) names differences in cultural norms, religious practices and customs. Specifically, differences in what is considered as ‘appropriate’ physical examination, patient's preferences regarding the gender of the practitioner, acceptance of therapies and treatment, perception of appointment times (Priebe 2011) Vujcic (2014) noticed that traditional hygiene practices can be a barrier for implementing hand washing programs. As well as specific preferences regarding hand washing facilities (Vujcic 2014). Discrimination can be a barrier for seeking health care (Mladovsky 2012) Shame and fear of being stigmatized can also be a barrier for seeking health services (Hacker 2015). Migrants felt that they do not want to be a burden to society (Hacker 2015) A negative attitude of patients towards professionals can also be a barrier for implementation. Priebe (2011) names a ‘lack of trust in professionals’, ‘fear of discrimination’ and ‘feeling of not being taken seriously’ as examples. Success of implementation can depend on the behavior that was present before the emergency

occurred (Vujcic 2014). For example, if people are used to handwashing they are more likely to be receptive for handwashing promotion in the emergency setting (Vujcic 2014).

Patient factors: expectation of outcome, motivation, self-efficacy, patient incentives

Motivation, expectation of outcome and self-efficacy are not named as a patient factor for implementation. In regards to incentives several barriers are named. Financial barriers such as user fees (Mladovsky 2012) and a lack of financial resources (Hacker 2015). Legal barriers, such as entitlement issues (Mladovsky 2012). Difficulty with transportation to the health facility (Hacker 2015, Mladovsky 2012). Difficulty with attending the appointments due to work obligations (Hacker 2015, Mladovsky 2012). Administrative difficulties can also be a barrier (Mladovsky 2012, Hacker 2012). Hacker (2012) identifies the lack of required documents for access to health care. This can even result in unauthorized parents not seeking care for their authorized children (Hacker 2012). Furthermore, Hacker (2015) addresses different forms of discrimination and stigma undocumented migrants may experience. For example, discrimination on the basis of their nativity status or sexual discrimination. Moreover, fear of being reported to authorities or being deported when making use of health services. Lastly, traumatic experiences together with social deprivation in the host country are making efforts to improve the health of migrants complex. (Priebe 2011)

Accessibility of health care services can be improved by different factors. To this end Mladovsky (2012) recommends to use 'mobile health units', but this also has the risk to "reinforce discrimination and undermine social solidarity and the unity of the health system, and remove pressure to adapt mainstream services to the needs of migrants" (Mladovsky 2012:4). Priebe (2011) argues for a 'flexible and individualized approach' and facilities near the immigrant population. Among others he names the following suggestions: "walk-in sessions, open appointment slots and advocacy services" (Priebe 2011:08). In regards to eligibility issues, Mladovsky (2012) suggests to make use of NGO services. However, he identifies the following problems with this: "the sustainability, continuity and quality of care cannot be guaranteed. In addition, the work of NGOs allows governments to maintain a state of functional ignorance". (Mladovsky 2012:4)

Patient-level: Provision of training and information

Educational programs or providing information material could help implementation. It would lower access barriers for patients and guide patients expectations of health care (Priebe 2011). Mladovsky (2012) addresses barriers for information and suggests ways to overcome these, among others 'targeted health promotion' and 'literacy and education activities'. Hacker (2015) advises to educate about laws, especially in regards to entitlement for health care. Teaching about how the health care system of the host country works is also considered as important (Hacker 2015, Priebe 2011). Moreover, Priebe (2011) suggests to provide information about healthy lifestyles. Hacker (2015) and Priebe (2011) advise to actively reach out to immigrant communities. Information leaflets could be used to also "reduce the burden of explaining by practitioners" (Priebe

2011). However, language can be a problem, therefore Hacker (2015) recommends to use 'linguistically appropriate information'. Illiteracy could also be an issue. Interpreter services can be used to overcome this barrier.

Patient-Professional interactions

Priebe (2011), who conducted a qualitative research containing views and experiences of care professionals in sixteen European countries, states that language and communication barriers between patients and migrants was the most named as a barrier for practice. According to Priebe (2011) the patient-professional interaction can be improved by establishing 'positive relationships', by showing "respect, warmth, being welcoming, listening and responding effectively" (Priebe 2011). In this regard he also advises to promote "non-judgmental, open-minded and equitable staff" (Priebe 2011)

Interpreter services

According to Pottie (2011) making interpreter services available is the number one priority for improving health care for refugees. Hacker (2015) also recommends to make use of these services. According to Mladovsky (2012) clinical care can be improved by making use of these services. There are however some difficulties with using interpreter services. For example, confidentiality issues (Priebe 2011), the high cost that are involved (Mladovsky 2012), difficulty with logistically arranging face-to face interpreting services (Mladovsky 2012). According to Priebe (2011) professional interpreters need to have professional discretion and know medical terminology. Using family members as interpreters can be problematic. Priebe (2011) identifies 'selective translation' and 'censoring' as issues, but also sees the benefit of using family because of trust and knowledge concerning the background of the patient. O'Reilly DeBrun (2016) recommends not to make use of friends and family for translation.

Next to interpreters, also 'cultural navigators'(Hacker 2015), 'cultural ambassadors' (Hacker 2015), 'cultural mediators' (Mladovsky 2015) and 'advocates' (Priebe 2011) are named as improving communication and increasing access to services. According to Mladovsky (2012) a 'cultural mediator' is an "interpreter with an additional role in joining the conversation to identify and resolve deeper misunderstandings between the parties." (Mladovsky 2012) To reduce the costs of interpreting services Mladovsky (2012) recommends to use telephone interpretation services. However, these have the risk of information loss (Mladovsky 2012). Therefore, videoconferencing (e.g. skype) would be preferred (Mladovsky 2012).

Incentives and resources

Resources were identified as a factor for implementation by four authors. Incentives are not identified as a factor on the organizational level. In general sufficient resources are important to realize 'good practices' in regards to migrant health care (Priebe 2011). Priebe (2011), Vujcic (2014) and Hollings (2012) see time as a resource for implementation. Priebe (2011) makes two suggestions to improve practice in terms of time. One is to take more time for consultations and second, assistance for practitioners in regard to administrative issues. Sufficient funding is also identified as a factor for

implementation. Hacker (2015), Priebe (2015) and Dauvrin (2014) address the lack of funding as a barrier. Funding issues in regards to using interpreter services (Dauvrin 2014), migrants without health care coverage (Priebe 2015) and 'funding cuts'(Hacker 2015). Lack of financial resources can also be a problem with the follow up of care (Priebe 2015). Priebe (2011) provides three alternative ways to overcome this financial barrier: 'patients could make use of the care NGOs provide, or go to specialized clinics for undocumented migrants, or professionals could register patients alternatively as a tourist to provide access to care'(Priebe 2011).

Equipment can be an essential resource for implementation. Hollings (2012) and Vujcic (2014) identify a lack of supplies. Vujcic (2014) argues that due to the lack of ownership the maintenance of soap and water was problematic. The maintenance of these facilities and material is considered by Vujcic (2014) as 'key for sustainability'. Furthermore, a lack of resources in terms of human capacity and services is also identified as an issue. Both Hacker (2015) and Hollings (2012) identified a lack of interpreter services. Hollings (2012) noticed an insufficient number of mental health professionals and social workers and a lack of mental health assessments. Furthermore, Vujcic (2014) addresses the problem "lack of sufficient numbers of experts trained in behavior change" and identifies the need for behaviour change experts on the global level as well. Daurvrin (2014) argues that professionals would be more inclined to deliver cultural competent care when they would receive the required resources. Vujcic (2014) identifies the lack of evaluation of practices as a result of a lack of resources.

Monitoring and evaluation

Mladovsky (2012), Hollings (2012) and Vujcic (2014) see monitoring and evaluation as an important factor for implementation. Mladovsky (2012) argues that data collection is needed because "In order to develop appropriate policies on migrant health and implement them effectively, a strong evidence base covering the health of migrants, their use of services and the causes of their health problems is required"(Mladovsky 2012:2). Both Vujcic (2014) and Hollings (2012) identify a lack of systematic data collection. Especially evaluation is seen as problematic by Vujcic (2014). In regards to handwashing practices he states "evaluations of programs are rare due to lack of resources, expertise and time and due to unpredictability of emergencies it is difficult to get third party evaluators" (Vujcic 2014). Furthermore, Hollings (2012) addresses the problem of access to data concerning public health and emergency response on the regional and national level in Hungary, Poland and Slovakia.

Division of roles and responsibilities and coordination

The division of roles and responsibilities, collaboration and coordination are seen as important factors for implementation. Vujcic (2014) argues that a 'strong coordination' is required for staff involved in the supply chain. In regards to the division of roles and responsibilities Vujcic (2014) argues for collaboration and joint responsibility instead of separate responsibilities of staff. Priebe (2011) recommends collaboration between medical professionals, communities, social services and also engaging the family of the

patients. Pottie (2014) sees inter-sectoral collaboration as one of the top priorities for improving migrant care. Collaboration can also be hindered by different factors. Hollings (2012) names 'insufficient exchange of information'. Vujcic (2014) list the following: "lack of understanding or agreement between relevant actors regarding the goals, objectives, and targets of handwashing promotion, thereby hampering the strategic development of programs"(p.5) and lack of transparency and mistrust regarding private sector involvement in humanitarian aid (Vujcic 2014).

Integration of care/ continuity of care and staff

The continuity of care is regarded as very important for migrant care (Pottie 2014, Priebe 2011). Hollings (2012) is pointing at a well-functioning referral system between institutions and countries for ensuring follow-up. Limited resources is challenging this. She identified two difficulties with referrals: "the discharge of migrants with potential communicable diseases and transfer of responsibility and medical files between different institutions" (Hollings 2012). A database with medical histories of patients could enable continuity of care (Priebe 2011). Furthermore, Priebe (2011) explains the importance of safeguarding the continuity of staff. Frequent staff changes can reduce patient's satisfaction with care. Continuity could enable building a "positive and trusting relationship" between patients and professionals.

