EUR-HUMAN

Expert Consensus Meeting Report Athens, June 8 -9 2016

Deliverable 4.1

Report on the content of optimal primary healthcare for refugees and other migrants based on the outcomes of the expert meeting

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Executive Summary

The EUR-HUMAN project: aim and previous work

The European Refugees-Human Movement and Advisory Network project (EUR-HUMAN), running from January to December 2016, aims to enhance the capacity of European member states in addressing refugee health needs in the early arrival period (first reception centres) as well as in transit countries and longer-term settlements (longer stay reception centres in countries of destiny).

The specific objective of EUR-HUMAN is to develop guidance documents, recommendations and training for the provision of cultural sensitive, integrated comprehensive person-centred primary care for refugees in these settings, and pilot these in interventions in six countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria).

The project started with participatory fieldwork among refugees and health care workers in Greece, Italy, Croatia, Slovenia, Hungary, Austria and the Netherlands about their health needs, experiences, wishes and expectations regarding health care and social care throughout the journey through Europe. Most health problems appeared to be war and journey related: wounds, burns, common infections due to overcrowded reception centres and mental health problems; as most important health needs were mentioned the provision of basic life provisions, care for pregnancy related problems, continuity of care for chronic conditions, compassionate care providers and the provision of information on procedures and health. Refugees face many barriers in accessing health care due to lack of time and linguistic and cultural barriers. (Deliverable 2.1)

A systematic review and survey among experts informed us about existing guidelines and guidance on primary care for refugees, as well as on factors that help or hinder health care improvement for refugees and other migrants. This resulted in the "*ATOMIC*" tool that can guide the implementation site in choosing interventions. (Deliverable 3.1)

And a protocol was developed regarding procedures in primary health care that enable rapid assessment of mental health status, provide psychological first aid and ensure referral for specialized care for highly traumatized refugees. (Deliverable 5.1)

Based on the information gathered in WP2, 3, and 5, we produced an operational plan (work-flow chart) with specific actions to optimize the primary health care (PHC) for refugees and other newly arrived migrants at the first reception centres as well as the longer stay reception centres (see figure 1).

A first overview was produced of existing guidance, tools, and training materials to support the provision of good primary health care in these settings. This overview revealed topics and areas where guidance was lacking or contradictory. These topics needed to be addressed by experts.

Expert consensus procedure

An important goal of EUR-HUMAN is to reach consensus about the content of good primary health care and social care services needed to assess and address the health needs of refugees and other newly arrived migrants in first reception centres as well as in transit and longer stay centres.

To achieve this goal, we developed a stepped consensus procedure.

1. International experts, chosen by the EUR-HUMAN consortium because of their experience and knowledge in the field of primary care, or care for refugees, were invited for the expert consensus meeting in June in Athens, and asked to reflect on specific questions related to the content of care. These questions concerned 4 **overarching topics (**Linguistic and cultural differences, Continuity of care, Primary Health care team and Health promotion and information), and **5 specific areas** (Acute illnesses and Triage, Infectious Diseases and Vaccinations, Chronic non communicable diseases, Mental Health, Mother, child and reproductive health care).The questions addressed:

- the process and workforce of PHC
- the content of PHC in that specific theme
- The skills / training / tools needed by professionals to deliver this type of service and care.

2. Based on the input of the experts new questions were formulated for discussion during the expert meeting.

3. On the 8th and 9th of June in Athens the expert consensus meeting was attended by sixty-nine (69) participants from fourteen (14) different countries. Consensus during the meeting was initiated by discussions in small groups that were reported and then discussed in the plenary sessions. Although, many barriers exist in providing accessible, affordable, good, cultural sensitive PHC for migrants, the meeting aimed to elucidate what PHC in these circumstances ideally consist of, and what can be done to achieve this.
4. The conclusions and recommendations of this expert consensus meeting are written down in this report that has been commented on by the participants of the meeting.

Main conclusions and recommendations

General principle

Primary Healthcare for refugees and other migrants should be person-centred, comprehensive, goal-oriented, minimally disruptive, compassionate, outreaching, integrated within the existing primary health system and other services, and provided by a multidisciplinary team.

Important contextual factors

- There are different migrant groups with different entitlements to care, undocumented migrants and unaccompanied minors are in need of special attention.
- There is a lack of resources and manpower, especially in crowded first reception centres. This challenges the provision of good quality integrated PHC.
- Local circumstances will to a high degree determine the extent to which ideal PHC can be implemented. The ATOMIC model, developed by NIVEL, may play an important role in local decisions on the implementation of interventions.

Recommendations

Recommendations relate to the necessary cultural competencies (attitude, knowledge and skills) of care providers, the content of care with disease specific recommendations and organisation of care.

1. All care providers need to be cultural competent, compassionate and person centred.

2. The content of primary health care should involve:

- delegating triage to several trained persons within the multidisciplinary team where possible.
- reaching out proactively to find vulnerably migrants
- assessing health needs and personal preferences of the patients at all stages and all sites
- applying the disease specific recommendations

3. The organisation of outreaching, integrated primary health care should include:

- Enabling the composition of multidisciplinary primary health care teams and task shifting
- Enabling the organisation of person-centred and culturally competent care:
  - → providing quality interpretation service → avoiding informal interpreters wherever possible
  - → providing culturally appropriate health promotion in adequate languages / literacy level
  - → providing necessary (on-line) training on cultural competences and compassionate care

4. Continuity of care should be guaranteed locally and throughout the migrant journey by

- Improving the continuity of care throughout Europe preferably by an electronic coded- system.
- Using the same language in medical patient held reports throughout Europe (prefer English over national Language) and using universal names/codes for diseases/medication/vaccination.

Next steps

The consensus meeting in Athens led to a list of recommendations and goals to optimize primary health care for refugees. Some of these recommendations are practical where others deal with difficult barriers, obstacles and political constraints in providing care. In the next steps of the EUR-HUMAN project, there will be a focus on the concrete realization of the described recommendations. A guidance and training will be developed and piloted that will take into account the recommendations of the expert.

How to read this report?

1. **Section 1** provides a description of the EUR-HUMAN project: aim and previous work
2. **Section 2** provides a detailed description of the consensus procedure followed to obtain consensus on the content of optimal primary healthcare for migrants including refugees
3. **Section 3** provides a description of the discussions during the expert meeting; the summaries of the group discussions are written by the various facilitators of the group discussions - this is reflected in differences in style.
4. **Section 4** summarizes all recommendations regarding A) cultural competencies of healthcare providers, B) content of care in different domains C) the organisation of Primary Healthcare in first reception centres and in longer-term centres.
5. **Section 5** describes how the results of the expert consensus meeting will be applied in the next steps of the EUR-HUMAN project.
6. The **appendices** include agenda of the expert consensus meeting, the list of participants and the questions guiding the discussions during the meeting.

Section 1: Information and Core Principles EUR-HUMAN project

Aim

In 2015 the flow of migrants, and especially refugees, entering Europe considerably increased. The high numbers of refugees arriving at the Greek islands and Italian shores, and travelling from there through South – Eastern Europe towards countries of their destination in Northern-Europe, led to the introduction of the term *'international refugee crisis'*. Many European countries are since then developing policies and plans to better define their role in supporting refugees entering Europe.

The European Refugees-Human Movement and Advisory Network project (EUR-HUMAN), running from January to December 2016, aims to enhance the capacity of European member states in addressing refugee health needs, safeguard them from risks and minimise cross-border health risks; both in the early arrival period and longer-term settlement - in first (short stay) reception centres as well as in temporary stay centres in transit countries and longer stay reception centres in countries of destiny.

The project objective is to provide good and affordable comprehensive person-centred and integrated care for all ages and all ailments, taking into account the trans-cultural setting and the needs, wishes and expectations of the newly arriving refugees, and to ensure a service delivery equitable to the services provided to the local population. Related to this, within the EUR-HUMAN project guidance documents, recommendations and training for the provision of integrated comprehensive person-centred primary care for refugees at first (short stay) reception centres (hotspots), temporary stay centres in transit countries, and longer stay reception centres will be developed and then piloted in six countries.

Summary of previous work in EUR-HUMAN

Work package 2: *PLA sessions with Refugees and other Stakeholders:*

To provide good and affordable comprehensive person-centred and integrated primary care for refugees at all ages and all ailments, we must know the needs, experience, expectations, wishes and barriers regarding accessing primary health care of the groups at stake.

Using Participatory and Learning Action (PLA) methodology in order to introduce a democratic dialogue with national, regional and local stakeholders as well as the refugees themselves we gained insight into the needs, experiences, expectations and barriers of health care for refugees. This qualitative, comparative case study was conducted in hotspots, transit centres, intermediate - and longer- stay first reception centres in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and the Netherlands) from February 2016 until the end of March 2016.

A total of ninety-eight (98) refugees participated in a total of forty-three (43) sessions. In addition to the sessions with refugees, in Croatia six (6) PLA sessions were held with twenty-five (25) health care workers or volunteers. Most health problems appeared to be war and journey related: wounds, burns, common infections due to overcrowded reception centres and mental health problems; as most important health needs were mentioned the provision of basic life provisions, care for pregnancy related problems, continuity of care for chronic conditions, compassionate care providers and the provision of information on procedures and health. Furthermore, the results revealed important

barriers in accessing health care such as time pressure, linguistic and cultural differences, and lack of continuity of care.

