EUropean Refugees - HUman Movement and Advisory Network

Work package 6, Task 6.8-6.13

Deliverable 6.2

Summary report on the interventions that were implemented by the different implementation site countries

Version 2016/12/28

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Co-funded by the Health Programme of the European Union

Funding

"This EUR-HUMAN summary report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020)".

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Executive summary

The outcome of the EUR-HUMAN project is a portfolio of comprehensive checklists, guidelines, guidances, tools and training materials. The piloting of some of these instruments showed that they are well applicable and deliver good results in strengthening the capacity of PHC providers. The need for piloting these instruments was appraised by using the ATOMiC developed in WP3.

Piloting the **online course** in Greece, Italy, Croatia, Slovenia, Hungary, and Austria, which are countries with different preconditions concerning the PHC for refugees and other migrants, has shown that, with the prescribed adaptations, the course was functional and suitable to all different settings. The courses potential for adaption and usefulness in different setting has thus been demonstrated. There are different preconditions and diverse challenges in each of the countries that host refugees and other migrants. Nevertheless, all of the different topics tackled in the different modules are of interest to the PHC providers in all of these countries; only the prioritisation of the topics in each setting is different.

The format of the course makes it possible to train a large number of PHC providers in a comparable short time. The format also makes it possible to easily, and quickly update the content, a fact that is especially important in regard to the comparably fast changing situation and the changing regulations concerning refugees and the health care for refugees. In the development, the preparation, adaptation, and testing of the online course it became apparent that resources are needed to ensure a full versability of the online course, as adequate time and resources are needed to maintain, update and further develop the online course.

The online course is an enabling instrument that makes available guidelines and knowledge to PHC providers and helps them to overcome barriers in the provision of high quality, person centered, integrated, holistic health-care for refugees; it has the potential for building the capacity of PHC providers. A larger roll out of the online course is thus recommended, because it is a convenient, flexible instrument that promotes skills, knowledge, and life-long learning. It is an effective tool for awareness-raising among PHC providers on the manifold issues of the refugees and other migrants, and for sensitizing the PHC providers to culturally sensitive health care.

It addresses the health care related needs of PHC providers and refugees that have been highlighted in the data collection phase of the EUR-HUMAN project (see: D2.1; D3.1; D3.2; D4.1; D4.2; D5.1; D5.2; D6.1). Based on the results of the piloting, it can be said that the course is a valuable

instrument, which could be well applicable in the other countries where the course is going to be rolled out in the future.

It is also supported by the pilot implementation of all these learned in the training course that carried-out in the Kara Tepe hosting centre of refugees and other migrants (Lesvos island, Greece). During this pilot intervention, the developed tools were tested, the questionnaires and the proposed procedures and approaches in order to enhance capacity building of the European countries have been utilised. In total 30 refugees and migrants (3 men, 15 women and 12 children) participated. The content of the on-line course was applied always according the person needs and health problems.

The need for capacity building in the area of **mental health** was a conclusive finding throughout the EUR-HUMAN project and its previous workpackages (WP2 – 6). The need for piloting the screening and referral procedure as well as the face-to-face training about mental health for refugees and other migrants was appraised using ATOMiC developed in WP3 (D3.1,2).

The piloting of the screening (RHS-13) and referral procedure was based on using a validated tool and principles derived from scientific reserach and practice (described in D5.1) were applied. The Croatian piloting proved the intervention and underlying training to be acceptable, easily understood, culturally appropriate, time efficient and furthermore supports resilience of refugees and other migrants. The RHS-13 instrument as well as the piloted procedure was extremely suitable for mental health screening and referral. The impementation facilitated patient-centredness, compassion, culture-sensitivity and non-stigmatization. It is strongly recommended that a systematic mental health screening and referral procedure is integrated into healh check-ups/ initial health assessments for all newly arriving refugees and migrants.

The piloting of the face-to-face training about mental health and refugees and other migrants was based on powerpoint-presentations and a detailed step-by-step guidebook developed by the FFZG team. The Croatian piloting showed that the implementation of the intervention and underlying training had a high level of applicability, feasibility and usability. The roll out of the mental health training in face-to-face modality is highly recommended in all refugee-hosting countries to strengthen capacity building of PHC providers and paraprofessional and volunteer staff. The training is available in Croatian and English, with very small adaption to other local contexts it can be implemented in any other European country.

For a larger roll out of either one of the aforementioned instruments over the next years, further funding is required, in order to continue to insure sustainable and effective improvements in the primary health care for refugees.

Content

Introduction

In 2015, the number of migrants and especially of refugees from the Middle East and Sub-Saharan countries entering Europe considerably increased. The refugees arrived mainly at the Greek islands and the Italian shores, and were travelling from there through Western Balkan route towards their destination countries in Northern-Europe. This strong migration flow led to the introduction of the term „international refugee crisis"(Khan et al. 2016).

The population on the move and – after arrival – the new population in the destination countries is in need of health care. The large number of people led to various challenges for primary health care (PHC) providers. In face of these challenges it is essential to strengthen PHC providers and to enable them to provide adequate health care to refugees and other migrants.

The EUR-HUMAN project, running from January to December 2016, aims to identify, design, assess and implement measures and interventions to improve primary health care delivery for refugees and other migrants with a focus on vulnerable groups. The 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 that of the local population. Related to this, the aim of WP 6, task 6.1 was to assess the local situation and resources available to be able start from the local needs when developing trainings and interventions to improve the situation.

Deliverable 6.2 ***"Summary report on the interventions that were implemented by the different implementation site countries"*** is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WPs) and in particular WP 4 (deliverable (D) 4.2), WP 5 (D 5.1 & 5.2) and WP 6 (tasks 6.2 – 6.13) of the EUR-HUMAN project. All the aforementioned is based on the results of the Participatory Learning and Action approach with refugees (WP2 with deliverable 2.1 – participating countries: the Netherlands (lead by Radboud University Medical centre (RUMC)), Croatia (Faculty of Humanities and Social Sciences, Zagreb (FFZG)), Greece (University of Crete (UoC)), Hungary (University of Debrecen (UOD)), Italy (Local Health Authority Toscana Centro (AUSLTC)), Slovenia (University of Lubljana (UL)), and Austria (Medical University of Vienna, (MUW)), the literature review and survey (WP3 with deliverable 3.1 – lead by Netherlands Institute for Health Services Research (NIVEL)) with health care providers and

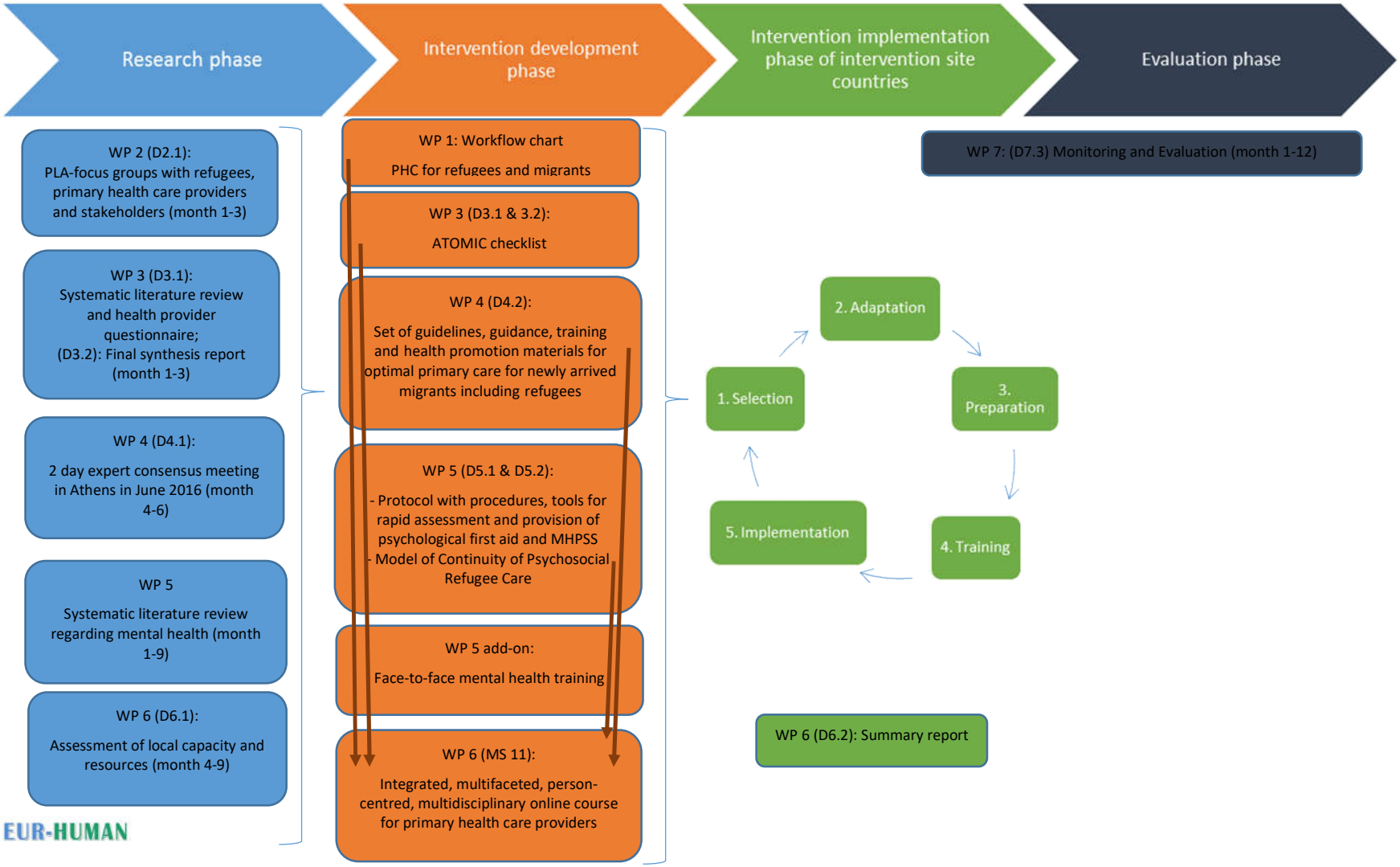
stakeholders, the consensus expert meeting held in Athens on 8th and 9th of June 2016 (WP4 with deliverable 4.1 – lead by RUMC jointly together with UoC and Univeristy of Liverpool (UoL)), the mental health assessment and intervention (WP5 with deliverable 5.1 – lead by FFZG), the model of integrated care (WP5 with deliverable 5.2 – lead by FFZG), and the local capacities and needs of the primary health care providers [WP6.1 with deliverable 6.1 – participating countries: Croatia, Greece, Hungary, Italy, Slovenia and Austria (lead by the Medical University of Vienna, MUW).

Picture 1 on page 10 shows the detailed workflow process of the project.

The team of the(MUW is responsible for the summary report with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSLTC), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the selection, adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

The summary report 6.2 aims to provide a summary about the implementation phase of the project. The evaluation report is provided in WP7 and in particular to the Deliverable 7.3.

Picture 1: Work process of the EUR-HUMAN project



Tasks 6.8 – 6.13

Intervention site countries have selected, prepared and implemented at least one intervention emerged from WP 3, WP4, WP5 or WP6 in a well-defined setting for refugees and other migrants.

Specific objective for task 6.8 – 6.13

To enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WP 4, WP5 and WP6 of the EUR-HUMAN project. All the aforementioned is based on the results of D2.1 (WP2), D3.1 & 3.2 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.

Picture 2: Work cycle for the intervention site partners of the implementation phase

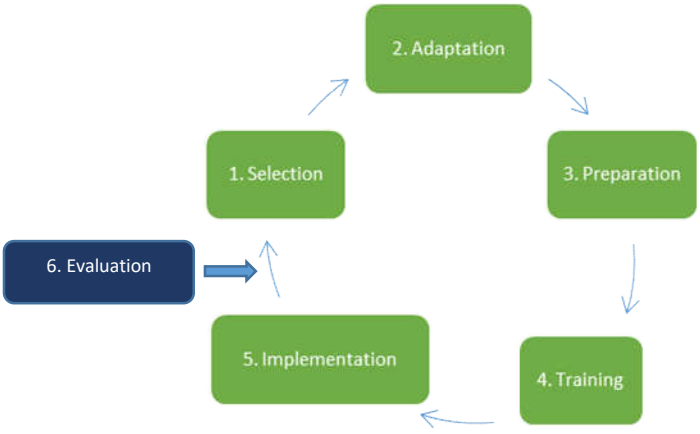


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
Until 31. Aug 2016	- WP1: Workflow: Primary Health Care (PHC) for refugees and other migrants - D 3.1: The ATOMiC Model checklist has been developed - D4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - based on the expert meeting that described the optimal PHC for refugees - D5.1 & D5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - MS11: English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed which content is based on the results of WPs 2-6 and includes also the checklists, guidelines and interventions described in D3.1, 3.2, 4.2 & 5.1 - Add-on face-to-face mental health seminar has been developed by FFZG based on D5.1 & 5.2 Intervention site partners select one or more intervention(s) described above which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and needs-based (support for the selection provides the ATOMiC checklist)	Selection

01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 1. Country-specific context adaptations (such as country specific legal system, health care system, epidemiology, links to helpful organizations and information etc.) 2. Target-group specific context adaptations 3. High quality translation (and editing) A translation and adaptation guideline for the inline course was provided by MUW to the intervention site countries	Adaptation
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to HeF)	Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)	Preparation
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events • E-groups • Round tables	Preparation
15. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s)	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts • Copoperation of local organisations of experts	Preparation
15. Sep. – 22. Nov. 2016	Online-courses: • Email-reminders for the participants	Training

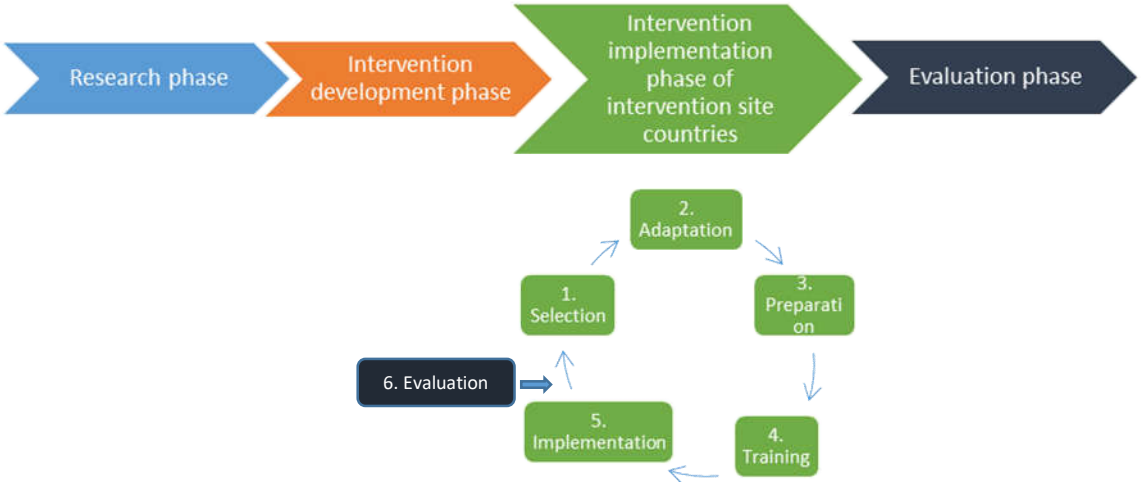
	• Pre- and post-tests • Certificates Other training(s) • Regional and local one day train the trainers meetings Evaluation of the intervention and underlying training with questionnaire provided by EFPC and UoL	
November 2016	Participants apply the new learned content into their specific working setting and reflect about it (which was assessed in the general intervention evaluation by EFPC and UoL)	Implementation
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D6.2
01. Nov – 30. Nov 2016	Writing the national report about the intervention(s) and sending them to MUW	D6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2	D6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2	D6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D6.2

Methods

This summary report is a description of the country-specific implementation process in accordance with the five steps of the work cycle. Data for this report was provided by the six intervention site countries partners of the EUR-HUMAN project, namely UoC, AUSLTC, UL, FFZG, UoD and MUW. The country-specific data were collected and described in the national reports for deliverable 6.2 by the respective responsible persons. The six national reports can be found as annex 6 - 11 to this report. For the national reports all six countries used the same template, which was developed and sent out to the partners by MUW after inclusion of the feedback of all EUR-HUMAN partners. The template for the national reports can be found as annex 5.

Since the results of the data collection phase are described in detail already in the deliverables 2.1, 3.1, 3.2, 4.1, 5.1, 5.2 and 6.1 the first part of the result section of this report deals with the intervention development phase, particular with the development of the online course.

The second part of the result section describes the implementation phase of the different interventions and underlying trainings that implemented in the six implementation site countries in accordance with the five-step work cycle.



Results

Part I: Intervention development phase

Based on the results of the data collection phase a portfolio of checklists, guidelines, guidance, tools and training materials for the interventions and underlying trainings was developed which are shown in table 2.

Table 2: Portfolio of checklists, guidelines, guidance, tools and training materials of EUR-HUMAN interventions and underlying trainings

Portfolio	Workpackage	Described in detail
Workflow chart: Primary Health Care (PHC) for refugees and other migrants	WP1	Dev. 2.1, 4.2
ATOMiC model checklist	WP3	Dev. 3.1 & 3.2, 4.2
Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees	WP4	Dev. 4.2
Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS	WP5	Dev 5.1
Model of Continuity of Psychosocial Refugee Care	WP5	Dev. 5.2
EUR-HUMAN Face-to-face training about mental health of refugees and other migrants	WP5 add-on	Report: Piloting mental health screening procedure
Integrated, multifaceted, person-centred, multidisciplinary online course for primary health care providers	WP6	Dev. 6.2

EUR-HUMAN Online course

In the framework of WP6 (tasks 6.2-6.7), MUW developed a comprehensive English template of a multifaceted, integrated, person-centred, multidisciplinary online course for primary health care providers. Since the online course was the basis for the main interventions in 6 different countries, this report D6.2 includes a detailed description of the development of this online course.

Online course development

According to the grant agreement the online course aims to…

- …support the knowledge and capacity building of an average, stressed primary health care provider who is responsible for the health care of refugees and other migrants as well as for the initial health assessment.
- …support the capacity building through the enhancement of the specific local health knowledge of refugees and other migrants who were PHC providers in their home countries.

In WP 6 tasks 6.2 – 6.7, an English template for a multifaceted, integrated, person-centred, multidisciplinary online course was developed by the team of the MUW for the target group of primary health care providers who are responsible for the health care of refugees and other migrants in the asylum procedure as well as for the initial health assessment.

The course was developed based on the results of the data collection phase:

- WP2 (D2.1 – PLA groups with refugees and other migrants),
- WP3 (D3.1 & 3.2 – systematic literature review and questionnaire survey with stakeholders),
- WP4 (D4.1 – expert consensus meeting),
- WP5 (D5.1 & 5.2 – literature review regarding psychological first aid and MHPSS & Continuity of Psychosocial Refugee Care) and
- WP6 (D6.1 – assessment of local situation and resources available via semi-structured interviews with primary care providers and stakeholders, narrative literature review and participant observations).

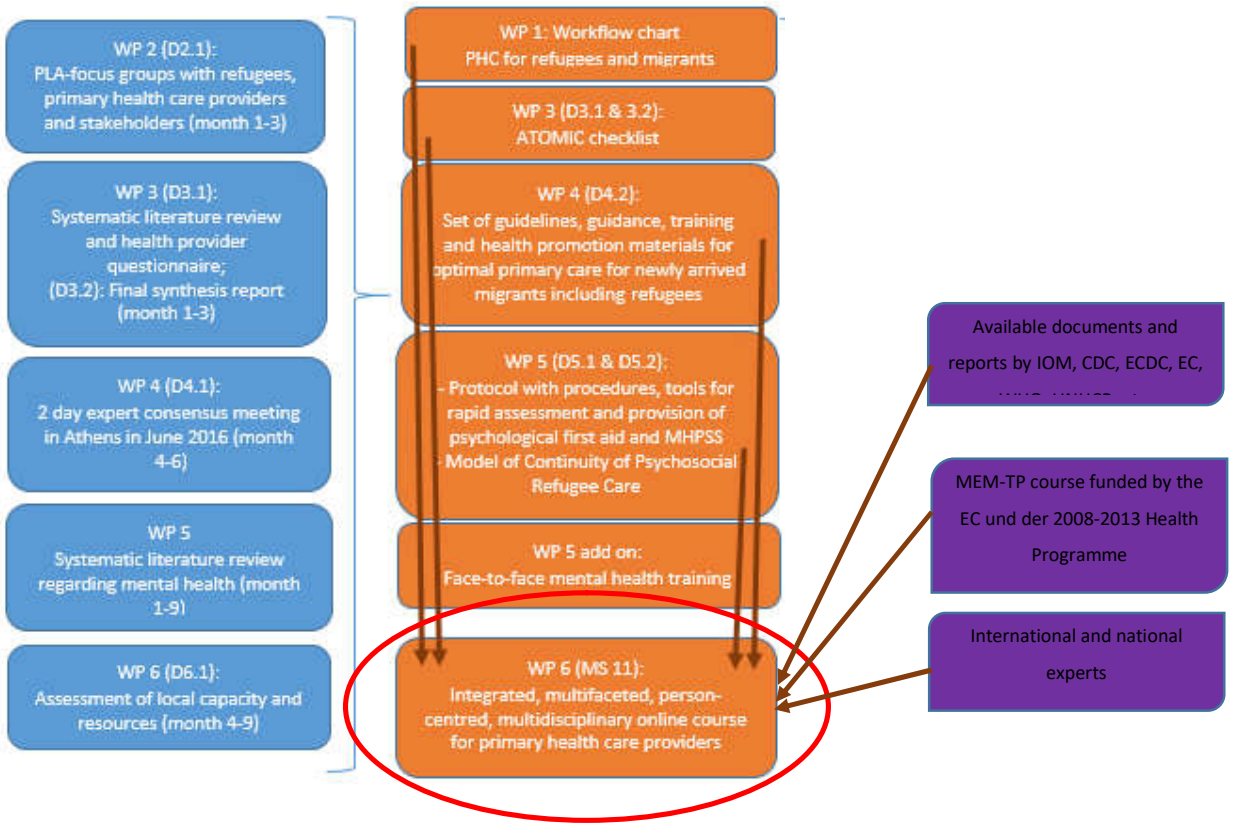
The course also, includes the checklists, guidelines, tools, training material and interventions described in table 2 which are based on the data collection phase results:

- WP1 (Workflow chart: Primary Health Care (PHC) for refugees and other migrants)
- Dev 3.1 & 3.2 (ATOMiC checklist)
- Dev 4.2 (Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees)
- Dev 5.1 (Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS) of the EUR-HUMAN project.
- MEM-TP course funded by the European Commission´s Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) under the 2008-2013 Health Programme
- Already existing documents and links from IOM, CDC, ECDC, EC, WHO, UNHCR etc.

Experts in particular fields supported the development of the course and created corresponding content.

Picture 3 shows an overview of the influences on the content of the online course.

Picture 3: Overview of the influences on the content of the online course



The advantages of an online course are that it is timely and locally flexible and provides the possibility to adapt the course locally and target-group specifically as well as it is possible to include already existing materials, videos and contact points of other local, national and international supporting organizations. Above all, it has the advantage that persons from all over the country are able to participate.

Due to feasibility reasons the aim was to develop a training which takes around 10h learning time and can be easily managed within 4 weeks. This was anticipated in order to avoid overhelming the target group which are PHC providers who often already have a high workload to manage.

Online course content

Due to the aforementioned the online course consists of eight modules, each with several chapters and pre- as well as post-module-questions for each module.

Table 3 provides an overview of the modules of the English EUR-HUMAN online course template.

Table 3: Overview of the modules of the English EUR-HUMAN online course template

Module 1. About the course
M1. Chapter 1. Welcome to the course
M1. Chapter 2. Background to the course
M1. Chapter 3. Educational objectives of the course
M1. Chapter 4. Overview of the course structure
M1. Chapter 5. Primary Health Care for refugees and other migrants (EUR-HUMAN workflow chart)
M1. Chapter 6. Introduction of the ATOMiC model checklist and further information
Module 2. Health monitoring, acute and infectious diseases and vaccination

M2. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M2. Chapter 2. Monitoring of the health status and initial health assessment
M2. Chapter 3. Red-flags and flight-specific health needs
M2. Chapter 4. Infectious diseases
M2. Chapter 5. Vaccination
Module 3. Legal aspects regarding PHC for refugees and other migrants
M3. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M3. Chapter 2. Legal basis for treatment
M3. Chapter 3. Appropriate medical treatment obligation
M3. Chapter 4. Information talk
M3. Chapter 5. Consent
M3. Chapter 6. Duty of confidentiality/secrecy and obligation to report
M3. Chapter 7. Social benefits for refugees
M3. Chapter 8. Insurance for doctors when working voluntarily for refugees (liability, accident and health insurance)
M3. Chapter 9. Special questions in connection with asylum seekers/foreign citizens
Module 4. Provider – patient interaction (communication and the relevance of culture in medical practice)
M4. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M4. Chapter 2. General communication strategies
M4. Chapter 3. Specific communication strategies
M4. Chapter 4. Non-verbal communication
M4. Chapter 5. Information about interpreting
M4. Chapter 6. The role of culture in health care
M4. Chapter 7. Stereotyping
M4. Chapter 8. Structural conditions
M4. Chapter 9. Idioms of distress (with examples from Syria and Afghanistan)

M4. Chapter 10. Perception of mental health issues
M4. Chapter 11. Explanatory models of disease
M4. Chapter 12. Self-medication and medical pluralism
M4. Chapter 13. What to ask during the consultation
M4. Chapter 14. Terminal illness, death and dying
M4. Chapter 15. Pain perception and pain management
Module 5. Mental health and psychological support
M5. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M5. Chapter 2. Mental health issues of refugees
M5. Chapter 3. Promoting recovery
M5. Chapter 4. Mental distress in professionals
M5. Chapter 5. Trauma and stress reaction
M5. Chapter 6. Phases of migration
M5. Chapter 7. Recommended behavioural advice in dealing with reactions to traumatic experiences
M5. Chapter 8. Emergency psychological measures
Module 6. Sexual and reproductive health
M6. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M6. Chapter 2. Background information
M6. Chapter 3. Sexual and reproductive health of women refugees and asylum seekers under particularly difficult living conditions
M6. Chapter 4. Peri- und postnatal phase
M6. Chapter 5. Mother and child bond - possible problems caused by trauma, flight and exhaustion
M6. Chapter 6. Special issue Female Genital Mutilation
M6. Chapter 7. Menstruation
M6. Chapter 8. Contraception
M6. Chapter 9. Abortion

M6. Chapter 10. Sexually transmitted diseases
M6. Chapter 11. Sexual and gender based violence
M6. Chapter 12. Gender and human rights
Module 7. Child health
M7. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M7. Chapter 2. Infectious diseases
M7. Chapter 3. Vaccination
M7. Chapter 4. General information about immunization
M7. Chapter 5. Prevention
M7. Chapter 6. Refugee children in the practitioners office
M7. Chapter 7. Nutrition
M7. Chapter 8. Child health
M7. Chapter 9. Psychological health
Module 8. Chronic diseases, health promotion and prevention
M8. Chapter 1. About this module (authors, funding, disclaimer, introduction)
M8. Chapter 2. Health care for refugees and other migrants (organisation of and orientation within the health care system of the destination country)
M8. Chapter 3. Chronic conditions
M8. Chapter 4. Preventive medical check-ups
M8. Chapter 5. Dental health
M8. Chapter 6. Toilet facilities
M8. Chapter 7. Nutrition and fluid intake
M8. Chapter 8. Physical exercise
M8. Chapter 9. Womens´ health
M8. Chapter 10. Link collection for psycho-social support for refugees in the destination country (orientation, information offices for refugees, family matters, children and adolescents´ matters, mental health support, …)

Online course adaptation and translation

The English template of the online course served as basis for the country- and target group-specific adaptation and translation:

- The content had to be adapted for the particular country's situation, legal system, health care system, epidemiology, as well as links to helpful organizations and information in that particular country had to be added.
- Target-group specific context adaptations (physicians, nurses, midwifes, health visitors, PHC teams etc.)
- High quality translation (and editing)

MUW sent out an adaptation and translation guideline to the partners together with the English template: All parts of the template that needed a country-specific adaptation were marked in yellow; all parts that needed a target-group-specific adaptation were marked in purple.

In addition, all partners were free to add content that is important or delete specific content that was irrelevent for the country-specific setting and the respective needs of the target-group.

Online course communication strategy of MUW (WP leader) with partners

- First information of the partners about WP6, tasks 6.2 – 6.13 (annex 1 – Implementation protocol WP 6) was sent out on April 4th 2016.
- Development of an overview of the modules of the course.
- Meeting in Utrecht to harmonize D3.1, 3.2, 4.2, and the content of the online course: May 9th 2016.
- Draft document "Overview of the intervention phase of WP6 tasks 6.8 – 6.13" sent out to partners for feedback on May 18th 2016.
- Second information of partners about the implementation phase of WP6: June 27th 2016 (annex 2 – Overview intervention phase of WP6).
- English template was developed and sent out to partners for feedback on July 14th 2016.

- The English template was finalized and the final modules were sent out and uploaded on the shared dropbox folder on July 28th and from then onwards available to all intervention site countries. A basic adaption guidance was included in the email on July 28th 2016 (indication of different colours).
- A detailed adaption and translation guidance was sent out to all intervention site countries on August 2nd (annex 4 – Adaption and translation guideline).
- A reminder to use the adaption and translation guidance was sent out on August 12th and furthermore pre- and post-test questions for module 2, 5, and 8 were distributed among the partners on that date.
- The exported document of the entire English course content was provided to the MUW team by e-Health Foundation (HeF) and consecutively sent out to all intervention site countries on September 2nd including additional guidance from HeF on how to use the exported document in order to efficiently proceed with the programming of the online course. Both documents were also uploaded to the shared dropbox folder.
- Revised and final pre- and post-test questions for modules 2, 4, 5, 6, 7, 8 were sent out on September 6th (for module 3 every country had to develop their own questions) and uploaded to the shared dropbox folder.
- MUW sent out an inquiry about the adaptation and translation progress of the intervention site countries on September 9th asking how far the partners were with their adaptation and translation process in order to prepare for the SC meeting dated September 12th 2016 12:00 Greek time.
- In the period between August 2nd and November 29th the communication between MUW team and intervention site countries was intense, special assistance and support was provided to responsible persons from intervention site country team members, this process was carried out in close collaboration with HeF. The MUW team also facilitated communication directly between HeF and intervention site countries.
- A final reminder to use the exported document (instead of the individual modules) and the adaption and translation guidance for the final
- Sending out the template for the implementation protocol of interventions and underlying trainings to partners on June 15th to be responded to until June 24th 2016. The MUW team sent out the first overview of the whole implementation

phase of WP 6 with a description, tasks and responsible EUR-HUMAN partners on June 27th. The MUW team sent out a first reminder on September 12th and a second reminder to update the implementation protocol regarding the timeline of the intervention on September 27th (annex 3 – Template implementation protocol of interventions).

- Sending out the Austrian example of the implementation protocol to support the partners (including how in Austria the CME procedure for the online course took place and kick-off events were held): 12th September.
- Including two more adaptations in the English template of the course asked by UoC and NIVEL in October. Communication of the changes to HeF and the partners. Inclusion of the ATOMiC model on September 9th, additionally inclusion of a chapter on chronic disease sent by UoC team on October 29th.
- Sending out the template for the national report for deliverable 6.2 on October 25th 2016 (annex 5 – template for the national report for D6.2).
- Sending out several reminders regarding the national reports and and the Austrian national report as an example on November 25th 2016.

Part II: Intervention implementation phase

In the following, each one of the interventions carried out in the framework of WP 6 is described in detail. For each intervention, the rationales for the selection and the adaptation (if at all necessary for the chosen intervention) are illustrated. Equally, the respective procedures for the preparations, trainings, and the implementation are outlined.

The content of the following chapters summarizes the national reports (annexes 6 -11). The national reports are not quoted separately.

Online course

The team at MUW developed an online course for primary health care providers involved in refugee health care. The course for primary health care professionals was piloted in 6 countries: **Greece, Italy, Croatia, Slovenia, Hungary** and **Austria** (2 versions). It was available on the online platform e-Health Foundation. The login code and password were provided to participants through online registration; the procedure is user-friendly and self-explanatory. After registration, an individually created username and password was sent to the participant with whom he/she could log in and start the course. The course format allows the target groups (physicians/general practitioners (GPs)/primary health care providers) to work on any device in their chosen location. The participants could follow their individual time management; they are able to switch back and forth between modules and chapters.

1. Selection

In each implementation country, multiple reasons lead to the selection of the course as underlying training for an intervention[1]: The **Austrian** partner selected the course because it uniquely fits to the Austrian situation where GPs are the main primary health care providers. The refugees stay in various accommodations across the country. Asylum seekers are covered by the conventional (public) health insurance and there is no special provision of health care for refugees. GPs and other primary health care providers provide care for refugees in their individual offices, which they run as sole proprietors. The target group in

[1] This chapter contains an overview on the selection step concerning the online course. For a detailled description of the selection step please see the respective national reports attached in the Annex.

Austria is spread across the country. Therefore, the online format of the course was the most sensible option to build the capacity of a large number of persons in all parts of the country. Furthermore, among the refugees in Austria there are numerous trained health providers; they face a long transition period before they are able to practice their profession in the destination country. The inclusion of primary health care providers into the primary health care workforce of specific countries is of major importance as the can serve as cultural experts and integration facilitators for other refugees. In the future, these trained health care providers will be important for the integration of refugee communities in the destination countries. An adapted version of online course was the best option to build the capacity of a large number of persons in the target group in all parts of the country.

In **Croatia** there is a similar initial situation: a large number of general practitioners deliver primary health care services. General practitioners and other PHC providers take care of refugees in the transit centre of Slavonski Brod and in medical health centres across Croatia. Due to the fact that Croatia is not a preferred destination country, overall, PHC providers do not have much experience in providing services to migrants. In anticipation of the Croatian government's plans to relocate refugees and migrants to different parts of Croatia where there is no experience with migrants the online course is a highly efficient mode of capacity building that can be taken by a large number of PHC providers across the country.

Similarly to Austria, in **Italy**, the National Health Service is responsible for the asylum seekers in the same manners as for all other Italian inhabitants. Just after their arrival at the hotspots in the South of Italy, refugees and asylum seekers are scattered among the Italian Regions. GPs are all potentially involved in the medical care for asylum seekers, since (after a first health screening at the hotspots) refugees and asylum seekers are enrolled in the National Health Service. Therefore, the intervention in Italy targeted primary health care providers (GPs, nurses and midwives) across the country.

Greece is the country with currently the highest influx of refugees and migrants. The National Health Care system as well as various NGOs (at hotspots and hosting centers) are responsible for the health status of this population. Most refugees and migrants stay in camps in several areas in Greece. Therefore, the intervention targeted PHC providers on the island of Lesvos (which receives the majority of refugees and other migrants) and on the mainland. The online course was chosen to enhance the knowledge and to build the capacity of the primary health care providers caring for the refugees and migrants in those centers.

The PHC personnel that was trained and participated at the phase of testing the tools, questionnaires and procedures partially used the "Appraisal Tool for Optimizing Migrant Health Care" (ATOMiC) to take this decision[2].

In **Hungary**, all official "camps," as well as the immigration office headquarter in Budapest, were targeted. The online course was selected because it appeared to be the most adequate to build capacity of primary health care providers in Hungary. Official invitation was send to the Health Care Branch of the Hungarian Army who is responsible for health care provision in temporary camps.

In March 2016, the migratory flow through the "Western Balkan Route" was halted and **Slovenia** received few refugees and/ or other migrants. The Slovenian police report that currently only 379 refugees and migrants are temporarily or permanently accommodated in 5 different asylum centers (Lubljana, Postojna, Logatec, and Vrhnika). Refugees and migrants are receiving health care in the registration centers as well as in the asylum homes and centres for foreigners. Based on international guidelines and legislation they have the right to: emergency medical services and emergency ambulance services; treatment of febrile conditions to prevent the spread of infection, which could lead epidemics; treatment and prevention of poisoning; medical care during pregnancy and childbirth and women's health care; care for vulnerable persons with special needs. Those activities are defined in international legislation. As the recognized need for capacity building for the provision of health care was the starting point of the EUR-HUMAN project, the consortium members defined that one of the main objectives was to identify, create and evaluate guidelines, training programs and other resources that can be made available for various stakeholders. The online course was considered the best option for this purpose.

2. Adaptation

The project partners in **Austria**, **Slovenia, Greece, Hungary and Croatia** chose to translate and adapt all 8 modules of the online course to the national context[3]. The partners in **Italy** translated and adapted 7 of the 8 modules. In all cases, module 3 on legal issues had to be

[2] At the end of the national report for Greece, there is a detailed example on how the ATOMiC was used in the context of vaccination. Most of the refugees and migrants in Greece reported that they have been immunized in their country of origin. However, they neither remember which vaccines they have received, nor do they have any documentation on vaccination.

[3] This chapter contains an overview on the adaptation step concerning the online course. For a detailled description of the adaption step please see the respective national reports attached in the Annex.

replaced entirely as the legal situation is different in each country. After the translation and adaption, the project partners at e-Health Foundation integrated the different course versions on their online platform.

In **Austria**, two versions of the online course have been prepared as two different interventions. Whereas versions 1 and 2 were straightforward translations into German and adaptions of the English template, version 3 is an abbreviated version. Version 1 of the course (for **Austrian** PHC providers) served as the starting material for the second intervention and underlying training for refugees and other migrants who were PHC providers in their home countries (versions 2 and 3). The online course version 2 was especially adapted for the second target group and complemented with several additional chapters in modules 3 and 8. An abbreviated version of version 2 was also translated into Arabic by a professional translation agency (Interlingua); this is referred to as the version 3 of the online course (which constitutes a component of the second intervention and underlying training). The following modules were prioritized and translated into Arabic in an abbreviated version: module 1, module 2, module 4.2, module 5.1, module 6, and module 8. Module 3 on legal issues is available in a full Arabic translation. The modules 4.1, 5.2 and 7 were deemed to be less relevant for the specific target group and are only available in the German version 2.

In **Croatia**, where the entire course template was used, some content (in module 2 and 4) that deemed irrelevant to the Croatian content were omitted while in some modules content was added.

The course in **Italy** consists of 7 modules that take into account the specific Italian situation. Modules 1, 3, 4, 5, 6, 7, and 8 where translated into Italian and adapted to the Italian context. Especially Module 3 (legal issues) and Module 8 (health promotion and prevention) have been significantly changed.

The project partners in **Greece** translated all modules of the course and made considerable amendments for instance to Module 2 concerning the initial health assessment of the refugees and migrants reaching Greece, communicable diseases, and vaccination programs. The module was also supplemented with information concerning problems that became apparent during the PLA sessions in Greece for WP2. Additionally, the online training

material served as basic material for video training material in Greek, and was made available via a EUR-HUMAN YouTube channel (see description below).

The **Hungarian** version of the online course is based mainly on the original template provided by the MUW team. The course template in English was translated into Hungarian and the content of the eight modules was adapted to the local context. Experiences of voluntary health care providers, who acted during the pike of the migrant "inflow crisis" in 2015, were taken into account. There were only minimal changes in modules 1, 4, 5, but more changes in the other modules, to ensure relevance for the national context. Additionally, the material of the online course was edited and printed in Hungarian and was distributed to health care providers, who were involved in the health care for migrants.

In **Slovenia**, the online modules were translated into Slovenian by a professional translation agency in Ljubljana. All national specific content was adapted to the Slovenian specific situation by the help of jurists from Medical Chamber and Ministry of Health and the Institute of Public Health of the Republic of Slovenia. Module 3 now reflects the Slovenian legal framework and Module 4 was abbreviated.

3. Preparation

All intervention site country partners followed a diverse recruitment strategy involving amongst others mailing lists, kick-off events and/or a snowball system[4].

In **Austria**, for two kick-off events for the two target groups with invited speakers were organised (both, one event for version 1 and one event for version 2+3). For the course for Austrian GPs, the event and the course were advertised through various channels: personal networks, e-mail newsletters of the Austrian Society of Public Health, and the network of the Austrian Society of General Practitioners (ÖGAM), at a symposium in Vienna, where one of the MUW team members held a plenary speech on Austrian results of WP2, and on the website of the Department of General Practice website of the Medical University of Vienna (http://allgmed.meduniwien.ac.at/). For the second target-group, physicians and health care providers with flight experience or migration background, the online course was primarily promoted through an informal network (Whatsapp group) of Arab-speaking health care providers (most have flight experience, all have migration background) in Austria. Both kick-

[4] This chapter contains an overview on the adaptation step concerning the online course. For a detailled description of the adaptation step please see the respective national reports attached in the Annex.

off events and the different versions of the online courses were advertised on the online DFP-calendar (calendar on CME accredited courses and events), as for both versions CME credits had been accredited.

The target groups for the online course in **Croatia** were primary health care providers who have experience of working in refugee settings. Croatian Institute of Public Health provided a list of 200 primary health care providers (GPs and nurses) that delivered PHC services in Slavonski Brod, the Croatian transit centre on the Western Balkan migration route. Furthermore, GPs who provide services in the Reception centre Porin in Zagreb were approached. All these identified PHC providers were sent email invitation to take the online course.

The **Italian** team disseminated information about the on-line course through a number of mailing lists of GPs, nurses and midwives and through the website and the mailing list of the Global Health Centre of the Region of Tuscany and of the Tuscan Medical Council. The course was also advertised through the project teams' personal networks.

The UoC research team pursued a diverse and snowballing recruitment strategy. The project team in **Greece** informed different target groups and policy makers– in particular on the island of Lesvos - about the training material. All persons were encouraged to persuade healthcare personnel to take part in the on-line training course. The EUR-HUMAN online course, as well as the YouTube channel, was furthermore presented at a Public Health conference (6th Panhellenic Congress of Forum: Public Health and Social Medicine) on October 31st 2016 in Athens. The EUR-HUMAN YouTube channel was also disseminated via the EUR-HUMAN website and the EUR-HUMAN Twitter account, as well on some of the UoC team members' social media accounts.