Authority of change and prioritization

Authority of change is not mentioned as a factor for implementation. Prioritization on an organizational level is mentioned as a barrier by Vujcic (2014) and Hollings (2012). According to Vujcic (2014) priority was not given to monitoring and evaluation and for "developing and implementing effective behaviour change communication approaches in regard to hand washing promotion" Vujcic (2014) Hollings (2012) addresses the lack of priority given to the occupational health of border staff.

Other

Other recommendation in regards to organizational capacity for change were also found. Mladovsky (2012) argues for embedding cultural competency in the organization. Vujcic (2014) recommends organizational capacity building to strengthen the relatively unskilled workforce (Vujcic 2014). Hacker (2015) argues for expanding the 'safety net' of undocumented migrants by building capacity of public, non-profit organizations, faith based organizations and clinics that deliver free care for undocumented migrants.

Social context

The context is considered as an important factor for implementation. "The circumstances of each humanitarian emergency are unique" (Vujcic 2014). Vujcic (2014) advises to take into account the fact that the circumstance change over time and therefore continued adjustment is required. He noticed that behavior change interventions regarding hand washing were not appropriate in the specific context (Vujcic 2014) Furthermore, the social situation in which migrants become to live in the

host country can influence their well-being (Hollings 2012, Mladovsky 2012). In this regards, Hollings (2012) names the poor living circumstances of detained migrants.

Community engagement and support is considered as priority in successfully implementing migrant care (Pottie 2014) Both Mladovsky (2012) and Priebe (2011) argue to actively reach out to migrant communities. Vujcic (2014) sees capacity building for communal ownership as key for sustainability. For migrants to connect with the community Priebe (2011) recommends to involve community centers.

4.2 Online survey

4.2.1 Introduction

This chapter provides an overview of the online survey findings, starting with a description of the participants (§4.2), the health categories they are experienced with (§4.3), and responses per country group (§4.4). Next, information is given on the practices (§4.5), tools and training courses (§4.6), and documents and other resources (§4.7) as mentioned by the respondents. The remainder of the chapter is devoted to relevant determinants for the optimization of refugee health care (§4.8) and, additional thoughts and concerns expressed by participants (§4.9).

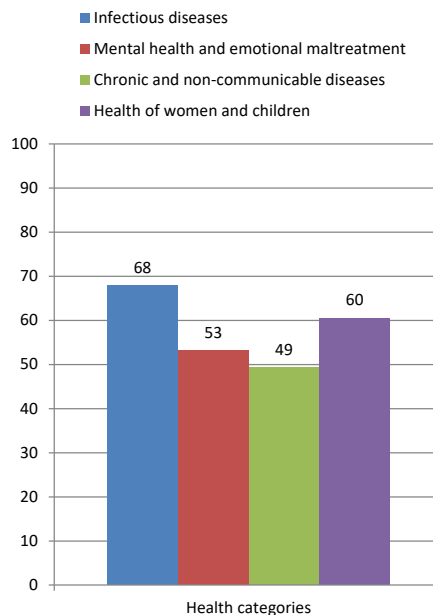
4.2.2 Participants

A total of 81 people completed the survey. Most of the participants view themselves as health care provider or health care professional (78%), the rest is involved in policy, management and organizational support (22%). They perform their work primarily at locations in Austria (N = 26), Croatia (N = 12), Hungary (N = 8), Germany (N = 1), Greece (N = 9), Italy (N = 1), Slovenia (N = 10), Netherlands (N = 15), and United Kingdom (N = 1) (total N per country is higher than total number of survey participants; some respondents work in more than one country).

4.2.3 Health categories

The respondents have experience in all four the health categories of the EUR-HUMAN project, most of them in more than one category (see Figure 4.1).

Figure 4.1. Experience in health categories (%) (N = 81)



4.2.4 Two country groups

The respondents were divided into two groups based on the primary status of their health service countries as “transfer country” or “Destination country”. The distinction was made based on the number of first-time asylum requests made. When this number was lower than 5.000,² respondents were assigned to the first country group (N = 37). Respondents working in countries with a number of asylum requests equal or higher than 5.000 were assigned to the second group (N = 44). This was done to make a distinction – additional to the difference in health categories – between the nature of the health care challenge in the survey responses (see Table 4.1). It is likely that other needs and problems have to be addressed in transfer countries compared to destination countries. In that case other practices and health care optimization factors play a role.

Table 4.1. Two country groups

Transfer countries (less than 5.000 first-time asylum requests in Q4 2015)	Destination countries (5.000 or more first-time asylum requests in Q4 2015)
Croatia Greece Hungary Slovenia	Austria Germany Italy Netherlands United Kingdom
<i>37 survey participants</i>	<i>44 survey participants</i>

4.2.5 Practices

There are both similarities and differences in the responses to the question which good practices the respondents are involved in at the sites where they work (see Table 4.2). In both country groups health screening and testing and regular GP work are important features of good practice. Respondents in transfer countries place more emphasis on nutrition, clothing and basis hygienic conditions, in destination countries chronic and non-communicable diseases are given more attention.

² Source: http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Five_main_citizenships_of_first_time_asylum_applicants_4th_quarter_2015.png (accessed 19th of May, 2016)

Table 4.2. Experience in health categories in both country groups (%) (N = 81)

Transfer countries (less than 5.000 first-time asylum requests in Q4 2015)	Destination countries (5.000 or more first-time asylum requests in Q4 2015)
<p><i>Mentioned:</i></p> <ul style="list-style-type: none"> - Nutrition (drinking water, fruit and other food) - Clothing - Basic hygienic conditions (e.g. disinfecting hands), safety clothes and masks, isolating sick people, and information about hygiene, prevention (e.g. scabies) - Screening, testing, medical exam after arrival (malaria, tuberculosis, HIV, chest pains), monitoring of vulnerable groups, (especially women and children) - Vaccination - Psychological first aid (see WP5) - Regular work as a GP - Dentistry 	<p><i>Mentioned:</i></p> <ul style="list-style-type: none"> - Information about local health care system - Separate healthy from ill people - Screening, testing, medical exam after arrival (malaria, tuberculosis, HIV, chest pains), and check-ups (also without apparent symptoms) - Vaccination - Child care - Youth health - Pregnancy - Sexual health care - Drug administration - Hypertension - Rheumatic problems - Dermatologic problems - Regular work as a GP - Hearing aid services - Basic hygienic conditions and information about hygiene - Mental health therapy, (targeted) psychotherapy - Family/group counselling - Multi-family therapy - Health education about diabetes - Healthy cooking sessions - Language learning

4.2.6 Tools and training

The majority of the respondents (60%) is not aware of any trainings or online courses for health care workers and volunteers. Those who are aware (40%) refer to materials and websites from IOM, Civil Protection, Red Cross, Medical Peace Work, Physicians for Human Rights, Society for Psychological Assistance, Mediciens du Monde, Pharos (migrant health knowledge centre), Arq (Psychotrauma Expert Group), NHG (Dutch College of General Practitioners), and GGD GHOR (umbrella organization for municipal health authorities).

A total of 21 respondents attended a training. The following examples were given:

- Right to health and access to social and health systems for asylum seekers and holders of international protection: from the territory to Europe;
- Organization of asylum care
- German online training program
- Psychological first aid
- Mental health crisis intervention
- Intercultural GP course

- Freedom from Torture
- Restoring Family Links and Psychosocial Support
- Multi-family groups
- PTSD and mourning
- Brief Eclectic Psychotherapy for PTSD

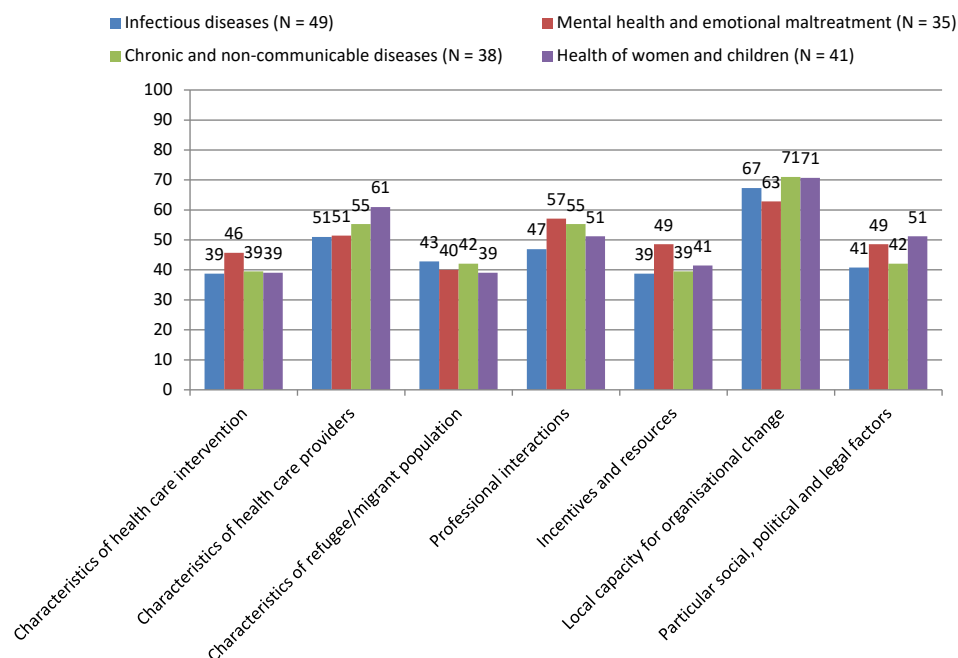
4.2.7 Documents and other resources

The respondents were asked to mention the documents they recommend for the optimization of refugee health care in Europe. Documents and other resources mentioned here were given to WP4 of the EUR-HUMAN project. At the same time, some respondents demonstrated themselves sceptical about the resources: “they are all just words on paper written by people who have never been in camps or in contact with refugees.” Regardless of the question whether this type of scepticism is legitimate for general or particular documents or not, it is certainly an obstacle for knowledge implementation.