Work package 3: *Review of Literature and expert knowledge*

Several initiatives are conducted to improve the healthcare of refugees and migrants in Europe by drawing lessons from research and practice. Many models, guidelines and tools are available. However, little was known about the factors that help or hinder health care improvement for refugees and migrants. Objective of this work package was to identify these implementation factors.

Within this work package a systematic search in different literature databases, an online survey at different European sites and expert interviews were conducted 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.

The general findings of WP3 points at recurring success factors and implementation obstacles. Many locally-relevant implementation factors and fundamental barriers and solutions at the level of EU and member states were found. The relevance of healthcare systems that are favourable towards refugees and migrants, a shared policy framework in Europe, EU health guidelines for refugees, a secure (online) health record that is accessible for both refugees and care providers in different member states, continuity of care across sites and an effective coordination and planning strategy per country were stressed. In addition, the development of a network for cooperation, exchange and capacity building at local, national and international level is of high relevance. For refugees it is important that their long-term perspective (i.e. societal participation) in their destination countries is taken into consideration. Finally, results stress the importance of monitoring and evaluating the needs of refugees as well as implementation of health services.

Stakeholders in refugee health care optimization should carefully consider the factors identified. Based on the results the “Appraisal Tool for Optimizing Migrant Health Care” (ATOMIC) was developed to provide practical guidance for improving health care services for refugees and other migrants. In the checklist the social, political and legal aspects are present.

Work package 5: *Development of rapid assessment for mental health needs*

In order to provide comprehensive and integrated primary health care for refugees and migrants, it is important to develop procedures that enable rapid assessment of mental health (MH) status, provide psychological first aid and ensure referral for specialized care for highly traumatized refugees. The aim of this work package was to develop and describe a protocol that will help primary health practitioners meet these requirements.

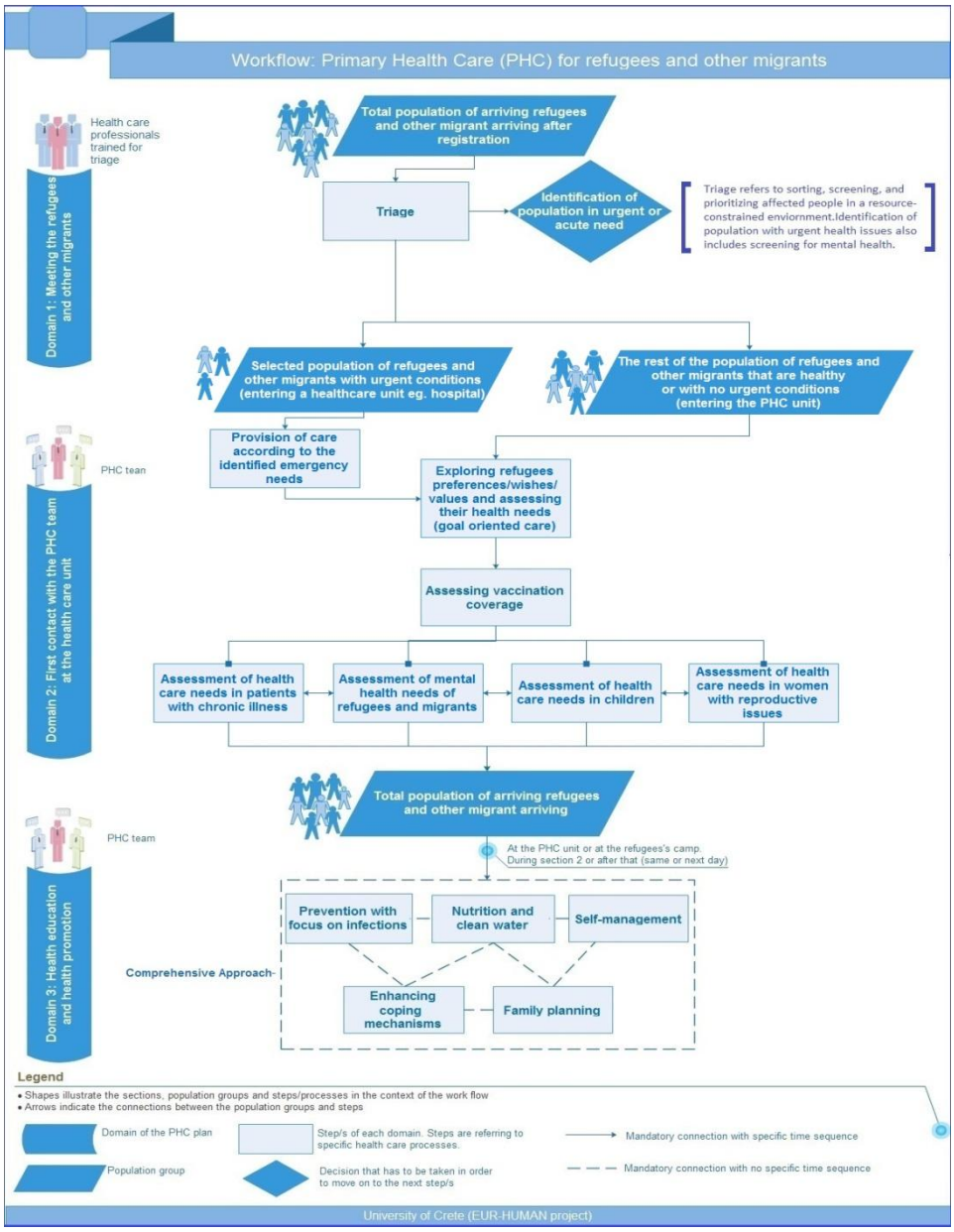
A systematic review of existing knowledge and expert consensus served to formulate the rapid assessment protocol. Key international guidelines, handbooks, manuals and reports were scrutinized, and a comprehensive search of peer-reviewed studies was conducted to identify specific tools for rapid assessment of MH needs.

It is recommended that the rapid assessment includes three steps: triage with the focus on recognising refugees whose functioning is severely impaired, their safety or safety of other people is endangered; screening for high risk for MH disorders that are common in the refugee populations, such as PTSD, anxiety and depression; for those who score above the cut-off on indicative trauma symptoms, immediate help based on psychological first aid principles should be provided together with referral to MH specialists for full assessment and further care. Most assessments tools that are used with

refugees are not comprehensive, but rather assess specific experiences and/or symptoms and disorders, while only a few assess several common MH problems. One specific and validated instrument that meets these requirements was identified.

Work package 4: *Developing tools and evidence-based practice for health care practitioners*
The objective of this work package is to define optimal content of primary healthcare and social care services and identify necessary knowledge, skills, training to provide comprehensive care for refugees and other migrants. Based on the information gathered in WP2, 3, and 5, the EUR-HUMAN consortium produced an operational plan with specific actions to optimize the health care offered to refugees and other newly arrived migrants at the first reception centres as well as the longer stay reception centres, the so-called work flow chart (see figure 1). A first overview of existing guidance, tools, and training materials was produced, as input for the questions to be asked to the experts participating in the consensus procedure. For more information on consensus procedure see section 2.

Figure 1: Workflow Primary Health Care for refugees and other migrants



Section 2: Consensus Procedure

An important goal of EUR-HUMAN is to reach consensus about the content of good primary health care and social care services needed to assess and address the health needs of refugees and other newly arrived migrants in first reception centres as well as in transit and longer stay centres.
To achieve this goal, we developed a stepped consensus procedure.

Preparation Phase

1. Inviting Experts

Approximately thirty (30) experts were invited to attend the expert consensus meeting on 8-9 June 2016 in Athens. Participants were chosen based on their experience and knowledge in the field of primary care or care for refugees. All consortium partners proposed experts they knew in their country and field of expertise. Also several participants were invited based on their involvement in other EU project targeting care for refugees and organizations such as SH-CAPAC, IOM-REHEALTH, CARE, 8 NGO's-11countries, and representatives of NGO's. There were also, invited officers from the Greek Ministry of Health and Greek Ministry of Migration and CHAFEA. Finally, the EU Commissioner of *Migration and Home Affairs* was invited (due to his busy schedule he was unable to participate). Besides, the members of the EUR-HUMAN consortium were invited.

2. Defining the workflow of PHC and relevant topics

In the first months of the EUR-HUMAN project, in WP2, 3 and 5 information was gathered on the content of optimal PHC for refugees and other newly arrived migrants, on relevant topics and guidance, tools or training materials to support professionals in PHC (see description in section 1). Based on this information, the EUR-HUMAN consortium produced the so-called work flow chart (see section 1).

3. Selected questions for the experts

Based on the results of WP2 (experiences of migrants), WP3 (review of literature), WP5 (mental health), the workflow and the knowledge and experiences of the consortium members, several themes emerged as important to address, as guidance on these themes was lacking or inconsistent.