In **Hungary**, all official "camps" and the Headquarter of the Immigration Office in Budapest were targeted. An official invitation was sent to the Health Care Branch of the Hungarian Army that is responsible for health care provision in temporary refugee camps. The target groups for the online course were the PHC providers who have experience of working with migrants and refugees or interesting for this information and knowledge. Beside the online course, the Hungarian team organised a face to face meeting for those, who do not wish to get online education.

The target groups for the online course in **Slovenia** were primary health care providers who have experience of working with migrants and refugees. Like in Italy, Greece and Hungary, before the participants started the online course, a face-to-face meetings and workshops were organised. At this event, participants were also working in small groups and provided feedback to the Slovenian team. The Slovenian institute for development of family medicine established mailing lists of GPs.

4. Training[5]

In **Austria**, the online course version 1 was launched on October 24th and participants were encouraged to finish latest until November 30th 2016. The versions 2+3 of the online course were launched on November 8th and participants were encouraged to finish latest until November 30th 2016. The course has been accredited by the Austrian Chambers of Physician and participants have the option to receive 10 CME credits. In order to allow more participants to participate in the online course, it was made available until December 31st 2016.

As of December 19th 2016, a total of 61 participants registered for the **online course version 1** in Austria, of which 21 persons already finished the course. They were aged between 25 and 72 years, with an average age of 52.2 years. Of all registered participants**,** 37 were female and 24 male. Of participants who finished the course**,** 10 were male and 14 were female. Registered participants came from multiple disciplines but the largest group was GPs, who worked in their own practice**.** Only one GP was employed in a hospital. Sixteen participants did not indicate their professional background**.** In terms of geographical distribution we found that 22 came from Vienna, 6 from Lower Austria, three from Upper Austria, two from Styria, one from Tyrol and 1 from Carinthia. 25 participants did not indicate their federal state. For a detailed overview see table in the national report (see annexe).

As of December 19st 2016 there were 37 participants registered for the **version 2+3** of the online course in Austria, whereof 21 participants already finished the course. Participants were aged between 26 and 54 years, with an average age of 35 years. Of all registered

[5] This chapter contains an overview on the training step concerning the online course. For a detailled description of the training step please see the respective national reports attached in the Annex.

participants 9 were female (5 finished) and 28 were male (16 finished). Registered participants came from multiple disciplines, there were 5 gynaecologists, 4 dentists and four GPs, of which two also specialised in radiology, and 10 persons did not indicate their professional background. In terms of country of origin we found that the largest group of participants came from Syria (28 persons); 3 participants came from Iraq and one from Algeria. Five participants did not specify their country of origin. Participants came to Austria on average 2.3 years ago, the range varies between 3 months to 8 and a half years. With regards to validation of foreign study degrees ("nostrification") we found that 7 participants already finished it, 7 were currently in the process, 13 planned their validation, and 10 did not indicate any information about validation of foreign study degrees. For a detailed overview see table in the national report (see annexe).

In **Croatia,** the online course was available online for six weeks, from November 16th to December 31st. It was estimated that the completion of the course would take participants altogether 16 hours in line with the standards of the Croatian Medical Chamber. By 30th November 2016 there were 28 general medical practitioners from Croatia registered as participants on the online platform. The participants who have completed the course received 7.5 CME.

In **Italy,** the online course was launched on October 25th. In order to get the certificate, participants were encouraged to finish the course within 4 weeks. Due to the rules of the Training Office of the Region of Tuscany (Formas), no CME credits were negotiated, but the participants receive a certificate. For each module approximately one hour of study time is recommended. Thus, a total of eight learning hours is estimated for the entire online course. Until December 1st, 92 people enrolled into the online course and 9 of them finished the course successfully.

In **Slovenia**, the online course was available for four weeks, from November 3rd 2016 onwards. Completing the online course in Slovenian including pre- and post-tests took the participants from 9 to 25 hours. At this moment (by December 24 2016), there were 30 health care providers from Slovenia registered in the participants portal. 19 primary health care workers successfully finished the online course. The Medical Chamber gave 24 CME credits and the Chamber of Nurses 25 CME credits for participants of the online course. All Slovenian participants of the online course received a certificate of attendance, which were sent to the Medical Chamber and to the Chamber of Nurses.

In **Greece,** the online course was launched on November 3rd and participants were encouraged to finish by the November 30th 2016. Until December 23rd 2016 there were 17 participants registered for the online course, of which 14 successfully finished the course. The participants are expected to need a total of 8 to 10 learning hours to finish the online course. CME credits were not applied for at this point of the project. The decision was made to wait until the pilot and the evaluation of the online course as well as the corrections and improvements (if any) were finalized. After that, a negotiation of CME credits is projected. All Greek participants of the online course receive a certificate of attendance.

In **Hungary**, the training was held in December 2016. Altogether, 2-4 learning hours were estimated for the participants. Altogether, 87 PHC providers participated. They did an online as well as face-to-face training.

Overview Table indicating how many persons in each country are registered, how many finished, which professions, maybe, age, gender, etc.:

ONLINE COURSE					
COUNTRY	**registered**	**age Ø**	**male**	**female**	**finished**
Austria version 1*	61	52	39%	61%	39%
Austria version 2+3*	37	35	76%	24%	57%
Greece	17	na	35%	65%	82%
Croatia	28	na	21%	79%	29%
Slovenia	30	na	20%	80%	63%
Hungary	87	na	na	na	na
Italy	92	na	na	na	9%
*as of December 29th 2016					

5. Implementation[6]

In **Austria,** the implementation of the training "online course version 1" began immediately during and after the training in the physicians's practices of the participating GPs or day-to-day practices of other participating primary health care providers. They applied the new knowledge and skills autonomously when they treat refugees, migrants, or other patients in their day-to-day practice. The feedback of the participants in Austria was overall positive.

[6] This chapter contains an overview on the implementation step concerning the online course. For a detailled description of the implementation step please see the respective national reports attached in the Annex.

They found the content for example “exciting and very interesting,” and asked for “further advanced training offers of this type and/or about this topic” (GP, female, 28.11.2016). Module 5 was highlighted to be especially interesting (psychologist, female, 28.11.2016). Negative feedback concerned spelling mistakes and the usage of gender sensible language, but also difficulties in the registration procedure and the layout and visual representation online.

The implementation of the training “online course version 2+3” in Austria was different: A lot of the participants are not yet working as physicians in Austria, thus the actual implementation of the intervention lies sometime in the future. Regarding their function as peers for their community the participants started immediately to bring the new knowledge to their communities.

More and detailed information about the implementation phase gathered via a comprehensive and standardized questionnaire by the WP7 leaders will be provided in the evaluation report in deliverable D7.3.

Croatia: The GPs who work on a regular basis in the Reception centre Porin have applied the new knowledge. They found the modules on intercultural communication, working with interpreters, legal frameworks and mental health most useful. No systematic follow-up of their practice was possible due to ending of the project. It is expected that other GPs will use the new knowledge once the refugees and other migrants gradually become integrated into the various local communities.

More and detailed information about the implementation phase gathered via a comprehensive and standardized questionnaire by the WP7 leaders will be provided in the evaluation report in deliverable D7.3.

In **Italy**, similar to the situation in Austria, the participants have applied the new learned content in their everyday practice, when dealing with refugees, asylum seekers and other migrants.

More and detailed information about the implementation phase gathered via a comprehensive and standardized questionnaire by the WP7 leaders will be provided in the evaluation report in deliverable D7.3.

In **Greece**, all the participants of the online course have applied the new learned knowledge and skills into their work settings. Additionally, a UoC team (a GP, a nurse with specialization in obstetric and gynaecological issues and one coordinator) applied the new earned knowledges in a three-day implementation procedure in collaboration with a MDM team (GP, nurse and two cultural mediators one Arabic; one Farsi). The phase of testing the tools, questionnaires and procedures took place in Kara Tepe refugee camp in the island of Mytilene[7]. During this pilot intervention, the tools, the questionnaires and the procedures were tested in order to enhance capacity building of the European countries that accept and host refugees and migrants. The trained PHC providers provided the services in a multidisciplinary team. The members of the UoC team did not provide any medical services. They only tested the tools, questionnaires and procedures as well as observed all the process. The trained MDM healthcare personnel provided all the medical services. In total 30 refugees and migrants were treated (3 men, 15 women and 12 children). The online course was applied always according the person needs and health problems (please see below more information on the implementation procedure).

In **Hungary**, participants have applied the newly acquired knowledge in their daily activities when providing care for refugees and other migrants. Special attention was expected in topics of childcare, reproductive health and in legal regulations. The biggest challenges in terms of implementation were logistic problems, language barrier, and problems with locum were reported.

More and detailed information about the implementation phase gathered via a comprehensive and standardized questionnaire by the WP7 leaders will be provided in the evaluation report in deliverable D7.3.

In **Slovenia** improvements and progression of knowledge in the group of health care providers and professionals were found in several areas. 47% of registered PHC providers participated in evaluation survey. PHC providers gained new knowledge on the legislation on the provision of health care for refugees. These sections about legislation, but also on

[7] Detailed information about the set of guidelines, guidance and trainings that were part of the learned content and that were applied in the intervention are described in detail in the national report of Greece.

vaccination and mental health were highly welcomed and found particularly useful. Participants indicated that they were acquainted with the well-prepared extensive documents on the health care of migrants for the first time. Through links to national and foreign websites they have discovered how the aid is offered abroad and they could compare national and international arrangements. Difficulties in dealing with refugees were mainly related to the Slovenian health care system. Refugee women and refugee children are provided with full health care, equally to Slovenian citizens. Other refugees with health problems receive urgent medical care. Thus, medical personnel are struggeling in the care of chronic diseases such as diabetes and heart failure particularly for male refugees. After the online training, doctors and nurses in Slovenia reported existing problems in PHC health care for refugees and other migrants to UL. For instance, psychologist stressed that the enforced idleness of the asylum seekers in Slovenia caused numerous mental health issues among them. Even with the newly gained knowledge on mental health care for refugees, psychologists were hardly able to change this detrimental factor.

More and detailed information about the implementation phase gathered via a comprehensive and standardized questionnaire by the WP7 leaders will be provided in the evaluation report in deliverable D7.3.

Add ons to the online course intervention and underlying training

Additional to the online course preparation done in other countries, in Greece, Italy, Slovenia, and Hungary, add-ons to the online course intervention were organized. The purpose of these add-ons was related to the preparation and dissemination, the recruitment of participants, as well as the preparation of participants for the online-course. The add-ons are briefly described in the following; more detailed descriptions are to be found in the national reports of the respective countries in the annexes.

Training lecture videos (YouTube channel) and GoToMeeting session in Greece

First, additionally to the online course the University of Crete team prepared, in collaboration with expert stakeholders, seven training lecture videos in Greek language on different topics in order to support the training of multidisciplinary PHC teams. The training lecture videos are available online on a YouTube channel (https://www.youtube.com/channel/UCvl3kOrEidGv2XA4zAUs01Q) on air since October 26th

(except of the triage video which is on air since November 12th). The Greek experts who developed the training lecture videos (consisting of powerpoint slides and presentation) based the content on the online course as well as international literature and their own working experience. All of the experts have provided or still provide services in the field to vulnerable refugee populations. Each expert (in his/her field) prepared a short presentation (around 25-30 slides) and sent it to the UoC team for formatting and editing, afterwards it was sent back to the expert for crosschecking. Upon the final approval, a meeting was arranged with the UoC IT expert in order to provide details on how to develop the training video, and then the video was uploaded on the created EUR-HUMAN YouTube channel. This procedure took place from the middle of September 2016 until beginning of November 2016.

Each video lasts at least 20 minutes to complete and the total of around four hours is estimated for completing all training lecture videos. The participants can follow their individual time management; they are able to switch back and forth or to restart each video wherever they want and according to their own agenda. The vidoes cover the following seven different topics in detail:

1. *Assessing refugees and other migrants with immediate healthcare needs. Triage upon their arrival*

Video 1 was created by an expert medical doctor and works on aero medical transportations at PHC services in Greece. The video deals with the signs and symptoms that a PHC provider should take under consideration in order to decide if the person needs healthcare services immediately or not.

2. *Communicable diseases on refugees and other migrants*

Video 2 was created by a junior doctor in Internal Medicine in close collaboration with a Professor of Internal Medicine and Infectious Diseases, at the University of Crete. The video (around 38 minutes) discusses the most common communicable diseases in refugee populations and how these issues should be dealt with.

3. *Mental health of refugees and other migrants*

Video 3 was created by a Clinical Psychologist, it (around 17 minutes) deals with the mental health issues that refugees and migrants cope with and the way how PHC providers could

address them. It also discusses the methods of promoting mental health in this vulnerable population.

4. *Provider-patient interaction. Providing cultural appropriate healthcare services*

Video 4 was created by a professor of Community Nursing and a scientific researcher at the National and Kapodistrian Univeristy of Athens. The video (around 46 minutes) deals with the cultural significance of understanding and managing a disease. The video also focused in the significant role of cultural mediators.

5. *Non-communicable diseases on refugees and other migrants*

Video 5 was created by a medical travel expert at KEELPNO. The video (around 25 minutes) deals with the most common non-communicable diseases in refugees and how to manage them in order to control them.

6. *Vaccination coverage of refugees and other migrants*

Vidoe 6 was created by an expert who is in charge of interventions in camps and hosting centres in Greece. The video (around 20 minutes) deals with the low vaccination coverage of this population. It is also discusses which vaccines should be administered (according age, gender, country of origin etc.). Finally, the video points to the procedure that should be conducted in the absence of vaccination documentation.

7. *Maternal and reproductive health*

Video 7 was created by an Assoc. Prof at ATEI Athens. The video (around 27 minutes) deals with the peri- and postnatal phase. It is discusses the procedures and examinations that should be undertaken during the pregnancy in detail.

The EUR-HUMAN YouTube channel has free access and it is available to anyone interested. The link to the EUR-HUMAN YouTube channel was included in the invitations that were sent out to participants in course of the recruitment process. The training videos are comprehensive and easy-understandable. All experts possess extensive experience in the field; however they used simple language and lecture in a friendly and polite manner. The training videos provide information about the context of the issues through a holistic and comprehensive approach. The videos are easy to access at any time and they offer a great opportunity for self-education. The video format is convenient, flexible and expecially

promotes skills, knowledge and life-long learning approaches. This method of training was organized by the members of UoC team.

Secondly, the University of Crete team organized a GoToMeeting on November 14th 2016 at the island of Mytilene where two Greek experts who are employed at KEELPNO (who developed some of the training lecture videos for the YouTube channel) trained a multidisciplinary team of a GP, a nurse, and a midwife. An IT expert and the coordinator of the UOC team in WP6 were also attending the GoToMeeting.

The training for Greek PHC providers was therefore threefold. At a basis lays the online course available through the HeF platform, which was complemented by the training lecture videos available through the YouTube channel as well as the organized GoToMeeting where three of the participants took part and were trained by two Greek experts.

Pilot implementation of these learned in the on-line course

In the context of EUR-HUMAN project, on 13-17 November 2016 took place in Kara Tepe hosting centre of refugees and other migrants (Mytilene island, Greece) the pilot intervention of the EUR-HUMAN project. During this pilot intervention, were tested the tools, the questionnaires and the procedures in order to enhance capacity building of the European countries that accept and host refugees and migrants. The intervention phase took place at the infirmary of the Medicine du Monde in the hosting centre. In total 30 refugees and migrants took place (3 men, 15 women and 12 children). Before the intervention, the PHC providers were trained via two different methods. Initially they were trained via the on-line platform that the consortium created and is consisted of eight different Modules (about this Module, acute diseases, legal issues, provider-patient interaction, mental health, sexual and reproductive health, child health and chronic diseases). In addition, primary healthcare providers were also trained via GoToMeeting by two Greek experts. Some of the PHC personnel watched also the videos in the EUR-HUMAN YouTube channel.

In Greece, an electronic health care record (e-HCR) based on the IOM personal health records and the existing EPR system was developed. Some of the migrants and refugees, who visited the infirmary during the aformentioned three days of the intervention, were invited to participate in testing this tool.

All patients were informed about their health status and received information about necessity of the proposed treatment (if any). Additionally, some of them were referred to specialists (mainly psychologists, gastroenterologists, gynaecologists etc.) for additional control or where referred to other healthcare units (mainly to Mytilene PEDY or the general hospital of the island) in order to conduct more laboratory and diagnostic tests. For every proposed referral, the patient was informed about the place, the date and the way to reach there. All participants were given information in order to improve health literacy and to promote their general health status. Many women received information about the importance of contraception methods and about the sexual transmitted diseases. Furthermore, information on the importance of breastfeeding and the risks during peri- and post-natal phase were also, administered. Information on the management of the diabetes mellitus was provided to a male patient. He was informed about the nutrition habits, the significance of physical activity and others in order to keep his problem under control. Another person was educated about the management of his respiratory disease. In case of a sick child, usually both parents came at the infirmary. In these cases, both parents were informed and educated about the next steps they should follow to treat the illness (i.e. nutrition or immunization needed). However, the assessment of mental health status was conducted with the RHS-13 screening instrument. On all participants older than 14 years old, the questionnaire was administered in order to evaluate their mental health status and according their score were referred to a specialist or not. Finally, some participants were provided information on the risks of communicable diseases, on their entitlements in receiving healthcare services out of charge etc. A patient received the Trauma Tapping Technique (TTT) and was provided recommendations and behavioural advices, in order to cope with his traumatic experiences and thoughts. During the interventions the general recommendations on communication strategies (open questions, specific questions, non-suggestive questions, repeating and summarising the discussion etc.) were followed with all participants. Finally, it is important to mention that all recommendations and the education procedure were conducted, taking always into consideration their culture, their perceptions and the structure of refugees' families. To conduct this procedure, a significant role was played by the cultural mediators who participated and have a huge experience working in the field.

The evaluation of the implementation in Greece showed that the procedure was effective and constructive. The PHC providers that participated in the online course were often better

able to deal with certain aspects of Primary Health Care for refugees such as mental health or cultural aspects than they were before the training. One of the biggest challenges in terms of implementation were found to be time pressure: regardless of the patient's problem and health literacy, at least 15 minutes were required to comprehensively assess his/her status. This was problematic especially in situations where already numerous other patients were waiting for an examination.

Face-to-face training additionally to the online course in Italy

Considering the results of WP2 and WP6 for Italy and the peculiarities of the Italian refugees plan a two day face-to-face training has been organized and carried out in Italy, Region of Tuscany, Central Tuscany Local Health Unit (ASLTC). The face-to-face training was organized in the Region of Tuscany, especially in the Central Tuscany Local Health Unit (ASLTC) because it covers the territories of Florence, Prato, Pistoia and Empoli and it is the area where the majority of refugees and asylum seekers in Italy live.

The training dealt with three main topic areas in-depth that were already touched upon in the online course. The first day of the face-to-face training consisted of different lectures by experts on the following three topic areas: First, lectures covered the basic informations on migration in Tuscany: how many foreign residents are in Tuscany? How many asylum seekers? How many refugees? How is reception organized? Wich are the main epidemiological issues? (main features of migration in Tuscany). Secondly, lectures provided the normative and legislative framework (definition of refugee and asylum seeker status; routes of arrival in Europe; regulation of access to health assistance; Italian and Tuscan policies) and anthropological and cultural knowledge, in order to increase health care providers' awareness of the relevance of cultural and anthropological factors in the fields of health and medicine. Thirdly, the lectures focused on mental health (with special reference to vulnerable groups). The second day of face-to-face training consisted of discussion of case studies, where participants met up in teams for participatory and interactive discussions.

The overview of the programm for the face-to-face training which was organized additionally to the online course:

1) Introduction to the EUR HUMAN project

2) Epidemiological framework in the Region of Tuscany
3) The role of GPs in Primary Health Care for asylum seekers and other migrants
4) Legal issues: refugee/asylum seeker status and right to health assistance
5) The relationship patient/health care provider: the cultural mediation
6) Mental health issues in refugees and asylum seekers population
7) Discussion of case studies

The Global Health Centre of the Region of Tuscany invited experts to hold lectures and cover the main issues of the training. The Italian responsible representative of the EUR HUMAN project, who is also a GP, presented the EUR HUMAN project and the aims of the training. The director of the Global Health Centre of the Region of Tuscany gave a lecture titled "Epidemiological features of the migrants' population in Tuscany". A GP gave a lecture titled "The role of the GPs in the Primary Health Care for migrants' health". A lawyer gave a lecture titled "Regulation of the access to health assistance"; another expert gave a lecture titled "The role of cultural mediation and main mental health issues in migrants' population".

The second day of the training, three staff members of the Global Health Centre presented and discussed with participants a number of case studies, facing the issue of migrants' access to health assistance.

The face-to-face training target group were GPs who are responsible for the first health screening of asylum seekers arriving in the territory of Central Tuscany, and other Primary Health Care providers such as nurses and midwives. The participants were recruited through a number of GP, nurses and midwife mailing lists and through the website and the mailing list of the Global Health Centre of the Region of Tuscany and of the Tuscan Medical Council. The face-to-face training took place in Empoli, at the Training Office of the Local Health Unit (Via Guglielmo Oberdan 13, Sovigliana, Empoli), on November 17th and 18th 2016, with an 8 hours training session on day 1 and a tree hours training session on day to. 27 GPs, nurses and midwifes participated in the training.

The Training Office of Empoli was responsible for the negotiation for CME points. The face-to-face training provided for 3 CME points.

Face-to-face training additionally to the online course in Slovenia

The online course was offered to health care providers in Logatec, Ljubljana, Izola and in North east part of Slovenia, at each of these settings face-to-face trainings or meetings were organized. The target group was interdisciplinary (GPs, psychologist, psychiatry specialist,

nurses, and district nurses) with different roles in health care system. The training was delivered by the Slovenian MFUL team.

The first one-day face-to-face training about the EUR-HUMAN project and especially the online course took place on September 14th 2016 in Logatec. There were 23 participants (18 GPs and 5 nurses). Logatec is a city in which one of the few Slovenia's refugee camps is also located and played an important role during the biggest migration flow in 2015. This is why the participants of this event were mostly doctors and other health care staff who had all gathered great experiences through direct contact in working with the migrants. In the first part of the workshop, MFUL team organized 2 lectures. In the first one MFUL team presented the current literature regarding the provision of health care to migrants and the results of the fieldwork in Šentilj, Dobova, Brežice and Vrhnika of the EUR-HUMAN project. In the second one MFUL team considered the socio-cultural factors that contributed to the migrant crisis and tried to explain how the gravity of the situation they had suffered also might have impacted their mental health status significantly, which must always be taken into account when providing primary health care to migrants.

In the second part MFUL team organised a brainstorming session and plenary discussion. Issues were raised about what comes next - how to organise the provision of migrant health care in the future; what constitutes emergency care for migrants and what are the financial aspects of it - who is financing the acute diseases that are not life-threatening but could lead to worsening of health; the problem of non-existing vaccination records of migrants, especially children, who stay in transit countries for only short periods of time - how to manage them and provide not only for their safety but also for the safety of the community. The second face-to-face training took place in Ljubljana on November 14th at the department of Family Medicine. The target group was primary health care providers; the group constited of 6 professionals: three nurses, two came from the Jesenice region, near the Austrian border and one nurse came from Ljubljana region, one MD who was also a psychiatry specialist from Ljubljana, and one psychologist who works mainly with children in Ljubljana.

Futhermore, there were face-to-face meetings organized on October 24th and a feeback face-to-face session on November 28th also in Izola, the group consisted of 12 nurses from the western an central part of Slovenia. The face to face meeting on 29th of November 2016 was organised by the help of Slovenian philanthropic organisation. MFUL team presented the EUR-HUMAN project. 2 GPs who have just finished one-line course spoke about the

knowledge which they have gained through the course. Participants were responsible leaders from all humanitarian organisations in Slovenia.

Another UL team member iniciated an e-group of GPs. 4 of them registered on online course and one GP from this group finished an online course.

A total of 47 participants were recruited for the face-to-face training/meeting and the online course. The list of primary health care providers and nurses was collected by open call from the Department of Family Medicine of University of Ljubljana and by the field work the Slovenian MFUL team. The list included 47 general practitioners, nurses, psychiatric specialist, psychology specialist, paediatrician, district nurse, urgent care technicians from different parts of the Slovenia with special interest in migrant care. Therefore, they were considered highly valuable resource to provide feedback on the online course.

Face-to-face training additionally to the online course in Hungary

Additionally to the online course the Hungarian project partner also held face-to-face meetings at different locations for participants who did not wish to have an online education. Thus, these face-to-face meetings/trainings were offered as alternative to the online course. The first face-to-face meeting took place in Budapest at the Headquater of Immigration office on December 2nd 2016. Eight nurses and other PHC providers were present, but no medical doctors took part. Additionally a meeting/training was carry out for Győr on December 5th.

Piloting of the mental health screening (RHS-13) and referral procedure

1. Selection

The intervention of the piloting of the mental health screening (RHS-13) and referral procedure consisted of 1) the training of screening teams who carried out the piloting and 2) the actual piloting of the mental health screening (RHS-13) and referral procedure itself.

The 1) training enabled the screening teams to conduct interviews that included introduction and clarification of the screening purpose, obtaining written informed consent, administering RHS-13 screening tool, and questions about available services in the reception

centre. They received detailed information about legal application procedure for international protection and about legal rights of refugees and migrants in Croatia. A separate section of the training was dedicated to mental health and psychosocial support (MHPSS), understanding the migration process, consequences of migration as a traumatic experience, and cultural issues in communication. The purpose of screening and referral procedures was explained in detail. The training also addressed how to work with interpreters, their roles in relation to the screeners and the interviewees.

The 2) piloting of the mental health screening (RHS-13) and referral procedure as described in deliverable 5.1 (*Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS*) contained the following steps:

1. Establishing trust
2. Administering the screener
3. Evaluating the results and immediate assistance (referral if needed)

Before administering the screening tool additional questions about needs and wishes were asked in order to establish contact before administering the screening tool RHS-13. The Refugee Health Screener 13 is a screening instrument for primary health care settings for migrants and refugees from age of 14. Based on the review in deliverable 5.1 the RHS-13 scale was identified as valid instrument, available in several languages, easily administrable and understandable covering several relevant constructs related to emotional distress, which is common in refugee populations. RHS-13 scale consists of 13 questions assessing posttraumatic stress disorder (PTSD), anxiety and depression symptom intensity with five possible answers (0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely) with addition of a visual scale to facilitate understanding. It can be used as quick assessment of the probable risk of having or developing PTSD, anxiety or depression (cut-off score ≥ 11). It is important to emphasize that a positive screen on the RHS-13 does not automatically indicate that the person in question should be provided with clinical MH treatment but indicates the need for full assessment and follow-up. The results were evaluated and referral procedures were in place.

Description of the setting where the piloting of the mental health screening (RHS-13) and referral procedure took place

The piloting of the screening and referral procedure took place in the reception centre for international protection applicants, Porin, Zagreb. The aim was to screen all adult refugees and other migrants living in the reception centre who agree to participate. The screening interview included introduction and clarification of the screening purpose, securing written informed consent, administering RHS-13 screening tool, questions about available services provided in the reception centre and refugees' needs, wishes and preferences, and discussion about the need for referral. If a refugee or migrant screened positive during the piloting, the interviewer offered referral to the GP and/or to the CRC social worker. If the individual scored below cut-off, interviewers provided information about available services and encouraged the person to seek MH assistance for themselves or their loved ones if ever the need is felt. Duration of an interview was about 30 minutes.

Description of why did you choose the piloting of the mental health screening (RHS-13) and referral procedure and how does it relate to the guidance developed in D4.2

The need for piloting the procedure of mental health screening was recognized from the provious work done in course of the EUR-HUMAN project where the need for improving mental health services was further stressed.

The need for piloting the procedure for mental health screening was recognised from the previous work done in the EUR-HUMAN project. Based on the fieldwork conducted in WP2, refugees and other migrants, as well as care providers, recognised a great need for improving mental health services. While providing initial health check-up to refugees and migrants upon entering EU member countries is standard, assessment of mental health status and needs of refugees and migrants are not among high priority services in the resettlement procedures. However, from the public health perspective it can be equally important to manage, for example, the risk of infectious diseases, as to address potential psychological trauma, which can lead to increased burden to health and social services, and increased societal costs and resource drain. Furthermore, the piloting procedure is in line with the conclusions of WP4 Expert Consensus Meeting (Athens, June 8th – 9th 2016), which aimed to reach consensus on the optimal content of primary health care and social care services needed to assess and address the health needs of refugees and other newly arrived migrants. The main conclusions regarding mental health pointed out that in longer stay

reception centres it is important to screen for mental health conditions, and provide referral for specialist mental health assessment and care as needed. Early identification of refugees and other migrants who are severely distressed, assessment of their mental health status and needs and providing appropriate services was deemed likely to prevent development or deterioration of mental health disorders.

Finally, the need for piloting the procedure was appraised using ATOMiC checklist developed by WP3. ATOMiC provides practical guidance in improving health care services and can be used to critically appraise the practical significance of the proposed service. In addition, it serves as a tool to rethink and improve the most important aspects of service delivery. Based on the self-reflection using the check-list, it was concluded that mental health screening procedure can greatly improve service delivery to refugees and other migrants. The proposed procedure addresses well known risk factors for developing serious mental health problems: it enables PHC providers to identify refugees and other migrants at such risk. Furthermore, it is based on using validated tool and principles derived from both scientific research and practice (described in deliverable D5.1) and offers guidance for referring refugees and migrants who screen above the cut-off to further care and appropriate interventions. Discussing mental health problems is a sensitive topic in most cultures, and without a systematic screening procedure it is possible that people with serious problems would be overlooked. Regarding potential risks, it is important to note that every PHC provision, including MH, should be systematic and comprehensive, patient-centred, compassionate, culture-informed, non-stigmatising and integrated. Key implementation issues identified using ATOMiC checklist included the need to train the staff who will be conducting the screening, not only regarding the procedure of screening, but also in intercultural competencies, attitudes and background knowledge about psychological aspects of migration and refugee life. Furthermore, an important issue of staff capacity and available time was recognised, especially the need to ensure enough capacity for follow-up in case of positive screen. In order to standardize the MH screening and referral procedure in the pilot study it was necessary to train the screening team. A face-to-face training was a good opportunity to introduce interviewers and interpreters to each other.

Detailed description of the target group in this setting

The target group was all refugees who live in the reception centre for international protection applicants, in Porin in Zagreb, Croatia.

2. Adaptation

The written materials for preparation such as invitation letters, written consent forms and interview questions and the screening tool were translated and adapted into Arabic, Farsi, Urdu, English and Croatian language. It informed the participants and invited them to take up the screening interview and included an invitation letter in different languages that were posted at bulletin boards in the reception centre.

The training of the screening team was especially designed and prepared for the purpose of piloting and the particular target group of screeners.

3. Preparation

Preparation process of the piloting of the mental health screening (RHS-13) and referral procedure

The piloting of the mental health screening (RHS-13) and referral procedure was conducted in three stages. First, relevant stakeholders were briefed about the piloting. Approval was obtained from the chief police officer and manager of the Porin reception centre. Referral pathway was established through the medical GP in the local community health centre and the Croatian Red Cross (CRC) chief social worker. The medical GP in the local community health centre, who serves also the population in this reception centre, was informed about the screening. His response was very positive and he accepted to receive referrals as needed. Along with the GP, referral pathways were established with CRC chief social worker. Non-governmental organizations that provide services to refugees and migrants in the reception centre were also briefed about the action. The piloting was approved by the relevant Institutional Ethic Committee. The written materials (invitation letter, written consent form and interviews question, including screening tool) were translated and adapted into Arabic, Farsi, Urdu, English and Croatian language. Informing the participants and inviting them to take up the screening interview included invitation letters in different languages posted at bulletin boards in the reception centre, personal information via CRC staff, and personal invitation by interviewers and interpreters from door to door.

Secondly, interviewers and interpreters jointly took a half-day training regarding piloting procedures and other competencies for MH screening.

Thirdly and finally, the piloting was conducted in July 2016 in the Reception centre for international protection applicants, Porin in Zagreb.

Recruitment and training of the screening team (interviewers and interpreters)

The interviewers for the screening team were recruited via a student group (psychology graduates) who were invited to a meeting with representatives of Croatian Red Cross working at the reception centre who presented some aspects of working with refugees and migrants in the Croatian context. Recruiting interpreters was a bigger challenge, whereas there is a small number of people in Croatia speaking Arabic, Farsi or Urdu languages and almost all of the interpreters for these languages are already full-time engaged by other organizations working with migrants. Criteria for interpreters were: native speaker of the language, having experience in interpreting and advanced knowledge of Croatian language. In the end, there were 4 Arabic, 2 Farsi and 1 Urdu speaking interpreters.

The training of the screening team was held at the Faculty of Humanities and Social Sciences in order to prepare the screening team to conduct the MH screening and referral procedure in the reception centre for international protection applicants Porin in Zagreb, Croatia. Both, interviewers and interpreters participated in a half-day training that took place at the Faculty of Humanities and Social Sciences on June 23rd 2016 between 9am and 1pm. The training lasted 4 learning hours and included lectures, group discussions and role-plays. The training was delivered by the WP5 leader of the EUR-HUMAN project and piloting field coordinator. A total number of 15 participants attended the training. The group consisted of seven graduate students at the Department of Psychology (Faculty of Humanities and Social Sciences, University of Zagreb - FFZG) and a psychologist from Médecins du Monde who all served as interviewers in the piloting of the screening procedure and seven interpreters. All of them had been working before in the refugee transit centre Slavonski Brod until the Balkans route was closed and had previous work experience in the migration context. According to the languages, there were 4 Arabic, 2 Farsi and 1 Urdu native speaking interpreters.

The training was especially prepared for this purpose and the target group and was based on the face-to-face training about mental health of refugees and other migrants (see below) and included topics such as consequences of migration, psychological trauma and reactions to trauma, legal framework, MH screening procedure and working with interpreters. The training contained also detailed information about application procedure for international protection and about legal rights of refugees and migrants in Croatia. A separate section was dedicated to mental health and psychosocial support (MHPSS), understanding the migration

process, consequences of migration as a traumatic experience, and cultural issues in communication. The purpose of screening and referral procedures was explained in detail. The training also addressed how to work with interpreters, their roles in relation to the screeners and the interviewees. The training format included short presentations on key topics, interactive discussions, sharing of experiences by the interpreters, and role play exercises based on several prepared scripts.

Recruitment process of target group for screening

The invitation letters in Arabic, Farsi, Urdu, English and Croatian language were posted at bulletin boards in the reception centre. It informed the target group about the piloting of the mental health screening and referral procedure and invited them to take up the screening interview. CRC staff was personally informed and screening team members and interpreters invited participants during the piloting days, they went door to door and asked persons to participate.

4. Piloting

Timeframe of the piloting of the mental health screening (RHS-13) and referral procedure

The piloting of the mental health screening (RHS-13) and referral procedure was carried out on 11 working days between July 6th and July 20th 2016 in two shifts from 9:30am to 12:30am and from 13:00pm to 16:00pm at the reception centre Porin. The daily number of interviews varied, depending on the number of available dyads (volunteers and interpreters) and the schedule of other activities within the reception centre. Approximately 10 screening interviews were completed per day.

Organization of the piloting of the mental health screening (RHS-13) and referral procedure

The piloting of the mental health screening (RHS-13) and referral procedure was developed and organized by the the FFZG, the Croatian partner within the EUR-HUMAN consortium. The recruitment and training of the screening team was carried out by FFZG, the piloting was carried out by the screening team and the referral pathways were established in collaboration with the CRC chief social worker and general medical practitioner who serve the population at the reception centre.

Participants

The piloting of the mental health screening (RHS-13) and referral procedure aimed at screening all adult refugees and other migrants from the reception centre Porin who agree to participate. From the total number of 200 adults in the reception centre at that time, 123 participated (61.5%). Participants were primarily male (86.2%), aged between 18 and 50 years (M = 29.1), with mostly secondary education (average 11 years of formal education), who applied for international protection in Croatia (90%). According to the country of origin, most of the participants were from Iraq, Afghanistan or Syria. The reasons for non-response were that some people were not living in their rooms (although registered as such) and could not be accessed; other did not open the door at several attempts. From those who were approached, 11 refused to participate. About 10 persons could not participate because of the language barrier and lack of appropriate interpreter. These were individuals from Russian Federation, Somalia, Sri Lanka and Kosovo. Participants speaking Arabic, Farsi and Urdu were assisted by interpreters in their native language, while interviews in English had no intermediator.

Content

The procedure included described steps of MH-screening provided in an interview between a trained screener, migrant and interpreter. Depending on the result on the screening tool, migrants were encouraged to seek professional help (from social worker or GP) or got a short psychoeducation.

5. Implementation

The training prepared the screening team to conduct MH screening among refugees and migrants and referral to specialised services if needed. The content of the training was applied during piloting study in the Reception centre for international protection applicants Porin in Zagreb. A total number of 123 refugees and other migrants participated in the screening. They were primarily young, single men from Iraq, Afghanistan and Syria. Results on the RHS-13 showed that 80.5% of the participants screened positive, about half of the positively screened participants accepted referral to further assessment and care.

The piloted screening procedure for assessing mental health needs and status of refugees and other migrants proved to be time efficient, applicable and feasible. The RHS-13 proved to be an acceptable, easily understood, culturally appropriate and time efficient instrument.

The related focused training which served to enable the high-quality screening was well accepted by the participants and proved to be efficient way to build the capacity for health-allied volunteers to conduct screening in a resources limited environment.

Face-to-face training about mental health of refugees and other migrants

1. Selection

Description of the face-to-face training about mental health of refugees and other migrants

The two-day face-to-face training about Mental Health of Refugees and other Migrants aims to meet the needs of a broad group of care providers who work with refugees and migrants, ranging from professional health and allied personnel (GPs, nurses, psychologists, social workers) to paraprofessional and volunteer staff (health care volunteers, community workers, volunteers among the migrant population, cultural mediators and interpreters). The training program consists of 8 training sessions, introduction and evaluation sessions (further information about content and structure of the training see below).

Description of the setting where the face-to-face training about mental health of refugees and other migrants took place

The two full day face-to-face training about mental health of refugees and other migrants was held for a group of PHC providers working in refugee settings on November 4th and 5th 2016 in a downtown venue in Zagreb.

Description of why did you choose the face-to-face training and how does it relate to the guidance developed in D4.2

The need for capacity building in the area of mental health is a common finding in all EUR-HUMAN project work packages. This need was voiced by refugees and migrants themselves, during the field work in WP2. Mental health problems were mentioned at all implementation sites, and they included distress related to shocking events before or during the migration journey, depression, insomnia, fatigue, anxiety and uncertainty (D2.1). In most cases a supportive and caring dialogue (guided by psychological first aid (PFA) principles) would suffice, but for some people there is also a need for more specialised psychological

interventions. The refugees and migrants perspective was also identified during the piloting exercise of the mental health screening procedure (see intervention description above) conducted in the reception centre for international protection applicants in Porin, in Zagreb, Croatia (WP5). In this first intervention 80% of the newly arrived refugees and migrants screened "positive" on a mental distress scale. Scientific papers (WP3, D3.1) and expert opinions (WP4 Expert Consensus Meeting; Athens; June 8th – 9th 2016) further point to the need for stepped-up mental health care, taking into account different stages of the migration/flight. Expert consensus was especially strong on the issue of training volunteers for providing mental health care assistance, which allows task shifting and alleviating the burden of specialised care providers (D4.1). Finally, care providers perspective collected in the WP6 national reports on local resources and challenges for primary care providers in the 6 intervention site countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) clearly found that one of the biggest challenges in service delivery to refugees and other migrants is the lack of psychosocial support.

As the recognized need for capacity building for the provision of primary health care was the starting point of the EUR-HUMAN project, the consortium members defined that one of the main objectives was to identify, create and evaluate guidelines, training programs and other resources that can be made available for various stakeholders. Based on the recognized importance of mental health care for refugees and other migrants, the FFZG developed and selected a special curriculum focusing on the topic of mental health that would provide deeper specific knowledge and skills building through a face-to-face training. Moreover, in line with the strategy of the EUR-HUMAN project to adapt the tools and resources to the local conditions, the face-to-face training on this specific topic was deemed culturally appropriate to the Croatian situation.

Detailed description of the target group in this setting

The target goup of the face-to-face training was representatives of relevant institutions and organizations providing services for refugees and migrants, both governmental and non-governmental, including organizations involved in other projects funded by CHAFEA under the same call which are implemented in Croatia (IOM, Médecins du Monde and Croatian Institute for Public Health) and organizations we collaborated with during the piloting of the MH-screening procedure (Croatian Red Cross and GPs). The target group includes different

professionals (GPs, psychologists, interpreters, social workers, occupational therapist, volunteers) with different roles in refugee settings in Croatia.

2. Adaptation

The face-to-face training about mental health of refugees and other migrants was prepared in both, Croatian and English language, therefore no special adaptation to the Croatian context was needed. With very small adaptation to other local contexts it can be implemented in any other European country.

3. Preparation

Recruitment process of target group

Invitations to the face-to-face training were sent out to all relevant contact persons from the target groups described above, such as persons from service provision organizations, both governmental as well as non-govermental, e.g. IOM, Médicins du Monde, Croatian Institute for Public Helaht, Croatian Red Cross and GPs from reception centres, Medical Health Centre Zagreb, Jesuit Refugee Service (JRS), Society for Psychological Assistance (SPA), Centre for Peace Studies (CPS), Rehabilitation centre for stress and trauma (RCT), National Protection and Rescue Directorate (NPRD), Andrija Štampar Teaching Institute of Public Health, Department of Social Services Zagreb (DSS), Primary School "Fran Galović" Zagreb.

Location for the training

The face-to-face training took place in a venue downtown Zagreb, Croatia.