4.2.8 Relevant determinants for optimization of refugee health care

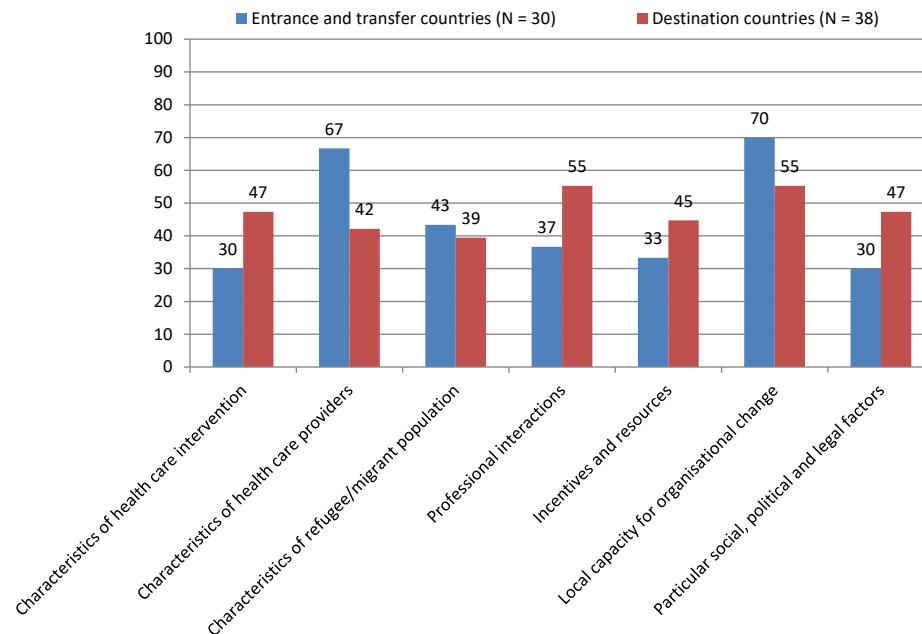
The survey participants could score multiple options in reaction to the questions which factors, in general, help the implementation of health care measures and interventions in their local setting. Although, the factors show some variation between health categories (Figure 4.2), there is a pattern. Local capacity for organizational change, characteristics of health care professionals, and professional interactions were selected as success factors most often.

Figure 4.2. Success factors recognized per health category (%)



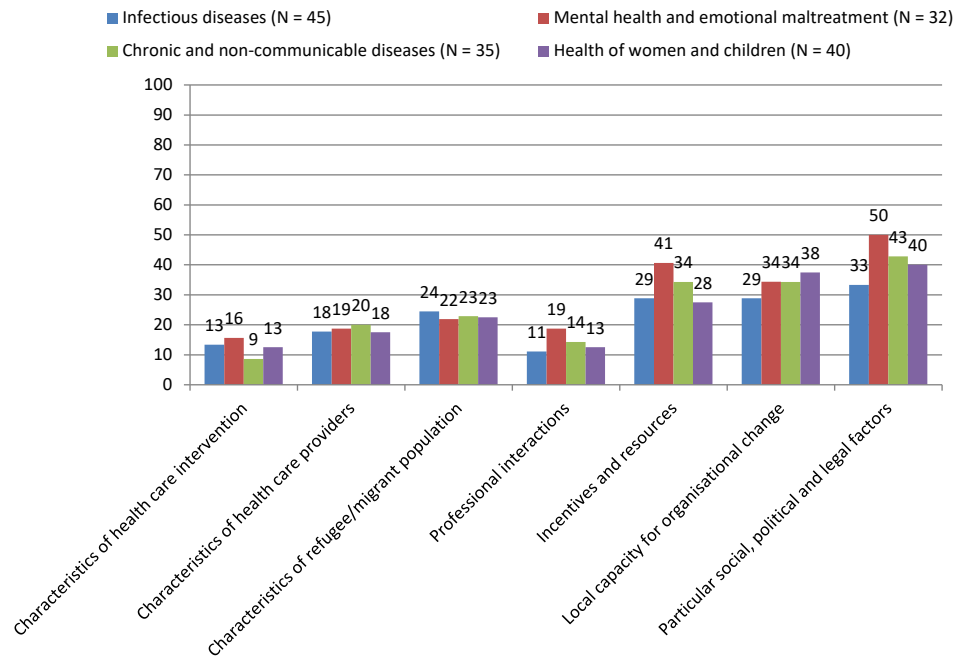
The differences between country groups are similar (Figure 4.3) but point at larger differences between transfer countries on the one hand, and destination countries on the other. Destination countries score higher on characteristics of health care intervention, professional interaction, incentives and resources, and particular social, political and legal factors. Apparently, characteristics of health care providers and local capacity for organizational change are recognized more often as success factors in exchange and transfer countries.

Figure 4.3. Success factors recognized per country group (%)



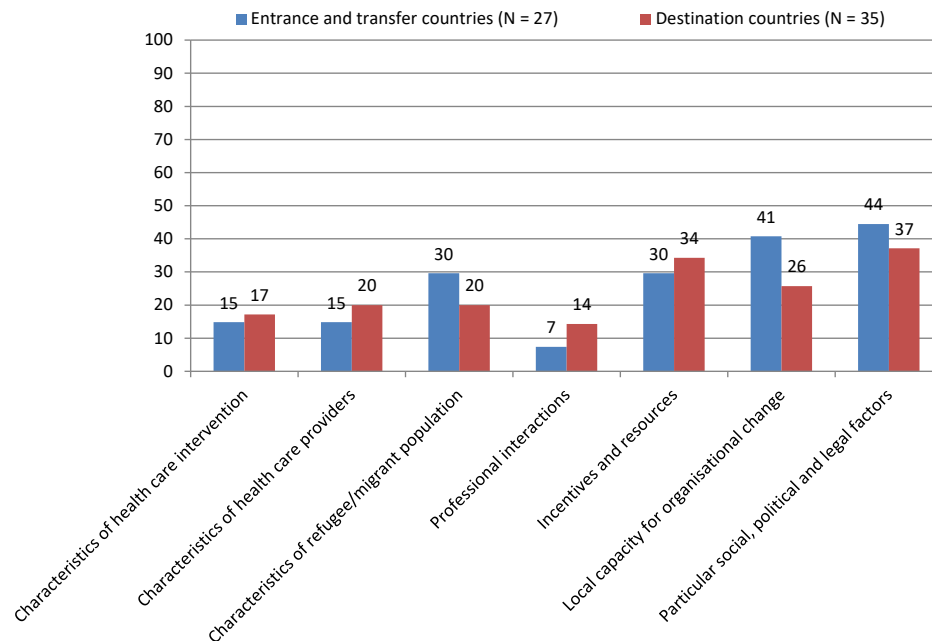
The three factors identified as obstacles most frequently were social, political and legal factors, and local capacity for organizational change, incentives and resources. Respondents active in mental health and emotional maltreatment perceived obstacles in incentives and resources and social, political and legal factors (Figure 4.4).

Figure 4.4. Obstacles recognized per health category (%)



Respondents in transfer countries seem to recognize more obstacles in relation to the local capacity for organizational change, and characteristics of the refugee/migrant population.

Figure 4.5. Obstacles recognized per country group (%)



Characteristics of health care intervention

One particular wish is addressed repeatedly by the respondents, namely the availability of accurate medical records that gives information on the health of refugees on their travel through Europe.

Respondents working in transfer countries gave little additional information on the preferred characteristics of interventions they apply. Interventions should be simple, and acceptable and familiar to the staff working with them. Effective assessment tools are welcome. Also, the need for health education is recognized. Respondents give information on the local setting that illustrates the chaos and difficult circumstances:

"At one point we were handling 13.500 refugees at 5 different locations. (...) Our system worked primarily as a paramedic system. Doctors were assigned to life-threatening situations."

"Be fast, specific and long-lasting because transit takes time and is unpredictable. Refugees, even when in serious danger, feel a great need to leave as soon as possible. On the other hand, leaving them there would cause serious mental health risks."

In destination countries there is also a need for good tests and special immunization programmes. Interventions should be culturally sensitive and adaptable to necessities of the refugee population, risk groups in particular. Low-level access via general practice is recommended. Several survey participants are in favour of multi-problem solutions (including screening) for multiple persons (e.g. family approaches).

Characteristics of health care providers

The factors mentioned in transfer countries are (lacking) primary care skills, good and qualified health care providers with professional leadership, patience, command of languages, and being able to deal with aggression. *"Even with the language barrier, showing sympathy, being kind and understanding greatly influence diagnosis and caregiving."* Specific training for refugee health care is considered relevant as well as the ability to communicate with other organizations – as a variety in professional backgrounds is involved.

Provider characteristics in destination countries are similar. The staff should be knowledgeable and experienced with migrant health, equipped with intercultural competencies (also concerning taboos, especially in women's health). Tolerant health care providers with a positive personality, with a recognizing eye of psychosomatic problems and trauma-related health complains, and knowledge about specific health risks in certain populations. Lack of knowledge, cultural competence and unawareness about how to take care of refugees are among the identified problems, as is insufficient training.

Characteristics of refugee/migrant population

The respondents refer to the need for specialized staff for different groups of patients: children, pregnant women, women in general, elderly. Age groups and both gender groups require other health services. Moreover, addressing the needs of the diverse population means that specific skills are needed that are related to cultural characteristics and, for instance, religion. Barriers in language, culture and education form an obstacle. And people only stay at a site for only a short period of time.

The language, cultural, and religious implication of the diverse refugee population for health care provision is also recognized by respondents in destination countries. These factors have consequences for prevention and treatment care. Providers are confronted with unexpected sensitive topics and differences in the extent to which refugees can play a role in promoting their own health: *"Groups differ in their understanding of health and their knowledge on how to cure and to prevent problems."* Information on the vaccination status of refugees and other migrants is incomplete but important. Knowledge about the country of origin is informative for epidemiologic investigation and blood tests.

Professional interactions

When it comes to professional interactions, respondents in transfer countries mention the need for tolerance, respect, cooperation, and good communication. Personal opinions are to a large extent irrelevant, the interaction should not be different in case of refugees or non-refugees, and responsive to the possibility of traumatic experiences.