These include **4 overarching topics**:

- Linguistic and cultural differences
- Continuity of care across sites and countries
- Primary Health care (team) at refugee reception centres
- Health promotion information and addressing information needs

And **5 specific areas** that needed to be discussed:

- Acute illnesses and Triage
- Infectious Diseases and Vaccinations

- Chronic non communicable diseases
- Mental Health
- Mother, child and reproductive health care

Based on these themes specific questions were formulated. These questions addressed, a) the process and workforce of PHC, b) the content of PHC in that specific theme and c) the skills / training / tools needed by professionals to deliver this type of service and care.

4. Consultation with consensus meeting participants

All participants of the consensus meeting were asked to reflect on these themes and topics, by answering specific questions the EUR-HUMAN consortium sent them early in May. Each participant was asked some general questions on the overarching themes, as well as some questions related to his/her expertise. Many participants provided us with their feedback.
Their answers to these questions were processed by the EUR-HUMAN team and from this, together with the results of the previous EUR-HUMAN work packages, preliminary conclusions and new questions were formulated for discussion during the expert meeting. A week before the meeting all participants received the final questions that had to be discussed and background materials in preparation of the consensus meeting.

Meeting in Athens

Aim of the meeting

The overall aim of the consensus meeting was to reach consensus on the content of PHC and social care services needed to assess and address the health needs of refugees and other newly arrived migrants. See Appendix1 for the official agenda of the meeting and Appendix 2 for the participant list.

The content of good equitable PHC for refugees/ migrants was discussed taking into account the different types of refugee centres: first (short stay) reception centres (hotspots), temporary stay centres in transit countries, and longer stay reception centres, and by looking at different aspects of care (linguistic and cultural barriers, compassionate care, organisation of care and health promotion) and different health problems (rapid assessment of urgent needs as well as chronic conditions, infectious diseases and vaccinations as well as mental health and reproductive health)at all three domains of the workflow (as described in previous section).
Regarding these topics we wanted:

- To discuss the **primary care team** (composition, role, dynamics, and skills) that would be accountable for the implementation of the pilot intervention in six European settings.
- To discuss and suggest effective and suitable **tools** in assessing the health care needs of their newly arrived or in transition refugees and migrants and as well as practice guidelines in regards to their management on a primary care and person centred basis.
- To discuss and suggest **training modules** and associated **educational material** that requested for the health care practitioners to meet the refugees and migrants' health and social care needs.
- To highlight all **key issues** that may have an impact on the implementation of the pilot interventions.

Consensus during the meeting was initiated by discussions in small groups, and then discussed in the plenary sessions.

1. Small group discussions

According to the themes and topics described above, small groups of participants were formed, based on their preferences and expertise, one group for each topic. During day 1 the overarching topics were discussed in the small groups and at day 2 the specific topics were addressed. See Appendix 3 for the topics and questions.
Every group was led by two facilitators, who were a member of the EUR-HUMAN consortium. Minutes were taken during the session and a report was send to the RUMC team.

Facilitators were instructed to focus on the following:

- Concrete solutions – not barriers
- PHC – not public health, not politics
- PHC for refugees – not in general

2. Plenary report, discussions and conclusions

The outcome of the small group discussions were reported in the plenary session by the facilitator of the session and then discussed by the whole group of participants. The overarching themes were discussed on day 1 and the specific topics on day 2.

Report of the expert consensus meeting (D4.1)

The conclusions and recommendations of this expert consensus meeting are written down in this report, section 4. The report has been commented on and finally approved by the participants to the meeting.
Based on the conclusions in the report, guidance with tools and set of guidelines and training will be developed and piloted in the implementation sites.

Section 3: Results of the Expert Consensus Meeting

Participants

In total 69 participants from 14 different countries attended the meeting.

Programme Oversight

The Expert Consensus meeting was held on the 8th and 9th of June 2016 in Athens at the National School of Public Health. The meeting was chaired by Professor Chris Dowrick. See Appendix 1, for the official agenda of the meeting and Appendix 2 for the participant list.

Day 1:

Introductions

- The meeting started with the refugee perspective, impressively presented by Ms Philomène Uwamaliya, Senior Lecturer Mental Health Nursing at Liverpool John Moores University, UK. Being a survivor of the genocide in Rwanda who sought asylum with her children to the UK, she shared her experiences.
    - Key points:
        - Refugees carry many visible and invisible scars.
        - The asylum procedure is very difficult and adds to mental problems.
        - Be aware of what you ask parents in front of their children.
        - Try to avoid people telling their story over and over again.
        - Ask as little details on experiences of violence as possible, but show a welcoming attitude so people feel welcome to share their story if they want.
- Thereafter the Greek general secretary for primary health care of the ministry of Health, Mr. Stamatis Vardaros, welcomed all participants and gave an introduction of the refugee situation in Greece and the importance of PHC that his government fully acknowledges.
- A short introduction on EUR-HUMAN project was provided by professor Christos Lionis
- Dr. Maria van den Muijsenbergh explained the aim and procedure of the meeting
- The results of the previous work packages within the EUR-HUMAN were presented by Tessa van Loenen (WP2), Michel Dückers (WP3) and Dean Ajdukovic (WP5).

Group discussions

Participants were divided into four smaller groups, according to their preferences and their expertise and discussed the overarching topics and questions (Appendix 3)

General discussion and conclusion

- Results of the small groups discussions were presented by the facilitators and discussed by all participants in a plenary session
- Professor Christos Lionis gave a summary of the conclusions.

Day 2:

Group discussions

- Participants started in five smaller groups, according to their preferences and their expertise and discussed the specific topics and questions (Appendix 3).

Plenary discussion

- Results of the small groups discussions were presented by the facilitators and discussed by all participants in a plenary session.

Conclusions and first concluding statements

- Professor Christos Lionis gave a summary of the conclusions.

Summary of discussions

Day 1: Discussion on Overarching Topics

Here follows the short summary of the discussions in the different groups, as was produced by the facilitators of each group. Besides this summary, all groups provided names and links to assessment tools and training materials that will be incorporated in the guidance developed in WP4 and the training that will lead the implementation of the interventions in WP6. Note that in this summary, the mentioned tools, guidelines and trainings are **not** specified; these will be assembled in deliverable D.4.2, the set of guidance, tools and training materials. Neither are described in detail the many barriers in achieving optimal PHC for refugees, as the meeting specifically focused on the *optimal*, and on what is needed to achieve this.

Group 1: Cultural and linguistic barriers

Facilitators:

Michel Dückers and Marieke van Veldhuizen

Key issues emerging from discussion

1. Four different groups were identified who can help translation / communication during the PHC consultations with migrants:
   - Informal interpreters (family, community):
     Several participants from different backgrounds felt huge resistance against the use of informal interpreters; however it was recognised, especially by the primary care workers with experience in working in reception centres, that in a lot of cases these are the only ones available. Using informal interpreters involves considerable risks, including privacy and trust issues, accuracy of translation and selective translation.
     - Only use informal interpreters in emergency situations, otherwise this should be avoided
     - Do not use informal interpreters in sensitive situations (these are specified in several existing guidelines)
     - When using informal interpreters, highlight and discuss privacy, their role and why certain questions are asked.
   - Paraprofessionals (trained but not qualified):
     Minimal requirements of these groups:
     - Understand what confidentially means (concrete)
     - Understand their role in translating
     - Basic knowledge from the culture of the refugees
     - Knowledge and information about the current health care system
     - Discussion about fraud (in some cases interpreters ask money for access to health care)
   - Cultural mediators:
     Minimal skills & knowledge - cultural background of this group
     - Ask refugees themselves how they do things, instead of thinking in stereotypes
     - Being receptive & communicative
     - Basic knowledge from culture of refugees e.g. how to approach women etc.
     - Diversity - be open to different cultures
     - Be aware of your own culture
     - Cultural desire and compassion

- Competence in translating process concerning specifically health context
- Medical professionals (qualified & tested):
  - Need to be trained on how to use interpreters
  - Need to inform patients about how the translation is going to take place and that they should not pay for translation services
  - Include interpreters as part of the health care team when discussing cases

2. Overall conclusions: The current system of using interpreters should change. Minimise extremely the use of informal interpreters, we have to strive for available qualitative formal interpreters or, cultural mediators in order to have a deeper support in the care relationship with refugees.

Group 2: Continuity of care

Facilitator:

Dean Ajdukovic and Helena Bakic

Key issues emerging from discussion

1. Continuity of care is dependent on entitlements → continuity requires a clear human rights approach to entitlements of care, and knowledge about the different migrant groups (especially undocumented).
2. Institutional continuity: in each country one organisation (NGO or governmental) should be responsible for the organisation of care and make very clear *what* services are available for *which* groups of migrants.
3. When it comes to continuity of care there should be at least informational continuity:
   - There is a support for (electronic) coded systems that help bridging language problems.
   - A system based on international classification of care. Codes to describe symptoms, diagnosis in relation to certain episodes of care (ICPC).
   - ATC codes for medication in specific countries.
   - Structured code based data set that can be opened in any country. There should be a European platform and if this is not possible or trustworthy; a memory stick for refugees with password.
   - IOM will soon present the electronic platform for the PHR.
   - The application of the ICPC based Patient records is cost-effective.