CME points

The face-to-face training about mental health of refugees and other migrants was registered at the professional chambers (Croatian Medical Chamber, Croatian Chamber of Nurses, Croatian Chamber of Psychologists, Croatian Chamber of Social workers). The Croatian Medical Chamber approved 6 CME for this course.

4. Training

Timeframe of the training

The face-to-face training took place on November 4th and 5th 2016. The time schedule on both days was from 9am to 4pm, at each training day there were two coffebreaks and a lunch-break.

Organization of the training

The training was organised by the local team of the EUR-HUMAN project from Department of Psychology, Faculty of Humanities and Social Sciences in Zagreb (FFZG). Training was delivered by WP5 leader and the EUR-HUMAN team from FFZG, consisting of a full professor of social psychology at the Department of Psychology, University of Zagreb with extensive expertise in community mental health, particularly related to trauma healing and work with refugees, serving as a consultant for WHO, UNICEF, UNFPA, Norwegian Refugee Council, Catholic Relief Services, Health Net International, CARE, and regional organizations regarding to the aftereffects of war, displacement and organized violence. Parts of the training was also delivered by Ph.D. student at the Department of Psychology, University of Zagreb, with experience and education in psychological counselling, psychotraumatology and resilience factors in recovery process. Furthermore, a Ph.D. student at the Department of Psychology, University of Zagreb, with experience in counselling and psychosocial support to children and families in distress delivered part of the face-to-face training. The fourth contributor (univ. bacc. psych.,) has completed several trainings on the legal framework of asylum seeking process and has hands-on experience in psychological screening of refugees and other migrants and working with interpreters.

Participants

The face-to-face training was delivered to 30 multidisciplinary participants who were members of the following organizations: International Organisation for Migration (IOM), Médecins du Monde (MdM), Institute of Public Health (IPH), Croatian Red Cross (CRC), Medical Health Centre Zagreb, Jesuit Refugee Service (JRS), Society for Psychological Assistance (SPA), Centre for Peace Studies (CPS), Rehabilitation centre for stress and trauma (RCT), National Protection and Rescue Directorate (NPRD), Andrija Štampar Teaching Institute of Public Health, Department of Social Services Zagreb (DSS), Primary School “Fran Galović” Zagreb (children from the reception centre Porin are enrolled in this school). They were an interdisciplinary and experienced group well suited for piloting and evaluating the training. In their daily practice they face various MH issues among refugees and other migrants. Some of the participants highlighted during the session that they have learned much from own mistakes and wished they had the knowledge provided by this training when they started working in refugee settings.

The evaluation form was completed by 27 participants aged 26 to 59 (M=33 years) who have on average 18 months working experience in refugee and migrants setting, working from one (e.g. psychological counselling) up to 50 hours a week (e.g. interpreters), depending on their role. Most of participants (77%) have previously attended training about working with migrants (54% of them have attended 3 or more courses) while 88% participants have attended courses about mental health and psychosocial support of migrants (46% have taken 3 or more trainings).

Role	Organisation	N
Psychologist	CRC, SPA, MdM, RCT, NPRD, Primary school	8
Interpreter	IOM, MdM, CRC	5
General practitioner	Medical health centre Zagreb	5
Social worker	JRS, RCT, DSS	4
Occupational therapist	CRC	2
Volunteer	CPS, SPA	2
Epidemiologist	Andrija Štampar Teaching Institute of Public Health, IPH-Ploče	2
Visiting nurse	Medical health centre Zagreb	1
Project assistant	IOM	1
Programme administrator	CRC	1
Lawyer	DSS	1

Content

The face-to-face training program consists of eight training sessions, indroduction and evaluation sessions. Training sessions cover topics concerning mental health, psychosocial needs and various activities aimed at supporting and helping refugees and migrants in the context of the European migration crisis. Three sessions are scheduled on day one and five sessions are on day two. Day one covers topics about refugee experiences and consequences of psychological trauma, core actions of PFA and mental health triage procedure. Topics on day two include mental health screening and referral, cultural considerations, working with interpreters, PFA for children and legal framework of international protection in Croatia. Training materials in English and Croatian comprise two

power-point presentations (for day 1 & 2) and a detailed step-by-step guidebook that were shared with the EUR-HUMAN consortium. This guidebook for facilitators describes the aims and content of the training, and includes: training schedule, a slide-by-slide guide to the contents of the training, 7 handouts for the participants, 2 role-play scenarios and an evaluation questionnaire.

5. Implementation

The trained target group was an interdisciplinary and experienced group well suited for piloting and evaluating the face-to-face training. In their daily practice they face various MH issues among refugees and other migrants. Depending on work place requirements, participants were planning to implement knowledge and skills gained in the face-to-face training. In the evaluation, participants listed challenges for implementing the knowledge and skills gained in the training. The most frequent challenges mentioned are language barriers and lack of interpreters, legal framework and administrative barriers, lack of time, demotivated migrants, lack of personnel (psychiatrists, paediatricians), poor organisation and not enough collaboration among institutions. Some of the participants highlighted during the session that they have learned much from their own mistakes and wished they had the knowledge provided by this training when they started working in refugee settings. The evaluation showed high level of applicability, feasibility and usability.

The training was evaluated on 15 self-rating items and several open-ended questions, which showed that participants were very satisfied with the training in general (M=4.4) and would recommend it to their collegues (M=4.5). They were confident in their ability to provide different aspects of MH care to adult refugees and migrants, including triage, screening procedures and PFA. Confidence for working with children was lower, and most appreciated topics were PFA for children and adults, new tools, triage and screening procedures.

Discussion

Based on the results of the data collection phase in the EUR-HUMAN project a portfolio of checklists, guidelines, guidance, tools and training materials for the interventions and underlying trainings was developed. The mental health screening procedure and referral (RHS-13) was piloted in Croatia and the *EUR-HUMAN Face-to-face training about mental health of refugees and other migrants* was developed and also piloted in Croatia. . The online course for primary health care professionals was piloted in 6 countries: Greece, Italy, Croatia, Slovenia, Hungary and Austria (2 versions). Additionally, the pilot implementation of these learned in the training material took place in Kara Tepe hosting centre of refugees and other migrants (Mytilene island, Greece). During this pilot intervention, were tested the tools, the questionnaires and the procedures in order to enhance capacity building of the European countries that accept and host refugees and migrants.

Online-course

After the pilot of the online course, several strengths and weaknesses of the course on different levels became apparent amongst others concerning its adaptability, its content, as well as its format.

A specific strength of the online course is the fact that the training **builds on already existing** training materials and guidelines that complement the newly developed content. The course contains up-to date information and guidelines regarding refugees and builds on the excessive data collection phase prior to the development of the online course. It contains a comprehensive list of helpful links to NGOs, social support organisations etc. Several modules of the course were developed by experts in particular fields and experienced in refugee care (paediatrics, immunisation, psychiatry, social anthropology, etc.).

The online course offers the participants **comprehensive knowledge** on the respective health care system in relation to health care for refugee and on the issues of migrants' health. This is especially important for PHC providers without previous experience in the health care for refugees and other migrants. Many PHC providers in the field emphasized the importance of this training material and expressed positive feedback. Several chapters, such as the one on vaccination, were considered of particular importance. The existing

module on sexual- and reproductive health lead participants to critical remarks: In Slovenia one participant had problems regarding the module of sexual and reproductive health. The participant reached 70% of correct post-test examination after 3 attempts. One participant in Austria considered the mentioning of abortion as a legal option as problematic and pointed to post-abortion-symptomatic.

A great strength of the online course lies in its **adaptability** to the country-specific circumstances and to the target group. It is a time efficient way to reach a great number of professionals in various geographical locations throughout a country where it is distributed. However, it became apparent that **translations of the content** of the online course into multiple languages needs to be perfected, in order to allow PHC workers to fully benefit from participating in the course. In the intervention countries parts of the course or the entire content were translated by official translation agencies. Nevertheless, a criticism that this translation was not good enough or adequate has been reported by several participants in certain settings. We can assum that some translators were not familiar with the respective fieleds of knowledge. The translations done by the experts themselves or team members of the EUR-HUMAN project were considered acceptable. In Greece the whole material was translated by research associates of the UoC team.

Beside the implemented adaptations and additions done by the intervention site countries, several more adaptations might have been possible with a more generous **time frame** for the adaptation and translation of the course. The overall time frame of the project did not allow enough time for comprehensive reflection and according revision. To give an example: an additional chapter, for instance, on introducing physicians from abroad to the Austrian health care culture and the expectations of the Austrian health seeking population, might further strengthen this target group. Furthermore, the physicians from abroad would have benefitted from an indepth chapter on sex education as well as substance abuse and addiction, because the refugee health providers might not be aware of national regulations.

In general, the **accessibility** of the online course was considered to be very good – especially with a good Internet connection. A main advantage is that it can be accessed at anytime and anywhere, from any electronic/smart device with Internet access. However, the only option to access the course via Internet can also, constitute a barrier: For instance, currently, in Greece most of the hotspots and refugee hosting centres have no Internet connection. Thus, the PHC providers, who wanted to participate in the online course could easily access it from

their homes, however, it was difficult for them to participate in the course at hotspots and hosting centres, as there is neither an offline version, nor a printed version available in Greek.

The video lectures developed in Greece represent an attempt to make the content of the online course available to a larger audience. The lectures, which are in Greek language, will remain online on the YouTube platform. A strength of this format is that it is low-threshold; users do not need to go through a registration process. The lecture videos can potentially be watched anytime, anywhere, by anyone who is interested in the topic. Additionally, the YouTube gives participants tha ability to communicate and interact to join discussions and to apply direct questions.However, these easily accessed video lecture cannot give any credits or certificates to their users, apart from the gained knowledge. Furthermore, training providers can never know how many persons actually fully watched the video lectures. Furthermore, participants have to actively seek out the videos via the link on the EUR-HUMAN webpage or they need to know what to look for on the YouTube platform, as any user of the YouTube channel.

A basic characteristic of the **format "online course"** is that individuals do a course from their own devices and that there are limited possibilities for interaction with others. This was on the one hand considered to be weakness of the course: limited possibilities were given for the participants to exchange and interact, in order to join discussions and to apply direct questions. Basic possibilities for interaction for the participants would have been available on the portal's homepage, but they were not promoted, due to lack of time and resources to supervise the training as e-tutor. Furthermore, the format of an online course makes it potentially easier for the participants to procrastinate or to neglect the learning process. On the other hand, the chosen format of the course as online accessible version allows the participants to be **flexible** in terms of participation, as they can log in the course whenever they have time available; the participants are also flexible to choose the sequence of the modules. The participants are autonomous in the choice of the content: they can prioritize on issues that are of most relevance to them.

All intervention countries received feedback that individual participants considered the **registration** procedure as too difficult and as an unnecessary formality. However, in the countries where the online course leads to CME credits the registration is necessary and indispensable. Other participants had technical issues, which were sometimes caused by the

lack of IT skills of the users. There is a basic technical competency required for the participants to do an online learning or training. A weakness of the course for the specific target group may, therefore, lie in the online/technical nature of the training, which some participants might not be used to.

Different strategies served as way to recruit participants for the online course. The kick-off events and face-to-face trainings or meetings **facilitated a dialouge and direct exchange** between the participating stakeholders and the course providers. In Slovenia, it was reported that the trainings were organized with lectures, case studies and participatory methodology, which was highly appreciated by participants. Through this blended learning participants had the chance to simulate real issues and discuss umcoming questions with experts from the field. The dialogue with other participating stakeholders was also, extremely valuable for future cooperation and improvement of the intervention and the underlying training. However, the organisation of such events takes considerable time and effort for the course providers.

To some extent, the **instructional design and didactical methods**, but also, in the limits of the online format and the framework of the available platform constitutes a weakness of the current version of the course. While the online course incorporates pictures, graphs, statistics, excerpts from policy documents, links to relevant websites, to videos, to external documents, to organizations, still most of the course content is conveyed through (reading) text. The translation of the content of the course into audio-visual material (video presentations, films, web streaming, video conferencing etc.) in all countries is strongly suggested to be considered in upcoming projects.

Strategies to complement the online course with more **interactive** (blended) learning methods were additional face-to-face trainings with lectures on the course topics (Italy, Slovenia, Hungary), trainings by video call technology (Go-To Meeting, Greece). Furthermore, the course content was provided to the participants in print form (Hungary). In general, the course could be improved further by mutual group activities, posting, sharing, blogging, commenting on content online or through actual additional face-to-face trainings, workshops or gatherings e.g. at the beginning of the online-course.

In each of the intervention countries diverse efforts were made to reach the different target groups (kick-off meetings, face-to-face meetings and trainings,) and to provide **incentives** for

participate in the online training. The course in Austia, was accredited by the respective medical chambers of the intervention countries, thus allowing the participants to gain CME credits for finishing the online training. The Italian partners reported that the main weakness of the Italian version of the online course was the absence of such an accreditation and of CME credits.

Participants especially of disciplines with high workloads in their daily practice have to have enough **time** available to do the online course – as it would be also, with other forms of training. Other participants gave the feedback that they actually liked the format because it needed less time and effort to be able to get CME credits, than a face-to-face training course would have needed (Austria).

Beyond the above discussed strength and weaknesse of the online course (format, adaptability etc.), there are points concerning the **implementation** of the training and the application of the newly gained knowledge in day-to-day practice:

Due to the different initial situation in each country concerning PHC regulations and health system, the implementation needs to be **assessed** in different ways. As outlined above, the preconditions for the implementation varied between the intervention countries. In Greece, a particular group of PHC providers was trained and the implementation of the newly gained knowledge observed in practice. In Italy, Slovenia, Austria, Hungary, and Croatia, participants of the online course apply the new learned content in their everyday practice, when dealing with refugees, asylum seekers and other migrants, or the general population. PHC providers are spread over the countries; in the individual practices, the way PHC providers apply the newly gained knowledge is impossible to directly observe.

One of the biggest challenges in the implementation concerned the **amount of time** that PHC providers can dedicate to their patients: For instance, in Greece, regardless of the patient's problem and health literacy, at least 15 minutes were required to comprehensively assess his/her status. This was problematic especially in situations where already numerous other patients were waiting for an examination. The time needed for the PHC providers to apply the new skills, equally considers a barrier in other countries: The legal framework in terms of health insurance and the regulations for compensation for services determines the time available for patients. It has to be taken into account that the application of new skills and knowledge in the practice might sometimes require additional time. For the individual

PHC provider, there is – at least – no financial incentive to take more time per patient; interpreters are also not covered by health insurance.

In the application of the newly gained knowledge, some aspects dissemated by the online course were not applicable because of the **legal- and institutional framework** within the intervention countries. Most of the participants mentioned the important role of the multidisciplinary teams that the course is addressing on. Participants praised the comprehensive overview of links of aid organizations and documents. However, overall it became clear that some recommendations of the course or tools recommended by experts in the framework of the EUR-HUMAN project would be difficult to implement in the existing primary health care systems. It is implied that certain tools and questionnaires should be adapted appropriately in the local settings prior to the implementation and the practical of the current primary healthcare providers in order to use it. The online course promotes the use of certain documentation instruments that aim at enabling a continuity of care, however, an implementation of these might not be feasible since there are numerous issues connected to questions of privacy and data safety.

Other issues related to the legal- and/or institutional framework become apparent in Slovenia where male refugees are not covered by health insurance unless it is an emergency. Therefore, PHC providers are not able to provide adequate care for male refugees with e.g. chronic diseases. Hungary reported implementation barriers in terms of logistics, and the use of interpreters. In other intervention countries (Greece, Austria, Croatia, Italy), similiar barriers were reported that concerned the lack of support staff, such as interpreters or cultural mediators. A lack of multidisciplinary teams in some of the intervention countries equally hinders the application of certain knowledge in the practice. In Austria, general the PHC providers (GPs) do not work in teams, because there is no encouragement within the legal framework to cooperate in multidisciplinary teams.

Despite the above illustrated challenges a **gain of knowledge** for PHC providers through the course became visible in the implementation of the online course: The project partners in Slovenia reported that doing the online course led PHC providers to gain awareness and to identify existing problems in the care for refugees. Participants in Austria reported having this knowledge it was easier for them to provide compassionate and culturally sensitive health care for refugees. The evaluation of the implementation in Greece showed that the PHC providers that participated in the online course were better able to deal with certain

aspects of Primary Health Care for refugees such as mental health or cultural aspects than they were before the training.

Recommendations Online Course

- Sufficient time and resources need to be availble for adaptation and translation of the online course to a country specific setting in order to ensure comprehensiveness of the content.
- The translations of the content of the online course need to reflect the semantic meaning of the original template. The course providers, therefore, need more time and financial resources to ensure that translators that are familiar with the respective fields of knowledge are engaged to do the translations.
- In the future, making available a version of the course that can be downloaded and be done offline would potentially make the online course even more accessible. Participants especially in settings without good Internet connection might profit from this option.
- The online course can be improved in terms of didactic and instructional design of the course. In general, the course would improve by allowing more interactivity: include more videos, face-to-face trainings, role-plays, workshop, interactive methods, etc. We propose the creation of a chat room so participants could interact, discuss and to apply questions.
- It is recommended to advertise the online course with well-designed promotion material that communicates the core message and the incentives for the participants continuously during the period of time the course is available and updated.
- We propose that local, regional and national authorities in a respective country advertise and endorse the online training material so that more PHC providers can be trained.
- Each country/organization that adapts, translates, and makes the course available to PHC providers, should ensure that strong incentives, such as CME points that are valuable and usable to medical doctors or similar for other professional groups, are provided.
- Explicitly promote EUR-HUMAN online course as qualification program for medical personnel working in initial reception centres and distribution centres and strongly

advise all GPs and other health care providers to attend the course. Another option would be to make the course mandatory for all PHC providers who work with refugees.

- To fully understand the process and outcome of implementing the online course in all country specific settings, as well as the gain of knowledge of the PHC providers, it would be advisable to develop more specific evaluation methods and to find new approaches how to understand not only the PHC providers' but also, the refugees or other migrants' views on the potential improvement of the online course.
- Lobbying on a policy level is needed so as to allow PHC providers to apply the gained knowledge.
- The most important recommendation is to ensure the availability of the online course after the end of the EUR-HUMAN project. Adequate time and resources are needed to maintain, up-date and further develop the online course.

Integration of the training material in the curriculum of medical schools or health science faculties would enhance the sustainability of the key findings of the EUR-HUMAN.

Piloting of the mental health screening (RHS-13) and referral procedure

The piloting of the mental health screening (RHS-13) and referral procedure consisted of 1) the training of screening teams (screeners and interpreters) and 2) the actual piloting of the mental health screening (RHS-13) and referral procedure itself. It was piloted in Croatia in the reception center in Porin, Zagreb.

The biggest strength of the 1) training was that it successfully showed that mental health screening requires only a short training of PHC providers, volunteers and interpreters and in order to enable them to appreciate the specifics of this procedure and implement it in a patient/client-centred, compassionate, culture-informed and non-stigmatising way. Furthermore, the interactive nature of the training constitutes another strengthening aspect, and the sharing of experiences by interpreters and role play exercises should be particularly highlighted. No specific weaknesses were identified during or after the training.

The biggest strength of the 2) piloting of the mental health screening (RHS-13) and referral procedure was that it proved that screening can be done efficiently and in a short period of time by trained PHC staff and trained volunteers. The Refugee Health Screener (RHS-13) proved to be an acceptable, easily understood, culturally appropriate and time efficient instrument. During the mental health screening refugees and other migrants typically

appreciated the opportunity to share their needs and worries with the screeners, which opens a window of opportunity to provide brief psychosocial intervention to support their resilience. The screening was implemented in a patient/client-cetered, compassionate, culture-informed and non-stigmatizing way.

A minor weakness in the piloting was that difficulties arose to establish a systematic time schedule for interviewing due to the given setting and circumstances of the participants in Proin, Croatia. Some of the underlying reasons were that time conflicts arose with language classes and sports activities within the centre; that migrants often changed rooms or that cultural differences in perception and meaning of time prevailed. A considerable number of persons moved in and out of the facility on a daily basis, and finally, as it is an open facility, residents are free to spend time out of Porin. In terms of recruitment of participants there were some minor weaknesses in the piloting. The reasons for non-response were that some people were not living in their rooms (although registered as such) and could not be contacted; others did not open the door even after at several attempts. From those who were approached, 11 refused to participate. At the same time, about 10 persons could not participate because of the language barrier and lack of appropriate interpreter. These were individuals from Russian Federation, Somalia, Sri Lanka and Kosovo.

Recommendations

- **On the intervention level** it is recommended to clarify privacy and ethical issues before the mental health screening, as it was done in the Croatian case.
- It is crucial to establish and ensure referral pathways as a part of mental health screening and before the screening takes place in order to ensure an adequate treatment is guaranteed if a person screens positive for high level of distress as indicated by above the cut-off point score.
- **On the organizational level** is recommended that systematic mental health screening becomes an integral part of the health check-up or initial health assessment allowing all newly arrived refugees and migrants in the reception centres.
- The mental health screening should be scheduled towards the end of the initial health assessment.

- Local stakeholders (organizations involved in other projects funded by CHAFEA) which were interested in the procedure and results could be collaboration partners in the efforts.
- For screening of mental health status and issues of refugees and other migrants the instrument RHS-13 is recommended due to its features described before in this report.

Face-to-face training about mental health of refugees and other migrants

The described face-to-face training provides a complete starter-kit on mental health and psychosocial support (MHPSS) for an interdisciplinary target group of health care providers who work with refugees and migrants, ranging from professional health and allied personnel (GPs, nurses, psychologists, social workers) to paraprofessional and volunteer staff (health care volunteers, community workers, volunteers among the migrant population, cultural mediators and interpreters). The training was carried out at the FFZG in Zagreb.

The suitability of the training for different target groups is considered a great strength of the face-to-face training. The participants were actively included in role-plays and received handouts in order to support their learning efforts. The preliminary evaluation showed already that the training was highly feasible and applicable. All participants pointed out that it would have been a very useful tool at the beginning of their work in the refugee and migration context. Participants would also recommend this training to their colleagues. Another strength of the training was the interactive nature of delivering the training and the clearly outlined structure of the topics that were covered by the face-to-face training.

For Croatia, in this specific setting there where many participants which already gained extensive work experience in refugee settings and only a few topics were very new to them. The FFZG team identified barriers to implement new skills at the workplace, which were lack of staff (e.g. interpreters and specialized care providers), legal obstacles (e.g. limited access to specialized non-acute care), and lack of time in general and organizational barriers (lack of coordination and overall organizational climate).

Recommendations

- **On an intervention level** it is recommended that future trainings include even more excercises and discussions. The face to face modality of the training is strongly

encouraged, further trainings could be organized on specific related topics such as working with interpreters, unaccompanied minors, women and topics on professional self-care and burnout.

- It is furthermore recommended to dismantle the abovementioned barriers for implementation of new skills at the workplace and further support capacity building efforts.
- It is recommended that in the different intervention site countries different approaches to the training might be needed and that the face-to-face training as it exists now is primarily offered to less experienced participants in order to e.g. prepare them for working in refugee settings. Thus, the target group could be paraprofessional and volunteer staff in different settings. For professional health and allied staff the face-to-face training could be available in an extended in-depth version, building on the content of the already existing training.
- **On a country level** it is recommended to deliver face-to-face trainings about mental health of refugees and other migrants to paraprofessional and volunteer staff in other countries with refugee populations.
- It is recommended to integrate the face-to-face training e.g. in the curriculum for all different kind educational training programs for groups beyond the health care profession, such as social workers, teachers, pedagogues, or persons working in refugee resettlement and housing programmes.
- The face-to-face training could be established in the curriculum for medical students and persons working in public health research.

Further recommendations

In order to improve the implementation and the capacity building efforts within WP6, there are several general recommendations that go beyond the scope of the EUR-HUMAN project, or concern all interventions and underlying trainings described above.

- Collective action approach for interventions and underlying training: We recommend that the trainings take place as coordinated effort of different stakeholders involved care for refugees and other migrants are needed. It is recommended that training

providers build on existing structures (NGOs, other projects, etc.), and lobby for a strengthening of these structures.

- Training providers need to ensure that their efforts go hand in hand with official recommendations by policy makers, minstries etc. A common effort should also include manifold forms of cooperation of different stakeholders and different institutions.
- Addressing barriers to implementation of intervention ahead of the intervention and underlying training by ensuring that tools, guidelines as well as the ATOMiC produced by the EUR-HUMAN project partner countries are applied.
- Establish regular exchange procedures, e.g. it would be helpful for PHC providers of refugees to meet periodically so as to re-assess and re-evaluate the situation regarding for instance the psychological effects on PHC providers and their need for psychological support, or a re-adjustment of management approaches concerning e.g. mental health problems – on a local level, on a country level and on an international expert level.
- Improve the continuity of care between different countries and within different organization involed in refugee care in a country by ensuring a complete documentation on patients' histories and courses of disease. A safe, adequate, practical health information tool or electronic patient record that can be accessible for health care providers and will facilitate the continuity of care needs to be developed.
- Promote provision of PHC by multidisciplinary teams both for the general population and for refugees and other migrants.
- The additional efforts for the PHC need to be recognized in the time management and the compensation for services by the health insurance system. In some countries there is no incentive for the PHC to work for instance in culturally sensitive ways. The efforts need additional incentives. This demands changes in the health insurance system.
- It is proposed the provision of healthcare services to be supported by an electronic patient record as well as an e-smart card.
- Warrant the existence of enough and paid health professionels and infrastructure resources (it could be applicable in some settings).
- We recommend a clear inclusion strategy of health care providers who have flight experience or migration background. Potentially they can be integration facilitators for their own communities in destination countries in terms of health care. They can enhance health literacy of their communities in a culturally sensitive way. Thererfore,

migrant health care providers need to be included in trainings such as the ones developed by the EUR-HUMAN project.

Conclusion

The outcome of the EUR-HUMAN project is a portfolio of comprehensive checklists, guidelines, guidances, tools and training materials. The piloting of some of these instruments showed that they are well applicable and deliver good results in strengthening the capacity of PHC providers. The need for piloting these instruments was appraised by using the ATOMiC developed in WP3.

Piloting the **online course** in Greece, Italy, Croatia, Slovenia, Hungary, and Austria, which are countries with different preconditions concerning the PHC for refugees and other migrants, has shown that, with the prescribed adaptations, the course was functional and suitable to all different settings. The courses potential for adaption and usefulness in different setting has thus been demonstrated. There are different preconditions and diverse challenges in each of the countries that host refugees and other migrants. Nevertheless, all of the different topics tackled in the different modules are of interest to the PHC providers in all of these countries; only the prioritisation of the topics in each setting is different.

The format of the course makes it possible to train a large number of PHC providers in a comparable short time. The format also makes it possible to easily, and quickly update the content, a fact that is especially important in regard to the comparably fast changing situation and the changing regulations concerning refugees and the health care for refugees. In the development, the preparation, adaptation, and testing of the online course it became apparent that resources are needed to ensure a full versability of the online course, as adequate time and resources are needed to maintain, update and further develop the online course.

The online course is an enabling instrument that makes available guidelines and knowledge to PHC providers and helps them to overcome barriers in the provision of high quality, person centered, integrated, holistic health-care for refugees; it has the potential for building the capacity of PHC providers. A larger roll out of the online course is thus recommended, because it is a convenient, flexible instrument that promotes skills, knowledge, and life-long learning. It is an effective tool for awareness-raising among PHC providers on the manifold issues of the refugees and other migrants, and for sensitizing the PHC providers to culturally sensitive health care.

It addresses the health care related needs of PHC providers and refugees that have been highlighted in the collection data phase of the EUR-HUMAN project (see: D2.1; D3.1; D3.2; D4.1; D5.1; D6.1). Based on the results of the piloting, it can be said that the course is a valuable instrument, which will be well applicable in the other countries where the course is going to be rolled out in the future. It is also supported by the pilot implementation of all these learned in the training course that carried-out in the Kara Tepe hosting centre of refugees and other migrants (Lesvos island, Greece).

The need for capacity building in the area of **mental health** was a conclusive finding throughout the EUR-HUMAN project and its previous workpackages (WP2 – 6). The need for piloting the screening and referral procedure as well as the face-to-face training about mental health for refugees and other migrants was appraised using ATOMiC developed in WP3 (D3.1,2).

The piloting of the screening (RHS-13) and referral procedure was based on using a validated tool and principles derived from scientific reserach and practice (described in D5.1) were applied. The Croatian piloting proved the intervention and underlying training to be acceptable, easily understood, culturally appropriate, time efficient and furthermore supports resilience of refugees and other migrants. The RHS-13 instrument as well as the piloted procedure was extremely suitable for mental health screening and referral. The impementation facilitated patient-centredness, compassion, culture-sensitivity and non-stigmatization. It is strongly recommended that a systematic mental health screening and referral procedure is integrated into healh check-ups/ initial health assessments for all newly arriving refugees and migrants.

The piloting of the face-to-face training about mental health and refugees and other migrants was based on powerpoint-presentations and a detailed step-by-step guidebook developed by the FFZG team. The Croatian piloting showed that the implementation of the intervention and underlying training had a high level of applicability, feasibility and usability. The roll out of the mental health training in face-to-face modality is highly recommended in all refugee-hosting countries to strengthen capacity building of PHC providers and paraprofessional and volunteer staff. The training is available in Croatian and English, with very small adaption to other local contexts it can be implemented in any other European country.

For a larger roll out of either one of the aforementioned instruments over the next years, further funding is required, in order to continue to insure sustainable and effective improvements in the primary health care for refugees.

List of abbreviations

Table 1: List of abbreviations

ARQ	Arq Psychotrauma Expert Group
AUSLTC	Local Health Authority Toscana Centro
ATEI	Greece: Technological Education Institute of Athens
CDC	Centre for Disease Control and Prevention
CHAFEA	The Consumers, Health, Agriculture and Food Executive Agency
CPS	Croatia: Centre for Peace Studies
CME	Continuous Medical Education
CRC	Croatian Red Cross
DFP	Austria: Diplom Fortbildungs Punkte – CME for Austria
DSS	Croatia: Department of Social Services Zagreb
e-HCR	Electronic Health Care Record
EC	European Commission
ECDC	European Centre for Disease Conrol and Prevention
EFPC	European Forum for Primary Care
EPR	Electronic Patient Record
FFZG	Faculty of Humanities and Social Sciences, Zagreb
GP	General practitioner
HeF	e-Health Foundation
KEELPNO	Greece: Hellenic Centre for Control and Prevention of Diseases
IOM	International Organization for Migration
IPH	Croatia: Institute of Public Health
JRS	Croatia: Jesuit Refugee Service
JRS	Croatia: Jesuit Refugee Service
MdM	Croatia: Médecins du Monde
MEM-TP	Migrants and ethnic minority training package
MoH	Ministry of Health
MHPSS	Mental health and psychosocial support
MUW	Medical University of Vienna
NGO	Non-governmental organisation
NIVEL	Netherlands Institute for Health Services Research
NPRD	Croatia: National Protection and Rescue Directorate
ÖGAM	Austrian Society of General Practitioners
PHC	Primary Health Care
PEDY	Greece: Institution of Primary Health Care Provision in Greece
PFA	Psychological First Aid
PTSD	Posttraumatic Stress Disorder
RadboudUMC	Radboud University Medical centre
RCT	Croatia: Rehabilitation centre for stress and trauma

RHS	Refugee Health Screener (RHS-13)
SPA	Croatia: Society for Psychological Assistance
TTT	Trauma Tapping Technique
UL	Univerza V Ljubljani
UNHCR	Office of the United Nations High Commissioner for Refugees
UoC	University of Crete
UoD	University of Debrecen
UoL	University of Liverpool
WHO	World Health Organization
WP	Work Package

Annex

Co-funded by
the Health Programme
of the European Union

EUR-HUMAN

ANNEX 1

Implementation protocol of WP6

Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

Version 04.04.2016

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Co-funded by
the Health Programme
of the European Union

Content

This EUR-HUMAN implementation protocol of WP6 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Overview

Aims and objectives of WP 6

1. To enhance the capacity building for staff in Community Oriented Primary Care centres as well as other existing primary care settings with regard to refugee care.
2. To select, prepare and implement an intervention that emerged from of the WPs 2, 3,4, 5, 6 tasks 6.2 – 6.7 in a well-defined setting in existing Early Hosting and First Care Centres for refugees (Greece, Italy, and Croatia are responsible for the realization) and in existing Transit Centres and centres for refugees and migrants with uncertain residency status who have applied for asylum (Austria, Hungary and Slovenia are responsible for the realization).

To achieve the previously mentioned aims WP 6 consists of three parts:

Part 1: Summary report about the local resources available (**Deliverable 6.1 month 6** – preliminary results in month 5 should be available for WP4 already

Tasks 6.1: Identification and assessment of existing capacity of local organizations and of refugees and other migrants who have themselves worked in medical care

Part 2: Development of an e-curriculum for primary care providers who work with refugees in different settings as well as for refugees who are primary health care professionals **(Milestone 13 – month 8)**

Task 6.2: Drafting of content and structure of an online curriculum in English (month 6)

Task 6.3: Distribution of the English curriculum and material to the partners for feedback and integration of the feedback (month 6)

Task 6.4: Translation of the curriculum into Arabic (month 8)

Task 6.5: Distribution of the curriculum and training material to the partners who selected this intervention for their intervention site, for translation of the documents into their mother-languages and local adaption of the materials (month 8)

Task 6.7: Development of the e-learning curriculum (month 8)

Part 3: Interventions (months 7-11) and summary report about the interventions (**Deliverable 6.2 – month 11**)

Task 6.8:Greece has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 (tasks 6.2-6.7) in an Early Hosting and First Care Centre for refugees and migrants

Task 6.9: Italy has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 (tasks 6.2-6.7) in an Early Hosting and First Care Centre for refugees and migrants

Task 6.10: Croatia has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 (tasks 6.2-6.7) in an Early Hosting and First Care Centre for refugees and migrants

Task 6.11: Hungary has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 (tasks 6.2-6.7) in a Transit Centre or centre for refugees and migrants with uncertain residency status who have applied for asylum

Task 6.12: Slovenia has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 (tasks 6.2-6.7) in a Transit Centre or centre for refugees and migrants with uncertain residency status who have applied for asylum

Task 6.13: Austria has prepared and implemented the intervention from WP 6 (tasks 6.2-6.7) in a centre for refugees and migrants with uncertain residency status who have applied for asylum

Existing capacity of local primary health care for refugees (task 6.1)

Identification and assessment of existing capacity of local organizations and of refugees who have themselves worked as physicians or nurses

Implementation timeline

Timeframe	Actions	Partners involved
1. March – 15. March	Distribution of template on: 1) how to conduct the identification and assessment of existing capacity– **see Appendix page 9** 2) how to write the national report for deliverable 6.1	**MUW, UoC, RUMC, ARQ, NIVEL**
16. March – 21. March	Comments and feedback to MUW	**All partners**
22. March – 24. March	Inclusion of the feedback in the template	**MUW, UoC**
25. March – 30. March	Distribution of templates on how to conduct the mapping and how to write the national report for deliverable 6.1 to the intervention country partners	**MUW**
1. April – 30. April	Mapping of the existing capacity of local organizations and of refugees who have themselves worked/engaged as physicians or nurses	**All intervention countries (UoC, UoD, UL, FFZG, MUW, AUSL11)**
1. May – 15. May	Writing and sending their national reports to MUW	**All intervention countries (UoC, UoD, UL, FFZG, MUW, AUSL11)**

16. May – 31. May	Preliminary summary report of deliverable 6.1 for WP4	**MUW**
30. June	Final summary report **(deliverable 6.1)**	**MUW**

Development of an e-curriculum (task 6.2 – 6.7)

Development of an e-curriculum for primary care provider who work with refugees in different settings as well as for refugees who are physicians and nurses and would like to volunteer in refugee care.

Implementation timeline

Timeframe	Actions	Partners involved
1. March – 7. April	Draft about the structure of the e-curriculum to UoC and RUMC for discussion and feedback	**ARQ, MUW**
8. April– 30. June	Development of the curriculum in English for primary health care providers and refugees who are physicians and nurses. The e-curriculum will consist of two modules: • Relevant information for family doctors involved in refugee care in different settings • Relevant information for refugees and other migrant who are physicians and want to volunteer in health care facilities for refugees Each module will consist of several	**MUW with support from ARQ, RUMC, UoC**

	chapters some of which can be the same in both modules	
15. May – 20. May	Meeting between MUW, ARQ, RUMC (UoC?) to fine-tune the e-curriculum content with the other WP4 interventions	**RUMC, UoC, ARQ, MUW**
20. Mai – 4. June	Presentation of draft version to partners for feedback	**MUW**
8./9. June	Presentation to experts at expert meeting in WP4 for feedback	**MUW**
11. June – 30. June	Feedback from all partners and experts to MUW and ARQ	**All partners**
30. June – 26. July	Inclusion of feedback and final version in English	**MUW with support from ARQ, RUMC, UoC**
27. July –15. August	Development of the e-curriculum (English template)	**MUW, eHF**
27. July – 15. August	Translation of the curriculum into German and Arabic and sending to eHF	**MUW**
15. August – 30. Sept	Translation of the curriculum into their mother-language and sending to eHF	**All intervention countries that select the e-curriculum like Austria as intervention**
From 31. August on	**E-curriculum is available online Milestone 13**	**MUW eHF**

Implementation of interventions (tasks 6.8 – 6.13)

The six intervention countries have selected, prepared and implemented at least one intervention that emerged from WP 4, 5, or 6 (tasks 6.2-6.7) in a refugee site (First Hosting, Transit, Centre for refugees who applied for asylum).

The aim is to implement different interventions in the different sites.

Implementation timeline

Timeframe	Actions	Partners involved
June	Presentation to all intervention countries the interventions that emerged from WPs 2, 3, 4, 5, and WP6 task 6.2-6.7	**UoC, RUMC**
1. July – 7. July	Selection of one intervention per intervention country guided by MUW and UoC and the ATOMiC guideline of WP3	**All intervention countries, MUW, UoC**
7. July – 7. Nov	Implementation of the intervention selected	**All intervention countries**
7. July –20. July	Circulation of the NPT evaluation approach to all intervention countries and guidance on how to applied within their intervention	**UoL, EFPC**
7. July – 7. Nov	Concomitant evaluation of the intervention, at least one baseline- and one end-evaluation. The implementation processes should be guided by the principles of NPT, making use of NoMAD, a new quantitative measure of the implementation ability of proposed tools and guidelines.	**All intervention countries, EFPC**

10. Oct – 15. Oct	Send out a template to all intervention countries on how to write the national report about the interventions for deliverable 6.2	**MUW**
26. Oct – 10. Nov	Writing and sending the national report to MUW	**All intervention countries**
10. Nov – 30. Nov	Writing of the summary report **Deliverable 6.2**	**MUW**

Appendix

Existing capacity of local primary health care for refugees

Task: Identification and assessment of existing capacity of local organizations and of refugees who have themselves worked in primary care

Deliverable: Summary report about the local primary health care capacity available

What we need to know from each intervention country to be able to complete the task and deliverable:

- How many refugees centres, estimated number of refugees
- What kind of refugee centres
- Who is providing primary health care in these different centres (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)
- Primary health care staff situation
- Composition of the primary health care staff (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)
- Biggest challenges and barriers for primary health care providers
- What kind of tools or support would be helpful (would be important also for **WP4**), what kind of knowledge they need to bebetter prepared to treat the refugees (important for **WP6** tasks 6.2-6.7)
- Number of refugees who have themselves worked/engaged in primary care and have now applied for asylum

Methods to gather this information:

- Literature search including grey literature(existing documents on the local/national primary care capacity situation which include our questions raised)

- (Semi-)structured interviews with local primary health care providers and stakeholders involved in the organization of primary health care for refugees (~ 10 persons)
- Participatory observations in refugee camps and centres (like the report from Dean from the Croatian transit centre)

It would be optimal to combine all methods for the local report but in the context of limited resources the literature search alone is the minimum criterion.

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ANNEX 2

EUR-HUMAN

Overview of the intervention phase of WP 6 tasks 6.8 – 6.13

Version: 27th of May 2016

Authors: Kathryn Hoffmann, Elena Jirovsky, Elisabeth Sophie Mayrhuber

Title of WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

Tasks 6.8 - 6.13: Greece, Italy, Croatia, Slovenia, Hungary, Austria have **selected**, **prepared** and **tested/implemented** at least one intervention that emerged from WPs 2, 3, 4, 5 and 6 tasks 6.2 – 6.7 in a well-defined setting.

Specific objectives of tasks 6.8 – 6.13:

- to enhance capacity building for staff in Community-oriented Primary Care centres as well as other existing primary care settings (in six countries) in order to improve primary health care delivery for newly arrived refugees and other migrants with a focus on vulnerable groups
- to implement and test the feasibility and acceptability of best-practice interventions which should be multifaceted, integrated, person-centred, multidisciplinary, and needs-based regarding the local needs of primary care

providers in the well-defined intervention sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

- in existing Hot Spots or First Reception Centres in Greece, Italy, and Croatia
- in existing (Transit Centres) or Centres for refugees and migrant who applied for asylum in Hungary, Slovenia, and Austria

Overview of the intervention phase of WP 6 tasks 6.8 – 6.13

The intervention phase consists of:

- a selection phase
- a preparation phase
- a training phase
- an implementation/test phase

The aim of the intervention phase is to test to what extent the **multifaceted, integrated, person-centred, and multidisciplinary** care intervention - based on the results of the Participatory Learning and Action approach with refugees (WP2 with deliverable 2.1 (due end of April 2016) – participating countries: the Netherlands (lead by RUMC), Croatia, Greece, Hungary, Italy, Slovenia and Austria), the literature review and survey (WP3 with deliverable 3.1 (due end of May 2016) – lead by NIVEL), the consensus expert meeting held in Athens on 8th and 9th of June 2016 (WP4 with deliverable 4.1 (due end of June) – lead by RUMC jointly together with UoC and UoL), the mental health assessment and intervention (WP5 with deliverable 5.1 (due end of April 2016) – lead by FFZG), and the local capacities and needs of the primary health care providers (WP6.1 with deliverable 6.1 (due end of June 2016) – participating countries: Croatia, Greece, Hungary, Italy, Slovenia and Austria (lead by MUW)) - is feasible and acceptable in the different settings.