Respondents working in destination countries plead for an open, respectful and interactive attitude and believe peer group exchange helps to better understand problems. Although different professions are needed, one could run into the pitfall of having too many organizations involved.

Incentives and resources

Incentives and resources is one of the categories with the most responses. The health care provision in transfer countries is pressured by scarcity in resources and appropriate infrastructure. Respondents mention shortages in drinking water and food, clothes, access to translator services, medication (e.g. insulin, antibiotics), toys, staff members with refugee and migrant experience, general practitioners and nurses, social workers, administrative support, waiting facilities for sick refugees, and governmental support. The examples mentioned can be seen in the light of an overall lack of capacity: *"The capacity of our migration centre is approximately 4.000 migrants. We had migration peaks with than 6.500 incoming migrants per day."*

Respondents in destination countries underscore the relevance of (financial) resources (including referral options for uninsured refugees), primary health care worker capacity, and availability of language interpreters. They add that available time is an issue, especially because refugees consults can take longer: *"care provision for refugees is*

more time-consuming", as 'contact' is a main issue in providing high-quality care, the doctor should realize that more time is needed for migrants and refugees."

Furthermore, reliable medical files and documentation of previous medical history is a very helpful resource in the provision of care.

Local capacity for organizational change

In transfer countries the high number of refugees and other migrants at the sites is pressuring the capacity for organizational change. *"We are used to work under pressure and are very resourceful. The absolute local capacity for organizational change is very small, but in those circumstances it was enormous." "The high influx limits the potential to make changes."*

Most of the reactions on what helps or hinders have to do with professional standards, teamwork and the cooperation with other professions and other institutions including community actors:

"Good communication between different types of professionals."

"Motivated professionals and high team standards"

"Share experiences and skills"

"Good communication regarding the organization of medical care in migration centres and collaboration with local clinical centres and public health centres."

"We were in touch with hospitals all over the country (...), with hospitals, (...) and clinical specialists."

"Caregiving for one patient or vulnerable refugee (children, mothers) involves at least five other professionals, volunteers and so on..."

"Interprofessional cooperation (with medical institutions as well as NGOs dealing with housing, social security, legal issues etc.)."

"Good cooperation with local organizations in improving the services."

"Collaboration with municipalities."

"Requires involved local politicians, sympathetic towards refugees."

"Support from local Red Cross, civil guard and volunteer organisations."

Although *"change requires coordination"*, in transfer countries the role of governments appears less strong; coordination is done by NGOs: *"Primary care is provided by NGOs not by the state", "till now NGOs had the main role in primary care for refugees."*

The setting of a camp is far from optimal with regards to the capacity for organizational change: *"Camps were located in places with little people, professional institutions and other emergency potential" with "long procedures for small changes (e.g. placing numbers on tents so people will not get lost)."*

Good coordination and cooperation are mentioned less often in destination countries as meaningful factor. The *"application of new knowledge"* is perceived as *"problematic"* and similar challenges are identified in relation to the health system: *"the primary health care sector must be strengthened"* and *"the health care system must be adapted to a changing society"*.

Other things respondents consider important in destination countries are easy registration, free access to services and a *"good relation between number of refugees and places to stay, sanitary facilities, and people who can take care of them"*. It is suggested that practice nurses can play a bigger role for refugees in general practice. Again, emphasis is placed on the capacity for organization change in relation to the local community: *"inform the local population regularly about activities for refugees", "organize exchange of experiences and transmutal cooperation with care givers in the neighbourhood", "local networks within communities"*.

In short-stay facilities mainly a first aid intervention is offered: *"long-term surveillance is not possible"*.

Particular social, political and legal factors

Respondents in transfer countries express their concerns about the negative impact of xenophobia, discrimination, legal restrictions, the political position of national governments and right-wing politicians in particular. *"Refugees live under very bad conditions." "There are different local legal, political and social factors that have a crucial influence on the help for people in need." "Blocking migrants from travelling, describing them as threat." "Providing some services is prohibited." "The police withheld people from treatment and placement."*

"Respondents have experienced that "1.000 migrants is a lot for a 16.000 people town." They feel how governments – strategic plans and government involvement are more than welcome – struggle with the response:

"There were no national guidelines for this situation. We have all kinds of different schemes, for example for terrorist attacks, for airplane crashes, for

earthquakes, for massive car crashes, for floods, for chemical disasters, for nuclear disasters etc. But not for a massive influx of refugees."

Health care providers are not always aware of rights of refugees, medical and legal terms can contradict, and although NGOs fulfil an important role, their involvement is nevertheless viewed as frustrating by some respondents:

"[International aid organizations] would just take pictures with the one family they could help that day, instead of helping other not so photogenic refugees."

"International policies changed a lot over times, big NGOs have a lot of political weight and they insisted on stuff like educating mothers on breastfeeding even though the situation was chaotic, children were hungry and mothers exhausted."

In destination countries respondents express their concerns about:

- the need to strengthen the primary health care system;
- poorly accessible health care systems in the host country (*"unfamiliarity with the health care system"*);
- lack of information;
- the fact that some care givers are not allowed to perform medical interventions without the personal assistance of a doctor;
- limited awareness in societies about problems (*"refugees are invisible"*);
- aggression;
- uncertainty about the future;
- lack of helpful governmental policy and political decisions;
- transitions in health care (*"result in chaos"*);
- *"prejudice of the population in the host country"/"acceptance by the local population" / "Inform local communities and repair myths (e.g. refugees seldom have communicable diseases)"*;
- government programs and asylum procedures that take too long;
- insurance issues;
- refugee rights/equal treatment;
- *"right-wing parties are blocking all good efforts"*.

4.2.9 Additional thoughts and concerns expressed by participants

The participants took the time to share their thoughts and concerns. The following fragments give an impression of the relevant factors, positive experiences and particularly problems in the provision of health care for refugees in Europe:

“During the refugee crisis in my countries, all migrants had the right to ask for medical assistance. Medical assistance was provided to them for free. When the case was serious, people were taken to a hospital and they had were fully entitled to health care.”

“The main problem in giving care is not having a global understanding that we are humans dealing with other less privileged humans that deserve to be treated as humans by all involved, including police, military, politicians, UNICEF, UNHCR and other NGOs. Doctors can't help it if they can't get to people, don't have the medication and conditions they need, and if they can't even give insulin for travel. People that provide care for refugees on the site are good, well-intentioned people that can't help if there are restricted by policy regulations, if the police is not cooperating, if refugees are treated as cattle and not people, if politicians only care about their voters and if big NGOs are only concerned with their image and not real care. (...)They patronize women that are already in great distress and educate them about breastfeeding instead of showing a little compassion, and hand food and baby formula. Naked and wet children have to wait in line for hours and the police are not letting us get them warm cloths. And then, you find yourself giving a child a grown-up antibiotic and sent it on its way, even though you don't know when he can receive another dose and when they can see a doctor again.”

“We will have to invest in the most important determinant: goodwill. That means we will have to support all the professionals with good information: facts instead of believes. We must support, encourage and appreciate them.”

“A more efficient organisation in order to fully use the available staff.”

“Coordination between EU countries of refugee and migrant health care.”

“Uniform guidelines for screening and preventive measures.”

“Coordination between different authorities, information about the services and the availability of interpreters is fundamental to allow the long-term integration of settling refugees in the health care services.”

“Knowledge about medical response in major incidents is not sufficient and does not include the situation, as it happened with refugees in my country and is still happening in Europe. In massive incidents excellent cooperation, communication and qualifications of the professionals involved (firefighters, police, medical teams and others) are needed in order to succeed. The situation with refugees is more delicate, complicated and multidisciplinary as there are many different services, profiles, organisations and even civilians involved. We experienced that it was impossible to know what kind of health care was already given to each individual. An essential problem was that they lack identification papers. If every one of them would have legally entered each country on their way to their final destination, it would have been impossible to track their needs and perform appropriate medical care, because Europe does not have a uniform online electronic system for refugees. This situation also pointed at several handicaps of the emergency system in my country, such as lack of dispatch, issues regarding communication (in such cases cellular phones are inappropriate, and each profile uses different kind of systems), the ability to adapt and react quickly. And a discrepancy exists between the minds of those who make decisions from their offices and us, operatives, who need answers and immediate solutions.”

“I strongly suggest the development of a uniform medical protocol for acute and chronic health care of migrants.”

“To improve migrant health care the medical file of asylum seekers should be linked with the medical file of GPs.”

“I need information as a GP to explain refugees and migrants how our particular health system works.”

“There should be more time for training on the job. Let new professionals find out that it is also fun and interesting to work with people with another background. Train people to look in an open and fresh way to newcomers. Teach them to talk and listen better, and work together with clients.”

“The shift from individual orientation towards family orientation, and from disease to resilience seems essential to me. This shift is challenged by researchers and financial resources who want easy measurable, controllable programs. So, effort is necessary to ensure evidence-based practice.”

4.3. Expert interviews

4.3.1 Introduction

This chapter contains information from the interviews with international experts regarding health care for migrants and other refugees. The interview methods were described in chapter 2. Hereafter, the results are presented describing different implementation factors at different levels: guidelines, protocols and policies (§4.3.2), international and national conditions (§4.3.3), resources (§4.3.4), organizational level (§4.3.5), professional interactions (§4.3.6), patient level (§4.3.7), professional level (§4.3.8).

4.3.2 Guidelines, protocols and policies

Guidelines, protocols and policies were an important topic of discussion. Respondent (09) explicitly mentioned the need of guidelines and protocols for improving implementation. Specifically, it is suggested by respondent (04) to use the ethical guidelines that are developed by the Council of Europe to guide practices in which norms, such as ‘respecting different cultures’, are recommended. In regards to mental health care interviewee (01) argues that agreement about best practices is needed before implementing guidelines.