Group 3: Primary health care providers

Facilitator:

Diederik Aarendonk and Nadja van Ginneken

Key issues emerging from discussion

1. Compassionate component of care needs to be facilitated in practice:
   - Need for larger multidisciplinary team (MDT), including OT, physiotherapist, nurse, social worker, doctor, midwife, dietician, volunteers) with the mix within it of multi gender, multi age, and cultural sensitivity.

- Relying on direct colleagues within MDT will increase compassion (i.e. everything can be dealt with within this team so increase sense of trust and more immediate help provided thus more satisfaction and better response). The support of the MDT, and regular team meetings, also will help to avoid compassion fatigue and to keep all health care workers compassionate. Sharing good and bad keeps the spirits high.
- Having a key worker allocated can help with communication and navigation through the system and help with rapport building and thus building trust.
- It is possible to still be compassionate even if explaining to migrants about procedures/management plans they are not familiar with (For example treatment that the refugee may not be familiar with and does not meet their expectations of management for their complaint which would be different in their country). When we discuss these issues we can dress the information so as to acknowledge different values, but explain the value of evidence-based and how we know it works for individuals. This would increase compassion or not make it sound like a power balance.
- Compassionate care can be done effectively in less than 5 minutes →It is often non-verbal; include smiling, touching (depending on if culturally appropriate), showing someone respect by examining them in a private room, introducing yourself, listening, being interested, providing the right support and care.
- Invest above all in social workers, volunteers and community health workers to assure continuous mental support and compassionate care. Better training in multiple aspects (triage, management, but also in behavioural aspects) for volunteers and health care providers:
- Include in the training: cultural awareness, potential psychological stress on providers, compassion and compassion fatigue.
- Ensure consistency of messages; ongoing support, supervision, monitoring and competency assessment would be important to also ensure this consistency is applied.
- Doing online courses will help with reaching more workers and reduced costs of training, by ensuring also the diffusion of basic knowledge on the relevant topics.

2. Basic organisational values/ Infrastructures to facilitate care:
   - Task-shifting minor complaints (e.g. scabies/lice treatment, management of minor colds, coughs, contraception etc.) to be managed by nurses.
   - Triaging to be done by the whole MDT (all do the same thing) and then refer to each other.
   - Potential outreach to difficult places (e.g. those who don't live in camps but have settled in scattered areas – often the most hidden and vulnerable/have most poor access to health services).
   - Group meetings/world cafes for refugee/migrants: two fold reason for these: 1/ safety/security problem prevention and 2/support wellbeing of different groups (pregnant women, young male).
   - Primary care providers play a role in facilitation of these groups (e.g. social workers, trained/supported volunteers potentially, even dieticians/nurses/OTs etc.).
   - Coordination of care to also include adequate transitioning of care from refugee settings to streamlined primary care.
   - Security/safety for health care providers: suggested having 'hidden' security officer dressed and acting as a receptionist (so he also monitors the flow of patients). Health care providers need to feel secure.

- Need to also make sure that basic human rights are addressed and reinforced through healthcare: access to dietician for nutritional advice as much malnutrition, provision of sufficient amount of water, sanitation and hygiene facilities.

3. Organisational issues on which above are dependent/need to be taken into account in implementing above core values
   - Resources
     - Financial resources available.
     - Infrastructure: halls, centres, are they adequate for assessment and for respecting basic human rights.
     - Existing mix of human resources: e.g. doctor resources: in thinking about workforce need to think not just of GPs but all specialists in terms of frontline doctor workers as in Greece there are not enough GPs to be working on the frontline so use cardiologists, surgeons, other medics too. So can't use generic term of GPs for frontline doctors providing primary care.
     - Using accredited human resources: e.g. for dieticians: use term dietician not nutritionist as dietician has 5 years recognised accredited training whereas nutritionist could be from a short course of 2 days and is NOT accredited.
   - Coordination with all authorities
   - Size of camps: may need quite different organisation for a small camp of 1000 people or if you have 50 000.
   - Changing political situation (e.g. borders closing and nature of hotspots changing and people staying longer so care will need to be adapted as these changes occur).
   - Systems needed to facilitate our work.
     - Better registration so that we are certain of the validity of the personal data of each person seeing.
     - Online health data sharing – pan European system.

Group 4. Health promotion and information

Facilitators:

Kathryn Hoffman and Elena Jirovsky

Key issues emerging from small discussion group

- PHC providers should have an overall knowledge about the asylum process. Not too detailed, as the situation is too dynamic. It is important for the PHC providers to have an idea about the process the refugee patients go through, as this process can have severe effects on the mental and physical wellbeing of the refugees: long waiting period, stress, separation from family, feeling powerless. The PHC provider should be able to facilitate the access to more detailed information (facilities).
  - Good practice example:
    - Supporting point for the PHC providers (telephone service) in terms of organisational aspects (existing in the Netherlands).
    - Applications for refugees in Austria and Germany (also on health care).
  - Possible other strategies:
    - Lists or leaflets of organisations in the surrounding area of PHC providers in different

languages to give to the patients.
    - For illiterate refugees: involvement of trained community members as health promoters and mediators ("community health workers"), practice nurses, health secretaries.
    - Training courses such as EUR-HUMAN course, MEM-TP, etc. for people caring for refugees.
    - Leaflets and apps with regularly updated information on the health care system and asylum laws etc. on the internet.
- PHC providers should have knowledge about the health system and the regulations for the different groups of asylum seekers, settled refugees and other migrants in this health system.
- Regarding the question what non-medical information refugees need, the following issues were mentioned:
  - accommodation facilities
  - sanitary facilities and personal hygiene
  - food
  - opportunities for work (for destination countries)
  - information about educational system (for destination countries)

  These aspects were mentioned by various group participants and emphasised as core aspects.
- It is recommended to inform refugees about the respective health system (and the asylum procedures) in the destination countries. Providing information could ideally be linked to other registration procedures for the asylum process or the initial health assessment (if there is one, like in Austria).
  - Refugees need information about their legal rights concerning health care in the transit and destination countries such as:
    - No costs for medication
    - contraception is legal
    - women's rights
    - pre- and post-natal care
    - availability of health checks
  - Possible strategies:
    - Involvement of trained community members as health promoters and mediators ("community health workers"), practice nurses, health secretaries, social workers.
    - Training courses such as EUR-HUMAN course, MEM-TP, etc. for people caring for refugees
    - Written information in form of leaflets.
    - Leaflets, homepages and apps with regularly updated information on the health care system and asylum laws etc. on the internet.
- Interpreters would urgently be needed in all health care related institutions; however, the consensus is that this issue can only be solved on the health authority and policy level. There ought to be legal requirements that there has to be an interpreter or cultural mediator in health care.
- Health promotion on 2 levels:

a) Basic level (hot spots, transit camps, destination country)
  - The role of the PHC provider is the detection, documentation, and communication of gaps in the provision of the basic and immediate needs, such as hygiene, water, sanitation, nutrition, and accommodation etc., to responsible organizations.

- Nutrition is included in these basics, as in many camps the food is provided by third parties such as the military. PHC has to detect, document, and communicate nutritional deficiencies.

b) Advanced level (destination country)

- To deal with issues like drinking and drugs, underlying problems like stress caused by the flight situation needs to be tackled.
- It is recommended to be attentive to mental health issues among refugees and to screen for mental health problems (e.g. WP5; MIRROR tool).
- Provide and promote tools for self-help among the refugees (many easily available).
- Mental health first aid.
- Short movies, video clips on symptoms of stress and trauma in media, social media, under consideration of cultural understandings of stress and trauma for the refugees.

- Include the refugee population in existing health promotion and prevention programs (e.g. preventive health check-ups) as well a disease management programs for self-empowerment.

Highlights from the plenary discussion

- PHC workers should inform the authorities if they notice basic provisions are lacking or non-hygienic etc.
- There was additional emphasis on the fact ICPC and ICD “speak” to each other, thus, facilitating continuity across primary and secondary. Participants emphasised during the plenary discussion this aspect along with the fact this would allow quantifying the cost to the system (i.e., ICPC/ICD “translating” seamlessly into DRG/DBC, etc.) and generating robust evidence for the “cost” discussions /burden of these groups to the overall HC system.
- Especially when are refugees scattered emphasize the importance of outreaching.
- The importance of a stepped approach was highlighted, depending on priorities in situations. For instance doing something in one hotspot; has to be continued in the next one. In relation to this, accessible information should be provided for those who need it.
- Integrate refugees (with a medical background) in the care for refugees.
- From a human right perspective there should be no mandatory of compulsory assessment or screening. Screening only when you are able to treat or refer people to specialist care. In addition, be aware of the difference between screening and assessment.

Day 2: Discussion on Specific Topics

Here follows the short summary of the discussions in the several groups, as was produced by the facilitators of each group. Besides this summary, all groups provided names and links to assessment tools and training materials that will be incorporated in the guidance developed in WP4 and the training that will lead the implementation of the interventions in WP6. Note that in this summary, the mentioned tools, guidelines and trainings are **not** specified; these will be assembled in deliverable D.4.2, the set of guidance, tools and training materials.

After the summary the additional remarks are reported that were made during the plenary discussion.