Overview of the timeline, tasks and responsible partner

Selection phase		
Timeline	**Tasks**	**Responsible EUR-HUMAN partner**
15. – 24.06.2016	Completion of the baseline questions for the interventions regarding the setting, the needs of the primary care providers, the local situation, and regarding the underlying training needed for the interventions which were sent out on the 15th of June by MUW to the intervention site partners	UoC, UoL, UoD, FFZG, AUSL, MUW
11. - 06.07.2016	The WP4 intervention set of guidelines and tools will be developed based on the results of WP2, the results of the literature review and survey of WP3, the results of the consensus expert meeting held in Athens (WP4), the mental health assessment and intervention deliverable (WP5), and the preliminary results of local capacities and needs of the primary health care providers (WP6 task 6.1): In this intervention set of guidelines and tools different recommendations, assessments as well as existing training materials regarding primary health care for newly arrived refugees and migrants will be described and presented. RUMC jointly with the	RUMC and UoC

	Coordinator will prepare a report with a detailed workflow chart and relevant instructions on how the pilot intervention should be implemented in each setting. Moreover, it will highlight which aspects are important to consider before selecting an intervention. In addition, guidance on the specific training (trainers and educational material) that is needed to be implemented prior the intervention will be also provided.	
11.06 – 15.08.2016	A specific underlying baseline training for the intervention will be developed which is multifaceted, integrated, person-centred as well as adaptable to the local settings, and which reflects the WP4 intervention set of guidelines and tools: • An online course for health personnel that provides primary health care services for newly arrived refugees and other migrants The English template for the online course will be developed by the 15th of August by MUW and ARQ and approved by the Coordinator (UoC) and the Steering Committee.	MUW
07.07. – 18.08.2016	Each EUR-HUMAN partner who is responsible for the implementation of a feasibility intervention has to select a multifaceted, integrated, person-centred, and multidisciplinary set of activities and underlying training (described in the WP4 intervention set) which is suitable for the local intervention setting and existing needs of the local primary care providers. As baseline training in all settings the online course described above is recommended.	UoC, RUMC, UL, UoL, UoD, FFZG, AUSL, MUW

	This baseline training should, then, be completed with a specific training for an intervention for the local needs and circumstances of the intervention setting (face-to-face trainings or train-the-trainer seminars developed and coordinated jointly by UoC, RUMC, UL and FFZG (MH)). While selecting the intervention and underlying training it is very important to consider: • The country-specific results and recommendations of WP2, WP3, WP4, WP5, and WP6. Respectively the recommendations of the Athens expert meeting (WP4) and recommendations of Deliverable 6.1 • The answers to the baseline questions • The ATOMiC implementation guidance developed in WP3 • The report jointly developed by RUMC and UoC within WP4 with a detailed workflow chart and relevant instructions on how the pilot intervention should be implemented in each setting including aspects which are important to consider before selecting an intervention	
Latest 18.08.2016	Information of UoC, MUW, RUMC, EFPC, and UL about the selected intervention and underlying training	UoC, UoL, UoD, FFZG, AUSL, MUW
Preparation phase		
19. – 26.08.2016	Development of a detailed, setting-specific implementation protocol for the intervention and underlying training. MUW will send out a related template by the 19th of July	UoC, UoL, UoD, FFZG, AUSL, MUW

19. – 31.08.2016	Country/setting-specific adaptation of the selected intervention and underlying training. E.g. adaptation of the English templates for the online course (language, content, links …) and organization of a train-the trainer or other seminar for the underlying training jointly together with UoC and RUMC.	UoC, UoL, UoD, FFZG, AUSL, MUW
07.07. – 31.08.2016	Jointly with the WP7 leader: development of comparable evaluation indicators for the interventions (process and outcomes)	EFPC, UL, UoC
01.08. – 30.09.2016	Programming of the online course by including all country-specific adaptations	eHF
Training phase		
15.09. – 10.10.2016	Depending on the underlying training selected the time needed for the training will vary; however, **the training should take place latest until mid of October**	UoC, UoL, UoD, FFZG, AUSL, MUW
Implementation phase		
10. – 31.11.2016	Implementation of the intervention selected and prepared for each setting in accordance with the protocol that was developed in the preparation phase. Depending on the intervention selected the time needed will vary; however, **the intervention should take place latest until end of November.** Concomitant evaluation.	UoC, UoL, UoD, FFZG, AUSL, MUW
20.10. – 30.11. 2016	Writing the national report about the specific intervention and results of the evaluation and sending them to MUW MUW will provide a template for the national	UoC, UoL, UoD, FFZG, AUSL, MUW

	report by the 20th of October	
30. Nov. – 28. Dec. 2016	Writing the summary report for deliverable 6.2, approval by UoC	MUW
30. Dec. 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	UoC

Funding:

This EUR-HUMAN Overview for the intervention phase of WP 6 task 6.8 - 6.13 is part of the project '717319 /EUR HUMAN' which has received funding from the European Union's Health Programme (2014-2020).

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A3. Template for the implementation protocol of the intervention(s) (12.09.2016)

ANNEX 3

EUR-HUMAN

Austrian implementation protocol for WP 6 task 6.13 as example for the national implementation protocols

Authors: Kathryn Hoffmann, Elena Jirovsky, E. Sophie Mayrhuber

Title of WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

Task 6.13: Austria has prepared and implemented the intervention that emerged from of the WP6 tasks 6.2 – 6.7 in a well-defined setting in existing Transit Centres and centres for refugees and migrants with uncertain residency status who have applied for asylum with the support of the Austrian Red Cross and Caritas.

Aim of WP 6 task 6.13: To prepare and implement the intervention that emerged from of the WP6 tasks 6.2 – 6.7 in a well-defined setting in existing Transit Centres and centres for refugees and migrants with uncertain residency status who have applied for asylum

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Content

Introduction

Many refugees and immigrants had an experience of long and dangerous journeys to their countries of asylum and immigration in which they hope to find a safer place to live and work.[1] In Austria, if refugees and other migrants apply for asylum, are not Dublin III - refugees, and are registered as asylum seekers, they are assigned to federal distribution centres where the initial health assessment is conducted by the ORS Service GmbH http://www.ors-jobs.com/de-CH/Home, a private organization commissioned by the federal government, in this case the Ministry of Interior.[8] For asylum seekers who are registered but do not get a physical place in the federal distribution centres and/or in another refugee camp the Austrian Red Cross was commissioned to conduct the initial health assessment. After registration, admission procedure and initial health assessment, asylum seekers are allocated to one of the nine provinces of Austria to refugee camps (either organised camps or private refugee accommodations). After the registration and the initial health assessment the asylum seekers receive a white card and a kind of (e-)health card or alternative (e-)health card, which incorporates financially free access to all basic health services in Austria (like for all other Austrians). **This means that in Austria for refugees who are in the asylum procedure, in general, the regular health care system is in charge of taking care of the health needs of these persons**.

This is a particular challenge for the Austrian health care system because, like this, all health providers should be capable of treating these persons with their flight-specific and bio-psycho-social health needs and not only special teams (2, 3). Particularly, the primary level of health care is challenged since the first contact with the health care system should take place here. Although Austria has a secondary care focused health care system without a primary health care sector with gatekeeping, general practitioners (GPs) are strongly recommended as first points of care (4). In Austria, primary health care teams are not common (5). GPs are the main primary health care providers. They work mainly with a health secretary and/or a nurse together in a small office and are self-employed. Other primary health care providers like physio-therapists, occupational-therapists, midwives, or

[8] Since the closing of the Balkan route there are no transit centres in Austria anymore (status 02.05.2016).

social workers do exist but mainly not as part of the office team. An average GP in Austria was already before the refugee crisis highly stressed, had a high workload, and perceived a high workload regarding unnecessary administrative tasks (6).

Description of the target group and intervention site in Austria

Since in Austria the general health care system is responsible for the asylum seekers like for all other Austrian inhabitants, the intervention targets not a specific centre or camp but targets all primary health care providers (which are mainly GPs) across the country that are responsible for the care of the asylum seekers living in different kind of centres, camps and private accommodations.

In addition, the intervention targets Arabic speaking refugees and other migrant who were PHC providers in their home countries and who are living as asylum seekers or other migrants in Austria. Austria is one of the rare countries where a network of this group exists which is a valuable resource for a health care system of a country

Description of the intervention in Austria

Against this background, it was the aim of WP 6 tasks 6.2 – 6.7 to develop an intervention which:

1. … Supports the knowledge and capacity building of an average, stressed primary health care provider who is responsible for the health care of refugees and other migrants who are in the asylum procedure as well as for the initial health assessment.
2. … Supports the capacity building through the enhancement of the specific local health knowledge of refugees and other migrants (who are in the asylum procedure) who were PHC providers in their home countries.

In WP 6 tasks 6.2 – 6.7, a multifaceted, integrated, person-centred, multidisciplinary online course has been developed as intervention for these target groups. **The advantages of an online course** are that it is timely and locally flexible and provides the possibility to adapt the course locally and target-group specifically as well as to include already existing materials,

videos and contact points of other local, national and international supporting organizations. Above all, it has the advantage that persons from all over the country are able to participate.

The content of the two online courses emerged from the results of the work-packages 2 – 5 (**deliverables 2.1, 3.1, 4.2, 5.1, 6.1**) and were developed on the basis of co-operations with national and international experts in the related fields as well as internal experts of the HURAPRIM team.

For Austria e.g. it became clear through the results of D 2.1 – 6.1 that the main challenges for PHC providers were as follows:

For primary health care providers there exist specific challenges when treating refugees under the (conventional) primary health care system. First of all systemic challenges were identified, such as the difficulty of remuneration and the lack of interpretation services available free of charge. On a more practical level, interviewed physicians referred to the problem of language barriers and communication differences as well as the lack of specific knowledge relevant in refugee care. Culture related communication differences were mentioned as challenging especially with regards to interpretation and diagnosis of trauma. Also non-verbal communication and differences in voicing symptoms were mentioned as relevant in this context. Another aspect was the lack of psychological support available to refugees that was challenging for primary health care providers, but also the lack of knowledge about mental health care support possibilities was considered problematic.

With regard to the information and documentation about the initial health care assessment in Austria, several primary health care providers and stakeholders point to the huge challenge that results from the lack of knowledge about the assessment. The situation was reported to be specifically challenging for GPs and pediatricians who usually conduct a first anamnesis with every new patient and are often uninformed about what kind of medical assessments occurred already beforehand in the country. This challenge is linked to the lack of information available to primary health care providers about what is included in the initial health assessment, e.g. possible vaccinations, etc. In terms of information, some GPs also refer to the lack of information about the health care system of the country of origin of the refugee, the home country in general as well as flight conditions, etc. and other documentation of previous disease of refugees. Then also knowledge about nutrition habits and taboos of refugees were mentioned to be helpful to overcome health related barriers. In terms of post-traumatic stress disorders, it was noted that the lack of knowledge

on specific refugee related mental health issues might be a challenge. (for a detailed overview see: National Report Austria WP6, task 6.1)

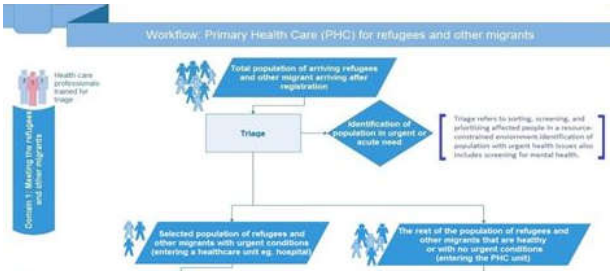
Therefore, the online course consists of eight modules. Altogether, after the online-registration the course will take two to four weeks. Since one module will take about one hour the participant has to dedicate two hours per week to the course. At the end of the course participants will receive a certificate.

Overview of the modules of the two courses

The structure of the modules will be similar in both courses; however, the content will differ.

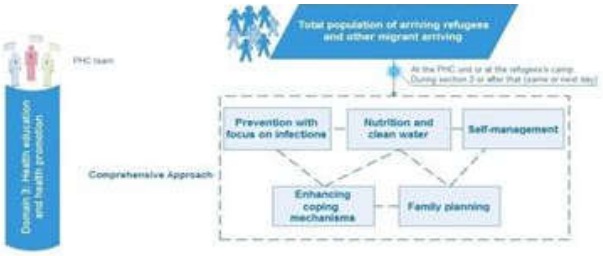
1. Introduction (with explanation which chapters are recommended for which of the three settings described in the operational handbook) **T**=triage; **F**=First contact with PHC; **L**=Long-term PHC
2. Initial health assessment, acute conditions and infectious diseases: red flags; travel disorders, wounds; infectious diseases, hygiene and vaccination, dental health; monitoring and IOM health record **(T, F)**
3. Legal issues: (legal issues and insurance for PHC providers), documentation (overall and regarding torture and violence, Istanbul protocol); knowledge about legal issues and insurance for refugees (two stamps, e-cards, e-card alternatives, etc., e-cards for children, recognition of the qualifications as health care workers) **(T, F, L)**
4. Provider – patient interaction: communication, idioms of distress, pain and diseases; information about video-interpreters; knowledge about interpreters; **(T, F, L)**
5. Mental health: burnout-prevention, avoiding re-traumatization; short and longer assessments and interventions for acute psychological stress of the refugee; mental health issues; post-traumatic distress conditions; enhancing coping strategies → WP 5 **(T, F, L)**
6. Sexual and reproductive health: special risks faced by women during perinatal and postnatal period including nutrition for mother and child, breastfeeding, ongoing perinatal care; menstruation, contraception; abortion; STD; sexual violence; gender and human rights **(T, F, L)**
7. Child health (**T, F, L)**
8. Chronic conditions, empowerment and & health literacy; elderly; terminal illnesses, death and dying; local health care system; vaccination, prevention, preventive check-ups, hygiene, nutrition, exercise; family planning, integration into society **(F, L)**

T= Triage and first assessment at entry point



F= First contact with the primary health care system

L= Long-term PHC



Description of the intervention implementation process (task 6.13 AUSTRIA)

Timeframe	Action
15. Aug. 2016 **(MS 11)**	English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course will be developed
15. Aug – 17. Sep 2016	Country-specific adaptation of the English template (language, content, links, …) For Austria: 4. Country-specific adaptation for Austrian context 5. Target-group specific adaptation for Arabic speaking PHC providers who migrated to Austria
01. Aug. – 15. Oct	**Programming of the online versions of the country-versions**

2016 (depending on the delivery of the country-specific versions to eHF) **(MS 13)**	**by eHF**
18. Sep – 15. Oct 2016	Recruiting of the participants (for Austria): • At least 30 primary health care providers (in Austria via the Austrian Society of General Practitioners, Caritas, Red Cross and Austrian Chamber of Physicians) • At least 20 refugees/other migrants that are physicians (in Austria via an established network of asylum seekers who are physicians/dentists/health care workers in Austria)
18. Sep – 15. Oct 2016	• Negotiation with the Austrian Chamber of Physicians that the physician-participants receive for the online course CME credit points (10 points)
15. Oct – 08. Nov 2016	Kick-off event for the courses (19.10. and 7.11.)
15. Oct. – 22.Nov. 2016	Online-courses: • Email-reminders for the participants • Pre- and post-tests • **End-evaluation of the online course with questionnaire provided by EFPC and UoL**
November 2016	Participants apply the new learned content into their specific setting and reflect about it which will be assessed in the general intervention evaluation by EFPC and UoL
	Evaluation of the training and other interventions by EFPC and UoL
End of October 2016	MUW will send out the template for the national report for D 6.2 to the intervention countries
01. Nov – 30. Nov	Writing the national report about the intervention and

2016	sending them to MUW
07.Dec 2016	Preliminary draft of summary report of D 6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2

Ethical approval

The MUW team is on the way to apply for a second ethical approval from the Medical University of Vienna for the implementation of the online-course and the related evaluation.

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Disclaimer:

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Funding:

"This EUR-HUMAN Austrian implementation protocol for WP 6 task 6.13 is part of the project '717319 /EUR HUMAN' which has received funding from the European Union's Health Programme (2014-2020). "

A4. Adaptation and translation guideline (02.08.2016)

ANNEX 4

EUR-HUMAN

Guideline how to adapt and translate the Modules

1. The yellow parts contain Austrian specific content, please adapt this according to your country specific situation.
2. The turquois parts contain links between modules and links to important websites, which should remain if they are useful for your country. The links which refer to Austrian organizations, etc. and are only useful for primary health care workers in Austria need to be replaced by links to organizations that are useful in your countries.
    a. If you put the link into square brackets [www.examplewebiste.com] the link will be programed as hyperlink in word that you used before like "Here you will find information on examplewebsites" [www.examplewebsite.com] If you klick on here then you will automatically be directed to the website.
    b. If a website is in the text without square brackets, it will appear as www.examplewebsite.com and be visible as link.
3. The pink references NEW PAGE, should not be translated, these are indications for HeF.
4. The fields with a grey background (family physician/ general practitioners/ health care worker) indicate the choice of your target group for the course, please choose the right term(s) and use it throughout the course. (e.g. in Austria the course targets mainly GPs but also other physicians and health professionals who are involved in PHC for refugees are free to participate)
5. If you want to use the **pictures** that we provided please leave the references [insert Picture 1] and forward the pictures to HeF separately as loose files such as .png or .jpg. If you want to include your own pictures please insert such an indication with square brackets see example above, that it becomes clear which picture you want to be inserted where.
    a. Please be aware of copyright regulations when using pictures!
6. The Modules will be built according to the ONLINE COURSE_FINAL VERSION_ENGLISH, however, of course you are free to adapt and change the Modules. Generally we would recommend to **adapt and translate** the Modules as **similar as possible** to the Modules that are available in English in order to ensure a timely proceeding.

a. The more a Module is adapted and changed the more work it is for HeF and the longer they will take to finish the translated version of the online course.
b. But of course if you change sections we would kindly ask you to indicate as precisely as possible what you have changed and who is the author, this is also extremely important with regards to copyright.

Information on the **pre-post-test questions:**

1. There will be 10 Test-questions per Module 2-8, of which 5 will be inserted as pre-test questions, and all 10 will be asked after the Module was finished.
2. We are still working on the pre- and post-test questions, as soon as we finish it, they will be uploaded to the drop box folder and you can translate the questions of the modules that you chose.
3. Concerning the certificate for online course participants, please draft a certificate for your course participants and send it with the translated and adapted modules to HeF (see below).

Some information about the **automatic login procedure** (information by HeF):

1. Implementation partners send a generic e-mail to participants with a link and a code from HEF
2. Participants click on the link and then fill in a short registration form
3. Participants get an e-mail back and then have access to specific modules

COMMUNICATION and sending of Modules:

1. If you finished translating and adapting a module, we would kindly ask you to indicate which module it is and what name it has: “Module X_Name_Language” e.g. “Module 1_About the course_German” so it is easy to recognize and assign.
2. Please send the translated and adapted modules that you chose directly to the Health[e]Foundation!!
    a. Send it to HeF: Judith de Lange: judith@healthefoundation.eu, Prof. Fransje van der Waals: vanderwaals@biomed.nl and copy the email to Corné: c.versluis@arq.org, and the MUW team: Kathryn.hoffmann@meduniwien.ac.at, elena.jirovsky@meduniwien.ac.at, and Elisabeth.mayrhuber@meduniwien.ac.at
3. Please also upload your translated and adapted modules (that you chose) to the drop box, there are folders created on the same plane as ONLINE COURSE_FINAL VERSION_ENGLISH, the folders are named according to your country:
    a. GREECE_Online course
    b. Etc.

General remarks:

1. Please make sure you only **copy/download** the content (files, pictures, etc.) from drop box to your own computer, because if you "move it to…" the whole content is not available any longer for any other person who has access to the shared folder! Thank you!
2. Between August 15th and 21st the MUW team will be on holidays, before and afterwards please contact the MUW team if you have any general or organizational questions.
3. If you have specific questions on the programming of content please contact Judith de Lange: judith@healthefoundation.eu from HeF.

Thank you for the fruitful collaboration!

Kind regards,

On behalf of the MUW team,

Elisabeth Sophie

Funding

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

Disclaimer

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

Co-funded by the Health Programme of the European Union

A5. Template for the national report for deliverable 6.2 (25.10.2016)

ANNEX 5

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (COUNTRY) – Version 10/28/2016

Report on the interventions that were implemented by the different implementation site countries

WP6, National report for Deliverable 6.2

Name of authors

Co-funded by the Health Programme of the European Union

Disclaimer

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

Funding

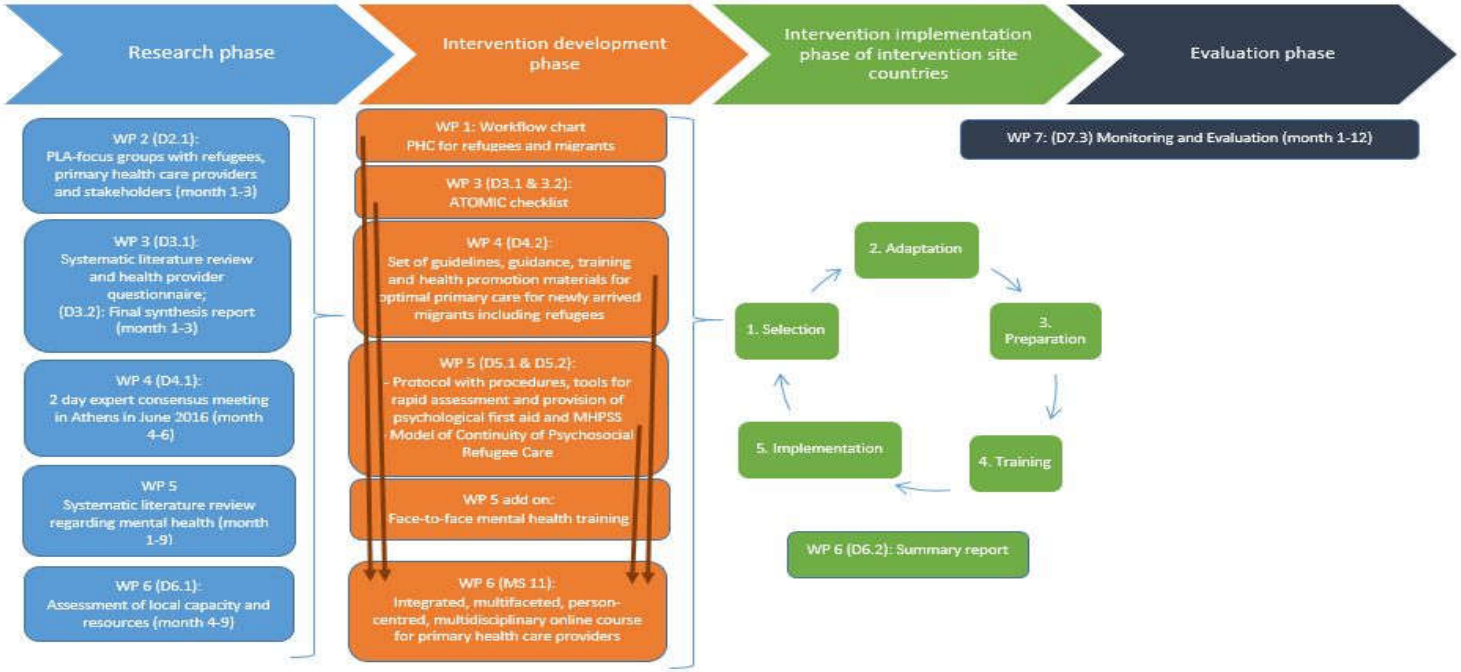
This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

Introduction

The national reports will provide input to Deliverable 6.2: Summary report on the interventions that were implemented by the different implementation site countries. Deliverable 6.2 is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WP) 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and D4.2 (WP4), D5.1 and D5.2 (WP5) and D6.1 (WP6) of the current project.

Picture 1: Work process of the EUR-HUMAN project (next page).


Research phase
Intervention development phase
Intervention implementation phase of intervention site countries
Evaluation phase
WP 2 (D2.1): PLA-focus groups with refugees, primary health care providers and stakeholders (month 1-3)
WP 3 (D3.1): Systematic literature review and health provider questionnaire; (D3.2): Final synthesis report (month 1-3)
WP 4 (D4.1): 2 day expert consensus meeting in Athens in June 2016 (month 4-6)
WP 5 Systematic literature review regarding mental health (month 1-9)
WP 6 (D6.1): Assessment of local capacity and resources (month 4-9)
WP 1: Workflow chart PHC for refugees and migrants
WP 3 (D3.1 & 3.2): ATOMIC checklist
WP 4 (D4.2): Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees
WP 5 (D5.1 & D5.2): - Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS - Model of Continuity of Psychosocial Refugee Care
WP 5 add on: Face-to-face mental health training
WP 6 (MS 11): Integrated, multifaceted, person-centred, multidisciplinary online course for primary health care providers
WP 7: (D7.3) Monitoring and Evaluation (month 1-12)
1. Selection
2. Adaptation
3. Preparation
4. Training
5. Implementation
WP 6 (D6.2): Summary report

For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSL 11), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report 6.2. aims to provide a summary about the implementation phase of the project. Evaluation results will be described in WP 7.

Tasks 6.8 – 6.13

Each intervention site country (as mentioned above) has selected, prepared and implemented at least one intervention that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and other migrants.

Commented [KH1]: Please chose here the task under which your country is described in the GA (p 23).

Specific objective for task 6.8 – 6.13

To enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Commented [KH2]: Please chose here the task under which your country is described in the GA (p 23).

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.

Picture 2: Work cycle for the intervention site partners of the implementation phase

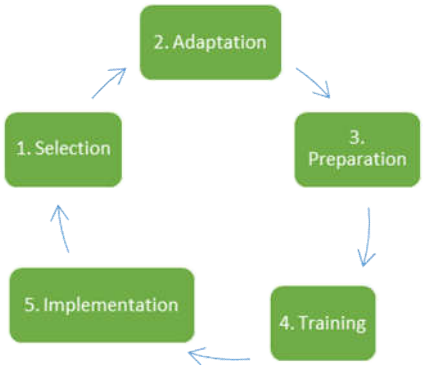


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
Until 31. Aug 2016	- WP 1: Workflow: Primary Health Care (PHC) for refugees and other migrants - D 3.1: The ATOMIC Model checklist has been developed - D 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - MS 11: English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed which content is based on the results of WPs 2-6 and includes also the checklists, guidelines and interventions described in D 3.1, 3.2, 4.2 & 5.1 - Add-on face-to-face mental health seminar has been developed by FFZG based on D 5.1 & 5.2 Intervention site partners select one or more intervention(s) which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and	Selection

	needs-based (support for the selection provides the ATOMIC checklist)	
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 6. Country-specific context adaptations (such as country specific legal system, health care system, epidemiology, links to helpful organizations and information etc.) 7. Target-group specific context adaptations 8. High quality translation (and editing) A translation and adaptation guideline for the inline course was provided by MUW to the intervention site countries	Adaptation
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to eHF)	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)** Cross-checking and last editing	Preparation
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc. • …	Preparation
15. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s)	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts • …	Preparation

15. Oct. – 22.Nov. 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • Certificates Other interventions from D 4.2: Other training(s): e.g. face to face... **End-evaluation of the online course provided by EFPC and UoL (NOMAD inventory) (WP7)**	Training
November 2016	Participants apply the new learned content into their specific working setting and reflect about it (which will be assessed in the general intervention evaluation by EFPC and UoL)	Implementation
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D 6.2
01. Nov – 30. Nov 2016	Writing the national report about the intervention(s) and sending them to MUW	D 6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D 6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2	D 6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D 6.2

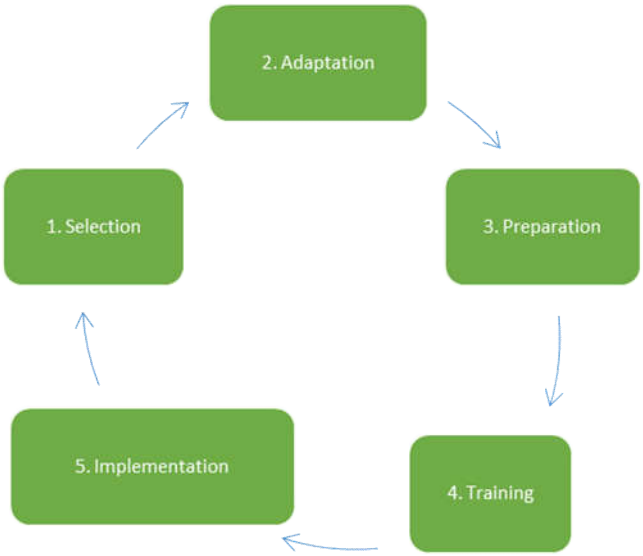
Commented [M3]: Please add if necessary

Commented [KH4]: Please, add if necessary

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a summary about the implementation phase of the project and not about the evaluation which is WP 7.

Results

1. Description of the selection step

What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention)? Please also indicate how you used the ATOMIC Model.

Commented [KH5]: You can take parts from your implementation protocol to answer this question but, please, follow the structure for the answer.

Answer: use as much space as necessary

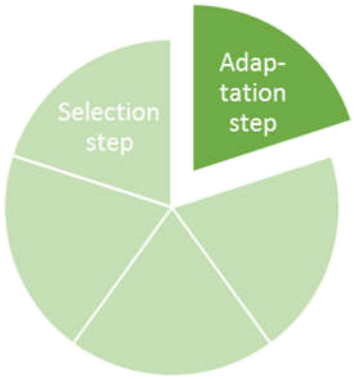
1. **Intervention and underlying training:**
    a. **Description of the first intervention and underlying training: …**
    b. **Description of the setting where the first intervention and training takes place: …**
    c. **Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1) of your country, the results of the questionnaire survey from WP3 (D3.1) for your country, the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) for your country) and how the intervention related to the guidance developed in D4.2*: …**
    d. **Detailed description of the target group in this setting (number, profession, etc.): …**

2. **Intervention and underlying training:**

a. **Description of the second intervention and underlying training: …**
b. **Description of the setting where the second intervention and training takes place: …**
c. **Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1), the results of the questionnaire survey from WP3 (D3.1), the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) and how the intervention related to the guidance developed in D4.2*: …**
d. **Detailed description of the target group in this setting (number, profession, etc.): …**

3. Etc.

2. Description of the adaptation step



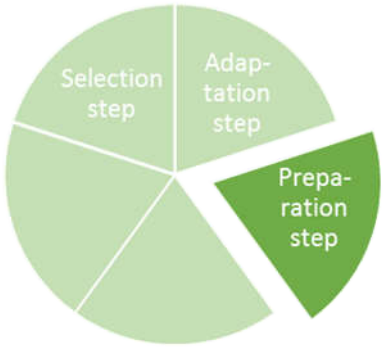
How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?
Answer: use as much space as necessary: **1. Intervention and underlying training:**

a. **Description of the specific adaptations for the first intervention and underlying training (context, language, terminology, translation process): …**

2. **Intervention and underlying training:**
   a. **Description of the specific adaptations for the second intervention and underlying training: …**

3. **Etc.**

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.

Answer: use as much space as necessary

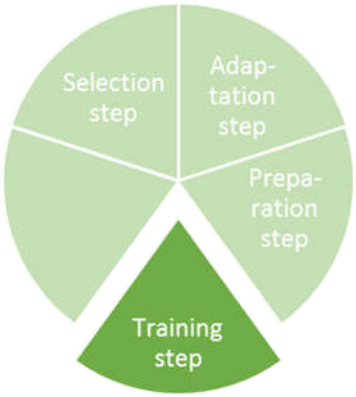
1. **Intervention and underlying training:**
   a. **Recruitment process of target-group: …**
   b. **Invitation of experts, speakers, etc. : …**
   c. **Location for training: …**
   d. **Negotiation process for CME points: …**
   e. **Kick-off event: …**

f. **Etc.: …**

2. **Intervention and underlying training:**

3. **Etc.**

4. Description of the training step



Please, describe the underlying training(s) in detail for each intervention and underlying training.

Answer: use as much space as necessary (1, 2, 3, 4)

1. **Training:**
   a. **Timeframe of the training (dates, hours): …**
   b. **Learning hours for the participants: …**
   c. **Organisation of the training (who, how, …): …**

d. **Participants (how many, which professions, …): …**
e. **Content of the training: …**
f. **Location of the training: …**
g. **Weaknesses of the training (in your opinion): …**
h. **Strengths of the training (in your opinion): …**

2. **Training:**
   a. **Timeframe of the training: …**
   b. **Learning hours for the participants: …**
   c. **Organisation of the training (who, how, …): …**
   d. **Participants (how many, which professions, …): …**
   e. **Content: …**
   f. **Location: …**
   g. **Weaknesses of the training (in your opinion): …**
   h. **Strengths of the training (in your opinion): …**

3. **Etc.:**

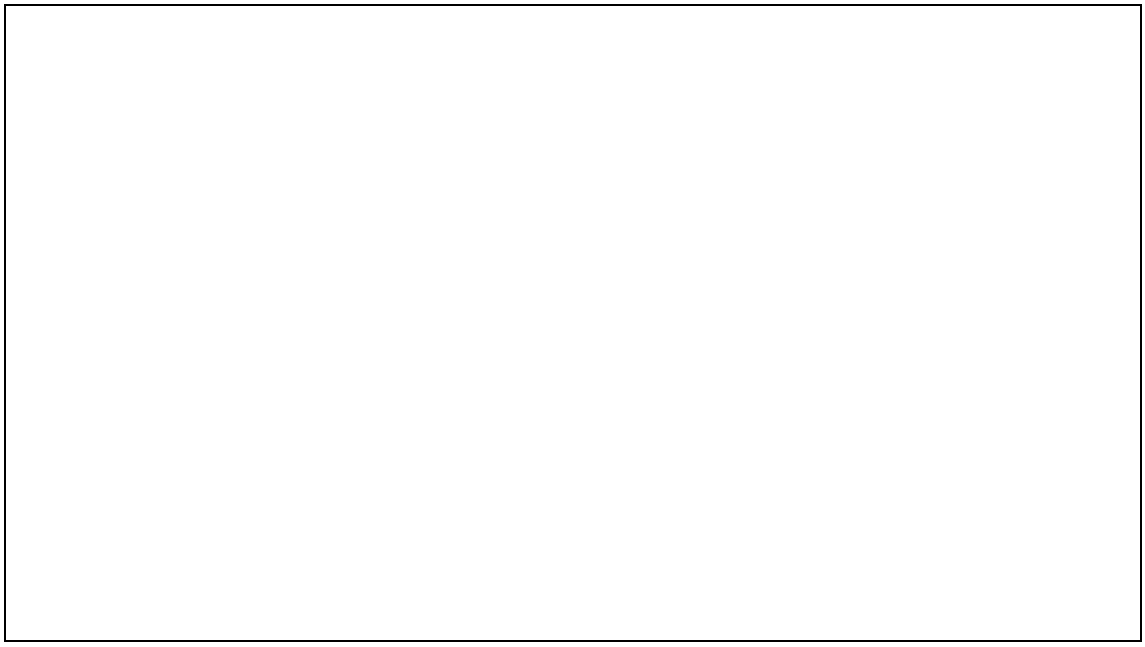
5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into their specific working setting) in detail for each intervention and underlying training.
Answer: use as much space as necessary (1, 2, 3, 4) **1. Implementation of first intervention and underlying training:** **a. When, how and where did the participants apply the new learned content into their specific working setting: …** **b. Which of the set of guidelines, guidance and trainings that were part of the learned content were applied to their specific working setting?** **c. What were the biggest challenges in terms of implementation? …** **2. Implementation of second Intervention and underlying training:** **3. Etc.**

Conclusion

Please, summarize the key points of the interventions that were implemented and suggest a few recommendations to improve intervention as well as implementation.

Use as much space as necessary



Thank you very much!

Best regards,

The Viennese EUR-HUMAN team!

A6. National Report Austria

ANNEX 6

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (AUSTRIA) – final Version 21/12/2016

Report on the interventions that were implemented in Austria

WP6, Austrian report for Deliverable 6.2

Elisabeth Sophie Mayrhuber

Elena Jirovsky

Kathryn Hoffmann

Co-funded by the Health Programme of the European Union

This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

Introduction

The national reports will provide input to Deliverable 6.2: *Summary report on the interventions that were implemented by the different implementation site countries*. Deliverable 6.2 is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WP) 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned is based on the results described in detail in D2.1 (WP2), D3.1 & D 3.2 (WP3), D4.1 and D4.2 (WP4), D5.1 and D5.2 (WP5) and D6.1 (WP6) of the current project.

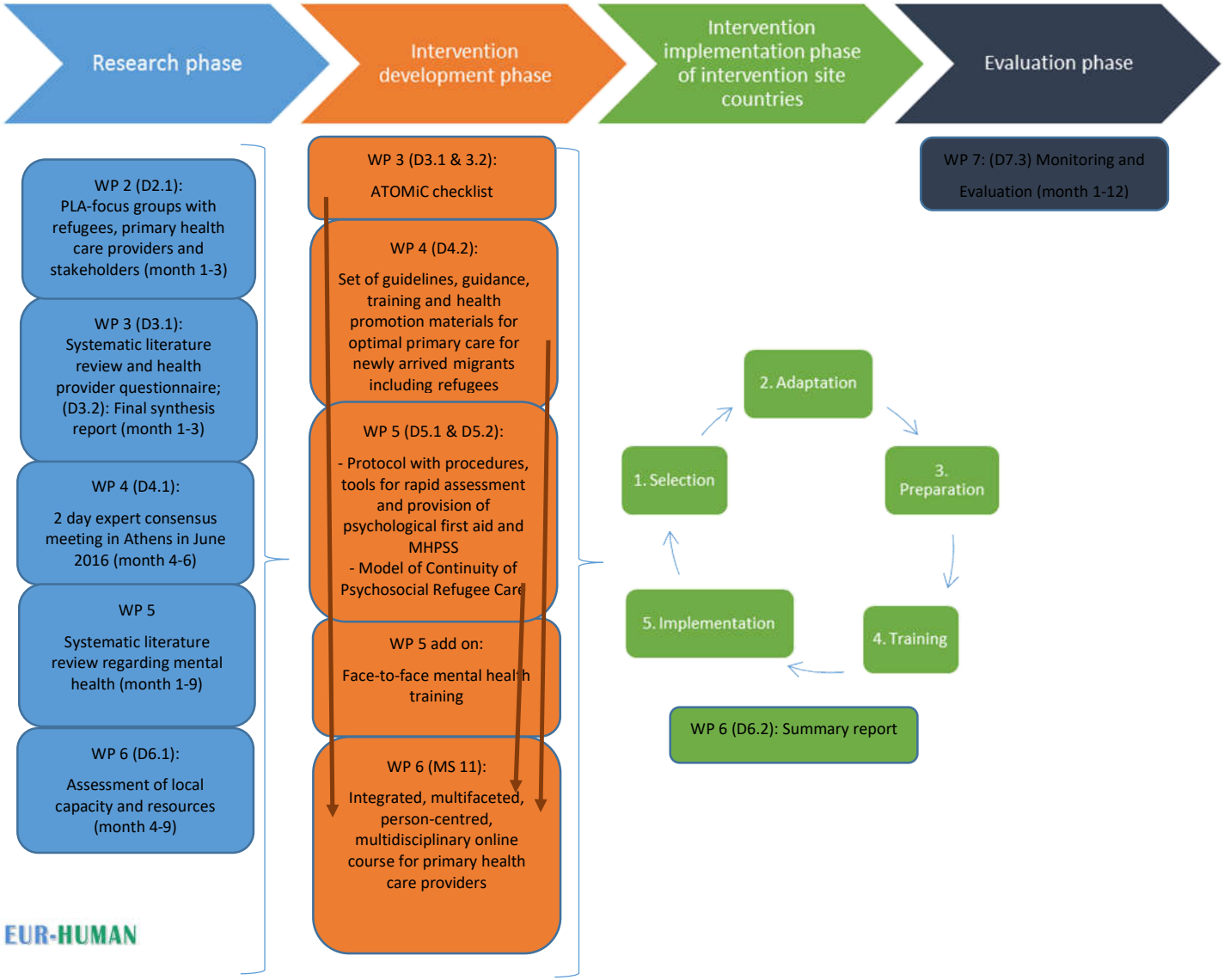
Picture 1 on the next page shows the detailed workflow process of the project.

For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSL 11), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report aims to provide a summary about the implementation phase of the project (and not the evaluation).

Picture 1: Work process of the EUR-HUMAN project



Tasks 6.13

Austria has selected, prepared and implemented the intervention that has emerged from WP 6 in a well-defined setting for refugees and other migrants.

Specific objective for task 6.13

To enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned is based on the results of D2.1 (WP2), D3.1 & 3.2 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of this implementation phase.