“if we don’t agree on whether early treatment for children for example is beneficial and necessary and so on, then the guideline might be too early. There’s the general guideline for Youth Health Care Services, and then the instrument that’s being used there, the strength and difficulties question is not validated for refugee children and it’s quite likely that they will score too often too unfavourable, just because of the questions. So it’s difficult to know what to do with it”(01)

In regard to policy different issues are identified. First of all, a lack of a ‘shared policy foundation’ in Europe is noted.

“Europe is 50 years behind a lot of other western countries that have policies that help us handle migration, which is growing. Europe did not develop policies and is unable to agree on anything in the last 3 years. (...) There are good people in Europe that want something, but there is no agreement in Europe, and this is probably because a shared policy foundation is missing.”(03)

Next to building consensus, it is suggested to develop international networks that could support the implementation of guidelines.

“There are like hundreds of guidelines and I don’t think you should try to do too many. Let’s say the status issue was looked after. Then you can actually do more. And then you need to build [capacity-building] networks. You need to implement these other guidelines that you are finding. (...) So you don’t want to waste all your energy trying to put 30 guidelines in [the networks] when no one is going to use them because the network is too weak and the practitioners are already not doing well. They don’t have the support they need. It’s just going to take time.” (03)

It is recommended to reduce the amount of guidelines, because this could overwhelm practitioners and would work counterproductive (03). Rather, it is important to build a supporting community, a framework to implement the guidelines.

“Build your community. That’s your #1 priority. If you give [practitioners] like 20 new guidelines, you are going to cause more confusion, more stress. If you take maybe 3 or 4 good ones, and you build a framework of implementing them - with the idea that you are going to maybe implement new ones every year. Lay the pathway. That was to me the smarter move. (...). I would be very keen on what your practitioners can handle. I mean, the practitioners are very good, the ones doing it, but they can actually be harmed, especially if you try to push too much stuff at them.”(03)

Respondent (02) and (01) argue for a standardized EU protocol of care. Now each country has a different protocol resulting in many people on the drift (08) .

4.3.3 International and national conditions

Lack of infrastructure

Lack of infrastructure regarding health care provision for refugees was identified as a problem (08). The context has changed in countries. Some transit countries are turning into destination countries. In Greece, for example, refugees are likely to stay. The respondents argue that the local health care structure needs to be adjusted to that fact (08, 05). Respondent (05) argues for the establishment of specific institutional frameworks, such as clinics or centers for refugees.

Furthermore, the large number of people that need health care is identified as a barrier for implementation (09, 06, 07, 05). It is suggested that countries prepare themselves, have systems in place, so they would not be surprised by these large numbers of newcomers (05). Respondent (02) suggests the following:

“We should use WHO data on health profiles per country to plan ahead (5). We can estimate the health needs of the refugees. We can then identify vulnerable people. It must also be used to change our interventions when the demographics of arrivals is changing. There used to come strong young males. Now we see pregnant women, children and elderly. (02)”

Physical distance to the facilities could also be an access barrier (08). This barrier could be overcome by using mobile clinics or camps near health facilities (08, 02).

“The coast guards was selecting people from the water and sending them to the police. The police then take them to the hospital. Nobody thought of organizing a mobile unit at the port to screen who should go to the hospital and who not.”(02)

Lastly, a lack of a workable registration systems is considered an issue (02, 05). This will be discussed in further detail under ‘continuity of care’.

Poor living conditions

Poor living conditions were identified as problem (10, 08, 04). Most migrants and refugees are relatively healthy compared to refugee crises in developing countries, however the poor living conditions at reception in the countries result in people getting ill (08).

“Research shows that a lot of the damage that refugees have experienced has actually been experienced after they got to safety. (...) People don’t just become depressed but they become very angry with each other. You know they become –people set fire to their rooms or set fire to themselves or each other. That’s just the environment. Stop moving them around like a sack of potatoes.”(04)

Conditions in camps/facilities, especially in transit countries, must be improved, with a focus on vulnerable subgroups (e.g. women, children, people with a chronic condition) (06). The living conditions are very important for the health outcome. Especially, because these conditions can influence the development of psychosocial problems.

“[There is a] lot of evidence that the conditions in which people live in the host country are very, “ very important for the actual health status. So the idea that every refugee enters the country with a psychiatric problem like PTSS that’s not true. The risks are rather low, say 10% to 25%, but whether people develop these disorders is dependent on how we treat them, how we have organized society in terms of; are they able to have paid labor, paid work or do they have good houses or are they being discriminated.”(10)

Unpredictable/bad weather conditions can further contribute to the already difficult life conditions of refugees in camps of transit countries (06). Respondent (07) speaks about overcrowded and unhygienic living conditions.

Furthermore, it is argued to treat the migrants the same as the host population (08,10,07,05). *“The first question should be ‘could it be organized in the same way as for the other groups in society in terms of lower socioeconomic groups?’(10).* For example, to provide migrants adequate housing, employment and health care services just as the host population receives (07,10,08). Respondent (07) argues for “an environment that gives a sense of belonging”.

Prioritisation

Prioritisation of certain health problems can be a barrier for implementation. A professional specialised in female health care (09) addressed the issue with the focus on physical care in transit countries, and missing a holistic approach including psychosocial care and reproductive health care.

Respondent (03) argues that chronic diseases among refugees have low priority in the Netherlands, whereas diabetes and high blood pressure is actually more common among Syrian refugees. Furthermore, she worries that only the highly vulnerable or highly traumatized will be treated and those with lower disease burden will be ‘lost’.

Prioritisation was also seen as barrier for implementing preventative interventions. A structural place for preventative interventions in health care is *“[...]very important and that’s probably even more important for these migrant groups because they don’t have or they have less capabilities, opportunities to use these kind of services if they are not offered to them [on a structural basis].” (10)*

Furthermore, it is argued that policy makers need to make sure that health care delivery for refugees is seen as a priority for countries.

“there is a major policy issue to convince policy makers, decision makers, that health and supporting the best possible health delivery to refugees should not only be a priority for the refugees themselves, but also for the countries in question, that the countries actually will benefit from solving health problems for the refugees as soon as possible and as qualified as possible. There is work to be done to convince decision makers that this should be a higher priority” (05)

Politics

Seven authors mention ‘politics’ as a barrier for implementation (02, 09, 10, 08, 04, 05, 03,). According to respondent (10) the political climate in the Netherlands is against allowing a ‘targeted approach’ which is needed to improve the health outcome of

migrants (10). According to respondent (08) and (09) the politics in Greece is a barrier for implementation. Respondents speak about a lack of political willingness (08, 05, 04).

“Yes, I think it’s possible (to implement health care interventions). But it’s a question of political will: if the European countries really want to deal with it and not only scare refugees away from entering Europe, but also want to welcome them and see them as a potential resource for the future, then I think it will be possible....It’s not mainly a technical problem. I think the technological issues are manageable. But it’s a political issue whether the policy makers (supported by the population) are ready to invest the resources required, and to see the importance of doing something”.(05)

“Let’s say you know the most fundamental kind of protection prevention which is not delivered by services. It has got nothing to do with health services. It has everything to do with ministries and national policies because the simple thing is: countries do not want asylum seekers to integrate. (...) They are put in a car park for 2 to 3 years and that drives them crazy. (04)

Furthermore, it is argued that the state is not taking responsibility for health care provision in Greece, instead NGOs are providing that (08, 04).

“You have separate care. It’s usually NGO care. That’s a sure sign. I mean where NGOs are active, it’s a sure sign that the main stream is not active and so obviously it’s going to be a different problem in the different countries depending on the level where they are at.” (04)

Respondent (02) argues that the (political) reality is changing too quickly to adapt services for.

“So then suddenly, 11.000 people have only access to one tap of running water. This will make them sick, and impossible for professionals to be trained, or interventions to be implemented.”(5)

Moreover, respondent (5) states that the EU or governments cannot organize the flexibility needed on such a short notice. Therefore, this must come from small flexible teams of trainers with experience in refugee settings.

Rights to care and entitlement

Entitlement and the right to care are mentioned by six respondents as an important barrier (08,04,05,06, 07, 08). Respondent (04) sees it as the ‘biggest challenge’ where professionals can’t do much about.

“I think the biggest challenge is entitlement because if you can’t get into the system, it doesn’t matter how good or bad the system is, you are on your

own anyway. And this is the elephant in the room which very few people talking about. You know they talk about adopting health services but they overlook the question of whether the migrants are being allowed into those services. It's like the USA in – well I guess it's certainly the second half of the 20th century. All the discussion was about cultural competence. Nothing was said about insurance. And you know, a very high proportion of the minorities were not insured and therefore not able to benefit from cultural competence and if you raise that with minority health expert, they would say yes, but that's out of our hands. That's politics. We are professionals. We are only concerned with nuts and bolts of service delivery but the system itself... unfortunately we have to keep our hands off that.”(04)

Respondent (05) argues for the same entitlements as the host population receives.

“[Most important is] first of all, of course, the formal access is important. Legislation and the formalities that provide access to health care under the same level as the majority population” (05)

Status is seen as an important barrier for access to health care.

“Status is a big factor everywhere but I'd say status is a little bit unique in Europe in that countries are afraid to give status. And by not giving status, they are afraid to not give health care. I think that this remains a white elephant, sometimes noted but usually not, that blocks care to refugee migrants. It's not just unique to Europe but it's pretty big in Europe. Many different things in Europe don't make any sense unless you trace it back to status, and status may mean rights, and rights may mean direction towards citizenship. It's that status issue that I think is really blocking health care and basic service.”(8)

When transit countries turn into destination countries, entitlement for the long term is considered an issue.

“And that means that also, the more long-term issues on the right to health care and on ensuring the organizational to take care of the diversity of population groups is relevant.”(05)

Both respondent (07) and (08) argue for seeing health of refugees and migrants as a universal right and argue for policies that adjusted to that viewpoint.

“plans should be improved for the use of the current infrastructure to fulfil the humanitarian social and health rights of the migrants. It is a very sensitive question so it requires a better understanding” (06)

Cultural factors

Culture can be a factor for implementation (09,10). Implementing reproductive health care is difficult because it is a culturally sensitive topic that requires a specific approach (09). Furthermore, respondent (10) argues that it is necessary to tailor interventions, in terms of language and culture, to the specific target group. Otherwise these can become barriers for take up by the target group.