Group 1. Acute illnesses and Triage

This topic refers to triage, as the process of identifying and assessing who is in immediate need for treatment or referral**.**

Facilitators:

Michel Dückers and Marieke van Veldhuizen

Key issues emerging from small discussion group

1. Nature of triage and emergency: background of triage as a concept is different from what could be considered an emergency in the context of a refugee camp.
   The ideal model of triage:
   - a camp is a site where refugees enter; registration is a first step; allocation ("this is where you are staying") is a second step
   - medical services are provided in different steps, starting with triage (preferably by a trained nurse), outside a building
   - inside the building there are at least three rooms:
     - medical doctor
     - psychologist/mental health
     - social medicine, clothes, milk, diapers
   - The camp itself is connected to hospitals and other specialist health care provision on the neighbourhood of the site.
   - Enough nursing, GP, psychological capacity available at the sites.
   - There are volunteers who provide social support and assist refugees through the medical stages at the site and the place where they and their families stay (navigators).
2. The triage itself requires red flags. Basically, the nurse should send refugees through to the GP or appropriate professional in case of: fever, coughing, dizziness, pains, feeling bad, and on every issue where a refugee is concerned and wants to see a doctor. Besides this general description there are specific overviews of red flags. Also, there is a list of mental health related symptoms and complaints useful during triage.
3. Important: in the ideal situation you should make an estimation of the size of refugee streams, the nature of expected health needs and problems (profiling), and use this to sharpen the red flags and the planning of health care capacity.
4. The triage and the follow-up in the primary health care team require a medical coordinator. This can be anyone from the different disciplines, however there are reasons to prefer a doctor ("doctors are odd", a non-doctor is not always acceptable).

5. Also there needs to be a form of practical and logistical management unifying the medical activities at the site to other activities like registration and supplies.
   - Confidentiality is important, make sure enough rooms are available.
   - Volunteers accompanying patients through the system, to build trust and safeguard continuity of care (navigators).

Additional remarks during plenary session

- One of the difficulties is that nurses often do not have a room leading to issues of confidentiality.
- Use volunteers as navigators through the system to assure continuity. This increases the trust building process.
- Look for possibilities to shift medical work to nurses.

Group 2. Infectious diseases and Vaccinations

Facilitators:

Imre Rurik and László Kolozsvari

Key issues emerging from small discussion group

1. Infectious diseases:
   - At the hotspots and short stay reception centres there is no need for screening for asymptomatic patients. Recommendation only if they have visible symptoms they can be further tested if they are in need of treatment. At the longer stay centres screening on hepatitis B, C and HIV is recommended.
   - A rapid test for common infectious diseases is only necessary for suspicious cases (e.g. Malaria, TB).
   - For prevention of common infectious diseases the following should be organised:
     - Hygienic measures
     - Flyers/leaflets
   - In many countries there are already local guidance on how to deal with infectious disease outbreaks. ECDC also developed a useful evidence based guidance.
2. Vaccination:
   - Ideally the same registration of vaccination should be used in all countries. At least, use local form of vaccination registration in English.
   - Practical guidelines in assessing, administrating, and monitoring vaccination among refugees are described by ECDC and national guidelines.
   - If there is no written proof/documentation of vaccination refugees should be treated as unvaccinated. However in exceptional cases of a very reliable, convincing story, we can accept oral declaration. This can for instance be in case of a refugee who can prove his medical background.
   - Follow the national guidelines and vaccination protocol.
   - A set of vaccines should be used for all refugees, some only after outbreaks:
     - All: MMR 9months-15 years, DPT IPV 2 months to 6 years, DVT over 7 years
     - Outbreaks: Polio, Measles, TB, Hep A
     - In longer stay centres the national vaccination schedule should be started

Additional remarks during plenary session

- Develop a practical tool for available information on vaccination with videos of the disease and side effects.
- ICPC can help increase informational continuity for vaccinations as it has codes for vaccinations.
- Prof Maurer has developed a practical tool on how to vaccinate children that he will share with us.
- There was a discussion on the possibilities for obligatory vaccination. In some European countries this seemed the case. For children this is a difficult case. One of the human rights for children is that they have the right for the highest possible health. Non appropriate vaccination is therefore sometimes seen as neglect.

Group 3. Non-communicable and chronic conditions

Facilitators:

Diederik Aarendonk and Corné Versluijs

Key Issues emerging from small discussion groups

1. Instead of focussing only on chronic diseases, shift to a focus on multi-morbidity. We should be less disease oriented and much more goal orientation.
2. The most important chronic diseases that have to be identified at the hotpots are: COPD, diabetes, hypertension. This can easily be done via Point of Care testing (drop of blood testing).
3. Care for chronic disease should be provided within the existing infrastructures, the regular services. Primary care in the country could be provided with special 'health care kits', which are already available.
4. There should be no investment in specific disease programmes in hotspots. Instead promote people centred care through investment in integrate primary care systems.
5. Minimal health assessment for chronic diseases in the hotspots: those who present themselves at healthcare spots, but for the vulnerable of the vulnerable active assessment via a Fast Track is needed and create awareness among stakeholders (police etc.)
6. Care provided for chronic diseases should be interdisciplinary. After the hotspot, refer to (specialized) care, if needed.
7. Intercultural information is needed but is already available. The right information has to be available at on one spot (database) were it is easily accessible if needed.

Additional remarks during plenary session

- Aim should be: minimal disruptive to cause minimal burden.
- Seamless coordination is needed between PHC in refugee centres with regular local PHC, especially for follow up. The problem is how to organise this in overcrowded situations.
- Interventions should all be tailored to local needs.

Group 4. Mental Health

Facilitators:

Dean Ajdukovic and Helena Bakic

Key Issues emerging from small discussion groups

1. It is important to take into account the differentiation between GP tasks in the countries. Not in all countries mental health care is provided by GPs.
2. At the first reception centres triage for mental health is like an emergency setting and crisis response: it can be done by different people such as social workers or trained volunteers. At this point they are more important than psychologists. The tasks to be done are identifying distress and self-harm risk so this can be done by a non-specialist. It is important to offer some intervention at this point too: psychological first aid for example (e.g. ALGEE).
3. In longer destination countries and in camps (second level): Assessment/screening: Using a stepped care model.
   - Screening should be done as part of the physical check-up → identify people who need more care → either referral for specialist care or primary care.
   - Validated instrument for screening most often mental health conditions is important and it has been identified (e.g. Refugee health screener – 13 or 15).
   - Since there is limited time interdisciplinary team is important → other staff than GP should be trained and help. Can use paraprofessionals in providing basic help, coping skills, and navigation through system – practical help to reduce distress.
   - Training for workers to screen people → a range of staff with different roles should be trained to the level of required competency for culturally appropriate and reliable screening. A number of tools have been mentioned during the session.
4. After screening a short and culturally appropriate intervention should be available and integrated with other services like housing, legal assistance as they have every important mental health consequences. Interventions at longer stay should also include psychological first aid and referral to more specific care to then deal with the wider psychological issues.
5. Several tools were mentioned for suicide screening e.g. Columbia suicide severity scale or CPR (decided NOT mhGAP tool as it is too complex and not adapted). MIRROR can be used for screening of common mental health problems.
6. Issue of appropriateness of health worker and navigator: the right gender, the right background (not someone from same country as may cause more distress and issues of trust).

Additional remarks during plenary session

- Traumas don't stop when you arrive. They continue when you arrive. Inappropriate care modalities and setting can determine re-traumatisation.
- Important to have a multidisciplinary team: everyone triages everyone. In this team also mental health volunteer or social worker. They are in the immediate response more important than psychologist.
- There is also a gender element → the provision of gender sensitive services is specifically important for maternal and child health given the histories of these people.

Group 5. Mother and child care and reproductive health

Facilitator:

Erika Zelko and Nicole Mascia

Key Issues emerging from small discussion groups

1. It is crucial to know if a woman is pregnant at the first arrival. However it is not always possible to identify pregnancy in just a few hours (at hotspot or transit centres) and in an uncomfortable setting, without the possibility to ensure confidentiality and privacy. At the moment of triage, pro-active identification of all women about pregnancy by a female health care professional.
2. In case of evident pregnancy, a female healthcare professional (midwife, if possible) should perform the following minimal assessment procedures:
   - Perform clinical examination of woman and fetus (such as nutritional conditions, ongoing medications, blood pressure, dehydration, anaemia and, if possible to check about signs of violence-especially in the area of belly).
   - Ask about previous pregnancies and abortions, chronic and infectious diseases, pregnancy problems, use of medicaments.
3. Provide information on health services available and health related issues, through trained personnel and informative material in support:
   - At the hotspots and transit centres:
     - Short leaflet with general information about mother and child care of all the countries on the way to final destination, risky pregnancy, healthcare facilities and accessibility, legal contraception.
   - At long term reception centres:
     a. Provide information about all available and cost-effective contraception methods (condoms, day after pill, spiral).
     b. When a woman gives birth they should be informed about the possibility of IUD contraception option.
     c. Discuss breastfeeding as a contraception method.
4. To increase safety for woman and girls there should be accommodation in separate units for families and girls/woman who are travelling alone. It might be useful to provide information about illegality of (sexual) violence in most European countries.
5. (Sexual) violence:
   a. Medical examination immediately after assault
   b. Document well in written form
   c. Take pictures of injuries
   d. Immediate psychological aid and care: to prevent PTSS.
   e. Provide a peaceful, calm, safe and empathic atmosphere
   f. In long term facilities observe women and screen for PTSD after a few weeks.
6. It should be taking into account that women may have been subjected to violence previously in their country or during the trip. Particular attention should be paid to recognize physical or mental signs of this.
7. Recommendation regarding delayed development among children. It can be difficult to distinguish these from the normal effects of being a refugee.