Picture 2: Work cycle for the intervention site partners of the implementation phase

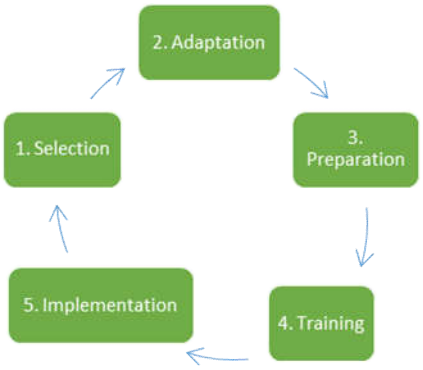


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
01. July 2016 – 31. Aug 2016	- D 3.1: The ATOMiC Model checklist has been developed - D 4.2: Set of guidelines, guidance, training and	Selection

	health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - MS 11: English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed which content is based on the results of WPs 2-6 and includes also the checklists, guidelines and interventions described in D 3.1, 4.2 & 5.1 - Add-on face-to-face mental health seminar has been developed by FFZG - Intervention site partners select one or more intervention(s) which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and needs-based (support for the selection provides the ATOMiC checklist)	
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 9. Country-specific context adaptations (such as country specific legal system, health care system, epidemiology, links to helpful organizations and information etc.) 10. Target-group specific context adaptations 11. Translation (and editing)	Adaptation
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to HeF)	- Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13) which is a sub-contractor of ARQ - Cross-checking and last editing	Preparation
15. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s)	Preparation

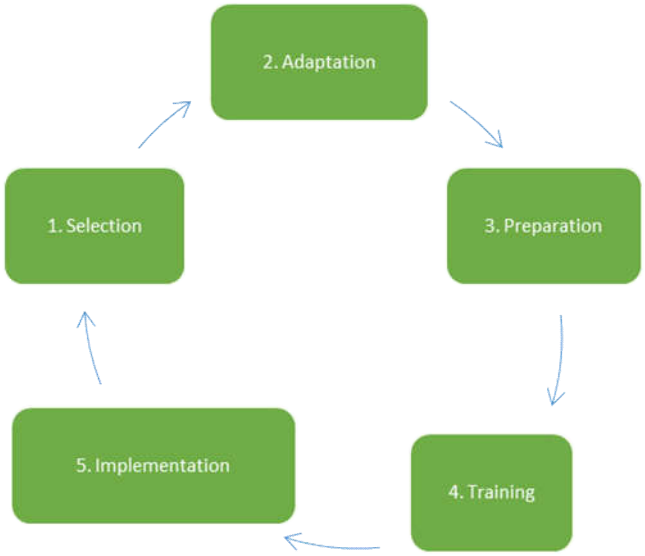
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc.	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts	Preparation
15. Oct. – 22.Nov. 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • Certificate procedure • Assistance for participants **Start of WP7 (EFPC is responsible): End-evaluation of the online course with questionnaire provided by EFPC and UoL (Nomad inventory)**	Training
November 2016	Participants apply the new learned content into their specific working setting and reflect about it (which will be assessed in the general intervention evaluation by EFPC and UoL)	Implementation
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D 6.2
01. Nov – 30. Nov 2016	Writing the preliminary national report about the intervention(s) and sending them to MUW	D 6.2
07. Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D 6.2
16. Dec 2016	Final national reports about the intervention(s) and sending them to MUW	D 6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2 sending out the draft D6.2 to all partners on 22.Dec	D 6.2

Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D 6.2

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle and the ATOMiC checklist in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a summary about the implementation phase of the project (and not the evaluation).

Results

1. Description of the selection step

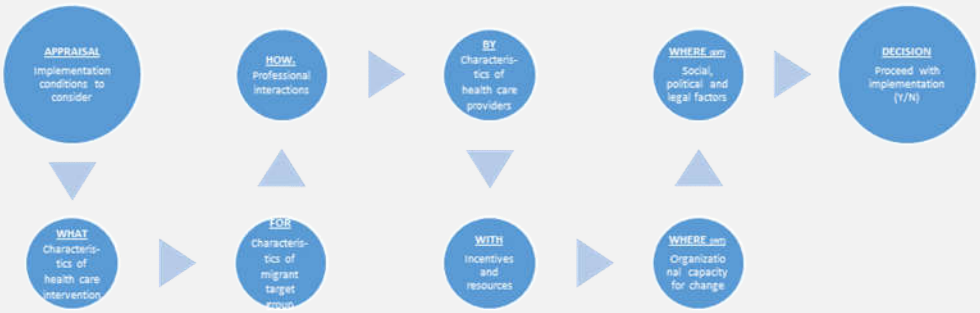
What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention(s))? Please also add how you used the ATOMiC Model checklist.
The decision which kind of intervention to select out of the EUR-HUMAN portfolio has been made with the support of the ATOMiC checklist, which has been developed in WP 3 and was presented and described in-depth in D 3.1, D 3.2, and D 4.2 of the project: 

Fig.: ATOMiC checklist

The questions answered in the following describe the kind of intervention as well as summarize the questions raised in the ATOMiC checklist, which have been answered for each country already more in depth in D 2.1, D 3.1 & 3.2 and D 6.1.

4. <u>Intervention and underlying training:</u>

a. Description of the first intervention and underlying training

In WP 6 tasks 6.2 – 6.7, an English template for a multifaceted, integrated, person-centred, multidisciplinary online course has been developed for the target group of primary health care providers who are responsible for the health care of refugees and other migrants in the asylum procedure as well as for the initial health assessment.

The course was developed based on the results of WPs 2 (*D 2.1 – PLA groups with refugees and other migrants*), 3 (*D 3.1 & 3.2 – systematic literature review and questionnaire survey with stakeholders*), 4 (*D 4.1 – expert consensus meeting*), 5 (*D 5.1 & 5.2 – literature review regarding psychological first aid and MHPSS & Continuity of Psychosocial Refugee Care*) and 6 (*D 6.1 – assessment of local situation and resources available via semi-structured interviews with primary care providers and stakeholders, narrative literature review and participant observations*). The course also includes the checklists, guidelines and interventions described in D 3.1 & 3.2 (*ATOMiC checklist*), D 4.2 (*Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees*) and D 5.1 (*Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS*) of the EUR-HUMAN project. Experts in particular fields supported the development of the course and created corresponding content.

The English template consists of 8 modules (including an introductory module):

- **Monitoring of the health status and initial health assessment, flight-specific health needs and red flags, infectious diseases, and vaccination**
- **Legal basis for PHC providers regarding health care for refugees and other migrants**
- **Provider-patient interaction (communication, relevance of culture in medical practice)**
- **Mental health and psychological support, first aid for stress reduction in people with**

primary and secondary traumatization

- **Sexual and reproductive health**
- **Child health**
- **Health promotion, prevention, and chronic diseases**

For the country-specific use, the English template needed the following country-specific adaptations:

- **The content had to be adapted for the particular country's legal system, health care system, epidemiology, as well as links to helpful organizations and information in that particular country were added.**
- **Target-group specific context adaptations (physicians, nurses, midwifes, PHC teams etc.)**
- **Translation (and editing)**

In Austria, as first intervention and underlying training, the online course was selected and adapted for the Austrian context. The main target group for this first intervention and underlying training was GPs and other primary health care providers who are involved in health care for refugees. The course in Austria consists of all 8 modules that take into account the specific Austrian situation. The online course was adapted and translated into German by the Austrian EUR-HUMAN team members and crosschecked for completeness of content and for readability. Then, the course was made available on the online platform e-Health Foundation.

b. ***Description of the setting where the first intervention and training takes place***

The participants were able to do the online course at home or in their practices all over Austria with individual time management, participants were encouraged to finish the course within a period of 4 weeks in order to be included in the evaluation (WP7). A kick-off event took place in Vienna.

c. Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1) of your country, the results of the questionnaire survey from WP3 (D3.1)*

***for your country, the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) for your country)*:**

If a person applies for asylum in Austria in most cases he/she is accommodated in a federal distribution centres, where an initial health assessment is conducted by the ORS Service GmbH http://www.ors-jobs.com/de-CH/Home, a private organization commissioned by the Ministry of Interior.[9] For asylum seekers, who are registered but did not undergo the initial health assessment in the federal distribution centres, the Austrian Red Cross has been commissioned to conduct the initial health assessment. After registration, admission procedure, and initial health assessment, asylum seekers are allocated to refugee camps in one of the nine provinces of Austria (either organised camps or private refugee accommodations). After the registration and the initial health assessment, the asylum seekers receive a white card and a kind of (e-)health card or alternative (e-)health card, which incorporates financially free access to all basic health services in Austria (under the same terms as for Austrians).

In Austria, GPs are the main primary health care providers. They work mainly with a health secretary and/or a nurse together in a small office and are self-employed. Other primary health care providers like physiotherapists, occupational therapists, midwives, or social workers are commonly not part of such office teams and are no first contact points. Already before the refugee crisis, a GP in Austria faced a high workload, and had to fulfil multiple administrative tasks leaving the GP additionally stressed. Dentists are also PHC providers by definition, however, paediatrician and gynaecologists are not, as they are secondary care providers. However, since Austria has no gatekeeping system and patients can directly consult a specialist it is very likely that Austrian paediatricians and gynaecologists conduct medical tasks which are conducted in the PHC sector by GPs, nurses or midwives in countries with strong PHC systems. Therefore, the target group for Austria is somewhat larger as all these health professionals potentially treat refugees in their day-to-day practice.

The results of D 3.1 & 3.2 as well as D 6.1 showed the following main challenges for PHC providers in Austria: First, systemic challenges were identified, such as the difficulty of remuneration and the lack of interpretation services available free of charge. Interviewed physicians referred to the problem of language barriers and communication differences as well as the lack of specific knowledge relevant for refugee care. Culture related communication

[9] Since the closing of the Balkan route there are no transit centres in Austria anymore (status 02.05.2016).

differences were mentioned as particularly challenging for mental health diagnoses. Furthermore, differences in non-verbal communication and differences in expressing symptoms were mentioned. Another aspect was the lack of psychological support available to refugees as well as a lack of knowledge about mental health care options for refugees among PHC providers in general. The challenges for the PHC providers (described in D 6.1) were clearly reflected in the results of the qualitative study with refugees and other migrants within the frame of WP2 (D 2.1): amongst others, the refugees reported severe difficulties in administrative matters resulting from their own and sometimes the doctors' lack of information; they also reported difficulties due to the language barrier. Furthermore, the refugees stressed their need for (more) psychological support.

In addition to the results of WP 2, above-mentioned challenges for the PHC providers were reflected in the results of the international experts at the EUR-HUMAN consensus meeting in Athens, which are described in detail in D 4.1.

Several PHC providers and stakeholders stressed that there are various issues resulting from their lack of knowledge about the details of the initial health assessment in Austria. GPs and pediatricians usually conduct a first anamnesis with every new patient. However, they do not receive sufficient information or documentation about the medical assessments done in the initial health assessment such as administered vaccinations.

Some GPs find it difficult that documentation of pre-existing conditions of the refugees are rarely existent, and that they do not have sufficient information about the health care system of the countries of origin, or of the home countries of the refugees in general. Furthermore, the PHC providers felt that they do not know enough about flight conditions. The PHC providers would also appreciate knowing more about nutrition habits and taboos of refugees in order to facilitate health related barriers.

The online course was chosen for the Austrian context as it is timely and locally flexible and provides the possibility of adaptation to the local conditions and the needs of the target-groups (including materials, videos and contact points of other local, national and international supporting organizations). In face of the Austrian conditions where PHC providers basically are sole proprietors, the online format was the most sensible option to reach a large number of persons in the target group in all parts of the country.

d. Detailed description of the target group in this setting (number, profession, etc.)

In Austria, the general health care system is responsible for the asylum seekers in the same manners as for all other Austrian inhabitants. Therefore, the intervention needed to target not a specific centre or camp, but primary health care providers (GPs and other physicians) across the country. GPs are all potentially involved in the medical care for asylum seekers living in different kind of centres, camps and private accommodations in the GP's catchment area. After the advertisement of the course in various networks (e.g. the Austrian Society of General Practitioners, Caritas, Red Cross and Austrian Chamber of Physicians) 61 participants were registered for the online training.

5. Intervention and underlying training:

a. *Description of the second intervention and underlying training*

In WP 6 tasks 6.2 – 6.7, a multifaceted, integrated, person-centred, multidisciplinary online course has been developed as intervention for the target group of refugees and other migrants (who are in the asylum procedure) who were PHC providers in their home countries for supporting the capacity building through the enhancement of the specific local health knowledge in Austria.

The course was developed based on the results of WPs 2 - 6 and includes also the checklists, guidelines and interventions described in D 3.1 & 3.2, D 4.2 and D 5.1 of the EUR-HUMAN project. Experts in particular fields supported the development. This course consists of 8 modules (including an introductory module) as well. The modules furthermore, take into account the specific Austrian situation and the particular target group.

For the second intervention and underlying training, the course structure remained the same as described for the first intervention and underlying training (please see the overview above). However, additional content has been added (in particular regarding legal concerns, and medical accreditation for migrants in Austria) since the target group is refugees and other migrants who were PHC providers in their home countries. This version of the online course was made

available in German and in an abbreviated Arabic version on the online platform e-Health Foundation. The target group was able to switch between the languages.

b. Description of the setting where the second intervention and training takes place

The participants were able to do the online course at home or in their practices all over Austria with individual time management, participants were encouraged to finish the course within a period of 3 weeks in order to be included in the evaluation (WP7).

c. Description of why did you choose this intervention for this setting (there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1), the results of the questionnaire survey from WP3 (D3.1), the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1):

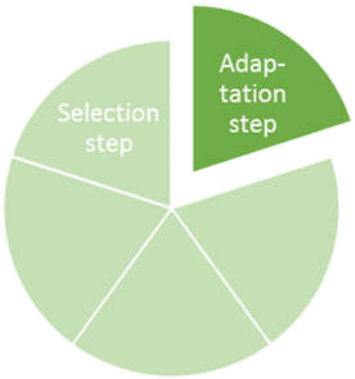
The inclusion of primary health care providers into the primary health care workforce of specific countries is of major importance. Among the refugees there are numerous trained health providers; they face a long transition period before they are able to practice their profession in the destination country. The inclusion strategy aims to include refugee primary care professionals as cultural experts and integration facilitators. Through the online course the target group is trained in order to meet the health needs of their own communities in destination countries, which will enhance health literacy of their communities in a culturally sensitive way. In the future, these trained health care providers will be important for the integration of refugee communities in the destination countries.

d. Detailed description of the target group in this setting (number, profession, etc.)

The second intervention targeted Arabic speaking refugees and other migrants who used to be PHC providers in their countries of origin and who are now asylum seekers or other migrants in Austria. Austria is one of the rare countries where a network of such a group is known to exist. The course was advertised via this established network of asylum seekers, who are likely going to be physicians/dentists/health care providers in Austria. In total, about 37 refugees/other

migrants who were primary health care providers in their home country participated.

2. Description of the adaptation step



How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?

4. Intervention and underlying training: online course for Austrian PHC providers (GPs)

a. <u>Description of the specific adaptations for the first intervention and underlying training (context, language, terminology, translation process):</u>

The English template served as basis for the specific adaptation of the first intervention and underlying training version 1. Country specific adaptations and additions were made according to the Austrian context, the primary health care system in place, and its terminology and in terms of applicability. The content was supplemented with links to supporting organizations or websites, such as the Austrian vaccination plan, ministerial websites and documents, and international guidelines (if not already included) specifically important for the Austrian context. Significant amendments were, for instance, the addition of details on the initial health assessment in Austria (module 2) and the addition of an overview on prevention measures, health check-ups, and health promotion in Austria (module 8). Module 3 on legal issues refers to the legislative framework of Austria especially in regard to patient-doctor interactions. In module 5, a chapter on nonverbal initial interventions after a traumatic event, which can be

applied especially when there are language barriers, was added. Furthermore, module 8 was supplemented with a chapter on LGBTIQ (lesbian, gay, bi-, trans, intersex, queer), which appeared relevant for Austria, as incidences of discrimination and assault to LGBTIQ persons have been reported in the news.

The text of the online course was adapted and translated into German by the Austrian EUR-HUMAN team members and crosschecked for completeness of content and for readability.

The programming of the online course was realized in close collaboration with Judith de Lange from HeF, which is a sub-contractor of the EUR-HUMAN partner ARQ. We used the export content document of the already programmed English course template to adapt it to the German version 1. According to the translation guideline we kept headings in English and inserted the German translation next to it. For added additional chapters we made comments and explained the changes. HeF implemented these changes.

5. Intervention and underlying training: online course for refugees and other migrants who were PHC providers in their home countries

a. <u>Description of the specific adaptations for the second intervention and underlying training:</u>

Version 1 of the course (for Austrian PHC providers) served as the starting material for the second intervention and underlying training for refugees and other migrants who were PHC providers in their home countries (versions 2 and 3). The online course version 2 was especially adapted for the second target group and complemented with several chapters. The overall target group specific adaptation comprised of changing the welcoming and introductory sections of all modules and the way participants and their specific situation are addressed in the text. In module 3, a chapter on the legal situation when working as a volunteer was added, and in module 8 a chapter on the process of validation of foreign study degrees (Nostrification) was added. Alaa Nadar, a dentist from Syria, who is currently in the process of validation of his foreign study degrees (Nostrification), was sub-contracted for independently checking and revising version 2 of the online course, he checked the content for necessary target group specific revisions and assessed linguistic comprehensiveness of the course content.

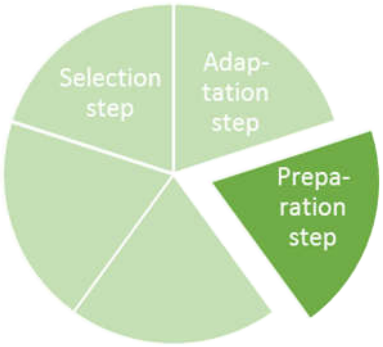
An abbreviated version of version 2 was also translated into Arabic; this is referred to as the

version 3 of the online course (which constitutes a component of the second intervention and underlying training). We decided on cuts based on relevance for physicians and health care providers who have experienced flight themselves or have migration background in discussion between MUW team members and Mr Nadar. The following modules were prioritized and translated into Arabic in an abbreviated version: module 1, module 2, module 4.2, module 5.1, module 6, and module 8. Module 3 on legal issues is available in a full Arabic translation. The modules 4.1, 5.2 and 7 were deemed to be less relevant for the specific target group and are only available in the German version 2.

Interlingua Language Service (ILS) GmbH was commissioned to translate the shortened online course content from German into Arabic as "premium translation" in accordance to their offer from 9th Sept 2016. The translation occurred between the 3rd and 24th October 2016. Mr Nadar cross-checked and proofread the Arabic content for target group specific revisions and linguistic comprehensiveness.

After registration at the online portal, participants can switch between the two languages.

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.

4. Intervention and underlying training: online course for Austrian PHC providers (GPs)

a. Recruitment process of target-group:

The MUW team pursued a diverse recruitment strategy. First, a kick-off event was organized and

advertised through various channels (see below). The speakers and stakeholders at the kick-off event as well as the authors of the online course advertised it in their networks. The course was advertised in the "medical aid for refugees" network which was an initiative of different aid organisations, private initiatives and pro bono physicians and health care providers. Hilde Wolf from FEM (module 6) informed us that she forwarded the course to the diversity and further education appointee of the Viennese hospital association OAR Reinhard Faber. Mariella Jordanova-Hudetz from Ambermed, which is an organization providing health care for uninsured people in Austria, sent out the online course information via email. The course was also promoted through the email newsletter of the Austrian Society of Public Health (on the 24th of October) and the network of the Austrian Society of General Practitioners (ÖGAM). The course was also advertised through the project teams' personal networks. The online course was furthermore advertised at a symposium on "Flight from a women's perspective: is health falling along the wayside?" on October 18th 2016 in Vienna, where Dr Jirovsky held a plenary speech on Austrian results of WP 2. The online course was also advertised on the website of the Department of General Practice website of the Medical University of Vienna (http://allgmed.meduniwien.ac.at/) and the online DFP-calendar (calendar on CME accredited courses and events).

b. Location for training:

As the selected intervention consists of an online course the location of training is the physicians/ GPs/ primary health care providers own office or computer.

c. Negotiation process for CME points:

The MUW team applied for the CME points (DFP points) at the Austrian Medical Chamber, the accreditation required the approval of a lecture board (Dr Manfred Maier and Dr Armin Prinz). Subsequently, Dr med. Wutscher, who is the appointed accreditor for the field of general practice, allocated the points. The completion of the full online course (8 modules) was accredited with 10 CME points (medical points).

d. Kick-off event:

The kick-off event was organized to promote the online course, and to inform about the

registration procedure, the CME points, and the evaluation. The kick-off event had been subcontracted to the Caritas Vienna; in the Caritas Dr med. Alice Wimmer was responsible for the organization and coordination of the event. The invitation to the kick-off event was sent out to the Caritas mailing list of 450 persons. The invitation for the kick-off event was also sent out via the mailing list of the Austrian Society of General Practitioners (ÖGAM), which comprises 1231 e-mail addresses of GPs across the entire country. It is highly possible that there were several persons on both mailing lists. In total, 55 persons registered for the event with Dr Wimmer, and 37 persons attended the evening event.

The kick-off event took place on 21st October between 18:30 - 20:30 at the Grüner Salon, *mag*das Hotel, Laufbergergasse 12, 1020 Vienna. Several interested persons, who could not attend the event, were nevertheless later added to the list for invitation/registration emails for participating in the online training.

The kick-off event was accredited with 2 DFP (other points), promoted through the DFP calendar and through the website of the MUW Department of General Practice and Family Medicine (http://allgmed.meduniwien.ac.at/).

i. Speakers at the kick-off event:

The speakers of the kick-off event were invited by MUW and involved different stakeholders relevant for the recruitment and implementation of the online course. Mag Ditto from the Federal Ministry of Health and Women, Dr med. Wilhelm-Mitteräcker, a GP and active in the Viennese Society of General Practice and Family Medicine, Dr med. Woechele-Thoma, MSc, also a GP and medical director of the Caritas (acting as host of the event), and Dr med. Al-Jord a physician from Syria who now works at the Caritas, were speaking. Prof. Kathryn Hoffmann, the Austrian EUR-HUMAN coordinator, held a welcome speech via video-stream. The MUW project team (Dr. Elena Jirovsky and Mag. Sophie Mayrhuber) presented the different modules of the course, the registration procedure and the background of the project.

5. Intervention and underlying training: online course for refugees and other migrants who were PHC providers in their home countries

a. **Recruitment process of target-group:**

The MUW team also pursued a diverse recruitment strategy for the second intervention and underlying training. The target-group of physicians and health care providers with flight experience or migration background (see selection step above) can be considered as a hard to reach group because there exists no official association or formal register of them in Austria. However, there is an informal network (Whatsapp group) of Arab-speaking health care providers (most have flight experience, all have migration background) in Austria; it is a private initiative, which aims at facilitating exchange of news and information on validation of foreign study degrees in Austria. The network includes Arab-speaking people from Syria, Iraq, Algeria and Egypt. We gained access to the network via a key person, Mr Nadar, who is a co-organizer of the group. We sent out invitations to the kick-off event through this group. The primary language in the Whatsapp group is Arabic; therefore, Mr Nadar volunteered to serve as an important key figure in the communication with the Whatsapp group. Mr Nadar set up a specific EUR-HUMAN Whatsapp-sub-group for all persons interested in the online course.

Furthermore, we advertised the second version of the online course at the first kick-off event, which took place two and a half weeks before the launch of the second version, as several Arabic speaking doctors were present. The online-course version 2 had also been advertised in the DFP-calendar of the Austrian Chamber of Physicians.

We compiled a list with interested persons to which we sent out the invitation/registration mail on November 9th 2016. Afterwards we sent out the invitation/registration mail to persons on demand, or who could only be reached later.

b. **<u>Location for training:</u>**

As the selected intervention consists of an online course the location of training is the physicians/ GPs/ primary health care providers own office or computer.

c. **<u>Negotiation process for CME points:</u>**

The CME points (DFP) procedure for version 2 of the online course was the same procedure as described above for version 1. For version 3, which is a shortened version of version 2 and available in Arabic, the participants will not receive CME points (DFP), but only a certificate of attendance. The Austrian Medical Chamber confirmed that the CME points can be processed up

to 5 years back, thus if a participant finishes the online course now but has not yet validated the study degrees, he/she can still receive the points up to 5 years later.

d. Kick-off event:

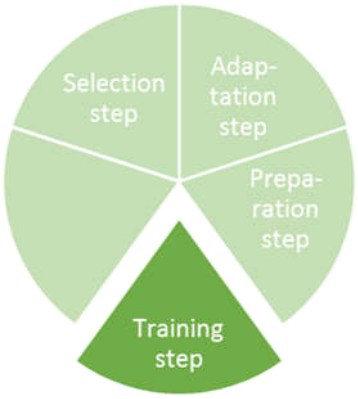
The kick-off event was organized by the MUW team in close collaboration with members of the informal network of the Arab-speaking health care providers. The district government of the 7th district of Vienna (Neubau) kindly made the district's conference hall available to us pro bono.

The event had been promoted in the above described Whatsapp group of the network of Arab-speaking health care providers; a specific EUR-HUMAN sub-group was set up for all persons interested in the kick-off and overall in the online course. The invitation to the kick-off was sent to several Whatsapp groups (all within the network) which reached in total of around 200 persons (several persons are in more than one group). In total, 28 persons registered for the event and 20 persons participated. Several persons who were not able to attend the event, but were interested in the online course, were added to the list for invitation/registration emails for the course. The Kick-off event was also accredited with 2 DFP (other points) and promoted in the DFP calendar.

i. Speakers at the kick-off event:

The speakers for the event were invited by the MUW team. Speakers included stakeholders relevant for the recruitment and implementation of the online course. The event was held in two languages, German and Arabic. Speeches that were given in German were translated into Arabic by Dr med. Ghazwan and Dr med. Al-Hachich. A welcoming speech was given by the national Austrian EUR-HUMAN coordinator Prof. Kathryn Hoffmann, the deputy district chair Mag Uhl, then Dr med. Benka from the Federal Ministry of Health and Women spoke, followed by Dr med. Al-Hachich a GP, originally from Syria, working in Vienna for 25 years. The different modules of the course, the registration procedure, and background of the project, were presented by Mag Elisabeth Sophie Mayrhuber (in German) and Mr Nadar (in Arabic).

4. Description of the training step



Please, describe the underlying training(s) in detail for each intervention and underlying training.
4. <u>Training: online course for Austrian PHC providers (GPs)</u> **a. <u>Timeframe of the training (dates, hours):</u>** **The underlying training online course version 1 was launched on October 24th and participants are encouraged to finish latest until November 30th 2016. In order to reach more participants and respond to the request of participants, the online course could be finished until December 31st 2016 as this also constitutes the end of the EUR-HUMAN project.** **b. <u>Learning hours for the participants:</u>** **The online course consists of eight modules. The first module is organizational; it provides an overview about the course structure, the learning objectives and the finishing procedure. The other modules 2 to 8 are content-related. Modules 2 to 8 consist of a pre-test, the module content, and a post-test. For each module approximately one hour of study time is recommended. Thus, a total of eight learning hours is suggested for the entire online course. The participants could follow their individual time management; they are able to switch back and forth between modules and chapters. In total, participants will have to devote approximately two hours per week to finish the course in the recommended time of four weeks.**

c. Organisation of the training (who, how…):

The course is online on the platform of the organization e-Health Foundation. The logon codes and passwords were provided to participants through online registration; the procedure is user-friendly and self-explanatory. After registration, an individually created username and password was sent to the participant with which he/she could log in and start the course.

d. Participants (how many, which professions, …):

As of December 19th 2016, a total of 61 participants registered for the online course in Austria of which 24 persons already finished the course. They were aged between 25 and 72 years, with an average age of 52,18 years. Of all registered participants, 37 were female and 24 male. Of participants who finished the course, 10 were male and 14 were female. Registered participants came from multiple disciplines but the largest group was GPs, who worked in their own practice. Only one GP was employed in a hospital. Sixteen participants did not indicate their professional background. Other disciplines that were represented are listed in the table below.

ROLE	NUMBER
GP	29
Paediatrician	2
Gynaecologist	2
Medical student	2
Psychologist	1
Psychiatrist	1
Neurologist	1
Dermatologist	1
Palliative Care	1
Occupational Health	1
Medical Law	1
Neurosurgery	1
Dentistry	1
not indicated	17
TOTAL	**61**

In terms of geographical distribution of participants we found that 22 came from Vienna, 6 from Lower Austria, three from Upper Austria, two from Styria, one from Tyrol and 1 from Carinthia. 25 participants did not indicate their federal state.

e. **Content of the training:**

The online course consists of eight modules, whereof module 1 provides an overview about the course structure, the learning objectives and the finishing procedure.

Module 2 deals with the monitoring of health status of refugees across countries, provides knowledge about the initial national health assessment procedure in Austria and provides information on flight specific health needs and red flags in a short term setting as well as infectious diseases and vaccination coverage. The module includes the bilingual IOM personal health record as well as recommendations regarding continuity of care.

Module 3 addresses legal issues regarding the medical care for refugees during and after the asylum process. It deals with the legal basis for treatment, where it can take place and by whom it can be provided, the appropriate medical treatment obligation, requirements for the medical consultation. Furthermore, the module addresses the legal aspects of language barriers between doctor and patient and provides a legal perspective on social benefits for refugees. The module also discusses the legal foundation for consent and refusal of treatment, patient decrees, health care proxy, confidentiality, and when a doctor is obligated to report something. Furthermore, it includes a chapter on insurance for doctors when working voluntary for refugees (e.g. in transit centres or at the borders).

Module 4 targets (intercultural) communication competence. The first part of the module deals with general communication strategies, non-verbal communication and aspects relevant for interpreting. Part two addresses the relevance of culture in medical practice and health care, and outlines issues such as stereotyping, idioms of distress (identifying examples from Syria and Afghanistan), and perception of mental health problems. Furthermore, it provides in-depth information about explanatory models of illness, medical pluralism, and perception of pain and cultural aspects of diseases, death and dying.

Module 5 deals with mental health and psychosocial support; it provides knowledge on mental health issues of refugees, how to recognize signs of distress, and informs about symptoms of anxiety and distress, Post-traumatic stress disorder, screening and assessment, and treatments. The module contains recommendations on how to approach refugees in need of mental health care and how to promote self-reliance but also points to mental distress in professionals, protective and risk factors and possible health complaints. The second part of module 5 offers an introduction to trauma and stress reduction; it outlines recommended strategies when dealing with reactions of traumatic experiences, and includes non-verbal procedures for

traumatized persons.

Module 6 comprises of knowledge on sexual and reproductive health and special risks and needs of refugee women. The module describes risk factors during the peri- and postnatal phase, on possible problems caused by trauma, flight and exhaustion in terms of mother and child bond, and gives an overview about the practice, the forms and effects of female genital mutilation (FGM). Furthermore, it deals with issues such as menstruation, contraception, abortion, sexually transmitted disease (STD) and sexual and gender based violence comprehensively and links to supporting organizations.

Module 7 is on child health. It contains information about special risks and needs of refugee children, provides useful tools for efficient diagnostics and therapy, the prevention of physical and mental health issues, as well as for the prevention of communicable disease in refugee children. The module deals with vaccination and immunization; it targets nutrition and diagnostic recommendations for malnutrition, adiposity and discusses how to improve compliance of to the families. Finally, it also includes the topic of cultural influence and health e.g. with regard to children and young adults who suffer from chronic disease or are physically/mentally disabled.

Module 8 is on chronic disease, promotion and health prevention. The module provides an overview on how health care is organized for refugees in Austria, the distribution of competences, insurance regulations and key facts about the Austrian health care system. It deals with strategies to support patients with acute and chronic diseases and how to enhance health literacy of patients that are asylum seekers or refugees. Additionally, the module consists of a large link collection of psychosocial support institutions in Austria.

f. Location of the training:

As the selected intervention consists of an online course the location of training is the physicians/GPs/primary health care providers own office or computer.

g. Weaknesses of the training (in your opinion):

A weakness of the current version of the online course/ the training lays in its instructional design and didactical methods, but also in the limits of the online format and the framework of the available platform. While the online course incorporates pictures, graphs, statistics, excerpts

from policy documents, links to relevant websites, to videos, to external documents, to organizations, still most of the course content is conveyed through (reading) text. Due to the given timeframe and resources of the EUR-HUMAN project, audio-visual processing of contents by means of video presentations, films, web streaming, video conferencing or other forms of processing which includes sound and visual component is limited in the current version. The course could be improved by mutual group activities, posting, sharing, blogging, commenting on content online or through actual additional face-to-face trainings, workshops or gatherings at the beginning of the online-course.

We received feedback that individual participants considered the registration procedure as too difficult and an unnecessary formality. However, the registration is necessary for receiving CME credits and therefore indispensable. Other participants had technical issues, which, however, were caused by the lack of knowledge of the users. The weakness of the course for the specific target group in Austria may lie in the online/technical nature of the training, which these participants are not used to.

Furthermore, it became clear that some recommendations of the course or tools recommended by experts in the framework of the EUR-HUMAN project, which were promoted in the course, would be difficult to implement in Austria because of the existing primary health care system (single handed practice and no multidisciplinary teams).

Additionally, it is a challenge that the course needs regular update, as the situation concerning refugees and according regulations keep on changing.

h. <u>Strengths of the training (in your opinion):</u>

The greatest strength of the intervention and the underlying training lies in its adaptability (to the country-specific circumstances and to the target group) and its applicability for users. The online training is extremely flexible in terms of participation, as the participants can log in the course whenever they have time available; the participants are flexible to choose the sequence of the modules. Furthermore, they can access the training and the platform from any electronic device (computer, laptop, tablet, phone) as long as there is internet access available.

A specific strength is also the fact that the training builds on already existing training materials and guidelines. The EUR-HUMAN online course e.g. includes parts of the *MEM-PT Training packages for health professionals to improve access and quality of health services for migrants*

and ethnic minorities, including the Roma **(2016), which was funded from the European Union in the framework of the Health Programme (2008-2013). It includes content from deliverable 4.2 of the EUR-HUMAN project: *Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees*, developed by Maria van den Muijsenbergh (RUMC) and Tessa van Loenen (RUMC). The online training, furthermore, includes the *ATOMiC tool – Appraisal Tool for Optimizing Migrant Health Care*, which is an implementation checklist described in deliverable 3.2. It has been developed by NIVEL under the lead of Michel Dückers. Module 5 of the online course which was developed by ARQ bases on D 5.1: *Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS* which was developed by Dean Ajduković and Helena Bakic from FFZG. Several modules of the course were developed by experts in particular fields and experienced in refugee care (paediatrics, immunisation, psychiatry, social anthropology…).**

The course contains up-to date information and guidelines regarding refugees, because of the excessive research phase prior to the development of the online course. It contains a comprehensive list of helpful links to NGOs, social support organisations etc. in Austria. In this regard, it is important to note that such recommended psychosocial support organizations for refugees are currently overrun.

5. <u>Training: online course version for refugees and other migrants who were PHC providers in their home countries</u>

a. <u>Timeframe of the training:</u>

The underlying training online course versions 2+3 was launched on November 8th and participants were encouraged to finish latest until November 30th 2016. However, in order to reach more participants the online course versions 2+3 was available until December 31st.

b. <u>Learning hours for the participants:</u>

The online course consists of eight modules. Each module consists of a pre-test, the module content, and a post-test, and for each module one hour of study time is recommended. Thus, a total of eight learning hours is suggested for the entire online course.The study time can be organized by participants themselves, it is possible to jump back and forth between modules and chapters. However, as the participants' native language might not be German, the study

time could be longer.

c. Organisation of the training (who, how, …):

The online course is available on the platform of the organization e-Health Foundation. The logon codes and passwords were provided to participants through online registration; the procedure is user-friendly and self-explanatory. After registration, an individually created username and password was sent to the participant with which he/she could log in and start the course. When logged in, the participants could switch between version 2 in German and the shortened version 3 in Arabic.

d. Participants (how many, which professions…):

As of December 19th 2016 there were 37 participants registered for version 2+3 in Austria whereof 21 participants already finished the course. Participants were aged between 26 and 54 years, with an average age of 35 years. Of all registered participants 9 were female (5 finished) and 28 were male (16 finished). Registered participants came from multiple disciplines, there were 5 Gynaecologists, 4 dentists and four GPs, of which two also specialised in radiology, and 10 persons did not indicate their professional background. The following table provides a more detailed breakdown.

ROLE	Number
Gynaecologist	5
Dentist	4
Dermatologist	2
GP	2
GP and Radiologist	2
Internist/Cardiologist	2
General Surgery	2
ENT physician	1
Paediatrician	1
Biomedical engineering	1
Anaesthetist	1
Urologist	1
Pharmacists	1
Nuclear medicine	1

Psychologist	1
not indicated	10
TOTAL	**37**

In terms of country of origin we found that the largest group of participants came from Syria (28 persons); 3 participants came from Iraq and one from Algeria. Five participants did not specify their country of origin. Participants came to Austria on average 2,3 years ago, the range varies between 3 months to 8 and a half years. With regards to validation of foreign study degrees ("nostrification") we found that 7 participants already finished it, 7 were currently in the process, 13 planned their validation, and 10 did not indicate any information about validation of foreign study degrees.

e. **Content:**

The online course version 2 also consists of eight modules, whereof module 1 provides an overview about the course structure, the learning objectives and the finishing procedure (please see the description above). Additional content has already been described in the chapter on the adaptation process. Version 3 of the online course consists of 7 modules, which have also been described in the chapter on the adaptation process.

f. **Location:**

The selected intervention consists of an online course; therefore, the location of training is the physicians/GPs/primary health care providers own office or computer.

g. **Weaknesses of the training (in your opinion):**

Beside the implemented adaptations and additions, several more adaptations might have been possible with a more generous time frame for the revision of the course. An additional chapter, for instance, on introducing physicians from abroad to the Austrian health care culture and the expectations of the Austrian health seeking population, could strengthen the content. In this context typical idioms of distress in Austria could be described.

It is a weakness of this version of the course that there is no comprehensive chapter on sex education as well as substance abuse and addiction in Austria, as the refugee health providers

might not be aware of corresponding national regulations.

Strengths of the training (in your opinion):

It is a strength that the participants gain comprehensive knowledge on the Austrian health care system. Furthermore, the refugee health providers get an insight into to the many referral institutions in Austria.

5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into their specific working setting) in detail for each intervention and underlying training.

4. Implementation of first intervention and underlying training:

a. When, how and where did the participants apply the new learned content into their specific working setting:

In Austria, the implementation of the training "online course version 1" began immediately during and after the training in the physicians practices or other primary health care settings. Participants applied the new knowledge and skills autonomously when they treat refugees, migrants, or other patients in their day-to-day practice. The feedback of the participants of version 1 in Austria was overall very positive and received via mail. They found the content for example "exciting and very interesting," and asked for "further advanced training offers of this type and/or about this topic" (GP, female, 28.11.2016). Module 5 was highlighted to be especially interesting (psychologist, female, 28.11.2016). Negative feedback concerned spelling

mistakes and the usage of gender sensible language, but also difficulties in the registration procedure and the layout and visual representation online.

5. <u>Implementation of second Intervention and underlying training:</u>

a. When, how and where did the participants apply the new learned content into their specific working setting:

The implementation of the training "online course version 2+3" in Austria was different: A lot of the participants are not yet working as physicians in Austria, thus the actual implementation of the intervention lies sometime in the future. Regarding their function as peers for their community the participants started immediately to bring the new knowledge to their communities. The preliminary feedback was received from discussions in the whatsapp-group, from participants of version 2+3 and was overall positive, one mentioned that "a lot of subjects in the course is forensic material, which you have to also know for nostrification" (Physician, male, 09.11.2016). Module 7 and module 5 was mentioned as particularly hard to study, as the test questions were assessed as difficult to answer (6 participants, male, 15.11.2016, and 17.11.2016).

Conclusion

Please, summarize the key points of the interventions that were implemented and suggest a few recommendations to improve intervention as well as implementation.

Improve intervention:

- Improve the online course in terms of didactic and instructional design of the course; include more videos, face-to-face trainings, role-plays, workshop, interactive methods, etc.
- Revise and cross-check questions for Module 5, 6 and 7 again
- Dedicate adequate time and resources to maintain, up-date and further develop the online course
- Ensure availability of the online course after the end of the EUR-HUMAN project

Improve implementation:

- Explicitly promote EUR-HUMAN online course as qualification program for all medical personnel working in initial reception centres and distribution centres and strongly advise all GPs and other health care providers to attend the course, support efforts should go hand in hand with official recommendation by Federal Ministry of Health and Women as well as Federal Ministry of Interior.
- In the future the online course could become compulsory for CME for Austrian physicians
- Customize CME points, the final point recognition for the online course should increase to around 20 medical points, according to the actual amount of learning hours.

Thank you very much!

Best regards,

The Viennese EUR-HUMAN team!

A7. National Report Croatia

ANNEX 7

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (CROATIA) – Version 11/10/2016

Report on the interventions that were implemented in Croatia.