"[...] we are inclined to offer a general service which is not targeted to characteristics of the population like ethnic minority groups and I think this is a barrier for these interventions being successful because we know that the interventions for example in terms of language but also cultural aspects do not fit with the characteristics of these groups and therefore they are less inclined to use them and also the interventions are less effective then." (10)

Collaboration

Both within countries and between countries collaboration is recommended to enable implementation of care for refugees. Respondent (05) sees it as a priority to have coordinating mechanisms in place to ensure coordinated and planned action.

"I think there is a need to establish coordinating mechanisms in each country and across the countries. I think, that's an urgent primary need that there are many actors in the field (public actors and NGOs and other civil society groups) that are trying to do something in this area. I think it's quite urgent that every country organizes coordinating mechanisms in order to ensure coordinated and planned action"(05)

Furthermore, it is recommended to build international networks, beyond Europe, to build capacity and learn from each other's experiences with refugees (8).

"I am a big believer in networks and evidence based multidisciplinary networks could be the ideal ones. I am also a big believer in international networks for the same thing. Europe is not the only country facing challenges. These networks require a lot of capacity building, they may require some consensus guidelines, they need to be kind of linked. I noticed in Europe that there is a lot of disconnect going on. (...) Networks are really key. International networks are key. I found that Europe was thinking that the problems are more important, but it's really unfortunate. You are not a part of the international network. It seems a little bit silly because migration is a global phenomenon. And Europe is actually only like #3 or #4 in the most migrants. You guys seem to think you are #1 and we have Bangladesh to India, we have Russia and Ukraine, we have Mexico and US. So you guys are like #4 in numbers and yet, you can't handle the numbers at all."(8)

Respondent (06) also argues for better and closer international collaboration between countries and also better coordination and networking with organizations and humanitarian organizations is required.

Other

In approaching migrant health care respondent (10) recommends to look at characteristics of the target group. Instead of looking at cultural differences, we have to look at what people have in common. This could for example be health literacy, educational level or level of income which influence health outcome. *“The first question should be, could it be organized in the same way as for the other groups in society in terms of lower socioeconomic groups [...] So looking for the characteristics that people have in common rather than the differences between these groups is very essential starting point I think.” (10)*

When looking at shared characteristics, beyond culture, care needs to be differentiated for different groups to receive the same health outcome (10).

“I think if you want to make a difference or if you want to achieve the same results at the end – at the end of the health status, it might be important to make a difference in the inputs side to make – to differentiate between groups in terms of resources and type of services you offer them. So making a difference in inputs to achieve the same results at the output side.” (10)

For transit countries, the issue of refugees avoiding registration is challenging the provision of health care. Respondent (05) argues that this results in refugees not being identified by the characteristics that are required for health services to work well. It is suggested that reception institutions need to take this reality into account and have to be quite flexible and work fast (05). Furthermore, services need to be adapted to the different needs they are confronted with. Being culturally sensitive because of the refugees coming from different countries. Moreover, respondent (08) argues that acute conditions and trauma are less frequently present and that it is especially important to make sure that chronic conditions are followed up (08).

Respondent (06) argues that infectious diseases are more difficult to manage compared to maternal and child care, due to their contagiousness and difficulties in recognizing the source and/or differentiating symptoms from other conditions. Therefore, health prevention/screening interventions are of primary importance.

4.3.4 Resources

Different resources are named as essential for implementing health care for refugees and other migrants. Among others, available translation, interpretation and mediation services are mentioned (02). Lack of financial resources is considered an important

barrier. According to respondent (06) an increase in funding is necessary, especially for early stage screening. The importance has also been highlighted by interviewee (05):

“Refugees not receiving sufficient health support in the beginning become much more costly later on...timely interventions (like prevention or even care of diseases) is valuable and also resource-effective if done qualified and go in a coordinated fashion from the early start. This is something that policy makers will have to be aware of. And I think that we need to provide the evidence and support for getting this going.”(05)

Respondent (01) argues as well that sufficient financial resources are essential for implementation

“We can implement or develop the most fantastic mental health programs, but as long as we don’t have funds for prevention, as long as we don’t have funds for translators, and as long as we don’t have a shared vision or view, then any.. I mean, you might have the best, best evidence, it will be very difficult to get it implemented.” (01)

Financial resources are also important for professionals to create willingness and possibility for professionals to provide good care (01). Furthermore, respondent (06) argues that the availability of equipment, human resources and services/specialized clinics within the health care sector are major determinants of success for organizations involved in refugee care. Especially in the case of transit countries. Moreover, she argues that in order to cope with scarce resources a sufficient number of personnel are especially important for meeting the needs of refugees.

The responsibility for establishing sufficient resources is laid with the state. *“The state needs to make resources available”* (08). In this regards, it is also recommended to improve collaboration between EU/countries with more experience/resources and non-EU/less resourceful transit countries within Europe. (06)

4.3.5 Organisational level

At the organisational level different factors are identified.

Infrastructure

Infrastructure on the organisational level is mentioned as a factor as well. Respondent (09) addresses the issue with appropriate space in the health care facilities.

“I mean having the appropriate space, the appropriate hygiene, the appropriate place that we can see privately someone because it’s a health care issue so something can be done privately and how to help these people maintain their health while being in this transit country” (09)

Monitoring and evaluation

“I think there is an urgent need to ensure a workable information system on health of the refugees or asylum seekers” (05)

More information on the health needs of refugees is named as an enabler for implementation (05,06, 02) Both identify a lack of relevant health data. According to respondent (06) a lack of (electronic) data regarding the health/demographic status of the refugees constitutes a major barrier. Especially since some people (try to) hide their health problems (06).

Division of roles and responsibilities, coordination & collaboration

Respondent (02) argues that high influx of volunteers and professionals that are offering services often do not meet the needs of the refugees resulting in inefficient organisation of care. On the other hand, different enablers are mentioned. Improved planning is suggested (08, 02, 06). Especially, the planning of resources at the start would enable implementation. Unpredictability regarding the numbers of refugees combined with lack of explicit planning is an important challenge (06). Both respondent (08) and (02) recommend better coordination and organization of all partners involved. Respondent (08) also recommends to involve stakeholders in implementation and emphasizes the importance of involving the minister of health to create support. Respondent (02) speaks about ‘working with the right people’, referring to those with relevant experience in training professionals in refugee situations.

“You must know what the need is of the professionals, or develop the training with professionals themselves. Many organizations are good in something and decide to offer that as training. It should be the other way round.” (02)

Continuity of care

“And then there is one particular issue related to the trajectory of refugees, that information on health of the individual is required in many parts of the health system. And there is a problem of continuity of care if health information is not available, following the refugees across the countries and across the health sectors in the specific countries.”(05)

[...] we need to consider what is going to happen with them the day after tomorrow.(08)

Continuity of care is considered important (08, 10,05). Different barriers are identified. In general it is difficult because people are on the move. Respondent (02) gives the example of patients escaping hospitals to move to the next country. Respondent (01) states that in long stay countries, such as the Netherlands, between reception centers

the continuity of care is well arranged, only when migrants move into the community there is transferal problem in regards to the medical record.

According to the MSF representative (08) there is lack of communication between facilities in Greece. There is a problem of continuity of care if health information is not available, following the refugees across the countries and across the health sectors. (05, 08) there is a need for a workable information system on the health of refugees and other migrants (05). Fragmentation of services is considered a barrier for continuation of care in the Netherlands (10), Macedonia (05) and Greece (08). Multiple suggestions are done to improve the continuity of care. Sharing information is key. To improve the continuity of care a medical passport would help.(08,02) However, patients could experience resistance, because they fear that the medical passport becomes a barrier for accessing countries.

“The [medical] passport is a very good idea, because (for the law), first of all that any service being provided is being recorded. Secondly, it will allow better follow up of the cases. But also, you need to explain to people that this medical passport is not going to be the barrier for them.” (08)

A medical passport is not being implemented at the moment. EU countries are still discussing how to implement it.

“It’s going to be, really a huge step forward. It will come with a database in a secured environment. The doctors can refer via the database. They can exchange information with doctors from the entry point to the transit country, to the country of destination. Again, in a secure environment. It has worked via IOM (the resettlement project) and we want to do something similar (02)”

The refugees should be registered and there is need for a system in place to identify vulnerable groups (02, 08, 07). This would enable follow- up. Respondent (08) suggests an electronic cloud system because “[...] people can have a map themselves, access to their medical files.” (08)

On the other hand, respondent (01) argues that merely the transfer of data will not help the continuity of care because follow-up care needs to be available and acceptable by patients.

Collaboration

The importance of teamwork for a successful organisation of health care for refugees and other migrants is emphasised (09). Who is leading the team is an important factor. The person needs to not only be knowledgeable about health, but also have a culturally sensitive approach.

Providing culturally sensitive care

"I guess you need one toolkit for countries which know nothing about cultural competence or equity or any of those things and that will have some further basic things like interpretation. (...)but the priority given to interpretation is nowhere very high. It's just high enough to get away with that in many countries, that's the most basic thing you are going to need. We know about cultural competence but now we have to develop it for this group of people." (04)

Using intercultural mediators is recommended to provide care adjusted to the needs of patients.

"[...] You need first of all, to adapt your services to another group or population. You need to intercultural mediators and not just some translators, and these people who also have an experience working with different communities [...]"- 08

According to respondent (09) it would be best to have a multicultural and multilingual health care team to provide health care, because this would minimise mistakes due to communication difficulties.

Furthermore a multidisciplinary team is recommended in which mental health professionals, doctors, nurses, translators and mediators are part. This would enable a holistic approach which could also reduce the barrier for getting psychosocial help (09) Paediatricians and midwives are also named as important team members (08)

Lastly, it is recommended to have available structures or programs that can be followed in a language that the target group can understand (07, 05).