- Signs of dissociation like amnesia, forgetfulness or daydreaming are typical symptoms for a trauma-related disease and can be understood as protection reactions. Often they are

accompanied by bodily symptoms and/or strong feelings of fear and despair, which affected the vulnerable persons.

- It is essential that children, when entering school in the country of destination, should be observed for a period of time (approx. 3-6 months) and in case of the assumption of delayed development (usually by the teacher) receive special attendance by school (e.g. coaching for special subjects) and/or individual support of their resources and strengthening of their inadequacies by a child's psychologists. Depending on the kind of the child's delayed development also ergo therapy/occupational therapy, speech therapy or other forms of individual therapy are recommended (usually by a child's psychologist, teacher, and pedagogue).

Additional remarks during plenary session

- Hygiene pads are often lacking or distributed only 1 x month. For many women this is not enough: inform authorities to provide on need
- Inform all other healthcare workers if woman is pregnant or breastfeeding.
- Women avoid going to the toilets out of fear for rape. They refuse drinking which leads to nutrition and hydration problems (especially problematic for breastfeeding women). One idea is to have a navigator to be mindful of these issues. In addition, information on women's rights (including abortion) is necessary and advocacy from PHC.

Closing session

Conclusions on the consensus meeting in Athens were drawn by professor Christos Lionis.
Christos summarized that the meeting has provided us with understanding of the direction to go after the meeting (see below 'next steps') and that the consensus contributed to:

1. Additional sources of information
2. Many more ideas and suggestions for tools for needs assessment, risk assessment
3. Additional guidance and practice guidelines

Next steps in consensus procedure

Christos Lionis pointed out during the closing session the next steps being
1. To synthesize what we have discussed and what we have learned from the consensus meeting in Athens. This will be written down in a report that will be circulated among all participants.
2. To triangulate elements and information identified through the consensus meeting with information received from the other quarters and sources (meetings with refugees, systematic literature review).
3. To translate all this into guidance for primary health care in specific pilot interventions in six (6) settings under the coordination of University of Vienna).

Section 4: Concluding statements and recommendations

General principle

Primary health care for refugees and other migrants should be person-centred, comprehensive, goal-oriented, minimally disruptive, compassionate, outreaching, integrated within the existing primary health system and other services, and provided by a multidisciplinary team. In all circumstances, the health needs and preferences of the migrant patients are guiding the healthcare process.

Important contextual factors

- There are different migrant groups with different entitlements to care, with undocumented migrants and unaccompanied minors in need of special attention.
- There is a lack of resources and manpower in crowded first reception centres. This challenges the provision of good quality integrated PHC.
- Local circumstances will predominantly determine the extent to which ideal PHC can be implemented. The ATOMIC model, developed by NIVEL, may play an important role in local decisions on the implementation of interventions.

Conclusions and recommendations

The synthesis of the discussions points towards three main areas of recommendations regarding the needs assessment and care of migrants/refugees as they transit through Europe:

1. Elements necessary for having caring and competent care providers.
2. The content of person-centred, comprehensive, goal-oriented, minimal disruptive and compassionate primary health care.
3. The organisational elements which are important for outreaching, integrated primary health care.

1. All care providers need to be cultural competent, compassionate and person centred.

This requires from all care providers the following cultural competencies in which they have to be trained and supported:

a. **an *attitude* enabling the building of a trustful relationship**
   - Awareness of the own personal background (gender, culture, language).
   - Awareness of the personal context of the migrant patient (language, educational level, culture, migrant status).
   - Ability to provide compassionate care.
   - Awareness of signs of compassion fatigue.

b. ***Knowledge***
   - Of the healthcare system, asylum process and entitlements for different migrant groups.
   - Of signs of vulnerability and vulnerable groups ((unaccompanied) minors, elderly, pregnant women).
   - Of specific tasks in triage, assessment, initial treatment, health promotion and of the specific content of healthcare for refugees and other migrants.

c. ***Skills***
   - To collaborate in a multidisciplinary team, including volunteers.
   - To deal with task shifting.
   - To communicate adapted to the linguistic, educational and cultural needs of the patient - including working with interpreters.

2. The content of person centred, comprehensive, goal oriented, minimal disruptive and compassionate primary health care

The content of care can differ between the first (short stay) reception centres (hot spots and transit countries) and the longer stay centres**.**

a. **Specific recommendations for hot spots/first reception centres:**
   - Where possible, delegate triage to several trained persons within the multidisciplinary team, like nurses, volunteers, midwife, and doctors.

b. **Specific recommendations for the longer stay centres:**
   - Work outreaching, proactive to find vulnerably migrants who do not reside in reception centres but are dispersed throughout local communities.
   - Collaborate with local PHC.

c. **General recommendations**
   - Assess health needs and personal preferences of the patient prior to treatment at all stages and all sites.

d. **Disease specific recommendations:**

	Hot spots/first reception	Longer term/Destination
Acute illness	- know and use the list of red flags - consider delegation of treatment for minor ailments to nurses	- same as usual primary care (PC) system
Infectious diseases	- follow ECDC or national / international guidelines for screening and treating - do not screen asymptomatic persons with high risk for Hep B/C HIV - use rapid testing for symptomatic / high risk (TB, HIV, malaria etc) - provide information on hygiene and prevention of communicable diseases	- follow ECDC or national/international guidelines for screening and treating - test asymptomatic persons with high risk for Hepatitis B/C or HIV , even if treatment is not available
Vaccination	- follow ECDC or national/ international guidelines - Without proof of vaccination consider as not vaccinated - ensure basic vaccinations: MMR 9m-15 yrs; DPT IPV 2m-16 yrs; DVT > 7yrs - provide information on vaccinations in English, the language of the migrant and the local language	- follow ECDC or national/international guidelines - Without proof of vaccination consider as not vaccinated - remember vaccination is always voluntary, but if a child is kept away from vaccination by parents, this could be considered as neglect (human rights).
Chronic conditions	- focus on multi-morbidity and change from disease oriented to goal oriented care. - do not develop specific disease programmes	- integrate with local PHC.

	Hot spots/first reception	Longer term/Destination
	- focus on promoting patient-centred minimally disruptive care, tailored to local needs - in case of scarce resources, make use of the existing facilities and personnel	
Mental health	- perform triage as crisis response: assess dysfunctional level of distress and self- and other-harm and provide urgent referral for specialist care if necessary - consider involving by trained non-specialist health personnel and allied staff and trained volunteers - include assessment of mental health problems in general physical assessment	- assess for delayed crisis cases - screen for mental health conditions (recommended instrument RHS-13/15) - consider involving by trained non-specialist health personnel and allied staff and trained volunteers - provide referral for specialist full MH assessment and care as needed for those who score above cut-off - provide psychological first aid to those who score bellow cut-off but have symptoms and monitor changes - link with PC in countries (depends on country which do MHC in PC and which don't but at least physical health of those with mental illness should be looked after)
Women and child care	- identify pregnant women - provide adequate care for pregnant women, by midwife preferably - identify victims of sexual violence for immediate initial examination by doctor and provision of psychological first aid - provide culturally appropriate information on pregnancy, contraception, women's rights. - make available all contraceptives, including post-natal IUD's, in line with national guidelines. - secure the provision of sufficient hygiene pad	- provide perinatal care as per national guidelines - be aware of sexual violence as cause of delayed PTSD - refer victims of sexual violence for MH support - be aware that apparent developmental delay in children can be a result of PTSD/abuse etc - provide adequate psychological care and assessment for these children - provide (more in-depth) culturally appropriate information on contraception, breastfeeding and on women's rights in that country
Health promotion	- provide information on basic human rights - provide culturally appropriate information / health promotion programmes on hygiene / sanitation, malnutrition	- provide more in-depth culturally appropriate health promotion in line with country's health promotion and national screening programmes - include mental health and wellbeing in health promotion.