WP6, Croatian report for Deliverable 6.2

Dean Ajduković

Nikolina Stanković

Co-funded by the Health Programme of the European Union

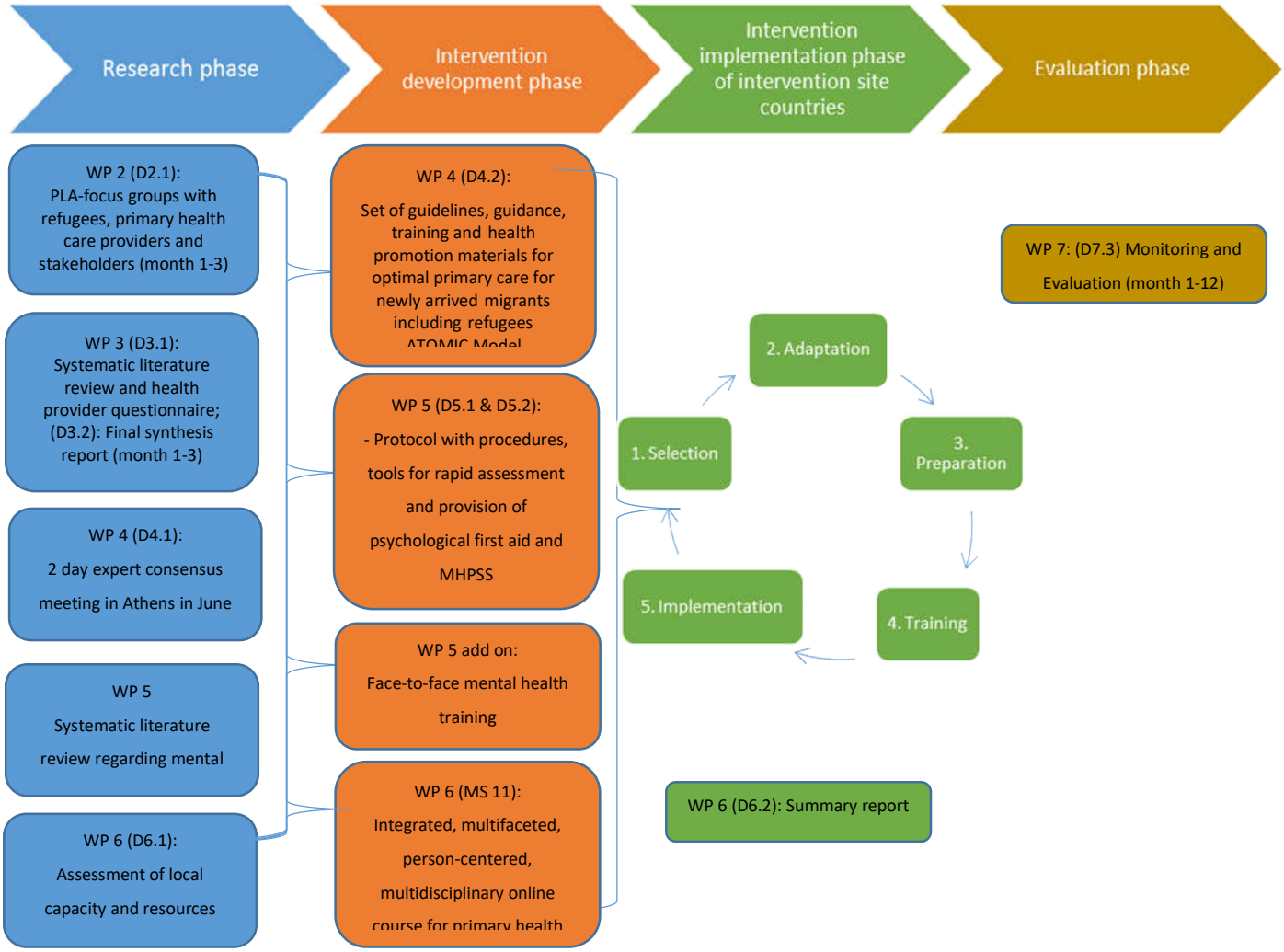
This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

Introduction

The national reports will provide input to Deliverable 6.2: Summary report on the interventions that were implemented by the different implementation site countries. Deliverable 6.2 is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WP) 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and D4.2 (WP4), D5.1 and D5.2 (WP5) and D6.1 (WP6) of the current project.

Picture 1: Work process of the EUR-HUMAN project



For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSL 11), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report 6.2. aims to provide a discerption about the implementation phase of the project.

Tasks 6.10

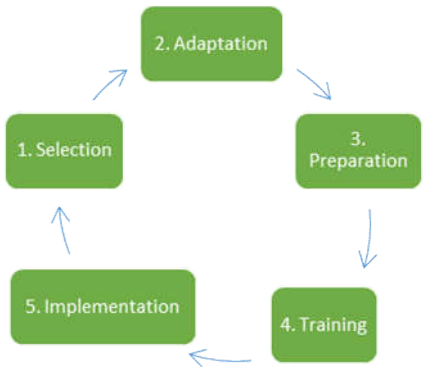
Croatia has selected, prepared and implemented at least one interventions that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and other migrants.

Specific objective for task 6.10

To enhance and support the primary care workforce in Croatia through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.



Picture 2: Work cycle for the intervention site partners of the implementation phase

Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
01. July 2016 – 31. Aug 2016	- D 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 4.2: Development of the ATOMIC Model - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed (MS 11) - Add-on face-to-face mental health seminar has been developed by FFZG - Piloting the screening for mental health procedure in the reception centre based on D 4.2, D 5.1, D 5.2 implemented by FFZG - Intervention site partners select one or more intervention(s) which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and needs-based	Selection
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 12. Country-specific context adaptations (such as country specific legal system, epidemiological picture, etc.)	Adaptation

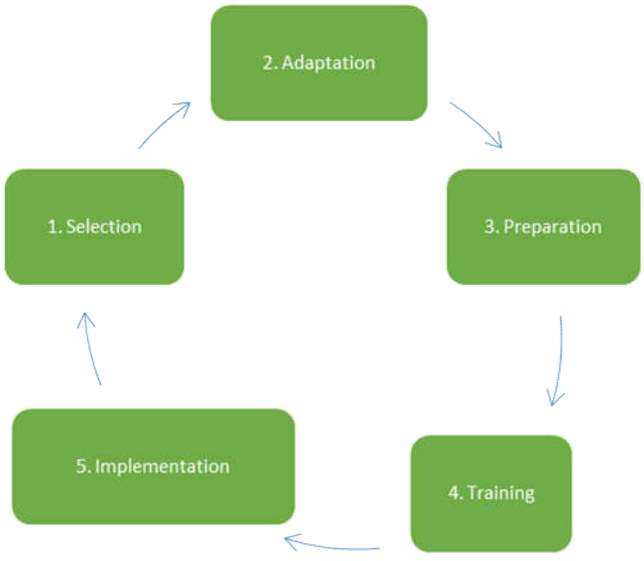
	13. Target-group specific context adaptations 14. Translation (and editing)	
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to eHF)	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)** Cross-checking and last editing	Preparation
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc.	Preparation
15. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s)	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts	Preparation
15. Oct. – 22.Nov. 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • End-evaluation of the online course with questionnaire provided by EFPC and UoL (NOMAD inventory) (WP7) Face-to-face training on Mental Health of Refugees and Other Migrants implemented by FFZG	Training
November 2016	Participants apply the new learned content into their specific working setting and reflect about it	Implementation

	(which will be assessed in the general intervention evaluation by EFPC and UoL)	
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D 6.2
01. Nov – 30. Nov 2016	Writing the national report about the intervention(s) and sending them to MUW	D 6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D 6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2	D 6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D 6.2

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a description of the implementation phase of the project.

Results

1. Description of the selection step

What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention)? Please also indicate how you used the ATOMIC Model.
1. Online course: **a. Description of the intervention and underlying training:** **The online course was prepared by the MUW for primary health care-providers that are involved in primary health care for refugees, asylum seekers and other newly arrived migrants. The online course is part of WP 6 and has the special aim to support building capacity of the primary health care providers through closing knowledge gaps regarding different issues of primary health care for refugees/asylum seekers and other newly arrived migrants in the respective countries. The course template in English was translated into Croatian and the content of all eight modules was adapted to the Croatian context.** **b. Description of the setting where the intervention and training takes place:** **The setting for the online course was home or offices of the participants all over Croatia with**

individual time management.

c. Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1), the results of the questionnaire survey from WP3 (D3.1), the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) and how the intervention related to the guidance developed in D4.2*):

An online course is a good solution when there is a large number of general practitioners that deliver primary health care services. This was the case in the transit centre of Slavonski Brod and for the PHC providers who regularly work in medical health centres across Croatia. Having in mind that Croatia is not the preferred destination country, PHC providers do not have much experience in providing services to migrants. Providers who work in two reception centres highlighted many obstacles in providing services after the refugees and migrants leave the reception centre and start living in the community. For instance, there are only few general medical practitioners who were informed about legal issues in serving people under international protection. Having an online course that can be taken by a large number of PHC providers across the country is highly efficient mode of capacity building. A great advantage is that they can take the course whenever they want during the period when the course will be accessible. The online course contains essential knowledge and skills for working with refugees and other migrants in their different stages, regarding the legal status and corresponding rights, which is very important at the period when the government plans to relocate refugees and migrants to different parts of Croatia where there is no experience with migrants.

d. Detailed description of the target group in this setting (number, profession, etc.):

The Croatian Institute of Public Health provided a list of all primary health caregivers engaged in serving migrants during their transit over the Balkan route in Croatia. The list included 200 general practitioners (GP) and nurses from different parts of the country and the GPs who work in the Reception centre for international protection applicants in Zagreb. They all have first-hand experience in delivering primary health care to migrants and refugees either in the transit or reception centre. Therefore, they were considered highly valuable resource to provide feedback on the online course.

2. Face to face training:

a. **Description of the intervention and underlying training:**

The two-day face-to-face training about Mental Health of Refugees and other Migrants aims to meet the needs of a broad group of care providers who work with refugees and migrants, ranging from professional health and allied personnel (GPs, nurses, psychologists, social workers) to paraprofessional and volunteer staff (health care volunteers, community workers, volunteers among the migrant population, cultural mediators and interpreters). The training program consists of 8 training sessions, introduction and evaluation sessions. Training sessions cover topics concerning mental health, psychosocial needs and various activities aimed at supporting and helping refugees and migrants in the context of the European migration crisis. Three sessions are scheduled on Day One and five sessions are on Day Two. Day one covers topics about refugee experiences and consequences of psychological trauma, core actions of Psychological First Aid (PFA) and mental health triage procedure. Topics on Day Two include mental health screening and referral, cultural considerations, working with interpreters, PFA for children and legal framework of international protection in Croatia. Training materials in English and Croatian comprise two power-point presentations (for Day 1 & 2) and a detailed step-by-step guidebook that were shared with the EUR-HUMAN consortium. This guidebook for facilitators describes the aims and content of the training, and includes: training schedule, a slide-by-slide guide to the contents of the training, 7 handouts for the participants, 2 role-play scenarios and an evaluation questionnaire.

b. **Description of the setting where the intervention and training takes place:**

The training about Mental Health of Refugees and other Migrants was held for a group of PHC working in refugee setting on 4th and 5th of November 2016 in downtown venue in Zagreb.

c. **Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1) of your country, the results of the questionnaire survey from WP3 (D3.1) for your country, the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) for your country) and how the intervention related to the guidance developed in D4.2***

The need for capacity building in the area of mental health is a common finding in all EUR-HUMAN project work packages. This need was voiced by refugees and migrants themselves, during the field work in WP2. Mental health problems were mentioned at all implementation sites, and they included distress related to shocking events before or during the migration

journey, depression, insomnia, fatigue, anxiety and uncertainty (D2.1). In most cases a supportive and caring dialogue (guided by psychological PFA principles) would suffice, but for some people there is also a need for more specialised psychological intervention. For example, In Austrian long-term refugee centres it a great need for mental health care was recognised, especially for children. Refugee and migrant perspective was also identified during piloting exercise of the mental health screening procedure conducted in the Reception centre for international protection applicants Porin in Zagreb, Croatia (WP5). In this intervention 80% of newly arrived refugees and migrants screened "positive" on a mental distress scale. Scientific papers (WP3, D3.1) and expert opinions (WP4 Expert Consensus Meeting; Athens; June 8th – 9th 2016) further point to the need for stepped mental health care, taking into account different stages of migrant journey. Expert consensus was especially strong on the issue of training volunteers for providing mental health care assistance, which allows task shifting and alleviating the burden of specialised care providers (D4.1). Finally, care providers perspective collected in WP6 report on local resources and challenges for primary care providers in 6 intervention countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) points out that one of the biggest challenges in service delivery to refugees and other migrants is lack of psychosocial support.

As the recognized need for capacity building for the provision of primary health care was the starting point of the EUR-HUMAN project, the consortium members defined that one of the main objectives was to identify, create and evaluate guidelines, training programs and other resources that can be made available for various stakeholders. WP6 has therefore created a multi-faceted and integrated on-line training course encompassing several important topics in primary health care, including mental health. However, based on the recognized importance of mental health care for refugees and other migrants, EUR-HUMAN project saw an opportunity for creating a special curriculum focusing on these topics that would provide deeper specific knowledge and skills building during a face-to-face training. Moreover, in line with the strategy of the EUR-HUMAN project to adapt the tools and resources to the local conditions, the face-to-face training on this specific topic was deemed culturally appropriate to the Croatian situation.

d. Detailed description of the target group in this setting (number, profession, etc.):

The invitations were sent to all relevant institutions and organizations providing services for refugees and migrants, both governmental and non-governmental, including organizations involved in other projects funded by CHAFEA under the same call which are implemented in

Croatia (IOM, Médecins du Monde and Croatian Institute for Public Health), organizations we collaborated with during piloting the MH-screening procedure (Croatian Red Cross and GPs). The target group consisted of a variety of professionals (GPs, psychologists, interpreters, social workers, occupational therapist, volunteers) with different roles in refugee settings in Croatia They were an interdisciplinary and experienced group well suited for piloting and evaluating the training. In their daily practice they face various MH issues among refugees and other migrants. Some of the participants highlighted during the session that they have learned much from own mistakes and wished they had the knowledge provided by this training when they started working in refugee settings. The training participants were members of following organizations: International Organisation for Migration (IOM), Médecins du Monde (MdM), Institute of Public Health (IPH), Croatian Red Cross (CRC), Medical Health Centre Zagreb, Jesuit Refugee Service (JRS), Society for Psychological Assistance (SPA), Centre for Peace Studies (CPS), Rehabilitation centre for stress and trauma (RCT), National Protection and Rescue Directorate (NPRD), Andrija Štampar Teaching Institute of Public Health, Department of Social Services Zagreb (DSS), Primary School "Fran Galović" Zagreb (children from the reception centre Porin are enrolled in this school). The evaluation form was completed by 27 participants aged 26 to 59 (M=33 years). They have on average 18 months of working experience in refugee and migrants setting, working from one (e.g. psychological counselling) up to 50 hours a week (e.g. interpreters), depending on their role. Most of participants (77%) have attended other courses about working with migrants (54% of them attended 3 or more courses) while 88% participants have attended courses about mental health and psychosocial support of migrants (46% have attended 3 or more trainings).

3. Piloting MH screening and referral procedure and related training

a. Description of the intervention and underlying training

Piloting.

Piloting was conducted in three stages. First, relevant stakeholders were briefed about the piloting. Approval was obtained from the chief police officer and manager of the Porin reception centre. Referral pathway was established through the medical GP in the local community health centre and the Croatian Red Cross (CRC) chief social worker. Second, interviewers and interpreters jointly took a half-day training regarding piloting procedures and other competencies for MH screening. Finally, the piloting was conducted in July 2016 in the Reception centre for international protection applicants, Porin in Zagreb. The aim was to screen all adult

refugees and other migrants living in the reception centre who agree to participate. The interview included introduction and clarification of the screening purpose, securing written informed consent, administering RHS-13 screening tool, questions about available services provided in the reception centre and refugees' needs, wishes and preferences, and discussion about the need for referral. If a refugee or migrant screened positive during the piloting, the interviewer offered referral to the GP and/or to the CRC social worker. If the individual scored below cut-off, interviewers provided information about available services and encouraged the person to seek MH assistance for themselves or their loved ones if ever the need is felt. Duration of an interview was about 30 minutes.

Training.

The training for MH screening and referral procedure was important part of the preparation step of piloting the MH screening and referral procedure. Aim of the training was to enable the screening team to conduct interviews that included introduction and clarification of the screening purpose, obtaining written informed consent, administering RHS-13 screening tool, and questions about available services in the reception centre. They received detailed information about legal application procedure for international protection and about legal rights of refugees and migrants in Croatia. A separate section of the training was dedicated to mental health and psychosocial support (MHPSS), understanding the migration process, consequences of migration as a traumatic experience, and cultural issues in communication. The purpose of screening and referral procedures was explained in detail. The training also addressed how to work with interpreters, their roles in relation to the screeners and the interviewees. The training format included short presentations on key topics, interactive discussions, sharing of experiences by the interpreters, and role play exercises based on several prepared scripts.

b. Description of the setting where the intervention and training takes place

Piloting.

The piloting took 11 working days (6-20 July 2016) in two shifts, from 9:30 to 12:30 and from 13:00 to 16:00 h at the reception centre Porin. The daily number of interviews varied, depending on the number of available dyads (volunteers and interpreters) and the schedule of other activities within the reception centre. Approximately 10 interviews were completed per day.

Training.

The training was held at the Faculty of Humanities and Social Sciences in order to prepare the screening team to conduct the MH screening and referral procedure in the reception centre for international protection applicants Porin in Zagreb, Croatia.

c. Description of why did you choose this intervention for this setting

The need for piloting the procedure for mental health screening was recognised from the previous work done in the EUR-HUMAN project. Based on the fieldwork conducted in WP2, refugees and other migrants, as well as care providers, recognised a great need for improving mental health services. While providing initial health check-up to refugees and migrants upon entering EU member countries is standard, assessment of mental health status and needs of refugees and migrants are not among high priority services in the resettlement procedures. However, from the public health perspective it can be equally important to manage, for example, the risk of infectious diseases, as to address potential psychological trauma, which can lead to increased burden to health and social services, and increased societal costs and resource drain. Furthermore, the piloting procedure is in line with the conclusions of WP4 Expert Consensus Meeting (Athens, June 8th – 9th 2016), which aimed to reach consensus on the optimal content of Primary Health Care (PHC) and social care services needed to assess and address the health needs of refugees and other newly arrived migrants. The main conclusions regarding mental health pointed out that in longer stay reception centres it is important to screen for mental health conditions, and provide referral for specialist mental health assessment and care as needed. Early identification of refugees and other migrants who are severely distressed, assessment of their mental health status and needs and providing appropriate services was deemed likely to prevent development or deterioration of mental health disorders.

Finally, the need for piloting the procedure was appraised using ATOMiC checklist developed by WP3. ATOMiC provides practical guidance in improving health care services and can be used to critically appraise the practical significance of the proposed service. In addition, it serves as a tool to rethink and improve the most important aspects of service delivery. Based on the self-reflection using the check-list, it was concluded that mental health screening procedure can greatly improve service delivery to refugees and other migrants. The proposed procedure addresses well known risk factors for developing serious mental health problems: it enables PHC providers to identify refugees and other migrants at such risk. Furthermore, it is based on using validated tool and principles derived from both scientific research and practice (described in deliverable D5.1) and offers guidance for referring refugees and migrants who screen above the

cut-off to further care and appropriate interventions. Discussing mental health problems is a sensitive topic in most cultures, and without a systematic screening procedure it is possible that people with serious problems would be overlooked. Regarding potential risks, it is important to note that every PHC provision, including MH, should be systematic and comprehensive, patient-centred, compassionate, culture-informed, non-stigmatising and integrated. Key implementation issues identified using ATOMiC checklist included the need to train the staff who will be conducting the screening, not only regarding the procedure of screening, but also in intercultural competencies, attitudes and background knowledge about psychological aspects of migration and refugee life. Furthermore, an important issue of staff capacity and available time was recognised, especially the need to ensure enough capacity for follow-up in case of positive screen. In order to standardize the MH screening and referral procedure in the pilot study it was necessary to train the screening team. A face-to-face training was a good opportunity to introduce interviewers and interpreters to each other.

d. Detailed description of the target group in this setting (number, profession, etc.):

Piloting.

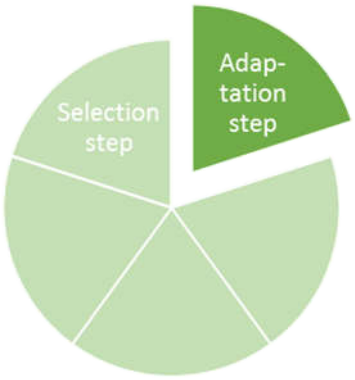
The aim of piloting the MH screening and referral procedure was to screen all adult refugees and other migrants who agree to participate. From the total number of 200 adults in the reception centre at that time, 123 participated (61.5%). Participants were primarily male (86.2%), aged between 18 and 50 years (M = 29.1), with mostly secondary education (average 11 years of formal education), who applied for international protection in Croatia (90%). According to the country of origin, most of the participants were from Iraq, Afghanistan or Syria The reasons for non-response were that some people were not living in their rooms (although registered as such) and could not be accessed; other did not open the door at several attempts. From those who were approached, 11 refused to participate. About 10 persons could not participate because of the language barrier and lack of appropriate interpreter. These were individuals from Russian Federation, Somalia, Sri Lanka and Kosovo. Participants speaking Arabic, Farsi and Urdu were assisted by interpreters in their native language, while interviews in English had no intermediator.

Training.

Participants were seven graduate students at the Department of Psychology (Faculty of Humanities and Social Sciences, University of Zagreb - FFZG) and a psychologist from Médecins

du Monde who served as interviewers, and seven interpreters for Arabic, Farsi and Urdu language.

2. Description of the adaptation step



How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?
1. Online course **The online module was translated into Croatian by a health professional with excellent proficiency in English and Croatian. Dilemmas were discussed with the WP leader as needed. The following adaptations were made:** • **All specific Austrian contents were adapted to the Croatian specific situation.** • **The photographs of the authors of each module were omitted while, of course, their names and affiliation remained. Names of the authors of Croatian adaptation were added.** • **All tables in all modules were translated into Croatian, as well as the workflow chart and other charts.** • **Module 1: Specific information about credits for completing the course in Croatian were**

included; information about initial health assessment was changed to reflect Croatian procedures; photographs were omitted.

- **Module 2: Chapter Infectious diseases: New paragraph on health assessment of migrants was added at the beginning of the chapter; page 5 Sexual Transmitted Diseases was omitted as not informative; Chapter Vaccination was adapted to the national guidelines and procedures with links to relevant national resources.**
- **Module 3 was completely changed to reflect the Croatian national legal framework.**
- **Module 4: Paragraph Specific Communication Strategies – paraphrasing, reflecting emotions and summarising was explained; non-violent communication was omitted as not relevant; section about interpreting was adapted to the Croatian situation; Paragraph Structural Conditions – examples were adjusted to the Croatian situation; Idioms of Distress - examples from Syria were not written in the Arab letters as it would not make sense for the course participants.**
- **Module 5: Links to local resources were provided.**
- **Module 6: Links to local resources were provided.**
- **Module 7: Some photographs and charts were omitted; national vaccination schedule in Croatia for 2016 was inserted; local resources were added;**
- **Module 8: Chapter One was completely changed to reflect the situation in Croatia; Chapter Prevention and Health Promotion was adapted likewise; links to local resources were added.**

2. Face to face training:

The face-to-face training on Mental Health of Refugees and Other Migrants was prepared in both, Croatian and English language, therefore no special adaptation was needed. With very small adaptation to the local contexts it can be implemented in any European country.

3. Piloting MH screening and referral procedure and related training

Piloting.

The aim was piloting the MH-screening and referral procedure described in D5.1 - *Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS*. The procedure contains following steps:

1. Establishing trust

2. Administering the screener

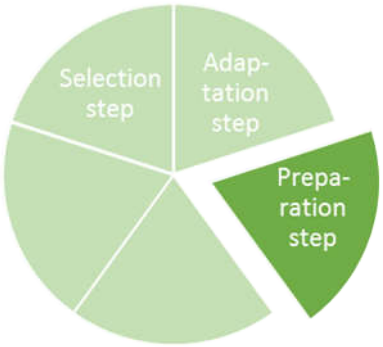
3. Evaluating the results and immediate assistance (referral if needed)

In this setting most of the refugees and other migrants went through a health check-up by a GP upon arrival at the reception centre. Because of this, the first step of the screening procedure (establishing trust) needed an adaptation. Therefore additional questions about needs and wishes were asked in order to establish contact before administering the screening tool, evaluating the results and referral as described in D5.1.

Training.

The training was specially prepared for this purpose and this target group. The training is based on the face-to-face training Mental Health of Refugees and Other Migrants (consequences of migration, psychological trauma and reactions to trauma, legal framework, MH screening procedure and working with interpreters).

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.

1. Online course:

The target groups for the online course were primary health care providers who have experience of working in refugee settings. Croatian Institute of Public Health provided a list of 200 primary health care providers (GPs and nurses) that delivered PHC services in Slavonski Brod, the Croatian transit centre on the Western Balkan migration route. Furthermore, GPs who provide

services in the Reception centre Porin in Zagreb were approached. All these identified PHC providers were sent email invitation to take the online course.

2. Face to face training:

The target group were interdisciplinary PHC providers (GPs, psychologists, social workers, occupational therapist and volunteers) with different roles in refugee setting. Training was delivered by prof. Dean Ajduković, Helena Bakić., Ines Rezo, and Nikolina Stanković. Prof. Dean Ajduković, Ph.D., is a full professor of social psychology at the Department of Psychology, University of Zagreb. He has extensive expertise in community mental health, particularly related to trauma healing and work with refugees. He served as a consultant for WHO, UNICEF, UNFPA, Norwegian Refugee Council, Catholic Relief Services, Health Net International, CARE, and regional organizations regarding to the aftereffects of war, displacement and organized violence. Helena Bakić is a Ph.D. student at the Department of Psychology, University of Zagreb, with experience and education in psychological counselling, psychotraumatology and resilience factors in recovery process. Ines Rezo is also a Ph.D. student at the Department of Psychology, University of Zagreb, with experience in counselling and psychosocial support to children and families in distress. Nikolina Stanković, univ. bacc. psych., has completed several trainings on the legal framework of asylum seeking process and has hands-on experience in psychological screening of refugees and other migrants and working with interpreters. The training was registered at the professional chambers (Croatian Medical Chamber, Croatian Chamber of Nurses, Croatian Chamber of Psychologists, Croatian Chamber of Social workers). The training took place on 4th and 5th of November 2016 in a venue in downtown Zagreb.

3. Piloting MH screening and referral procedure

Piloting.

The chief police officer and manager of the Porin reception centre was briefed about the pilot screening, and after the written request, approved it. The medical GP in the local community health centre, who serves also the population in this reception centre, was informed about the screening. His response was very positive and he accepted to receive referrals as needed. Along with the GP, referral pathways were established with CRC chief social worker. Non-governmental organizations that provide services to refugees and migrants in the reception centre were also briefed about the action. The piloting was approved by the relevant Institutional Ethic Committee. The written materials (invitation letter, written consent form and interviews question, including screening tool) were translated and adapted into Arabic, Farsi,

Urdu, English and Croatian language. Informing the participants and inviting them to take up the screening interview included invitation letters in different languages posted at bulletin boards in the reception centre, personal information via CRC staff, and personal invitation by interviewers and interpreters from door to door.

Training.

Interviewers were recruited via student groups (psychology graduates) who were invited to a meeting with representatives of Croatian Red Cross working at the reception centre who presented some aspects of working with refugees and migrants in the Croatian context. Recruiting interpreters was a bigger challenge, whereas there is a small number of people in Croatia speaking Arabic, Farsi or Urdu languages and almost all of the interpreters for these languages are already full-time engaged by other organizations working with migrants. Criteria for interpreters were: native speaker of the language, having experience in interpreting and advanced knowledge of Croatian language. In the end, there were 4 Arabic, 2 Farsi and 1 Urdu speaking interpreters. Both, interviewers and interpreters participated in a half-day training that took place at the Faculty of Humanities and Social Sciences on 23th of June. Training was delivered by the WP leader (prof. Dean Ajduković) and field coordinator (Nikolina Stanković) of piloting the mental health screening procedure in the reception centre.

4. Description of the training step

Please, describe the underlying training(s) in detail for each intervention and underlying training.
1. Online course: **Timeframe of the training.** **The online course was available for six weeks, from November 16th to December 31st on the web-portal of the Health[e]Foundation.** **Learning hours** **It was estimated that completing the online course in Croatian, including pre- and post-tests was took approximately 16 hours which is in line with standards of the Croatian Medical Chamber.** **Organisation** **The course is online on the platform of the organization Health-e-Foundation. The participants who have completed the course received 7,5 CME from the Croatian Medical Chamber.** **Participants** **By 30th November 2016 there were 28 general medical practitioners from Croatia registered as participants in the participants portal of the Health[e]Foundation.** **Content** **The online course contains 8 modules covering relevant aspects for working in refugee settings, such as acute diseases, sexual and reproductive health, mental health, legal framework, chronic diseases and health promotion.** **Location.** **Health[e]Foundation participants portal which can be accessed from anywhere with Internet connection** **Weaknesses** **The weakness of the course for the specific target group may be technical competencies required for the online learning. Another one is lack of opportunity for interactive exchange with the materials/training which is only based on reading the materials. The weakness may be also if the online course will not be continually available to the PHC providers beyond the life of the**

EUR-HUMAN project.

Strengths

The online course is time efficient way to reach a great number of professionals in various geographical locations throughout the country.

2. Face to face training:

Timeframe

The training took place on 4th and 5th November in Zagreb. The time schedule on both days was from 9 to 4 pm, including two coffee- and a lunch-break.

Learning hours

The two-day training contained 11 learning hours in total, divided into 7 hours lecture, 3 hours exercises and 1 hour of group discussion.

Organisation

The training was organised by the local team of the EUR-HUMAN project from Department of Psychology, Faculty of Humanities and Social Sciences in Zagreb (FFZG). Croatian medical Chamber approved 6 CME for this training.

Participants

Participants were members of following organizations: International Organisation for Migration (IOM), Médecins du Monde (MdM), Institute of Public Health (IPH), Croatian Red Cross (CRC), Medical Health Centre Zagreb, Jesuit Refugee Service (JRS), Society for Psychological Assistance (SPA), Centre for Peace Studies (CPS), Rehabilitation centre for stress and trauma (RCT), National Protection and Rescue Directorate (NPRD), Andrija Štampar Teaching Institute of Public Health, Department of Social Services Zagreb (DSS), Primary School "Fran Galović" Zagreb (children from the reception centre Porin are enrolled in this school). The evaluation form was completed by 27 participants aged 26 to 59 (M=33 years) who have on average 18 months working experience in refugee and migrants setting, working from one (e.g. psychological counselling) up to 50 hours a week (e.g. interpreters), depending on their role. Most of participants (77%) have previously attended training about working with migrants (54% of them have attended 3 or more courses) while 88% participants have attended courses about mental health and psychosocial support of

migrants (46% have taken 3 or more trainings).

Role	Organisation	N
Psychologist	CRC, SPA, MdM, RCT, NPRCD, Primary school	8
Interpreter	IOM, MdM, CRC	5
General practitioner	Medical health centre Zagreb	5
Social worker	JRS, RCT, DSS	4
Occupational therapist	CRC	2
Volunteer	CPS, SPA	2
Epidemiologist	Andrija Štampar Teaching Institute of Public Health, IPH-Ploče	2
Visiting nurse	Medical health centre Zagreb	1
Project assistant	IOM	1
Programme administrator	CRC	1
Lawyer	DSS	1

Contents

Training sessions cover topics concerning mental health, psychosocial needs and various activities aimed at supporting and helping refugees and migrants in the context of the European migration crisis.

Location

The training took place on 4th and 5th November 2016 at Hotel Palace in Zagreb.

Weaknesses

In this specific setting where many participants already gained extensive work experience in refugee setting few topics were very new to the participants.

Strengths

The training provides a complete starter-kit on mental health and psychosocial support (MHPSS) for interdisciplinary target group of care providers who work with refugees and migrants, ranging from professional health and allied personnel (GPs, nurses, psychologists, social workers) to paraprofessional and volunteer staff (health care volunteers, community workers, volunteers among the migrant population, cultural mediators and interpreters). The evaluation showed that the training was highly feasible and applicable. All participants pointed out that it would have been a very useful tool at the beginning of their work in the refugee and migration context. They would recommend this training to their colleagues.

3. MH screening und referral procedure and related training

<u>Piloting</u>

Timeframe and Location

The piloting took 11 working days (6-20 July 2016) in two shifts, from 9:30 to 12:30 and from 13:00 to 16:00 h at the reception centre Porin in Zagreb.

Organisation

Piloting of MH-Screening and referral procedure was provided by the local partner of EUR-HUMAN project (FFZG). Referral pathways were established in collaboration with the CRC chief social worker and general medical practitioner who serve the population at the reception centre.

Content

The procedure included described steps of MH-screening provided in an interview between a trained screener, migrant and interpreter. Depending on the result on the screening tool, migrants were encouraged to seek professional help (from social worker or GP) or got a short psychoeducation.

Participants

A total number of 123 refugees and migrants participated in interviews, predominantly young men from Afghanistan, Iraq and Syria.

Weaknesses

In the given setting it was difficult to establish a systematic time schedule of interviewing. Some of the reasons were: time conflict with language classes and sports activities within the centre, migrants often changing rooms, cultural differences in perception and meaning of time, considerable number of migrants moving in and out of the facility on a daily basis, and finally, as it is an open facility, residents are free to spend time out of Porin. The reasons for non-response were that some people were not living in their rooms (although registered as such) and could not be accessed; other did not open the door at several attempts. From those who were approached, 11 refused to participate. At the same time, about 10 persons could not participate because of the language barrier and lack of appropriate interpreter. These were individuals from Russian Federation, Somalia, Sri Lanka and Kosovo.

Strengths

Piloting of the mental health screening of refugees and other migrants proved that it can be done efficiently and in a short period of time by trained PHC staff and trained volunteers The Refugee Health Screener (RHS-13) proved to be acceptable, easily understood, culturally appropriate and time efficient instrument. During the mental health screening refugees and other migrants typically appreciated an opportunity to share their needs and worries with the screeners which opens a window of opportunity to provide brief psychosocial intervention to support their resilience.

<u>Training</u>

Timeframe and Location

The half-day training was held from 9 am to 1 pm on 23rd June 2016, at the Faculty of Humanities and Social Sciences (FFZG).

Learning hours

The training lasted 4 learning hours that included lectures, group discussions and role-plays.

Organisation

Provider of the training was the local team of the EUR-HUMAN project from the Department of Psychology, Faculty of Humanities and Social Sciences.

Participants

A total number of 15 participants attended the training. The group consisted of seven graduate students at the Department of Psychology (Faculty of Humanities and Social Sciences, University of Zagreb - FFZG) and a psychologist from Médecins du Monde who all served as interviewers in the piloting of the screening procedure and seven interpreters. All of them had been working before in the refugee transit centre Slavonski Brod until the Balkans route was closed and had previous work experience in the migration context. According to the languages, there were 4 Arabic, 2 Farsi and 1 Urdu native speaking interpreters.

Content

Training contained detailed information about application procedure for international protection and about legal rights of refugees and migrants in Croatia. A separate section was dedicated to mental health and psychosocial support (MHPSS), understanding the migration process, consequences of migration as a traumatic experience, and cultural issues in communication. The purpose of screening and referral procedures was explained in detail. The training also addressed how to work with interpreters, their roles in relation to the screeners and the interviewees. The training format included short presentations on key topics, interactive discussions, sharing of experiences by the interpreters, and role play exercises based on several prepared scripts.

Weaknesses

No specific weaknesses were identified during or after the training.

Strengths

Mental health screening requires a short training of PHC providers, volunteers and interpreters to help them appreciate the specifics of this procedure and implement it in a patient/client-centred, compassionate, culture-informed and non-stigmatising way. This short training successfully responded to this need.

5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into their specific working setting) in detail for each intervention and underlying training.
1. Online course: **No available information - evaluation data pending.** **2. Face-to-face training:** **Depending on their work place requirements, participants are planning to implement knowledge and skills gained in the face-to-face training. In the evaluation, participants listed challenges for implementing the knowledge and skills gained in the training. The most frequent challenges mentioned are language barrier/lack of interpreters, legal framework and administrative barriers, lack of time, demotivated migrants, lack of personnel (psychiatrists, paediatricians), poor organisation and not enough collaboration among institutions.** **3. MH screening and referral procedure and related training:** **The training prepared the screening team to conduct MH screening among refugees and migrants and referral to specialised services if needed. The content of the training was applied during piloting study in the Reception centre for international protection applicants Porin in Zagreb. A total number of 123 refugees and other migrants participated in the screening. They were primarily young, single men from Iraq, Afghanistan and Syria. Results on the RHS-13 show that 80.5% of the participants screened positive. About half of the positively screened participants accepted referral to further assessment and care.**

Conclusion

All three interventions and underlying trainings were fully aligned with the aims of the EUR-HUMAN project. They were implemented as planned. The online course was adapted to the local Croatian circumstances and made available to a number of PHC providers who have experience in working with refugee and other migrant patients.

As the add-on to the original project plan, the face-to-face training Mental Health of Refugees and Other Migrants was developed by FFZG and the English version of the slides and the guidebook for facilitators was made available to all consortium partners for further use. This training was delivered to 30 multidisciplinary participants over two days. The evaluation showed high level of applicability, feasibility and usability.

The piloted screening procedure for assessing mental health needs and status of refugees and other migrants proved to be time efficient, applicable and feasible. The related focused training which served to enable the high-quality screening was well accepted by the participants and proved to be efficient way to build the capacity for health-allied volunteers to conduct screening in a resources limited environment.

Best regards,

The Zagreb FFZG team!

A8. National Report Greece

ANNEX 8

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (Greece) – Version 11/10/2016

Report on the interventions that were implemented by the different implementation site countries

WP6, National report for Deliverable 6.2

Enkeleint-Aggelos Mechili

Kyriakos Maltezis

Agapi Angelaki

Christos Lionis

Co-funded by the Health Programme of the European Union

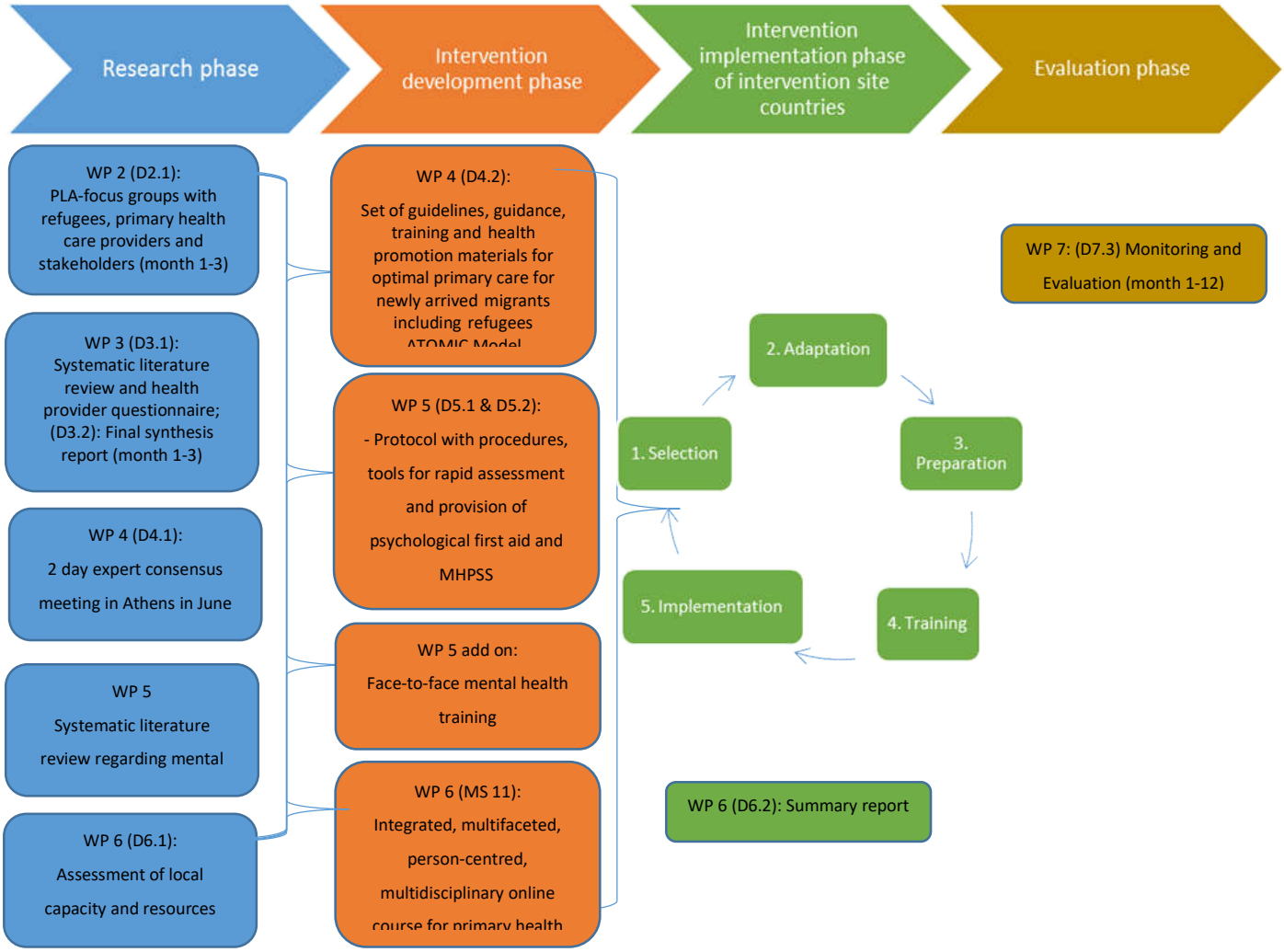
Funding: This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

Introduction

The national reports will provide input to Deliverable 6.2: Summary report on the interventions that were implemented by the different implementation site countries. Deliverable 6.2 is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WP) 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and D4.2 (WP4), D5.1 and D5.2 (WP5) and D6.1 (WP6) of the current project.

Picture 1: Work process of the EUR-HUMAN project



For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSL 11), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report 6.2. aims to provide a discerption about the implementation phase of the project.

Tasks 6.8

Greece (as mentioned above) has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 part1 in an Early Hosting and First Care Centre for refugees and migrants.

Specific objective for task 6.8

To enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.