"[...] general systems should be more diversity competent and open to people coming from refugee situations." (05)

4.3.6. Professional interactions

For improving interactions between professionals and refugees or other migrants, the respondents gave multiple recommendations. To overcome cultural and language barriers translators, interpreters, cultural mediators, multilingual and multicultural teams is recommended. Using multilingual teams was suggested for getting the proper information and reduce diagnostic mistakes (09). A multicultural team could increase the acceptance of care.

"That's why I said having a multidisciplinary and a multilingual or a multicultural team will help because if someone from their own culture

talked to them or provide them the necessary or the right information, maybe it's more acceptable [...]" (09)

Next to the need for translators (08, 01, 02) and interpreters (05), cultural mediators are recommended to link people to the services (08, 07). Respondent (07) emphasizes that these cultural mediators should be trained and could help overcome culture-oriented obstacles. However, respondent (01) argues that a lack of leadership and finance could become a barrier for implementing these services. Furthermore, translated information and a common language could enable professional interactions (09) Talking the same language as the patient could make patients feel more comfortable.

"I would like to have a person talking the same language with me because this makes them more comfortable. They feel more secure. They feel that we really care. I mean talking the same language I think it's one good part is that we could do because they feel more free to talk within their own language. They can express themselves." (09)

4.3.7. Patient level

Barriers and enablers could also be identified on the patient level.

Knowledge, awareness and perceived need & accessibility of services

Lack the knowledge or awareness regarding health problems was identified as a barrier(10). Patients could lack resources to access health care. " [They are] *less familiar or they don't have the money to use it or they don't know that they have a question.*" (10) Especially in regards to preventative measures there is a lack of need from the target group. As stated earlier, the physical distance to the facilities could also be an access barrier (08), and the fact that people are on the move could also make follow-up difficult (02). Refugees trying to avoid registration in transit countries is a challenge for health implementation(05)

"For transit countries an issue is that the refugees are not seeking asylum and therefore are not identified necessarily per characteristics that are required for health services to work well." (05)

Cultural and language factors

Cultural factors could be a barrier for implementation (07, 09). Respondent (09) addresses a potential cultural barrier, namely the gender of the health care professional. Female patients could have trouble with being examined or touched by male professionals.

Language could also be a barrier (07, 10). However, respondent (10) argues that this does not necessarily translate to low quality of care.

“So we have done some studies[...]on the quality of health care for different migrant groups and the indications that the quality is lower for migrant groups, for example specialist care or GP care in case people presented themselves with health problems, there is not much evidence to suggest this lower quality. So I think that in general, we are doing well in the Netherlands for quality of care and access to care along migrants and that’s also reflected in research on socioeconomic inequalities which does not indicate substantial inequalities between socioeconomic groups in the case of health care, quality of care either. So there are difficulties for people for example, doctors or other professionals in health care, when providing care to the migrants in terms of language problems but the evidence that these translate into low quality of care for ethnic minority groups is not very strong. So in that sense, we are doing good job” (10)

Training and provision of information

Informing patients is seen as essential by several respondents (09, 05, 07). Refugees will need information about how the health care system works (05,07), how they could get access to care (05) and regarding their rights to care (05, 08)

“the refugees will need information from the health care system on their rights and on how best to access, to utilize the health care system of the country in question”(05)

“Well, these refugees, they are not informed as they are supposed to be informed. So there is no system in place today systematically for thinking about their rights and their duties” (08)

A targeted approach with providing information is recommended, to differentiate between women, men, mothers, people with certain conditions such as diabetics and mental health (07) Health education in regard to sexual and reproductive health care is recommended (09). A group approach would be the best way to provide information (09)

“This is one of the approaches they accept particularly if it is coming from the leader of the group. The leader or the cultural leader you would say” (09)

4.3.8. Professional level

At the professional level barriers and enablers could be identified

Knowledge

A lack of knowledge among professionals was identified as a barrier (10).

“for teaching, for example medical doctors, on this kind of issues so that they know how to provide treatment, how to communicate for example with people from these groups. There is a lack of understanding among professionals. They don’t know how to do it.” (10)

Respondent (05) also identified a lack of knowledge regarding the health needs of refugees.

Cultural competence

Several respondents argue for the need for cultural competence among professionals. Respondent (08) talks about “Trained staff culturally equipped”. Health services need diversity competences to communicate and to deal with the health problems of the refugees (05) *“Both professionals and the organizations, need to take into account that they have new groups of citizens to include in their care. (05)”*

Attitude

Respondent (07) addressed the attitude of health professionals as a barrier, but did not specify what kind of attitude was troubling implementation. Respondent (06) speaks about a lack of perceived safety for personnel and the broader community.

Training

The IOM identified a great need for training. The IOM trainer (02) provides training to professionals and shared her experience. The main enablers to successfully develop a training for professionals at hot spots were according to her : Firstly, providing a practical training, no theory, with lots of exercises/practise. Second, involve professionals when developing training. Third, test the material in small groups of proposed end-users and adjust the material to their need. Fourth, involve trainers with a migrant background. As an example she told about coast –guards that expressed their need for grief support and the training they developed about how to deal with people who lost their loved ones.

Other

Respondent (10) addressed the lack of research in regards to effective measures for migrants as a barrier for implementation. She therefore argues for developing a knowledge base.

“I think that the health care sector, the evidence within the health care sector on what works and what doesn’t in terms of targeted interventions is not that large. It has little – it has been studied very little because it’s – most studies in this field do not include ethnic minority populations and therefore we do not know for lot of interventions whether they also work for people from other ethnic backgrounds. So I think that the developing the knowledge base for this is also very important recommendation” (10)

APPENDIX 5: Data extraction framework

Domain A. Legislation, protocols, guidelines, policies

Determinant	Description
Availability of guideline	Whether the guideline is available or not and influenced implementation
Quality and applicability of guidelines	When mentioned in the article that the quality of the guideline was a factor for implementation. When the guideline was difficult to apply in practice we noted the factors that had influence on the applicability.
Availability of protocols	Whether the protocol was available or not and influenced implementation
Quality and applicability of protocols	When mentioned in the article that the quality of the protocol was a factor for implementation. When the protocol was difficult to apply in practice we noted the factors that had influence on the applicability.
Availability of legislation	Whether legislation was available or not and influenced implementation
Availability of policies	Whether policies were available or not and influenced implementation
Accessibility of documents	Whether the guidelines, protocols, policies and legislation was accessible, within reach, or not. For example, the format can be inappropriate in a certain context.
Consistency with other documents	The extent to which the implemented intervention or measure is consistent with/supported by the guidelines, protocols, policies and legislation that are used in practice
Clarity of documents	Whether the guidelines, protocols, policies and legislation were understandable for those who had to implement the interventions and other measures
Other	Everything that seems relevant for implementation concerning this domain, but does not fit under the determinants described above

Domain B. Individual professional factors

Determinant	Description
Knowledge	Knowledgeable about guidelines, policies, protocols, legislation, intervention, measure, health problems, clinical management of diseases, communication, migrant and refugee related issues etc.
Awareness	Existence of guidelines, measures, policies, facilities, services, protocols, legislation, health problems, needs of target group etc.
Skills	Having the appropriate skillset to implement the interventions and other measures
Attitude/beliefs/cultural factors	Feelings towards the implementation of interventions and certain measures, feelings towards the target group, etc. and cultural

	beliefs, cultural issues where professionals are confronted with
Expectations of outcome	Thinking the intervention/measure would help or not
Motivation	The extent to which the health professionals are motivated to implement interventions and measures and the reasons mentioned why they are motivated as such.
Perceived barriers	When explicitly mentioned that a barrier is 'perceived' by professionals
Provision of training/ information	Whether the professionals are already trained or not or in need of training and what kind of training would enable implementation
Self-efficacy	Self-perceived competence or confidence in own abilities in regards to implement interventions and other measures
Staff incentives	The extent to which professionals are incentivized to implement interventions and other measures (e.g. are they receiving enough support, compensation, rewards, feel appreciated)
General/other	Everything that seems relevant for implementation concerning individual health professional factors, but does not fit under the determinants described above

Domain C. Target population factors

Determinant	Description
Knowledge	The extent to which knowledge influences the uptake of care or result in health problems. For example, lack of knowledge regarding maintaining health, health literacy, rights to health care etc.
Awareness	The extent to which awareness influences the uptake of care or result in health problems. For example, awareness of health risks, available health services, legislation, etc.
Skills	The ability to follow up recommendations, communicate with health professionals
Attitude/beliefs/ cultural factors	Feelings towards the health care interventions/ measures, cultural beliefs and factors that influence the success of certain interventions/ measures
Expectations of outcome	The extent to which the target group expects the intervention/ measure to help them
Motivation	The extent to which the target group is motivated to adhere to recommendations
Perceived barriers	When explicitly mentioned that a barrier is 'perceived' by the target group
Provision of training/ information	The extent to which the target group needs to be informed/ trained/educated

Self-efficacy	Self-perceived competence or confidence in own abilities to follow the recommendations or for example communicate health problems or negotiate needs
Patient incentives	Accessibility of services (for example the distance to the services, financial payment for services etc.)
Patient needs	When explicitly mentioned that certain needs need to be accounted for when delivering health care for refugees and other migrants
Refugee specific issues	When explicitly mentioned that certain factors are at stake for refugees and influence the success of implementation (for example fear of deportation can result in refugees not wanting to use medical passports)
General/other	Everything that seems relevant for implementation concerning target group factors, but does not fit under the determinants described above

Domain D. Professional interactions

Determinants	Description
Patient-professional interactions	Communication between professionals and the target group (refugees and other migrants)
Interpreter services	The extent to which these can contribute to the provision of health care for refugees and other migrants. & What factors can enable or are barriers for implementing interpreter services
Communication on organizational level/ between stakeholders	Communication within organizations or between different stakeholders involved with the implementation of interventions and other measures
Collaboration	Collaboration between different stakeholders
Continuity of care	The factors that influence the continuity of care for refugees and other migrants (e.g. referral process)
Other	Everything that seems relevant for implementation concerning professional interactions, but does not fit under the determinants described above