3. Organisation of outreaching, integrated primary health care

a. **Enable the composition of multidisciplinary primary health care teams**

- Install multidisciplinary teams that contain accredited quality workers including the following: doctor, nurse, midwife, social worker, dietician, mental health worker, 'navigator' or volunteer or CHW, interpreter (well trained, not informal).
- Enable task shifting, joint triaging.
- Shape supportive environment /information sharing and address compassion fatigue through joint meetings - develop and use protocols for task division, on responsibilities of nurses / paraprofessionals / volunteers and doctors.

b. **Enable the organisation of person-centred, culturally competent care**

- provide quality interpretation service
  - minimise the use of informal interpreters (family and friends).
  - consider trained peer professionals (other refugees with medical background) for interpretation if professional interpreters are not available and to enhance culturally appropriate healthcare.
- guarantee a safe and confidential environment
  - install separate toilets for women close to accommodation to reduce sexual violence.
  - introduce volunteers from migrant communities as navigator (to help with feeling of safety and trust).
    - provide separate examination rooms
    - consider the involvement of a security officer in normal clothing e.g. as a receptionist
- provide health promotion leaflets in adequate languages and adapted to intercultural differences, also on basic provisions and human rights
  - make sure all information is suitable for illiterate people
- provide all necessary (on-line or face-to-face) training on cultural competences and compassionate care
- Provide clinical and personal support and ongoing training for health care providers (for example a combination of informal (MDT meetings) and formal support (having allocated supervisors).

a. **Guarantee continuity of care locally and throughout the migrant journey**

- As continuity of care is highly dependent on entitlement, ensure a clear human rights approach to entitlement to care.
- Guarantee the internal institutional continuity of care by having one organisation/NGO in charge of coordinating all care by different providers and make very clear what services are available for which groups of migrants.
- Appoint a medical coordinator.
- Improve the continuity of care locally through the 'navigator' (volunteer helping refugees to 'navigate' through the system).
- Integrate with the local PHC system.
- Improve the continuity of care throughout Europe/ in transit with data sharing of health care provision and vaccinations (need a pan European electronic shared database to

ensure informational continuity), preferably an electronic coded- system. The feasibility of the forthcoming electronic personal health record and related platform IOM is developing will have to be established.

For all different aspects of the care process as well as the content of care, many tools, guidelines and training materials are available, many of them developed in other EU funded projects, that have been shared by the participants and will be included in the guidance that will be developed as Deliverable D4.2 of the EUR-HUMAN project.

Section 5: Next Steps

The consensus meeting in Athens led to a list of recommendations and goals to optimize primary health care for refugees. Some of these recommendations are practical where others deal with difficult barriers, obstacles and political constraints in providing care. In the next steps of the EUR-HUMAN project, there will be a focus on the concrete realization of the described recommendations.
First, in WP4, a guidance (D4.2) will be developed containing a) the recommendations of the expert-consensus meeting and existing practical tools and guidelines for the provision of comprehensive, person-centred, compassionate primary healthcare for refugees and other newly arrived migrants and b) a list of existing related training materials. This guidance will then be used to develop a training for PHC providers in WP6. Furthermore, it will support the selection and implementation of PHC interventions that will be piloted in the six intervention sites.

Development Guidance and Training

During the consensus meeting many tools, checklists, and guidelines were mentioned that can help primary health care workers in the provision of care for refugees (e.g. the guidance for the vaccination of children, the assessment of malnutrition, guideline on sexual violence). All these tools will be available in comprehensive guidance for primary health care workers in order to provide optimal primary care (deliverable 4.2.) and which also will contain the recommendations emerging from the consensus meeting and the results of WP2, WP3, WP5. The guidance addresses all topics and includes practical tools, checklists, tests and information necessary.
In addition, all knowledge will be used to develop an online training (Milestone 13 in WP6) for health care professionals providing care for refugees.

Implementation and evaluation of interventions

In July and August 2016, the EUR-HUMAN intervention sites team will choose interventions based on the guidance and training mentioned in the previous section. These interventions will be implemented between September and October 2016 in existing Early Hosting and First Care Centres for refugees (Greece, Italy, and Croatia) and in existing Transit Centres and centres for refugees and migrants with uncertain residency status who have applied for asylum (Austria, Hungary and Slovenia). The aim of the intervention phase is to test to what extent the multifaceted, integrated, person-centred, and multidisciplinary care intervention is practical, feasible and acceptable in the different settings.
Each EUR-HUMAN partner who is responsible for an intervention has to select a multifaceted, integrated, person-centred, and multidisciplinary intervention and underlying training (described in the WP4 results D4.2) which is suitable for that local intervention setting and existing needs of the local primary care providers.
After the intervention has been piloted, it will be evaluated and analysed to ascertain the practicality, acceptability, feasibility of its broader implementation and so that it can be adapted for future trials or dissemination.

Appendix 1: Agenda Meeting

The Meeting:	**EUR-HUMAN EXPERT MEETING**	
Date:	**8-9 June 2016, Athens**	**Time: 8 June 11:30-18:00** **9 June 09:00-13:00**
Venue:	**National School of Public Health** 196 Alexandras Avenue Athens.	

Day 1, 8 June 2016

11.30-12.00	Registration	
12:00–12:30	Refugee perspective	Philomene Uwamalya, Liverpool John Moores University
12.30–12.40	Welcome Ceremony by Greek general secretary for Primary health care of the ministry of Health Mr Stamatis Vardaros	Chair: Chris Dowrick
12:40-12:50	Introductory remarks	Christos Lionis (coordinator EUR-HUMAN)
12:50-13:00	Introductory remarks	Maria van den Muijsenbergh (WP4 Leader)
13:00-13:30	First EUR-HUMAN results	Tessa van Loenen , WP2 Leader *Experiences of refugees* Michel Dückers, WP3 Leader *Literature review* Dean Ajdukovic, WP5 Leader *Mental health*
13:30-14:15	Break	

14:15 - 16:15	Discussion in 4 groups Group 1: Linguistic and cultural barriers Group 2: Continuity of care Group 3: Primary Health Care Group 4: Health promotion and information	
16:15-16:30	Break	
16:30-17:45	Plenary report of the 4 groups General discussion	Chair: Chris Dowrick
17:45 - 18:00	Conclusions on overarching themes	Christos Lionis
18:00	Closure	Maria van den Muijsenbergh
18.30	Reception	

Day 2, 9 June 2016

08:30-09:00	Registration	
09:00-10:30	Work in 5 groups Group 1: Acute illnesses and Triage Group 2: Infectious Diseases and Vaccinations Group 3: Non communicable diseases Group 4: Mental Health Group 5: Mother and child care	
10:30-10:45	Coffee break	Coffee break
10:45-12:30	Plenary Report of the small group sessions Plenary Discussion	Chair: Chris Dowrick
12:30 - 13:00	Conclusions	Christos Lionis
13:00	Closure of the meeting	Christos Lionis

Appendix 2: Participant List

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Images of the EUR-HUMAN Expert Meeting, in Athens at the National School of Public Health.


IMPLEMENTATION CHECKLIST
To think through when shaping the improvement idea
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"Saving lives, Improving Lives"
Vulnerability Indicators
Different stages of a human life
Body
Mind
Emotions
Behaviours

Appendix 3: Guidance for groups discussions

DAY 1: Overarching topics, 8th June 2016, 14.15-16.15

Group 1: Cultural and linguistic barriers

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments to overpass cultural and linguistic barriers when health care providers meet the refugees

Introductory remarks:
The burden of linguistic and cultural barriers, both on the side of migrants as well as healthcare professionals are well known.
There are many guidelines and recommendations on how to work with cultural mediators en interpreters. Most of them emphasize the importance of formal and independent cultural mediators and interpreters and not using family for translating. However, in practical situations formal interpreters are often not available.
Regarding cultural barriers it is frequently advised that primary health care workers have knowledge on cultural differences regarding health care. For instance differences in male to female relationships, traditions, medical habits and communication.

Not to discuss during this session:

- The importance of formal and independent interpreters and mediators
- All the different cultural barriers
- Existing guidelines concerning interpreters
- existing training on cultural and linguistic barriers (as developed in the MEM- tp and other projects)

Topics to discuss regarding the role of interpreters and health personnel:
Role of informal interpreters
Appropriate training of interpreters and health personnel in cultural aspects

Specific questions:

- What are the minimal conditions and requirements for working with informal interpreters?
- In what situation should informal interpreters never be used?
- What are the *minimal* knowledge and skills professionals and volunteers need concerning cultural background?

Group 2: Continuity of care

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments to overpass continuity of care problems when health care providers meet the refugees.

Preparation literature:

Personal health record + handbook (IOM)

Introductory remarks:

Continuity of care is very important to assure optimal medical care. Recently the *IOM* developed a Personal Health Record (a medical passport) for refugees. In this passport care-givers can write down important medical information. The passport is confidential and is covered by European and national regulations on date protection (WP3). There is an ongoing discussion whether to implement a written or electronic medical passport, and under which conditions.

Not to discuss during this session:

- Importance of the continuity of care
- Continuity of care for specific illnesses and vaccinations (will be discussed on day 2)

Topics to discuss:

Appropriate tools and medical records to ensure continuity

Specific questions:

- What are the minimal requirements for a paper medical passport for refugees?
- What are recommendations for care-givers using a medical passport or other devices in order to increase cross border applicability/cooperation (e.g. regarding language, medication, treatment)?
- What are the pro's and con's of a paper medical passport compared to an electronic passport?

Group 3: Primary Health Care Provider

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Introductory remarks:

In primary health care dealing with refugees building a trustful relationship is of great importance and therefore it is advised to ensure compassionate care. This is a logical recommendation, but in a practical setting with for instance a noisy environment and a short amount of time this can be difficult. Furthermore it can also be a stressful situation for the providers of care.