Picture 2: Work cycle for the intervention site partners of the implementation phase

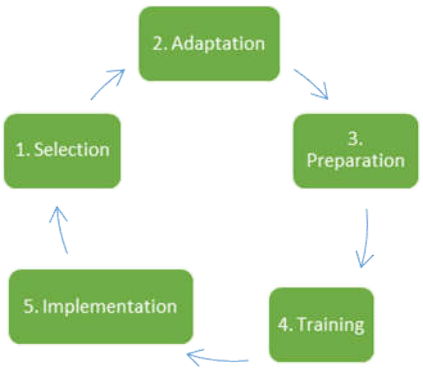


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
01. July 2016 – 31. Aug 2016	- D 3.2: Development of the ATOMIC Model - D 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed (MS 11) - Add-on face-to-face mental health seminar has been developed by FFZG - Intervention site partners select one or more intervention(s) which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and needs-based	Selection
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 15. Country-specific context adaptations (such as country specific legal system, epidemiological picture, etc.) 16. Target-group specific context adaptations 17. Translation (and editing)	Adaptation
01. Aug. – 01. Nov 2016 (depending on	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)**	Preparation

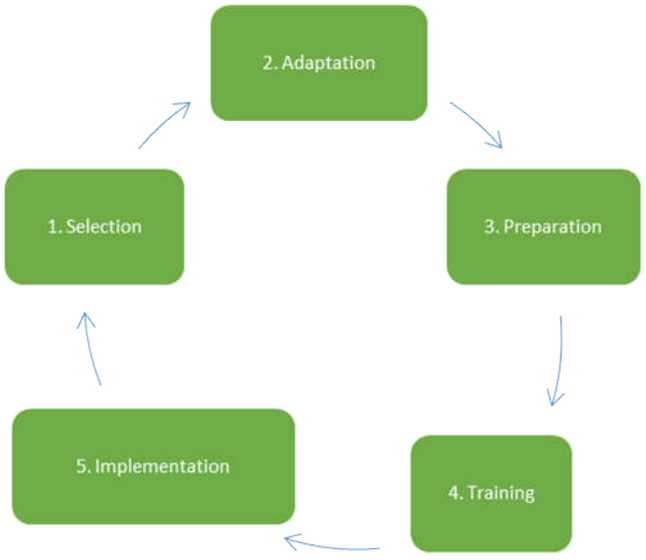
the delivery of the country-specific versions to eHF)	Cross-checking and last editing	
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc. • …	Preparation
15. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s)	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts • …	Preparation
15. Oct. – 22.Nov. 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • End-evaluation of the online course with questionnaire provided by EFPC and UoL (NOMAD inventory) (WP7) On the basis of WPs 2, 3, 4, 5 and 6 except the online training material Greek experts prepared ppts and videos with training material in order to train the participants. Other training(s): e.g. face to face training also took place for the Greek PHC providers. The training was conducted via GoToMeeting platform.	Training
November 2016	Participants apply the new learned content into their specific working setting and reflect about it	Implementation

	(which will be assessed in the general intervention evaluation by EFPC and UoL)	
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D6.2
01. Nov – 30. Nov 2016	Writing the national report about the intervention(s) and sending them to MUW	D6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2	D6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D6.2

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a description about the implementation phase of the project.

Results

1. Description of the selection step

What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention)? Please also indicate how you used the ATOMIC Model.
Answer: use as much space as necessary **6. Intervention and underlying training:** **a. Description of the first intervention and underlying training:** **After the EUR-HUMAN expert meeting that was held in Athens (8th - 9th of June 2016), the consecutive months the training material was prepared by MUW team for primary healthcare personnel who provide primary healthcare services to refugees and other migrants. The course was developed based on the results of WP2 (*D2.1 – PLA groups with refugees and other migrants*), WP3 (*D3.1 & 3.2 – systematic literature review and questionnaire survey with stakeholders*), WP4 (*D4.1 – expert consensus meeting*), WP5 (*D5.1 & 5.2 – literature review regarding psychological first aid and MHPSS & Continuity of Psychosocial Refugee Care*) and WP6 (*D6.1 – assessment of local situation and resources available via semi-structured interviews with primary care providers and*

***stakeholders, narrative literature review and participant observations*). The course also, included the checklists, guidelines and interventions described in D3.1 & 3.2 (*ATOMIC checklist*), D4.2 (*Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees*) and D.1 (*Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS*) of the EUR-HUMAN project.**

In 2015, Greece became the first entry point for 862,138 refugees and immigrants attempting to reach Europe.[1,2] This vulnerable population had crossed the Mediterranean Sea and arrived in Greece, mainly via the ports of Mytilene (Lesvos), Samos, Chios, Kos and Leros. The Greek government in order to stem the refugees and immigrants flows has delivered hotspots and hosting centres on the following Greek islands: Lesvos, Chios, Samos, Leros and Kos as well as in the mainland.[4] In order to tackle this issue, regional and municipal authorities were included, port authorities, Greek coast guard and police, hospitals, primary health care centers, Greek army, national and international non-government organizations (NGO's) and Frontex.[5] In the meantime, Primary Health Care (PHC) professionals of the national healthcare system undertook the important role of providing healthcare services to those populations. Since Greece is the country with the highest influx of refugees and migrants, the National Health Care system as well as NGOs (at hotspots and hosting centres) are responsible for their health status, we decided the intervention targets PHC providers in Mytilene island and in the mainland. This decision was based on the fact that the most refugees and migrants are living in camps in several areas in Greece. The purpose of the training produced is twofold: 1) to enhance the knowledge and capacity building of primary health care providers in the field, who are responsible for the health care of refugees and other migrants who are living in hotspots and hosting centres in order to initially assess their health problems and needs and 2) to apply the new knowledge as well as the tools, questionnaires and procedures in the field in order to test its feasibility, practicality and applicability.

Additionally to the on-line training material developed by the MUW team, the UoC team in collaboration with Greek experts prepared videos into Greek language (see below) in

order to train multidisciplinary PHC teams.

b. Description of the setting where the first intervention and training takes place:

Initially, in Greece, we have decided the implementation process (implementation of the intervention), to take place at Moria's hotspot in Lesvos island. The hotspot of Moria is located on Lesvos a Greek island of Northeastern Aegean Sea. Refugees who survive the journey and succeed in crossing the maritime border between Turkey and Greece are obligated to reach the hotspot of Moria in order to be registered and to continue their journey if so. However, the riots and the conflicts that very often occured in Moria hotspot, turned us to look for an additional option. In order to overcome this significant safety issue, we decided to implement the intervention to Kara Tepe hotspo, located t in the island of Lesvos, as well. Kara Tepe is located on the eastern Aegean island of Lesvos. The camp has been transformed into a small village of 665 refugees and other migrants (335 Syrians, 135 Iraqis, 136 Afghans, 17 Palestinians, 16 Iranians and other nationalities) including 184 houses. The camp has a capacity of 1700 people who can stay for a long period.[6] In general, the island of Lesvos, accepted around 60% (406,000) of all refugees and immigrants arriving in Greece in 2015. [2,5,7] The first step of the pilot intervention was held at the end of June beginning of July 2016. After the results of interviews with refugees and migrants at the hotspot of Moria, the interviews with Greek experts in the context of WP3, the results of Del. 5.1, 5.2, 6.1 and also, the results of consensus meeting held in Athens (8-9 June 2016), we chose to train a multi-disciplinary team that would be composed by GPs, community nurses, midwives and social workers, as mention above. We have had communicated with the GPs that served Primary Health Care services at nearby villages to Moria and Karatepe hotspot. Also, primary care personnel (physicians, community nurses, midwives and social workers) from PEDY (Greek public organization that provides primary health services) were also, invited to serve along to the training process. In addition, physicians and healthcare personnel of the NGOs Medicine du Monde (MdM) and Medicine Sans Frontiers (MsF) that already provided health care services at different hotspots and hosting centres all-

over Greece were also, invited to participate. A multifaceted, integrated, person-centred, holistic, multidisciplinary online course has been developed as intervention for these target groups by the University of Vienna which was translated and adapted in Greek language (see below). In addition to the online training, Greek experts (in collaboration with the UoC team) developed also training material (ppts and videos). The Greek experts that developed the material were based on the training material developed by MUW as well as their experience as all of them have provided or still provide services in the field to this vulnerable population. Initially the location of the course of the participating multidisciplinary teams was set in their own PC or laptop, as the training material is on-line (both the course and the YouTube channel). Additionally, a multidisciplinary team (GP, nurse, midwife) was trained via GoToMeeting session on November 14th in the island of Mytilene by two Greek experts, who developed the on-line training material on the YouTube channel. This training session involved a GP (Kyriakos Maltezis), a nurse (Argyro Kyrikou), a midwife (Panagiota Chavranli), an IT expert by distance (Eirini Theodosaki) and the coordinator of the UoC team in WP6 (Enkeint-Aggelos Mechili). The two Greek experts who trained the PHC providers were Dr. Androula Pavli and Dr. Elena Maltezou. Both of experts (who are employed at KEELPNO) have extensive experience in working with refugees and migrants. The training intervention took place in a threefold method. Initially the PHC providers were trained by the online platform that HeF developed and uploaded. Secondly, the participants were trained by watching and listening the videos developed and uploaded at the EUR-HUMAN channel in YouTube. Thirdly, some of the participants (3 in total) that participated at the intervention process in testing the tools, questionnaires and procedures were trained via GoToMeeting by two Greek experts.

c. **Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1) of your country, the results of the questionnaire survey from WP3 (D3.1) for your country, the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) for your country) and how the intervention related to the guidance developed in D4.2*:**

For Greece it became clear through the results of D 2.1 – 6.1 that the main challenges for

PHC providers were as follows:

- **The main health problems reported by refugees and migrants during WP2 were mental health problems, dental problems, chronic diseases problems, disabilities and injuries;**
- **The problem of time pressure and the related lack of trust and information were mentioned by refugees and health care workers as one of the biggest barriers to provide or receive care in Greece;**
- **Lack of continuity of care;**
- **The lack of the guidelines that need to be adjusted to the level of education of those who are implementing them;**
- **The necessity to invest in improving the knowledge, skills and attitudes (lack of all of the aforementioned) of professionals, particularly in cultural competency and diversity;**
- **Absence of interaction between professional and patient (communication problem and also lack of translated information);**
- **Lack of tools, resources and knowledge needed to provide the right care;**
- **Lack of knowledge of PHC personnel about refugees country of origin and idioms of distress;**
- **Lack of knowledge of refugees and other migrants about the health care system of the hosting country;**
- **Lack of data regarding the health needs of refugees;**
- **Importance of providing culturally sensitive care;**
- **In general, unavailability of useful guidelines;**
- **Lack of medical history;**
- **Lack of privacy when making use of health services;**
- **Lack of a supportive environment to make the right health decision;**
- **Cultural and belief difficulties and differences;**
- **Vast number of refugees and migrants in Greece;**
- **Lack of staff and resources (particularly the lack of multidisciplinary teams);**

- **No standardized initial health assessment in Greece;**
- **Lack of specific guidelines for vulnerable groups;**
- **Lack of knowledge and willness about needed lifestyle changes;**
- **The very often mental health problems reported leaded us to assess refugees mental health status;**
- **Non-verbal communication and differences in voicing symptoms.**

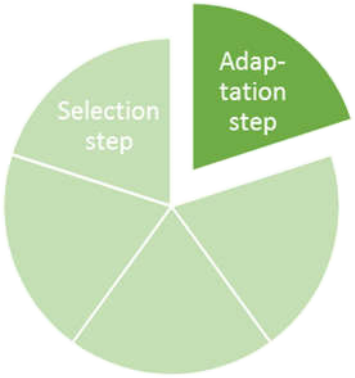
d. Detailed description of the target group in this setting (number, profession, etc.):

In the training process totally we expected twelve (12) to fifteen (15) PHC providers to be trained and included in the Greek implementation site. We chose to train a multi-disciplinary team that was composed by GPs, community nurses, midwives and social workers (3 or 4 professionals for each profession). This decision was due to the fact that our aim is to provide holistic, integrated, multifaceted and person-centred healthcare services.

e. Other issues (ATOMIC Model):

As about the "Appraisal Tool for Optimizing Migrant Health Care" (ATOMiC) the PHC personnel that were trained and participated at the phase of testing the tools, questionnaires and procedures used the above procedure to took decision. At the end of this report, we have reported one example of the way we used the ATOMIC, in the context of vaccination. This is due to the fact that the most of refugees and migrants in Greece reported that they have been immunized in their country of origin but they neither remember which vaccines they have conducted nor have any documentation on vaccination (please see the example at the end of this report).

2. Description of the adaptation step



How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?
Answer: use as much space as necessary: **6. Intervention and underlying training:** **a. Description of the specific adaptations for the first intervention and underlying training (context, language, terminology, translation process):** **Training curriculum was developed by the Medical University of Vienna (MUW team) based on the findings of WP2, WP3, WP4, WP5 and WP6 (Del. 6.1). The training material was composed of eight Modules. The structure of each Modules is:** **Module 1:** ***Introduction.*** **Module 2:** ***Initial Health Assessment, acute conditions and infection diseases*** **Module 3:** ***Legal issues*** **Module 4:** ***Provider-patient interaction*** **Module 5:** ***Mental Health***

Module 6: ***Sexual and Reproductive Health***

Module 7: ***Child Health***

Module 8: ***Chronic diseases and health promotion***

In order to translate and adapt the training material, we have used as basis the English template MUW team prepared. We translated all modules into Greek language. The translation process was undertaken by 4 research associates of the UoC team with excellent knowledge of English (certified), as well as the structure of Greek healthcare system. Greek adaptions and additions were made according the Greek healthcare system, Greek terminology and Greek legislation. We added links, in supporting non-governmental organizations or website, such as the Greek National immunisation programme or UNHCR, MDM, MsF, Praksis etc., links to Greek ministries (mainly to Ministry of Health and Ministry of Migration) and Greek guidelines produced mainly by the Hellenic Centre for Disease and Control (KEELPNO). All the above are very crucial for the Greek context of the EUR-HUMAN project. In each Module we made specific additions and adaptions as the conditions variated from those in Austria or in other European countries.

Module 1**, conveys a description of the content of the EUR-HUMAN project as well as of the course, its aims and objectives, explains those chapters that are recommended for each of the three settings described in the operational book (triage; first contact with PHC; long term with PHC). Finally, it is provides and explanation on the procedure with the pre – post questions.**

In Module 2**, we conducted significant amendments, especially on the initial assessment of the refugees and migrants reaching Greece, according to the guidelines and recommendations of Greek Ministry of Health and KEELPNO. We focused on the problems that were resulted during the PLA sessions (WP2) in Moria's hotspot (i.e. dehydration, diarrhoea, hunger signs, pregnancies issue, injuries, fever etc.). Additionally, specific attention was given on communicable diseases reported by**

refugees and migrants in Greece (based mainly their country of origin). Finally, were stated the vaccination programme that refugees and migrants should undertake, according the Greek National immunization programme, taking always into consideration, their immunization status (if any), age, gender and country of origin.

In Module 3, **(about legal issues) we referred to the differences between the status of someone being refugee, migrant and asylum seeker. We gave specific attention on patient consent on health interventions. Additionally, extensive information was provided on the legislative measures the Greek governments took during last two years.**

In Module 4, **the patient-provider interaction was mentioned on one the hand on the basis of the Greek PHC providers' knowledges and on the other, based on the refugees' culture and country of origin.**

In Module 5, **we gave specific attention on the initial assessment of mental health upon this population arrival based on the Zagreb team findings (WP5). In addition, we emphasised on verbal and non-verbal interventions based on migrants traumatic events occurred in the country of origin or during the journey.**

In Module 6, **we emphasized the problems that pregnant women or new mothers are facing in camps as well as specific attention on the sexual transmitted diseases (based mainly on Greek findings and guidelines) and the contraceptive methods.**

In Module 7, **we specifically adapted and referred to the Greek National Immunization programme, the recommendations of EOPYY as well as recommendations on child nutrition and prevention.**

In Module 8, **we adapted the main chronic diseases found in this vulnerable population in Greece. Specific attention was given on health literacy and mainly on the Greek organisations that provided compensated services to this vulnerable population.**

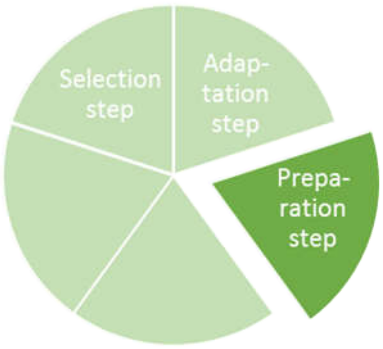
After the translation and adaption by the Greek team (since August 2016 until end of September 2016), the material was crosschecked for errors and possible improvements by the UoC member Enkeleint-Aggelos Mechili. The programming of the online course was realized in close collaboration with Judith de Lange from HeF, which is a sub-

contractor of the EUR-HUMAN partner ARQ. We used the export content document of the already programmed English course template to adapt it to the Greek version. According to the translation guideline we kept headings in English and inserted the Greek translation next to it.

Furthermore to the online training material, as mentioned already above, the Greek team in collaboration with seven Greek experts created training material via a YouTube channel

(https://www.youtube.com/channel/UCvl3kOrEidGv2XA4zAUs01Q). Each expert (in his/her field) prepared a short presentation (around 25-30 slides) and send to a researcher of the UoC team for formatting and editing, it according a specific template and the file was resent to the expert for crosscheck. Upon the final approval, a meeting was arranged with UoC IT expert (Ms. Eirini Theodosaki), in order to provide details on how to develop the training video. After all the aforementioned, Ms. Theodosaki uploaded the video on the EUR-HUMAN YouTube channel, she created. This procedure took place from the middle of September 2016 until beginning of November 2016.

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.
Answer: use as much space as necessary **6. Intervention and underlying training:** **a. Recruitment process of target-group:** **b. Invitation of experts, speakers, etc.:** **The UoC research team pursued a diverse and snowballing recruitment strategy. Initially, different target groups and policy makers were informed about the training material. At first, we informed the director (Michail Chatzigiannis) of PEDY (National Organisation for PHC services in Greece) in the island of Mytilene in order and on behalf of us, to inform the PHC personnel in this unit about the course. Secondly, a person in charge in PEDY of Mytilene (Dimitris Messaris) was also, informed about the training material and invited to take part as well as to inform and invited his colleagues. Thirdly, Dr. Konstantis Kampourakis who is in charge of monitoring the provided healthcare services in the field, on behalf of the Greek Ministry of Migration was informed and invited to share the on-line course with PHC providers across the country. In addition,**

the director of MDM Greece (Evgenia Thanou) and the director of MDM about the healthcare personnel in the island of Mytilene, Dr. Dimitris Patestos were informed and invited to share the on-line course. Additionally to MDM officials, the director of the Greek MsF, Dr. Apostolos Veizis was updated about the undertaken procedures. All persons mentioned above, were encouraged to persuade healthcare personnel to take part to the on-line training course. Each of them received by the UoC team, two emails (the first informing about the course and the second was two weeks later in order to kindly remind them). After the first reminder, a UoC team member communicated with all invited individuals (already mentioned) apart from Dr. Evgenia Thanou. On October 31st 2016, Dr. Mechili met in person with Dr. Thanou, in order to provide her detailed information about the EUR-HUMAN online course. In addition, Dr. Kyriakos Maltezis, who has extensive experience in providing healthcare services to refugees and other migrants, was invited to participate and share the online course with some of his colleagues. Finally, the EUR-HUMAN online course, as well as the YouTube channel, were presented at the 6th Panhellenic Congress of Forum: Public Health and Social Medicine, Social Inequalities and Public Health **on October 31st 2016 in Athens, where Dr. Mechili was invited for a lecture. Finally, the EUR-HUMAN YouTube channel was disseminated via the EUR-HUMAN website and the EUR-HUMAN Twitter account, as well on some of the UoC team members' social media accounts.**

c. Location for training:

Initially the location of the course of the participating multidisciplinary teams was set in their own PC or laptop, as the training material is on-line (both the course and the YouTube channel). Additionally, a multidisciplinary team (GP, nurse, midwife) was trained via GoToMeeting session on November 14th in the island of Mytilene by two Greek experts, who developed the on-line training material on the YouTube channel. This training session involved a GP (Kyriakos Maltezis), a nurse (Argyro Kyrikou), a midwife (Panagiota Chavranli), an IT expert by distance (Eirini Theodosaki) and the coordinator of the UoC team in WP6 (Enkeint-Aggelos Mechili). The two Greek experts who trained the PHC providers were Dr. Androula Pavli and Dr. Elena Maltezou. Both of experts (who are employed at KEELPNO) have extensive experience in working with

refugees and migrants.

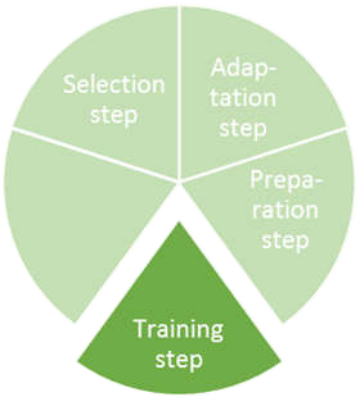
d. Negotiation process for CME points:

The UoC team has not applied for the CME points, yet. We chose initially, to conduct the pilot training of the PHC providers as well as the testing of the tools, questionnaires and procedures in order to check feasibility, acceptability, practicality etc. and after making corrections and improvements (if any) and afterwards to apply to Greek Medical chamber for CME points. However, all Greek participants of the on-line training course will take a Certificate of attendance.

e. Kick-off event:

Apart from the meeting with the director of MDM, the emails sent and the phone calls with the Greek participants and the training via GoToMeeting (see more information above), a kick-off event did not take place.

4. Description of the training step



Please, describe the underlying training(s) in detail for each intervention and underlying training.
Answer: use as much space as necessary (1, 2, 3, 4)

6. Training:

a. Timeframe of the training (dates, hours):

The underlying training online course was launched on November the 3rd and participants are encouraged to finish by the 30th of November 2016. The EUR-HUMAN YouTube channel, is online since October 26th (except the triage video which was uploaded on November 12th).

b. Learning hours for the participants:

The online course is consisted of eight modules. The first module is organizational; it provides an overview about the course structure, the learning aims and objectives and the total procedure. Each of the other Modules (2-8) are providing training material on different healthcare issues and not only. The seven modules are consisted of pre-test and post-test questions. Each participant initially has to respond to the pre-test questions then to study the training material and at the end to respond again the same questions. For each module approximately one and a half hour of study time is recommended. Thus, a total of eight to ten learning hours are required for all participants to finish the course. The participants could follow their individual time management; they are able to switch back and forth between modules and chapters. In order to finish the training course within one month, two hours approximately per week are required.

The training material at the EUR-HUMAN YouTube channel is consisted of 7 different topics. Each module needs at least twenty minutes to compete it. A total of around four hours are needed to finish all the videos. The participants could follow their individual time management; they are able to switch back and forth or to restart each video wherever they want.

c. Organisation of the training (who, how, …):

The course is online on the platform of the organization Health-e-Foundation. The logon codes and passwords were provided to participants through online registration; the

procedure is user-friendly and self-explanatory. After registration, an individually created username and password was sent to the participant with which he/she could log in and start the course.

The EUR-HUMAN YouTube channel has free access and it is available to anyone. The link of the EUR-HUMAN YouTube channel is also included in the invitations that are currently send out to participants. The videos are comprehensive and easy-understandable. All experts are using simple language and are speaking in a friendly and polite manner. These videos are easy to access at any time and they offer a great opportunity for self-education. This method of training was organized by the members of UoC team and especially by Mrs. Agapi Angelaki, Mrs. Eirini Theodosaki and Mr. Enkeleint-Aggelos Mechili.

d. Participants (how many, which professions, …):

Until November 30th 2016 there were 17 participants registered for the online course, of which 13 successfully finished the course. The majority of them (12 in total) are female and 4 are male. Seven (7) of them are general practitioners, four (4) are nurses, three (3) are health visitors and two (2) are midwives. All participants provide services at the field. Half of them (8 participants) provide services at Greek health care system and especially at PEDY. The rest of the participants are working on NGOs who provide services in different settings all over Greece.

e. Content of the training:

The online course consists of eight modules.

***Module 1* is organizational; it provides an overview about the course structure, the learning aims and objectives and the total procedure.**

***Module 2* is providing general information on monitoring of refugees and migrants health status, and provides also information about initial health assessment upon their arrival in Greece. Information are also provided about the urgent symptoms as well as**

the main needs and problems due to the journey. In the module are developed in a comprehensive manner issues about the vaccination coverage and the main infectious diseases. Finally, the IOM personal health record and recommendations regarding continuity of care are also included.

Module 3 **is talking about a very crucial subject; legal issues on providing healthcare services on this vulnerable population in Greece. Initially are mentioned the services and by whom can be provided on this population according their status (refugee, migrant, asylum seeker, undocumented person etc.) and then a detailed report on the therapeutic contract is done. Then, the entitlements and the obligations of each part (patient-provider) are reported. Furthermore, the module discusses the problems that come out due to language barriers and the absence of cultural mediators.**

Module 4 **consists of two parts. Part one emphasizes on general communication strategies, on non-verbal communication and general information on interpretation (who should and who shouldn't be used as interpreter, which are the criteria of being an interpreter etc.). Part two deals with the important role of culture in healthcare provision. Some examples are given on that issue, while at the same time the module discusses the different way (in comparison to Europeans) of expressing idioms of distress. Explanatory models of illness, self-healing, medical pluralism and perception of pain are among the core issues included in the module.**

Module 5 **is also consisted of two parts. In general the module is dealing with mental health issues. Part one emphasize on mental health and psychosocial support by providing information on the mental health issues of refugees (dealing with the origin of these problems). Information on mental health triage and screening procedures are reported in order to recognize signs of distress and to deal with them. Concrete examples on the approaching and the coping ways with all the above are provided. Finally, part 1 deals with professionals' mental anguish. As about part 2, it deals with trauma and the first aid needed in order to reduce stress.**

Module 6 **discusses sexual and reproductive health and special risks and needs of refugee women. Specific attention is given on the initial health assessment of these**

women as well as on the peri- and postnatal phase. It is also discussed mother-child relation and possible problems due to the journey. As the most of these women are not aware about contraception methods, abortion and sexual transmitted diseases, the module provides detailed information.

Module 7 **deals with child health. The module provides information on vaccination needed about specific communicable diseases. It deals also with significant prevention measures needed, emphasizing on mental and physical issues as well as on malnutrition. Except the aforementioned, general recommendations about initial assessment of young children is provided.**

Module 8 **deals with chronic diseases and health promotion. Initially, the general concept of healthcare services for refugees in Greece is discussed. In addition, management of the main chronic diseases, health literacy and the lifestyle changes are discussed. Significant attention is given to dental health issues as many refugees in Moria reported this as a main problem. Furthermore, information on institutions and organisations which provide services to this vulnerable population are mentioned.**

As we have mentioned above, except the on-line training, the UoC team in close collaboration with 7 Greek experts developed an additional training material for PHC providers. The material created is based on the on-line course, on the international literature as well as the knowledges and experience of them in the field. All of them are well-known in Greece with a significant contribution on refugee issue. There are academician and non-academician but all with a huge experience in the field.

Video 1 (Assessing refugees and other migrants with immediate healthcare needs. Triage upon their arrival) **was created by Dr. Dimitris Giannoussis who is a medical doctor and works on aero medical transportations at PHC services in Greece. Dr. Giannoussis is also, a volunteer on MsF with an extensive experience in managing this issue on the southern focuses on the discussion about the triage upon the arrival of refugees. The video also, deals with the signs and symptoms that a PHC provider should take under consideration in order to decide if the person needs healthcare services immediately or not.**

Video 2 (Communicable diseases on refugees and other migrants) **was created by Dr. Niki Kavvalou who is a junior doctor in Pathology in close collaboration with Prof. Achilleas Gkikas. Prof. Achilleas Gkikas is a Professor of Internal Medicine and Infectious Diseases, University of Crete. The video (around 38 minutes) discusses the most common communicable diseases on this population and how we should deal with these issues.**

Video 3 (Mental health of refugees and other migrants) **was created by the Clinical Psychologist Katerina Koutra. The video (around 17 minutes) deals with the mental health issues that refugees and migrants coping with and the way how PHC providers could address them. It is also, discusses the methods of promoting mental health in this vulnerable population.**

Video 4 (Provider-patient interaction. Providing cultural appropriate healthcare services) **was created by Prof. Athena Kalokairinou and Dr. Paraskevi Apostolara. Prof. Kalokairinou is a Prof. of Community Nursing. Dr. Apostolara has an exensive experience in transcultural nursing and is a scientific researcher at National and Kapodistrian Univeristy of Athens. The video (around 46 minutes) deals with the cultural significance of understanding and managing a disease. The video also focused in the significant role of cultural mediators.**

Video 5 (Non-communicable diseases on refugees and other migrants) **was created by Dr. Androula Pavli, who is a medical travel expert at KEELPNO. The video (around 25 minutes) deals with the most common non-communicable diseases on refugees and how to manage in order to keep them under control.**

Video 6 (Vaccination coverage of refugees and other migrants) **was created by Dr. Elena Maltezou who is in charge of interventions in camps and hosting centres in Greece. The video (around 20 minutes) deals with the low vaccination coverage of this population. It is also discusses which vaccines should be done (according age, gender, country of origin etc.). Finally, the video points out the procedure that should be conducted in the absence of vaccination documentation.**

Video 7 (Maternal and reproductive health) **was created by Assoc. Prof. Viktoria Vivilaki**

(ATEI Athens) The video (around 27 minutes) deals with the peri- and postnatal phase. It is discusses in details the procedures and examinations that should be undertaken during the pregnancy.

f. Location of the training:

Initially the location of the course of the participating multidisciplinary teams was set in their own PC or laptop, as the training material is on-line (both the course and the YouTube channel). Additionally, a multidisciplinary team (GP, nurse, midwife) was trained via GoToMeeting session on November 14th in the island of Mytilene by two Greek experts, who developed the on-line training material on the YouTube channel. This training session involved a GP (Kyriakos Maltezis), a nurse (Argyro Kyrikou), a midwife (Panagiota Chavranli), an IT expert by distance (Eirini Theodosaki) and the coordinator of the UoC team in WP6 (Enkeint-Aggelos Mechili). The two Greek experts who trained the PHC providers were Dr. Androula Pavli and Dr. Elena Maltezou. Both of experts (who are employed at KEELPNO) have extensive experience in working with refugees and migrants.

g. Weaknesses of the training (in your opinion):

One main disadvantage of the on-line course is that participants cannot cooperate and interact with other PHC providers, in order to join discussions and to apply direct questions. Another point is the lack of time of certain disciplines as the deal with high workload in their daily practice. In several occasions, the team of UoC sent multiple online and telephone reminders, in order to keep them on track with the training procedure (online courses make it easier to procrastinate or to negligate**). However, some of the participants found difficulties in the registration process. Another difficulty of the courses is that it is and online course with no option of off-line mode. Currently, in Greece most of the hotspots and refugees hosting centres have no internet connection. Finally, it is important to mention that the on-line course should be updated after the end of the EUR-HUMAN project with an email reminder to be sent to each participant.**

h. **Strengths of the training (in your opinion):**

One of the main advantages of the course is that it was well adapted in Greek language and context. Secondly, many PHC providers in the field emphasized on the importance of this training material and expressed positive feedback. Most of the participants mentioned the important role of the multidisciplinary teams that the course is addressing on. Another main advantage is that it can be accessed at anytime and anywhere, from any electronic/smart device with internet access. In addition, a participant may focus to issues that he/she is more interested in, instead to others that he/she is not. Furthermore, the current on-line course and the YouTube videos are convenient, flexible and especially promote skills, knowledge and life-long learning. Additionally, participants have the ability to decide when it is convenient (according their agenda) to complete the course at their convenience. Finally, the course was created by experts with an extensive experience in the field and knows better than anyone else these issues. Last but not least, both the training material and the YouTube videos are providing information in the context of a holistic and comprehensive approach of this population.

5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into

their specific working setting) in detail for each intervention and underlying training.

Answer: use as much space as necessary (1, 2, 3, 4)

6. Implementation of first intervention and underlying training:

a. When, how and where did the participants apply the new learned content into their specific working setting:

All the participants will apply or are already applying the new learned knowledge into their work settings. Some of them are going to implement at PEDY and the rest at hotspots and hosting centres. In addition to all of that, a UoC team (a GP, a nurse with specialization in obstetric and gynaecological issues and one coordinator) in collaboration with a MDM team (GP, nurse and two cultural mediators one Arabic; one Farsi) applied the new earned knowledges in a three day implementation procedure. The phase of testing the tools, questionnaires and procedures took place in Kara Tepe refugee camp in the island of Mytilene. During this pilot intervention, the tools, the questionnaires and the procedures were tested in order to enhance capacity building of the European countries that accept and host refugees and migrants. The trained PHC providers provided the services in a multidisciplinary team. The intervention phase took place at the infirmary of the Medicine du Monde in the hosting centre. In total 30 refugees and migrants participated (3 men, 15 women and 12 children). The mean age of the participants was 21,85 (min. 9 months and max 76 years old). Before the intervention, the PHC providers were trained via two different methods. Initially, they were trained via the on-line platform that the consortium created and is consisted of eight different Modules (about this Module, acute diseases, legal issues, provider-patient interaction, mental health, sexual and reproductive health, child health and chronic diseases). Furthermore, they watched the training material that the UoC team developed in the EUR-HUMAN YouTube channel. In addition, the primary healthcare providers, who participated in the pilot intervention were also, trained via GoToMeeting by two Greek experts (see above). Secondly, an electronic health care record (e-HCR) based on the IOM personal health records and the existing EPR system was developed by Dr. Dimitris Kounalakis.[7] Some of the migrants and refugees who visited the infirmary

during these three days of the intervention, were invited to participate by the UoC members in close collaboration with the cultural mediators. Initially they were informed by the cultural mediators about the aims and the procedures of the intervention. Ethical approval was received by the Director of 2nd National Health Region, as well as by the Ministry of Migration. Additionally, the Director of the Kara Tepe hosting centre was informed and provided his approval to test the tools, questionnaires and procedures developed by the EUR-HUMAN consortium.

b. Which of the set of guidelines, guidance and trainings that were part of the learned content were applied to their specific working setting?

The on-line course was applied always according the person needs and health problems. Upon refugee arrival at the infirmary, demographic data of the participants were asked and recorded in the e-HCR (name, family name, gender, age, place of birth, transit countries, number of family members travelling, number of family members under 10 years old, duration of home displaced etc.). After their registration was completed, a thorough medical history was received (illness or injuries, chronic illness, mental health issues, smoking or alcohol history, number of pregnancies and deliveries, blood transfusions etc.). Following that, participants were asked to respond questions about immunization status (if available/present) in order to check whether the immunization status meets the age specific requirements based on Greek National immunization programme. Then, the nurse measured some vital signs (temperature, arterial tension, O2 saturation, breaths, beats, height, weight etc.). Furthermore, the doctor conducted a clinical examination (general appearance, heart, breast, lungs, genitalia, skin, etc.). In some cases and if needed a clinical/laboratory test was conducted (i.e. pregnancy test, Mantoux, electrocardiogram etc.). After all were summarized the founded medical condition and was applied the appropriate medical treatment. At this point we have to clarify that the members of the UoC team did not provide any medical services. They only tested the tools, questionnaires and procedures as well as observed all the process. All the medical services were provided by the trained MDM healthcare personnel. All patients were informed about their health status and received information about necessity of the proposed treatment (if any). Additionally, some of them were referred

to specialists (mainly psychologists, gastroenterologists, gynaecologists etc.) for additional control or where referred to other healthcare units (mainly to Mytilene PEDY or the general hospital of the island) in order to conduct more laboratory and diagnostic tests. For every proposed referral, the patient was informed about the place, the date and the way to reach there. All participants were given information in order to improve health literacy and to promote their general health status. Many women received information about the importance of contraception methods and about the sexual transmitted diseases. Furthermore, information on the importance of breastfeeding and the risks during peri- and post-natal phase were also, administered. Information on the management of the diabetes mellitus was provided to a male patient. He was informed about the nutrition habits, the significance of physical activity and others in order to keep his problem under control. Another person was educated about the management of his respiratory disease. In case of a sick child, usually both parents came at the infirmary. In these cases, both parents were informed and educated about the next steps they should follow to treat the illness (i.e. nutrition or immunization needed). However, the assessment of mental health status was conducted via the questionnaire RHS-13. On all participants older than 14 years old, the questionnaire was administered in order to evaluate their mental health status and according their score were referred to a specialist or not. Finally, some participants were provided information on the risks of communicable diseases, on their entitlements in receiving healthcare services out of charge etc. A patient received the Trauma Tapping Technique (TTT) and was provided recommendations and behavioural advices, in order to cope with his traumatic experiences and thoughts. During the interventions the general recommendations on communication strategies (open questions, specific questions, non-suggestive questions, repeating and summarising the discussion etc.) were followed with all participants. Finally, it is important to mention that all recommendations and the education procedure were conducted, taking always into consideration their culture, their perceptions and the structure of refugees' families.

c. What were the biggest challenges in terms of implementation?

The general conclusion of the whole procedure is that was effective and very

constructive. Some of the biggest challenges were found to be:

- ***Time pressure.*** **Independently of the patient's problem and his/her health literacy, at least 15 minutes was required, in order to conduct a comprehensive assessment of his/her status, especially considering that outside of the infirmary were fifteen to twenty patients waiting to be examined *(Implementation).***
- ***Team Based approach.*** **It became clear that the more period of time a group of well-trained PHC workers worked together as a team, the more efficient it will become as they adjust better to local conditions and infra-structure procedures and conditions *(Implementation).***
- ***Training procedure.*** **The PHC workers that participated in the on-line training course were often more flexible to deal with certain aspects of Primary Health Care with refugees (mental health, cultural aspects) as they were before the training *(Training).***

Conclusion

Please, summarize the key points of the interventions that were implemented and suggest a few recommendations to improve intervention as well as implementation.

Key points of the training procedure:

- The training procedure is found to be acceptable by PHC providers and easy applicable;
- The training material is comprehensive, holistic and refers to multidisciplinary teams and not only GPs;
- The course contains the latest information and guidelines regarding refugees and other migrants;
- The training material is easily adaptable by different countries (and within countries too) according their specific needs;
- The training material is efficient and capable to improve knowledge, skills and

attitudes of PHC personnel in providing cultural appropriate healthcare services;
- As the training material is on-online is easily accessible by any electronic device with internet access;
- In general, the current training material could enhance the capacity building in PHC provision;
- In Greece we have not included refugees or migrants that in their country of origin were healthcare providers due to the fact that we did not have any official or unofficial network yet (to the best of our knowledge);

Recommendations

1a. On training program

- We propose the creation of a chat room so participants could interact, discuss and to apply questions. In general, is needed to be more interactive;
- The on-line training material need to refresh from time to time, even after the end of the EUR-HUMAN project and when an update is done , an email reminder has to be sent to each participant;
- We propose the on-line training material to be advertised by local, regional and national authorities in order more PHC providers to be trained.

1b. On training intervention

- It would be helpful for PHC providers to refugees periodic meetings to be established where the whole situation is assessed and re-evaluated (effects on PHC providers-e.g psychological support for them, better adjustment to certain management – e.g.

Mental Health problems);

- We have to improve continuity of care between different countries and within countries (i.e. refuges in the Kara Tepe camp received a paper recommendation when they were referred to another unit and sometimes they lost this paper and coming back to receive another);
- The provision of internet connection inside the refugees' centers will also help e-medical technologies to support the PHC providers work on the field so as an important amount of referrals to experts to decrease;
- The use of an e-smart card is recommended for this population in move; this e-card will hold all the participants health information with access only for healthcare providers. This will improve continuity of care.

2. On primary care-based implementation

- It is proposed the provision of healthcare services on multidisciplinary teams;
- It is proposed the provision of healthcare services to be supported by an electronic patient record as well as an e-smart card;
- It is proposed the multidisciplinary teams to be trained in all Modules in order to provide contemporary and person-centred healthcare services;
- In order to conduct a holistic health approach it is needed at least 15 minutes with each patient;
- It is proposed to use the tools and materials as well as the ATOMIC checklist produced by the EUR-HUMAN project in order to improve the provided healthcare services.

Using the checklist on the immunization of refugees and other migrants in Greece

WHAT - *Characteris-tics of health care intervention*	the intervention involves prevention ***YES***	the approach is directed at risk and protective factors identified in research ***YES***
		the approach is likely to influence these risk and protective factors adequately ***YES***
'no' is a reason to be critical about the improvement idea	the intervention involves screening/testing ***YES***	the screening tool/test is scientifically validated ***YES***
		the validity of the tool has been tested in the target population in a satisfactory way ***YES***
	the intervention involves therapy or treatment of prevalent problems ***YES***	there is scientific evidence for the effectiveness of the intervention ***YES***
		the intervention is likely to be effective in the target population ***YES***
	the intervention involves a model or framework ***YES***	proposed principles are supported by scientific evidence ***YES***
		proposed principles match the health care needs or problems to address ***YES***
	regardless of the type of intervention	expected positive effects weigh up to negative side-effects ***YES***
		the intervention seems better than alternatives ***YES***
		practical manuals, protocols and supportive materials are available in a language understandable to professionals applying the intervention ***YES***

FOR - *Characteristics of refugee/ migrant target group* *'no' indicates that the target group requires special attention*	the intervention is appropriate given the risk profile or health needs of the target group ***YES***	
	the intervention can be applied regardless of the gender and age of the target group (e.g. women, children, elderly) ***NO***	
	the intervention can be applied regardless of cultural and religious characteristics of the target group (e.g. sensitivity to stigma, shame) ***YES***	
	the intervention can be applied regardless of the level of knowledge and education of the target group ***YES***	
HOW - *Professional interactions* *'yes' indicates that patient contact requires special attention*	applying the health care intervention requires	awareness of particular symptoms or signals (e.g. psychological and physical trauma, child maltreatment, infectious diseases)? ***NO***
		information about the medical history and relevant personal background of patients? ***YES***
		language skills, interpreter services or cultural mediation ***YES***
		protective measures (e.g. vaccination, facemasks, gloves) ***YES***
		input from other professions or organizations ***DON'T KNOW***
		additional time for contact or history taking ***YES***
BY - *Characteristics of professionals* *'yes' suggests that care givers should meet particular requirements*	professionals applying the intervention, interacting with the refugee/migrant target group, require	specialized knowledge and education (incl. women, children and elderly) ***NO***
		language skills ***YES***
		intercultural competencies ***NO***
		attitudinal skills (open-minded, tolerance, respect, patience) ***NO***
		background knowledge and practical experience with the target group ***NO***

WITH - *Incentives and resources* *'yes' indicates that investments are needed in incentives and resources*	regardless of the type of intervention, the implementation requires investments in	staff capacity and time for each patient ***YES***
		education, training and other skill development activities ***NO***
		medical stock, supportive systems, equipment and technical aids ***YES***
		evaluation and monitoring capacity ***NO***
		other (financial) resources ***DON'T KNOW***
	if the intervention involves screening/testing, it requires investments in	capacity for a timely analysis of the screening/test data ***NO***
		capacity for a timely follow-up in case of notable risks or problems? ***NO***
	if the intervention involves therapy or treatment of prevalent problems, it requires investments in	capacity for completing the therapy/treatment including aftercare ***NO***

WHERE - *Organizational capacity for change* *'no' points at a potential problem in the organizational capacity for change*	the intervention is compatible with the key tasks of the health care organization ***YES***
	the staff that is going to apply the intervention is motivated ***DON'T KNOW***
	the management of the health care organization is positive about the intervention ***YES***
	crucial local stakeholders are willing to cooperate in implementing the intervention ***DON'T KNOW***
	crucial (inter)national stakeholders are willing to cooperate in implementing the intervention ***DON'T KNOW***
	additional incentives and resources required are likely to be (made) available ***DON'T KNOW***

CONTEXT - *Social, political and legal factors* *'no' points at a potential problem in the external implementation context*	the social environment of the health care optimization activities (community, society) is sufficiently involved and supportive ***DON'T KNOW***
	the political environment of the health care optimization activities is sufficiently involved and supportive ***DON'T KNOW***
	the intervention itself is allowed from a legal perspective (incl. medical ethics, privacy, human rights) ***YES***
	health care access for refugees and other migrants (i.e. payment and entitlement) are guaranteed ***DON'T KNOW***

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Thank you very much!