Domain E. Incentives and resources

Determinant	Description
Resources-time	The extent to which the amount of time available influences implementation
Resources-financial	The extent to which financial resources influences implementation
Resources-human	The extent to which human resources (for example amount of qualified health workers) influences implementation

Resources-equipment	The extent to which the (un)availability of equipment (for example lack of sanitary products in refugee camps influences success of health promotion intervention) influences implementation of quality health care for refugees and other migrants
Resources-services	The extent to which the (un)availability of services (for example lack of screening services or abortion options) influences implementation of quality health care for refugees and other migrants
Resources- general	When resources were mentioned to influence implementation without specifying what kind of resources
Incentives-financial	The extent to which financial incentives (rewards, compensation etc.) influences the implementation of interventions or other measures
Other incentives	The extent to which other incentives are mentioned to influence implementation of interventions or other measures
Other	Everything that seems relevant for implementation concerning resources or incentives, but does not fit under the determinants described above

Domain F. Capacity for organizational change

Determinant	Description
Monitoring and evaluation	The extent to which monitoring and evaluation becomes a barrier or enabler for implementation (this includes accountability)
Division of roles and responsibilities	The extent to which the division of roles and responsibilities becomes a barrier or enabler for implementation
Coordination	The extent to which coordination becomes a barrier or enabler for implementation
Authority of change	The extent to which professionals are authorized by the organization to implement interventions and other measures
Prioritization	The extent to which the prioritization (for example not giving priority to reproductive health care) plays a role in the implementation of interventions or other measures
Integration of care	Barriers and enablers that hinder or help the integration of care within or between organizations
Continuity of staff	The extent to which the continuity of staff helps or hinder the implementation of interventions or other measures
Other	Everything that seems relevant for implementation concerning the capacity for organizational change, but does not fit under the determinants described above

Domain G. Social and political circumstances

Determinant	Description
Cultural beliefs	Cultural beliefs, not of the individual, but in a group, institution, country, community, that help or hinder the implementation of interventions or other measures
Community	Factors that have to do with the community, (for example cultural norms, taboos , community involvement etc.) that help or hinder the implementation of interventions or other measures
Scale of problem	The extent to which the scale of the problem helps or hinders implementation (for example the amount of refugees arriving everyday)
Other	Everything that seems relevant for implementation concerning the social context, but does not fit under the determinants described above. For example political climate

APPENDIX 6. Refugee health care optimization checklist: ATOMiC test version³

ATOMiC – Appraisal Tool for Optimizing Migrant Health Care

Background

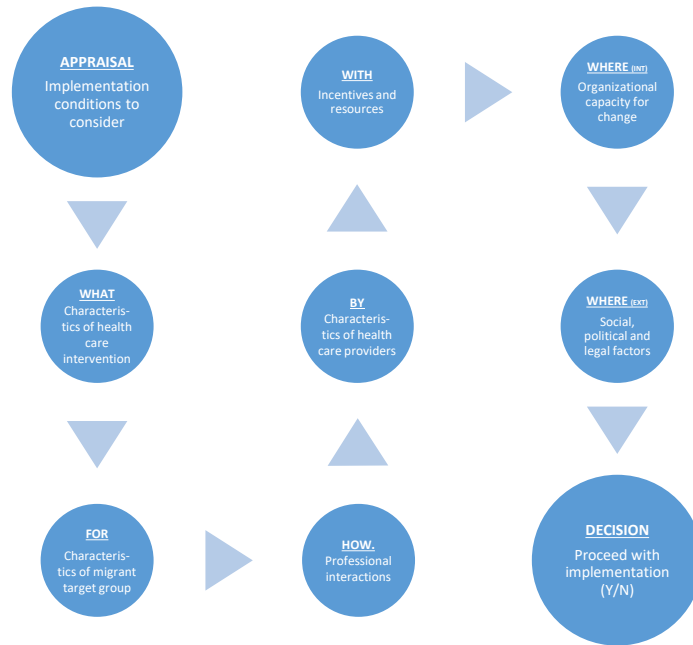
During the last couple of years Europe has been confronted with thousands of refugees and other migrants, entering member states in the south and southeast, and moving further away from conflict and insecurity. In the context of the EUR-HUMAN project a plethora of information has been collected to identify success factors and obstacles in the optimization of health care delivery for refugees and other migrants. The “Appraisal Tool for Optimizing Migrant Health Care” (ATOMiC) was developed to provide practical guidance for improving health care services for often vulnerable groups. ATOMiC is based on the findings of a systematic literature review, a survey among health care professionals at different European sites, and a series of interviews with international experts. The collected material points unambiguously at an interrelated set of recurring implementation factors. The checklist encourages users – health care professionals, managers, policy-makers, implementation advisors – to carefully contemplate these factors and identify issues that require special attention when proceeding, or might even warrant timely reconsideration.

How to use this checklist

When it comes to health care optimization for refugees and other migrants, many guidelines, tools and good practices are available. ATOMiC focuses on the route between appraisal of a promising idea or plan and the decision to proceed with its implementation. The sequence goes from characteristics of the health care intervention (“what”), the refugee or migrant target group (“for”), professional interactions (“how”), the providers – professional or volunteer – (“by”), incentives and resources (“with”), organizational capacity for change (“where”; internal environment) and social, political and legal factors (“context”; external environment).

After having ticked the checklist items, users will have a better view of the conditions that might be met (“yes”) or not (“no”), the topics that are inapplicable, and the things they must sort out because of a lack of information. ATOMiC supports users in their decision-making and encourages them to resolve obstacles to optimizing migrant health care at an earlier stage.

³ This version of ATOMiC is included in the set of guidelines, guidance, training and health promotion materials generated by WP4 and in the online course developed by WP6 during the EUR-HUMAN project.



To think through when shaping the improvement idea

We recommend you select only a few improvement topics at one time (to protect professional workload, scarce resources and organizational capacity for change)
 Pick an improvement topic or intervention related to a prioritized concern in your local health care setting (popular interventions might seem attractive, but when an intervention tackles a more pressing local problem, the sense of urgency and the readiness for change are likely to be bigger).

Make sure you can easily explain the intervention and its implications to randomly chosen professionals working regularly with the target group and familiar with the problem to address

The checklist

WHAT - Characteristics of health care intervention	the intervention involves prevention <small>YES / NO</small>	the approach is directed at risk and protective factors identified in research <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
		the approach is likely to influence these risk and protective factors adequately <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
'no' is a reason to be critical about the improvement idea	the intervention involves screening/testing <small>YES / NO</small>	the screening tool/test is scientifically validated <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
		the validity of the tool has been tested in the target population in a satisfactory way <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	the intervention involves therapy or treatment of prevalent problems <small>YES / NO</small>	there is scientific evidence for the effectiveness of the intervention <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
		the intervention is likely to be effective in the target population <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	the intervention involves a model or framework <small>YES / NO</small>	proposed principles are supported by scientific evidence <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
		proposed principles match the health care needs or problems to address <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	regardless of the type of intervention	expected positive effects weigh up to negative side-effects <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
		the intervention seems better than alternatives <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
		practical manuals, protocols and supportive materials are available in a language understandable to professionals applying the intervention <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
FOR - Characteristics of refugee/migrant target group	the intervention is appropriate given the risk profile or health needs of the target group <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>	
	the intervention can be applied regardless of the gender and age of the target group (e.g. women, children, elderly) <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>	
'no' indicates that the target group requires special attention	the intervention can be applied regardless of cultural and religious characteristics of the target group (e.g. sensitivity to stigma, shame) <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>	
	the intervention can be applied regardless of the level of knowledge and education of the target group <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>	

HOW - Professional interactions	applying the health care intervention requires	<p>awareness of particular symptoms or signals (e.g. psychological and physical trauma, child maltreatment, infectious diseases)? <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>information about the medical history and relevant personal background of patients? <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>language skills, interpreter services or cultural mediation <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>protective measures (e.g. vaccination, facemasks, gloves) <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>input from other professions or organizations <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>additional time for contact or history taking <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p>
BY - Characteristics of professionals	professionals applying the intervention, interacting with the refugee/migrant target group, require	<p>specialized knowledge and education (incl. women, children and elderly) <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>language skills <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>intercultural competencies <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>attitudinal skills (open-minded, tolerance, respect, patience) <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>background knowledge and practical experience with the target group <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p>
WITH - Incentives and resources	<p>regardless of the type of intervention, the implementation requires investments in</p> <hr/> <p>if the intervention involves screening/testing, it requires investments in</p> <hr/> <p>if the intervention involves therapy or treatment of prevalent problems, it requires investments in</p>	<p>staff capacity and time for each patient <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>education, training and other skill development activities <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>medical stock, supportive systems, equipment and technical aids <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>evaluation and monitoring capacity <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>other (financial) resources <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>capacity for a timely analysis of the screening/test data <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>capacity for a timely follow-up in case of notable risks or problems? <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p> <hr/> <p>capacity for completing the therapy/treatment including aftercare <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small></p>

WHERE - Organizational capacity for change	the intervention is compatible with the key tasks of the health care organization <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	the staff that is going to apply the intervention is motivated <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
'no' points at a potential problem in the organizational capacity for change	the management of the health care organization is positive about the intervention <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	crucial local stakeholders are willing to cooperate in implementing the intervention <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	crucial (inter)national stakeholders are willing to cooperate in implementing the intervention <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	additional incentives and resources required are likely to be (made) available <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
CONTEXT - Social, political and legal factors	the social environment of the health care optimization activities (community, society) is sufficiently involved and supportive <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	the political environment of the health care optimization activities is sufficiently involved and supportive <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	the intervention itself is allowed from a legal perspective (incl. medical ethics, privacy, human rights) <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>
	health care access for refugees and other migrants (i.e. payment and entitlement) are guaranteed <small>YES / NO / DON'T KNOW / NOT APPLICABLE</small>

DISCLAIMER

ATOMiC was developed in the context of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020). The content of ATOMiC represents the views of the authors only and is their sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.