Not to discuss during this session:

- Specific disease management

Topics to discuss:

Evidence-based approaches and team working and inter-professional collaboration

Decision management tools

Adequate and secure resourcing

Patient safety and quality assessment tools

Specific questions:

- What are concrete elements of compassionate care in the circumstances of hot spots? How do we obtain this?
- How can compassion fatigue be prevented?
- How can we achieve emotional and physical safety for the providers of primary care in hot spots and reception centres? (e.g. burn-out prevention, infectious diseases)

Group 4: Health promotion and information needs:

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Introductory remarks:

For adequate care, refugees as well as PHC workers need to be informed on important topics as asylum procedures, legal situation, travel possibilities etc. We would like to discuss what information is necessary and how we can assure the availability of this information.

General Health promotion belongs to the domain of *public health,* but can be considered a joint Primary care / public health task, especially in the hot spots and reception centres where Primary Care Workers are often the first or only contact with the health system.

Not to discuss during this session:

- The field of Public Health (stay focused on the role of Primary Care)
- Health promotion in Long-term prevention programs (e.g. obesity, smoking prevention)

Topics to discuss:

Appropriate training material and tools in assessing effective working health promotion and methods toward disease prevention

Brief behavioural activation to promote health

Specific questions:

- What non-medical information does the PHC worker need (e.g. legal situation, organisational level, asylum procedure)?
- What non-medical information do the refugees need?
- Which health promotion items/materials should be available in primary care in hotspots and for refugees regarding their health during the journey and stay in the reception centres?
- Do you know any existing suitable materials?
- What type of psychosocial intervention could be utilized in promoting health and facilitating behavioural change among the refugees?

DAY 2: Specific topics, 9th June 2016, 09.00-10.30

Group 1. Acute illness and triage

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Introductory remarks:

Refugees arrive in hot spots and reception centres often exhausted and with many journey and violence related health problems, sometimes critically ill or wounded. When large groups arrive, a triage system, assessing whom are first in need of care is urgent. Existing medical guidelines (like the ABCDE system) often are not feasible in these situations. Rapid assessment will in some occasions involve volunteers, besides nurses and doctors. Therefore it is important to make sure all care providers and volunteers know how to deal in such situations and are aware of each other's task and competencies.

Not to discuss during this session:

- Treatment of different conditions

Topics to discuss:

Screening tools for a rapid needs assessment and identification of refugees with communicable diseases

Appropriate training material and tools in assessing refugees' needs for acute illness

Specific questions:

- What instruments for rapid assessment or urgent health needs (triage) are available for primary care providers?
- What short list of red flags / recommendation to check what physical signs indicating acute illness can we provide? (Already available?)
- What kind of PHC worker should be responsible for each task? (e.g. triage, coordination, information)
- Which PHC worker should be supervising the process of triage and dealing with health related emergencies?

Group 2. Infectious diseases

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Preparation literature:

ECDC: Infectious diseases of specific relevance to newly-arrived migrants in the EU/EEA

Introductory remarks:

Infectious diseases can cause great health risks to individuals, as well as bigger populations. However, it is important to realise that the current influx of migrants does not represent a greater risk for EU/EEA populations. There is existing evidence concerning the incidence and prevalence of important infectious diseases (e.g. HIV, TB) in origin countries of migrants (ECDC, 2015). Furthermore we know that migrants can be more vulnerable to infectious diseases for instance because of poor and overcrowded living conditions and less access to healthcare. Here we would like to discuss how to handle prevention of infectious diseases and how we need to deal with infectious diseases that we cannot treat in Hotspot settings.

Not to discuss during this session:

- Specific infectious diseases among the migrant population
- Public health activities related to prevention and screening of infectious diseases
- vaccinations (different discussion group)

Topics to discuss:

Rapid test in monitoring infectious diseases
Practical guidelines to manage common infectious diseases among refugees
Disease outbreak plans
Communicable diseases surveillance
Training material and methods for infectious diseases

Specific questions:

- Do we want to test asymptomatic patients in primary care for infectious diseases like hepatitis B/C if we cannot treat them in the current setting?
- How to prevent most common infectious diseases (gastroenteritis, respiratory infections)?
- What are practical recommendations/solutions in case of such outbreaks?
- What rapid test could be utilized in monitoring common infectious diseases among affected refugees?
- What practical guidelines for the management of infectious diseases among refugees could be utilized?

Group 3. Vaccination

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Preparation literature: WHO-UNHCR-UNICEF joint technical guidance: general principles of vaccination of refugees, asylum-seekers and migrants in the WHO European Region

Introductory remarks:

The big influx of migrants poses challenges in deciding when and where to vaccinate. Mainly because the current vaccinations status of migrants is often unclear and continuity of the follow-up scheme is difficult to ensure. The WHO states the following: "Refugees, asylum-seekers and migrants should be vaccinated without unnecessary delay according to the immunization schedule of the country in which they intend to stay for more than a week. Measles, mumps and rubella (MMR) and polio vaccines should be priorities. Governments should consider providing documentation of the vaccinations given to each vaccinee or child's caregiver to help avoid unnecessary revaccination" (1).

They also state that vaccination is not recommended at border crossings, unless there is an outbreak of a vaccine-preventable disease in the host or transit countries. The WHO developed a framework for decision-making whether to vaccinate in these emergency situations (2). However, this document serves as a framework for policy makers, rather than community primary care health care workers. Therefore we would like to discuss recommendations for primary health care workers in dealing with vaccinations.

1. WHO-UNHCR-UNICEF joint technical guidance: general principles of vaccination of refugees, asylum-seekers and migrants in the WHO European Region, 2015

2. SAGE Working Group on Vaccination in Humanitarian Emergencies. Vaccination in Acute Humanitarian Emergencies: a Framework for Decision-Making, 2012

Not to discuss during this session:

- The field of Public Health (stay focused on the role of Primary Care)
- The differences between national vaccination programs

Topics to discuss:

Minimum dataset for the refugees vaccination registration

Practical guidelines in assessing and administrating vaccination among refugees

Practical guidelines in administrating and monitoring vaccination uptake

Specific questions:

- What to do if refugees can only give an oral declaration of vaccinations and has no written document?
- What information do *primary care workers* need about vaccination:
    a. In general?
    b. How to deal with refugees that are inadequately vaccinated
    c. What to do if refugees appear not to be vaccinated
- What vaccinations should primary care workers consider in what groups (e.g. in case of measles outbreak)

Group 4: Chronic and non-communicable diseases

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Introductory remarks:

Chronic diseases in migrants are often the same as those in host and transit countries, with sometimes a difference in specific features such as age and presentation of symptoms. Chronic diseases in long-term facilities will mostly be dealt with according to the treatment standards of the host country. However, in hotspot settings with migrants being less visible and staying for a shorter amount of time it is important to decide on which chronic diseases deserve immediate attention and which conditions are in no need of direct treatment or follow-up.

Not to discuss during this session:

- The differences in chronic and non-communicable disease between migrant populations and those of the host countries.
- Organisation of care concerning chronic diseases in long-term facilities.
- continuity of care (different discussion group)

Topics to discuss:

Assessment and management of chronic non communicable diseases in hotspots and first reception centres

Training methods of primary care team to monitor and manage chronic diseases of refugees

Interprofessional collaboration and team work in chronic diseases management

Specific questions:

- Which chronic diseases need to be identified at the hotspots and how?
- What is the minimal assessment of the identified chronic diseases?
- What is the essential care to be provided for the identified chronic diseases?
- Recommendations for an effective team working in the management of chronic diseases?

Group 5: Mental health

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Not to discuss during this session:

- Specialist care and treatment for mental health problems (focus on Primary Health Care)

Topics to discuss:
Integrated mental health into primary health care services
Tools in terms of assessing the refugees mental health needs
Training material and methods for health personnel
Suicidal assessment

Specific questions:

- Which PHC worker does what?
- What psychological care including psychosocial interventions should be offered in hotspot setting?
- How can PHC workers built a trustful relationship in hotspot settings?
- What tools for risk assessment and suicidal ideation could be utilized?

Group 6: Reproductive health, mother and childcare

The aim of the discussion groups is to form practical recommendations on guidance, training and implementation based upon current literature and evidence about approaches, tools and instruments.

Introductory remarks:

Pregnant women are a vulnerable group within the refugee setting with poor conditions and less access to healthcare. Furthermore both women and children are more susceptible to violence and exploitation. As primary health care workers it is important that we have knowledge on how to deal with these issues.

Not to discuss during this session:

- Prevention of physical violence
- Unaccompanied children
- Overarching cultural gender differences (discussed on day 1)

Topics to discuss:

Strengthening access to comprehensive reproductive health
Assessment and management of sexual and gender-based violence
Rapid tools in assessing developmental and mental health disorders among refugees children
Rapid tools in assessing health needs of women during pregnancy and post natal period
Rapid psychological intervention for affected by violence on woman and children

Specific questions:

- Do we want to pro-actively identify all pregnant women in the hot spots? If not; which pregnant women do need to be identified?
- What is the minimal assessment and care to be provided for pregnant women at the hot spots?
- What information should be provided on contraceptives?

- How can we track down (sexual) violence in hotspot settings?
- How do we act when there is or has been (sexual) violence?
- What tools could be utilized in assessing developmental and mental health care disorders in refugees' children?
- What rapid psychosocial intervention could be utilized in alleviating trauma and violence affected the refugees' family?
- How can we differ delayed development in children from *normal* effects of being a refugee?