Best regards,

The UoC team!

A9. National Report Hungary

ANNEX 9

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Hungary

National Report of HUNGARY– Version 15/Dec/2016

Report on the interventions that were implemented by the different implementation site countries

WP6, National report for Deliverable 6.2

prepared by Imre RURIK & **László R. KOLOZSVÁRI**

Co-funded by the Health Programme of the European Union

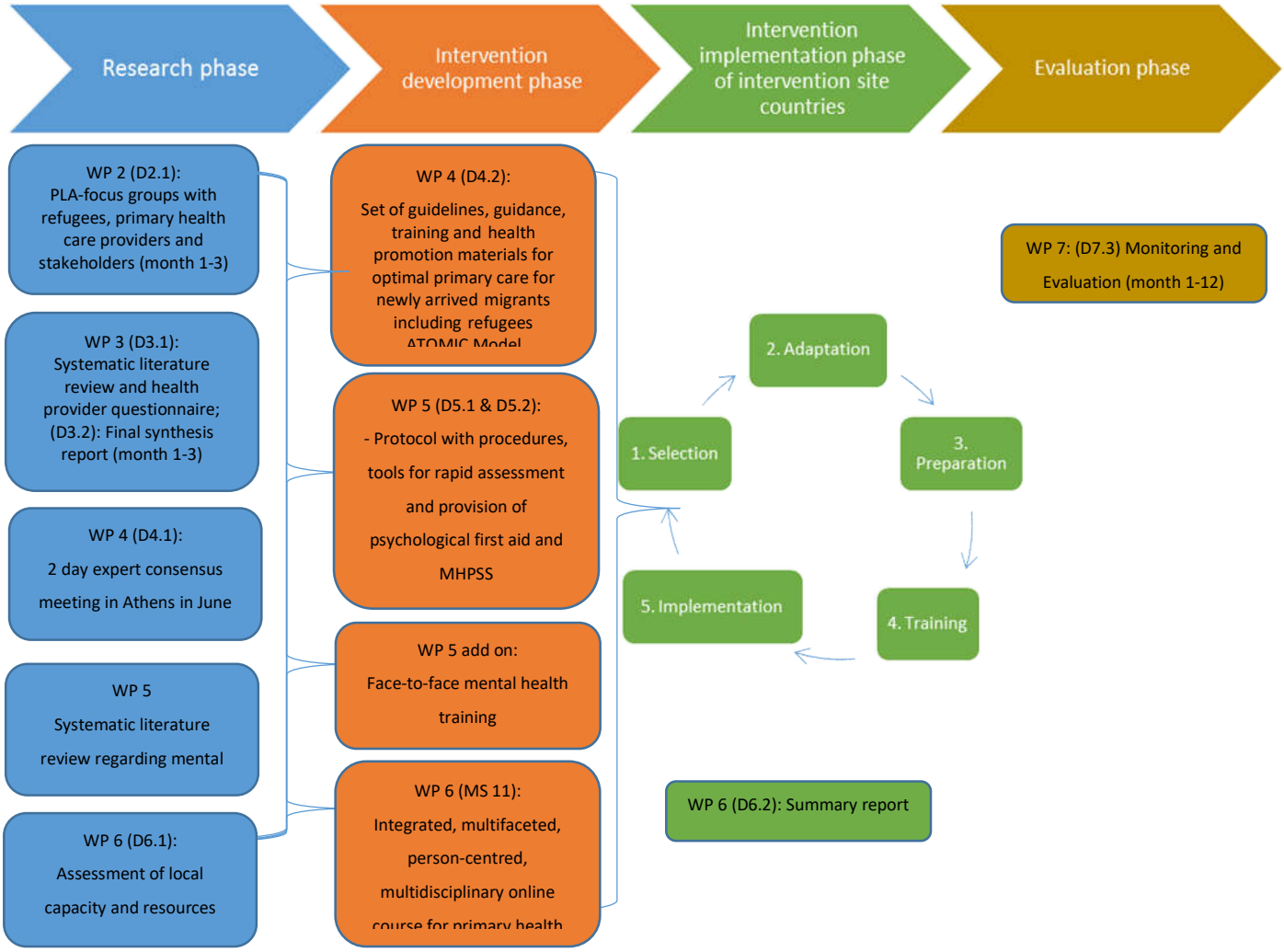
This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

Introduction

The national reports will provide input to Deliverable 6.2: Summary report on the interventions that were implemented by the different implementation site countries. Deliverable 6.2 is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WP) 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and D4.2 (WP4), D5.1 and D5.2 (WP5) and D6.1 (WP6) of the current project.

Picture 1: Work process of the EUR-HUMAN project



For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSL 11), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report 6.2. aims to provide a discerption about the implementation phase of the project.

Tasks 6.8 – 6.13

Hungary has been selected, prepared and implemented at least one interventions that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and migrants.

Specific objective for task 6.8 – 6.13

To enhance and support the primary care workforce (governmental financed and also voluntary based), through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.

Picture 2: Work cycle for the intervention site partners of the implementation phase

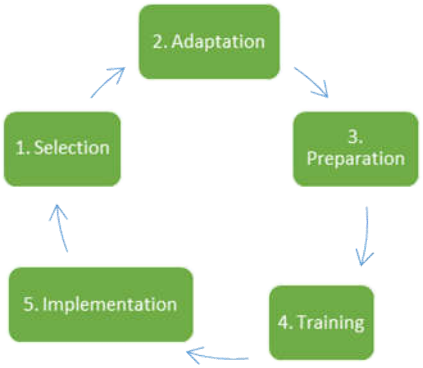


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
01. July 2016 – 31. Aug 2016	- D 3.2: Development of the ATOMIC Model - D 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed (MS 11) - Add-on face-to-face mental health seminar has been developed by FFZG - Intervention site partners select one or more intervention(s) which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and needs-based	Selection
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 18. Country-specific context adaptations (such as country specific legal system, epidemiological picture, etc.) 19. Target-group specific context adaptations 20. Translation (and editing)	Adaptation
01. Sept. – 01. Nov 2016 (depending on the delivery of the country-specific versions	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)** Cross-checking and last editing	Preparation

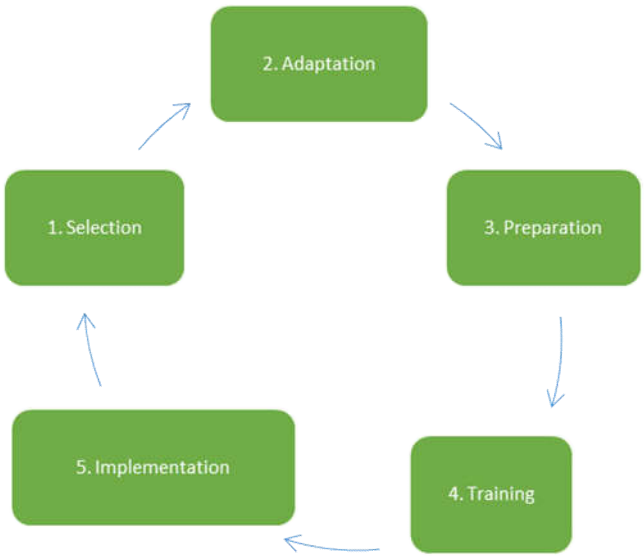
to eHF)		
15. Oct – 10. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc. • …	Preparation
15. Sep – 01. Oct 2016	Negotiation about CME credit points for the training(s)	Preparation
15. Sep – 15. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts	Preparation
15. Oct. – 12.Dec. 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • End-evaluation of the online course with questionnaire provided by EFPC and UoL (NOMAD inventory) (WP7) • Preparation of training materials for migrants, who officially applied for asylum.	Training
November, December 2016	Participants apply the new learned content into their specific working setting and reflect about it (which will be assessed in the general intervention evaluation by EFPC and UoL)	Implementation
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D 6.2
25. Nov – 15. Dec 2016	Writing the national report about the intervention(s) and sending them to MUW	D 6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D 6.2

15. Dec 2016	Writing the final report for deliverable 6.2	D 6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D 6.2

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a discerption about the implementation phase of the project.

Results

1. Description of the selection step

What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention)? Please also indicate how you used the ATOMIC Model.
Description of the first intervention and underlying training: Online course: **The written text of online course has been prepared by MUW. Hungarian adaptation was based mainly on original form. Experiences of voluntary health care providers, who acted during the pike of the migrant "inflow crisis" in 2015, were also asked. The course template in English was translated into Hungarian and the content of the eight modules was adapted into local context. There were only minimal changes in modules 1,4,5, more in the others, to improve national relevance.** **Description of the setting where the intervention and training takes place:** **All official "camps" and the Headquarter of the Immigration Office in Budapest were targeted. Official invitation was send to the Health Care Branch of the Hungarian Army who is responsible for health care provision in temporary camps. Because of their other tasks, this education will be held in January 2017.**

Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1), the results of the questionnaire survey from WP3 (D3.1), the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) and how the intervention related to the guidance developed in D4.2*:

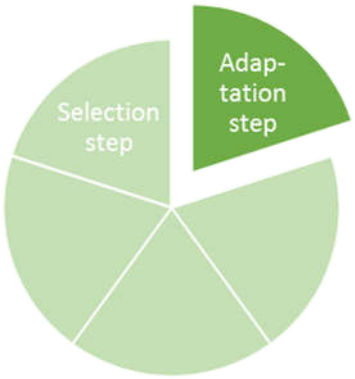
Detailed description of the target group in these settings (number, profession, etc.):

- primary health care providers, contracted or employed by the Government: doctors, nurses and other helpers (expected number: 30-40 persons)

-military health staff, providing health services (no data are yet available)

Education for migrants who are staying for a longer term in Hungary during the official evaluation of their application for asylum, are also planned.

2. Description of the adaptation step



How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?

Online course material

- **All specific Austrian (and international) contents were adapted into Hungarian context.**
- **Workflow chart was translated into Hungarian, were printed and disseminated.**

- **Module 1: Specific information about credits for completing the course in Hungary was added (Medical Educational Council, University of Debrecen accredited the course for 20 credit points (it is the highest, allowed for distance learning).**
- **Module 2: Chapter Infectious diseases was harmonised to recent updated Hungarian guidelines for infectious diseases.**
- **Module 3 was completely changed according to the Hungarian national legal regulations.**
- **Module 4: only small changes were performed, based on local context**
- **Module 5: Links to local resources were included.**
- **Module 6: Links to local resources were added.**
- **Module 7: National vaccination recommendation was considered in modifications.**
- **Module 8: Some reductions in the extent of content were made.**

The material of the online course were edited and printed in Hungarian. These books will be distributed later for health care providers, involved in migrant's care. Many of meetings were held at the Department of Family and Occupational Medicine, University of Debrecen, including phone calls and email correspondence with other experts.

Preferred locations were: Debrecen and Budapest

Description of the setting where the first intervention and training takes place: Budapest, Headquarter of the Immigration Office (8 persons were present, nurses and other providers, no medical doctors were present)

Description of why did you choose this intervention for this setting:

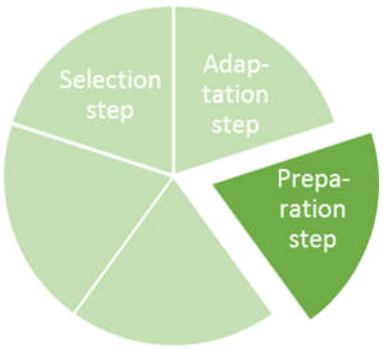
Office has a power to facilitate employers to be attended.

Next intervention was in Győr, on 5th Dec, where most of the doctors could be present. It was followed by 10 educational events for health staff members and 15 for refugees, (asylum seekers in Hungary) Educational activities in the camps were completed on 15th December. December.

Durations of educational activities were: 10x 2 hours.

Educational materials for migrants were also prepared including information from the relevant lay literature. There were 15 lectures for them and informational leaflets were distributed as well.

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.

Online course

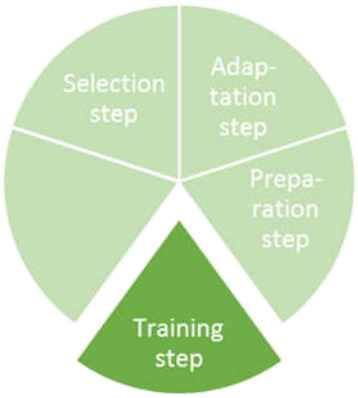
The target groups for the online course are the PHC providers who have experience of working with migrants and refugees or interesting for this information and knowledge.

Beside the online course, we organised a face to face meeting for those, who do not wish to get online education.

Face to face training was held in Budapest, 2nd December, on 5th December in Győr, thereafter followed at other locations in camps. One more session is planned for military health staff in January, 2017.

Since by the Autumn of 2015 migratory flow was halted, Hungary did not receive any additional refugees and/or migrants. According to recent governmental announcements camps will be closed in the very close future.

4. Description of the training step



Please, describe the underlying training(s) in detail for each intervention and underlying training.
7. Training: **a. Timeframe of the training (dates, hours): *workdays in December, 2016*** **b. Learning hours for the participants: *2-4 hours*** **c. Organisation of the training: *Company contracted to UoD, with invited experts*** **d. Participants: PHC providers, numbers: 87** **e. Content of the training: *online and face to face*** **f. Location of the training: online trainings: *at home or in the office*** **g. Weaknesses of the training (in your opinion):*it seems too long and time consuming, difficulties in the preparation and uploading for the website.*** **h. Strengths of the training (in your opinion): *New information for PHC providers***

5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into their specific working setting) in detail for each intervention and underlying training.

7. **Implementation of first intervention and underlying training:**
   a. **When, how and where did the participants apply the new learned content into their specific working setting:** ***In their daily activities when providing care for migrants***
   b. **Which of the set of guidelines, guidance and trainings that were part of the learned content were applied to their specific working setting?** ***Hopefully almost all. Special attention is expected in topics of child care, reproductive health and in legal regulations.***
   c. **What were the biggest challenges in terms of implementation?** ***Logistic problems, language barrier and problems with locum were reported.***

8. **Implementation of second Intervention and underlying training:** ***the same.***
Information about the existence and access of the online course were distributed for many hundreds Hungarian family physicians. Hopefully a big portion of them will register and complete the course by End of December.

Conclusion

Please, summarize the key points of the interventions that were implemented and suggest a few recommendations to improve intervention as well as implementation.

The educational material was very useful, but more flexibility was needed with higher focus to local (national) settings. The extent was often long, not easy to read. Because of the process of CME accreditation, online course participants could earn points only in 2017, while the website will be closed earlier.

Heath care providers in camps were satisfied the educational materials, they rated it as very useful.

15th December 2016.

The Hungarian EUR-HUMAN team

Imre RURIK & László R. KOLOZSVÁRI and

Zoltán JANCSÓ, Anna NÁNÁSI, Roland PALLA, Hajnalka TAMÁS, Tímea UNGVÁRI

A10. National Report Italy

ANNEX 10

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (ITALY) – Version 27/12/2016

Report on the interventions that were implemented by the different implementation site countries

WP6, National report for Deliverable 6.2

Maria Josè Caldes

Giulia Borgioli

Nicole Mascia

Co-funded by the Health Programme of the European Union

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

This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

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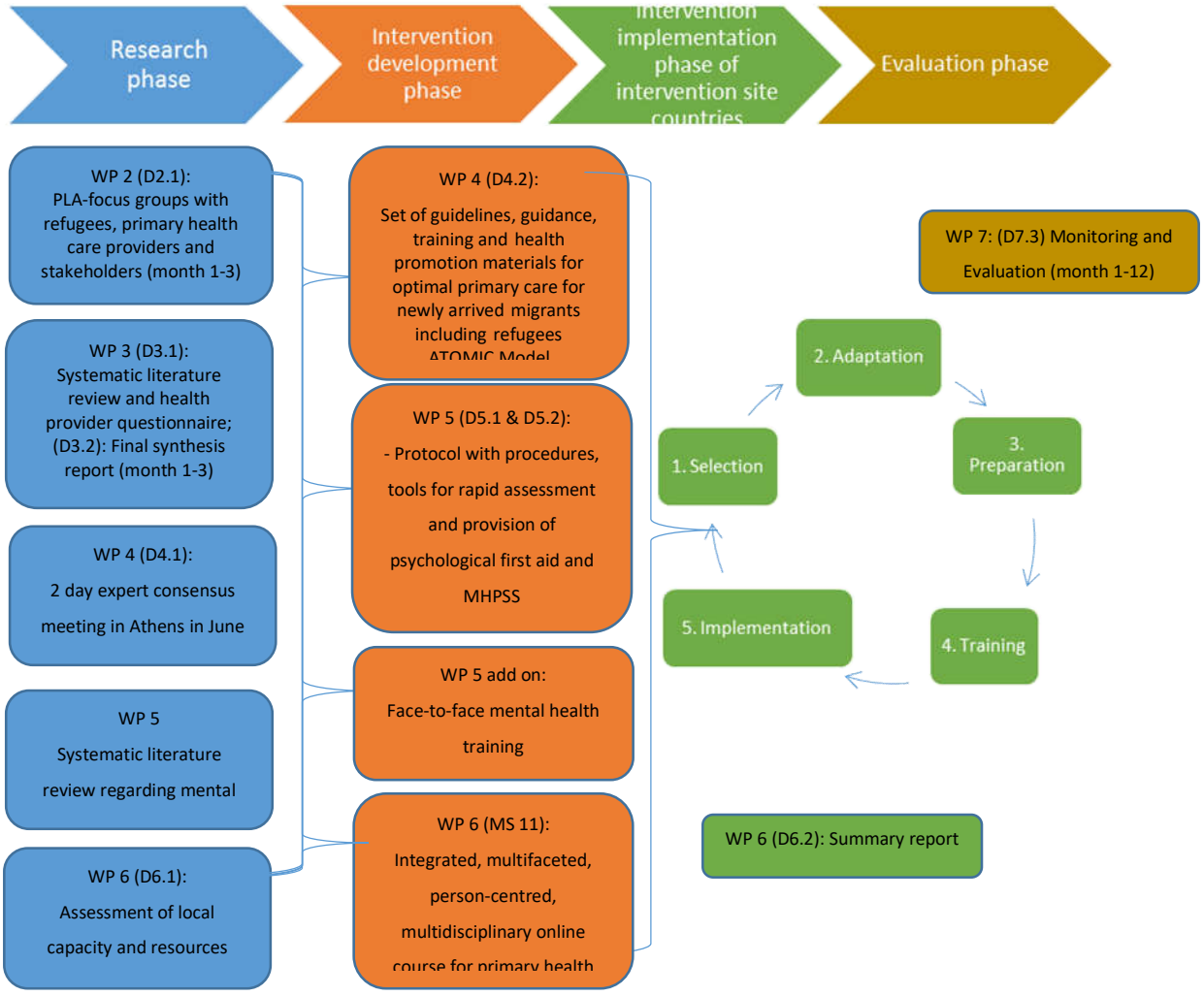
Picture 1: Work process of the EUR-HUMAN project



For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSLTC), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report 6.2. aims to provide a description about the implementation phase of the project.

Task 6.13

Italy (as mentioned above) has selected, prepared and implemented at least one intervention that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and other migrants.

Specific objective for task 6.13

To enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.

Picture 2: Work cycle for the intervention site partners of the implementation phase

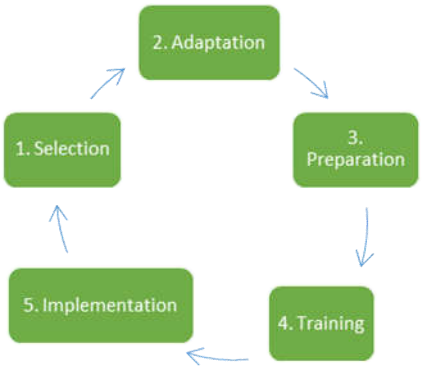


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
01. July 2016 – 31. Aug 2016	- D 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 4.2: Development of the ATOMIC Model - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS & Model of Continuity of Psychosocial Refugee Care has been developed - English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed (MS 11) - Add-on face-to-face mental health seminar has been developed by FFZG - Intervention site partners select one or more intervention(s) which fit(s) best to their setting regarding primary health care for refugees and other migrants and is at the same time multifaceted, integrated, person-centred, multidisciplinary and needs-based	Selection

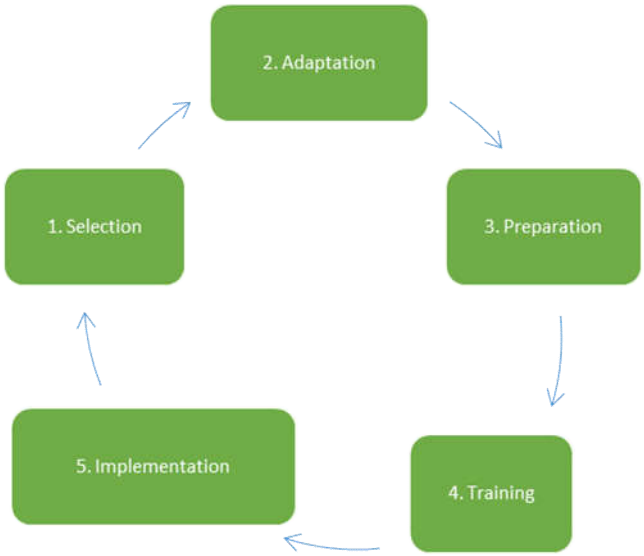
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 21. Country-specific context adaptations (such as country specific legal system, epidemiological picture, etc.) 22. Target-group specific context adaptations 23. Translation (and editing)	Adaptation
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to eHF)	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)** Cross-checking and last editing	Preparation
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc. • …	Preparation
15. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s)	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts • …	Preparation
15. Oct. – 22.Nov. 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • End-evaluation of the online course with questionnaire provided by EFPC and UoL	Training

	(NOMAD inventory) (WP7) Other training(s): two days face to face training, 17-18th November, Empoli	
November 2016	Participants apply the new learned content into their specific working setting and reflect about it (which will be assessed in the general intervention evaluation by EFPC and UoL)	Implementation
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D 6.2
01. Nov – 30. Nov 2016	Writing the national report about the intervention(s) and sending them to MUW	D 6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D 6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2	D 6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D 6.2

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a description about the implementation phase of the project.

Results

1. Description of the selection step

What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the

necessity/the need to choose exactly this intervention)? Please also indicate how you used the ATOMIC Model.

7. Intervention and underlying training:

a. Description of the first intervention and underlying training.

In WP 6 tasks 6.2 – 6.7, an English template for a multifaceted, integrated, person-centred, multidisciplinary online course has been developed for the target group of primary health care providers who are responsible for the health care of refugees and other migrants in the asylum procedure as well as for the initial health assessment.

The course was developed based on the results of WPs 2 (*D 2.1 – PLA groups with refugees and other migrants*), 3 (*D 3.1 & 3.2 – systematic literature review and questionnaire survey with stakeholders*), 4 (*D 4.1 – expert consensus meeting*), 5 (*D 5.1 & 5.2 – literature review regarding psychological first aid and MHPSS & Continuity of Psychosocial Refugee Care*) and 6 (*D 6.1 – assessment of local situation and resources available via semi-structured interviews with primary care providers and stakeholders, narrative literature review and participant observations*).

The course also includes the checklists, guidelines and interventions described in D 3.1 & 3.2 (*ATOMIC checklist*), D 4.2 (*Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees*) and D 5.1 (*Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS*) of the EUR-HUMAN project. Experts in particular fields supported the development of the course and created corresponding content.

The English template consists of 8 modules (including an introductory module):

- **Monitoring of the health status and initial health assessment, flight-specific health needs and red flags, infectious diseases, and vaccinations**
- **Legal basis for PHC providers regarding health care for refugees and other migrants**
- **Provider-patient interaction (communication, relevance of culture in medical practice)**
- **Mental health and psychological support, first aid for stress reduction in people with primary and secondary traumatization**

- **Sexual and reproductive health**
- **Child health**
- **Health promotion, prevention, and chronic diseases**

For the country-specific use, the English template needed the following country-specific adaptations:

- **The content had to be adapted for the particular country's legal system, health care system, epidemiology, as well as links to helpful organizations and information in that particular country had to be added.**
- **Target-group specific context adaptations (physicians, nurses, midwifes, PHC teams etc.)**
- **Translation (and editing)**

In Italy, as first intervention and underlying training, the on-line course was selected and adapted for the Italian context. The main target groups for this first intervention and underlying training were Primary Health Care providers (GPs, nurses and midwives).

The course in Italy consists of 7 modules that take into account the specific Italian situation. We have chosen module 1, 3, 4, 5, 6, 7, 8. The online course was translated into Italian by the translators of the Central Tuscany Local Health Unit and adapted to the Italian context by the Italian EUR-HUMAN team members and crosschecked for completeness of content and for readability. Then, the course was made available on the online platform Health-e-Foundation.

b. Description of the setting where the first intervention and training takes place:

The participants were able to do the online course at home or in their practices all over Italy with individual time management. In order to receive the certificate, the participants needed to complete the course within 4 weeks. We have disseminated the on-line course through a number of mailing lists of GPs, nurses and midwives and through the website of the Global Health Centre of the Region of Tuscany and the website of the Tuscan Medical Council.

c. Description of why did you choose this intervention for this setting (*there should be*

***a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1) of your country, the results of the questionnaire survey from WP3 (D3.1) for your country, the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) for your country) and how the intervention related to the guidance developed in D4.2*:**

The Italian plan for refugees and asylum seekers provides for reception centres covering widespread the Italian territory. Just after their arrival at the hotspots in the South of Italy, refugees and asylum seekers are scattered among the Italian Regions.

As for Primary Health Care, in Italy no special health assistance is provided for refugees and asylum seekers. After a first health screening at the hotspots, Primary Health Care for refugees and asylum seekers is regularly provided by the National Health Service (Local Health Units).

For this reason, we have involved Primary Health Care providers of the National Health Service dealing with refugees and asylum seekers in CAS (extraordinary reception centres) and SPRAR (Protection system for refugees and asylum seekers) structures. Until December 1st, 92 people enrolled into the course and 9 of them finished it successfully.

d. Detailed description of the target group in this setting (number, profession, etc.):

As already mentioned, in Italy, the National Health Service is responsible for the asylum seekers in the same manners as for all other Italian inhabitants. Therefore, the intervention needed to target primary health care providers (GPs, nurses and midwives) across the country. GPs are all potentially involved in the medical care for asylum seekers, since refugees and asylum seekers are enrolled in the National Health Service.

8. Intervention and underlying training:

a. Description of the second intervention and underlying training:

The second intervention has been a face-to-face training and has been developed according to three main issues. This intervention has examined in depth a number of the issues already touched in the online course, considering the results of WP2 and WP6.

The first part has provided the context analysis and the epidemiological framework (main features of migration in Tuscany). The second part has provided the normative and legislative framework (definition of refugee and asylum seeker status; routes of arrival in Europe; regulation of access to health assistance; Italian and Tuscan policies) and anthropological and cultural knowledge, in order to increase health workers' awareness of the relevance of cultural and anthropological factors in the fields of health and medicine. The third part has been focused on mental health (with special reference to vulnerable groups).

The first day of the face-to-face training has been organized with different lectures. The second day has been a discussion of case studies and participants have met up in teams for a participatory and interactive meeting.

This is the programme of the face-to-face training:

1) **Introduction to the EUR HUMAN project**
2) **Epidemiological framework in the Region of Tuscany**
3) **The role of GPs in Primary Health Care for asylum seekers and other migrants**
4) **Legal issues: refugee/asylum seeker status and right to health assistance**
5) **The relationship patient/health care provider: the cultural mediation**
6) **Mental health issues in refugees and asylum seekers population**
7) **Discussion of case studies**

b. **Description of the setting where the second intervention and training takes place:**

The face-to-face training took place in Empoli, at the Training Office of the Local Health Unit (Via Guglielmo Oberdan 13, Sovigliana, Empoli), on November 17th and 18th.

c. **Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1), the results of the questionnaire survey from WP3 (D3.1), the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) and how the intervention*

related to the guidance developed in D4.2

Considering the local results of WP2 and WP6, and the peculiarities of the Italian refugees' plan, we have decided to implement the face-to-face training in the Region of Tuscany, especially in the Central Tuscany Local Health Unit (ASLTC).

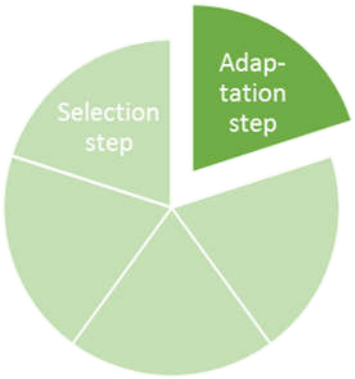
The Central Tuscany Local Health Unit covers the territories of Florence, Prato, Pistoia and Empoli, and it is the area where the majority of refugees and asylum seekers live.

We have involved the GPs who are responsible for the first health screening of asylum seekers arriving in the territory of Central Tuscany, and other Primary Health Care providers such as nurses and midwives.

d. Detailed description of the target group in this setting (number, profession, etc.):

27 people (16 GPs, 4 midwives and 7 nurses) participated to the face-to-face training.

2. Description of the adaptation step



How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?

7. Intervention and underlying training:

a. Description of the specific adaptations for the first intervention and underlying training (context, language, terminology, translation process):

The English template served as basis for the specific adaptation of the first intervention and underlying training. Country specific adaptations and additions were made according to the Italian context, the primary health care system in place, and its terminology and in terms of applicability.

The text of the online course was translated into Italian by the translators of the Central Tuscany Local Health Unit and adapted by the Italian EUR-HUMAN team members and crosschecked for completeness of content and for readability.

Considering the results of WP2 and WP6, Module 3 (legal issues) and Module 8 (health promotion and prevention) have been highly changed and adapted to the Italian context, aiming at filling the gaps of the Primary Health Care providers we had noticed during the work for WP2 and WP6.

The programming of the online course was realized in close collaboration with Judith de Lange from HeF, which is a sub-contractor of the EUR-HUMAN partner ARQ. According to the translation guideline, we kept headings in English and inserted the Italian translation next to it.

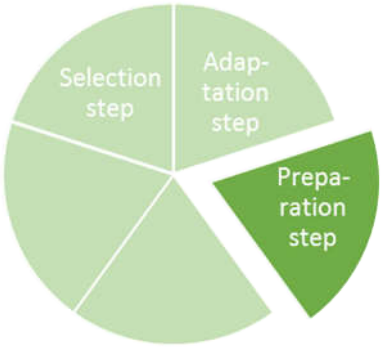
8. Intervention and underlying training:

a. Description of the specific adaptations for the second intervention and underlying training:

Considering the results of WP2 and WP6, we have pointed out a number of fundamental issues with a focus on the Region of Tuscany, aiming at filling the main gaps expressed by Primary Health Care providers we have interviewed. As mentioned before, the first part has provided the context analysis and the epidemiological framework (main features of migration in Tuscany). The second part has provided the normative and legislative framework (definition of refugee and asylum seeker status; routes of arrival in Europe; regulation of access to health assistance; Italian and Tuscan policies) and anthropological and cultural knowledge, in order to increase health workers' awareness of the relevance of cultural and anthropological factors in the fields of health and medicine. The third part has been focused on mental health (with special

reference to vulnerable groups).

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.

7. Intervention and underlying training:

a. Recruitment process of target-group: The Italian team pursued a diverse recruitment strategy. We have disseminated the on-line course through a number of mailing lists of GPs, nurses and midwives and through the website and the mailing list of the Global Health Centre of the Region of Tuscany and of the Tuscan Medical Council. The course was also advertised through the project teams' personal networks.

b. Invitation of experts, speakers, etc.: Since the selected training consists of an online course, no experts or speakers were invited.

c. Location for training: As the selected intervention consists of an online course the location of training is the physicians/GPs/primary health care workers own office or computer.

d. Negotiation process for CME points: Due to the rules of the Training Office of the Region of Tuscany (Formas), no ECM points were negotiated.

e. Kick-off event: No kick-off event took place

8. Intervention and underlying training:

a. Recruitment process of target-group: The Italian team pursued a diverse recruitment

strategy. We have disseminated the face-to-face training through a number of mailing lists of GPs, nurses and midwives and through the website and the mailing list of the Global Health Centre of the Region of Tuscany and of the Tuscan Medical Council. The course was also advertised through the project teams' personal networks.

b. Invitation of experts, speakers, etc.: The Global Health Centre of the Region of Tuscany invited the experts for the face-to-face training, in order to cover the main issues of the training. Dr. Piero Salvadori (GP, responsible of the EUR HUMAN project) presented the EUR HUMAN project and the aims of the training. Dr. Maria Josè Caldes (director of the Global Health Centre of the Region of Tuscany) gave a lecture titled "Epidemiological features of the migrants' population in Tuscany". Dr. Alessandro Bussotti (GP) gave a lecture titled "The role of the GPs in the Primary Health Care for migrants' health". Luigi Tessitore (lawyer) gave a lecture titled "Regulation of the access to health assistance"; Dr. Sergio Zorzetto gave a lecture titled "The role of cultural mediation and main mental health issues in migrants' population".

The second day of the training, Sara Albiani, Giulia Borgioli and Nicole Mascia (staff of the Global Health Centre) presented and discussed with participants a number of case studies, facing the issue of migrants' access to health assistance.

c. Location for training: Empoli Training Office, Via Guglielmo Oberdan 13, Sovigliana (Empoli)

d. Negotiation process for CME points: The Training Office of Empoli was responsible for the negotiation for CME points. The face-to-face training provided for 3 CME points.

e. Kick-off event: No kick-off event took place

4. Description of the training step

Please, describe the underlying training(s) in detail for each intervention and underlying training.
8. Training: **a. Timeframe of the training (dates, hours): The online course was launched on October 25th. In order to get the certificate, participants are encouraged to finish the course within 4 weeks.** **b. Learning hours for the participants: The online course consists of seven modules. The first module is organizational; it provides an overview about the course structure, the learning objectives and the finishing procedure. The other modules 2 to 7 are content-related. Modules 2 to 7 consist of a pre-test, the module content, and a post-test. For each module approximately one hour of study time is recommended. Thus, a total of eight learning hours is suggested for the entire online course. The participants could follow their individual time management; they are able to switch back and forth between modules and chapters. In total, participants will have to devote approximately two hours per week to finish the course in the recommended time of four weeks.** **c. Organisation of the training (who, how, …): The course is online on the platform of the organization Health-e-Foundation. The login code and password were provided to participants through online registration; the procedure is user-friendly and self-explanatory. After registration, an individually created username and password was sent to the participant with which he/she could log in and start the course.** **d. Participants (how many, which professions, …): On December 1st, 92 people enrolled into the course and 9 of them finished it successfully.** **e. Content of the training: The online course consists of seven modules, whereof**

module 1 provides an overview about the course structure, the learning objectives and the finishing procedure.

Module 2 addresses legal issues regarding the medical care for refugees during and after the asylum process. In particular, the module is focused on the Italian legislation on migration and on access to health assistance.

Module 3 targets (intercultural) communication competence. The first part of the module deals with general communication strategies, non-verbal communication and aspects relevant for interpreting. Part two addresses the relevance of culture in medical practice and health care, and outlines issues such as stereotyping, idioms of distress (identifying examples from Syria and Afghanistan), and perception of mental health problems. Furthermore, it provides in-depth information about explanatory models of illness, medical pluralism, and perception of pain and cultural aspects of diseases, death and dying.

Module 4 deals with mental health and psychosocial support; it provides knowledge on mental health issues of refugees, how to recognize signs of distress, and informs about symptoms of anxiety and distress, Post-traumatic stress disorder, screening and assessment, and treatments. The module contains recommendations on how to approach refugees in need of mental health care and how to promote self-reliance but also points to mental distress in professionals, protective and risk factors and possible health complaints. The second part of module 5 offers an introduction to trauma and stress reduction; it outlines recommended strategies when dealing with reactions of traumatic experiences, and includes non-verbal procedures for traumatized persons.

Module 5 comprises of knowledge on sexual and reproductive health and special risks and needs of refugee women. The module describes risk factors during the peri- and postnatal phase, on possible problems caused by trauma, flight and exhaustion in terms of mother and child bond, and gives an overview about the practice, the forms and effects of female genital mutilation (FGM). Furthermore, it deals with issues such as menstruation, contraception, abortion, sexually transmitted disease (STD) and sexual and gender based violence comprehensively and links to supporting organizations.

Module 6 is on child health. It contains information about special risks and needs of

refugee children, provides useful tools for efficient diagnostics and therapy, the prevention of physical and mental health issues, as well as for the prevention of communicable disease in refugee children. The module deals with vaccination and immunization; it targets nutrition and diagnostic recommendations for malnutrition, adiposity and discusses how to improve compliance of to the families. Finally, it also includes the topic of cultural influence and health e.g. with regard to children and young adults who suffer from chronic disease or are physically/mentally disabled.

Module 7 is on chronic disease, promotion and health prevention. It deals with strategies to support patients with acute and chronic diseases and how to enhance health literacy of patients that are asylum seekers or refugees.

f. **Location of the training: As the selected intervention consists of an online course the location of training is the physicians/GPs/primary health care workers own office or computer.**
g. **Weaknesses of the training (in your opinion): The main weakness of the Italian version of the on-line course is the absence of CME points, so people are not encouraged to attend the course.**
h. **Strengths of the training (in your opinion): The strength of the on-line course is that it provides basic knowledge on the issue of migrants' health, and this is good also for people without previous experience on the theme.**

9. **Training:**
   a. **Timeframe of the training: November 17th and 18th**
   b. **Learning hours for the participants: 11 hours (8 hours on November 17th and 3 hours on November 18th)**
   c. **Organisation of the training (who, how, …): The Global Health Centre of the Region of Tuscany, with the Empoli Training Office, has contacted the speakers and organized the training.**
   d. **Participants (how many, which professions, …): 27 participants: 16 GPs, 7 nurses and 4 midwives.**
   e. **Content: The first part has provided the context analysis and the epidemiological framework (main features of migration in Tuscany). The second part has provided the normative and legislative framework (definition of refugee and asylum seeker**

status; routes of arrival in Europe; regulation of access to health assistance; Italian and Tuscan policies) and anthropological and cultural knowledge, in order to increase health workers' awareness of the relevance of cultural and anthropological factors in the fields of health and medicine. The third part has been focused on mental health (with special reference to vulnerable groups).

The first day of the face-to-face training has been organized with different lectures. The second day has been a discussion of case studies and participants have met up in teams for a participatory and interactive meeting.

This is the programme of the face-to-face training:

1) **Introduction to the EUR HUMAN project**
2) **Epidemiological framework in the Region of Tuscany**
3) **The role of GPs in Primary Health Care for asylum seekers and other migrants**
4) **Legal issues: refugee/asylum seeker status and right to health assistance**
5) **The relationship patient/health care provider: the cultural mediation**
6) **Mental health issues in refugees and asylum seekers population**
7) **Discussion of case studies**

f. **Location: Empoli Training Office, Via Guglielmo Oberdan 13, Sovigliana (Empoli)**
g. **Weaknesses of the training (in your opinion): No weaknesses have been highlighted during the two days training but we are waiting for the evaluation of the participants.**
h. **Strengths of the training (in your opinion): The strength of the face-to-face training has been its organization, with lectures, case studies and participatory methodology. Participants have highly appreciated the case studies analysis, since they had the chance to put themselves in someone else shoes and to simulate real issues.**

5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into their specific working setting) in detail for each intervention and underlying training.
9. Implementation of first intervention and underlying training: **a. When, how and where did the participants apply the new learned content into their specific working setting: The participants will apply the new learned content in their everyday practice, when dealing with refugees, asylum seekers and other migrants.** **b. Which of the set of guidelines, guidance and trainings that were part of the learned content were applied to their specific working setting?** **Results of the evaluation D7.3** **c. What were the biggest challenges in terms of implementation?** **Results of the evaluation D 7.3** **10. Implementation of second Intervention and underlying training: The participants will apply the new learned content in their everyday practice, when dealing with refugees, asylum seekers and other migrants.**

Conclusion

Key points of the intervention:

- Translation and adaptation of the on-line course
- Finalization of the on-line course with Judith from HeF
- Definition of the content of the face-to-face training
- Identifying and contacting the speakers
- Identifying the case studies to discuss

Improve intervention:

- Negotiate for CME points for the on-line course

Improve implementation:

Since no primary health care is especially provided for refugees in Italy, and GPs see refugees, asylum seekers and other migrants in their everyday practice, it is not easy to monitor the knowledge they acquired and its application. It could be interesting to improve evaluation instruments that fit this situation.

Thank you very much!

Best regards,

The Viennese EUR-HUMAN team!

A11. National Report Slovenia

ANNEX 11

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (SLOVENIA) – 12-/12/2016

Report on the interventions that were implemented in Slovenia.

WP6, Slovenian report for Deliverable 6.2

Danica Rotar Pavlic

Eva Vicic

Erika Zelko

Alem Maksuti

Co-funded by the Health Programme of the European Union

Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains."

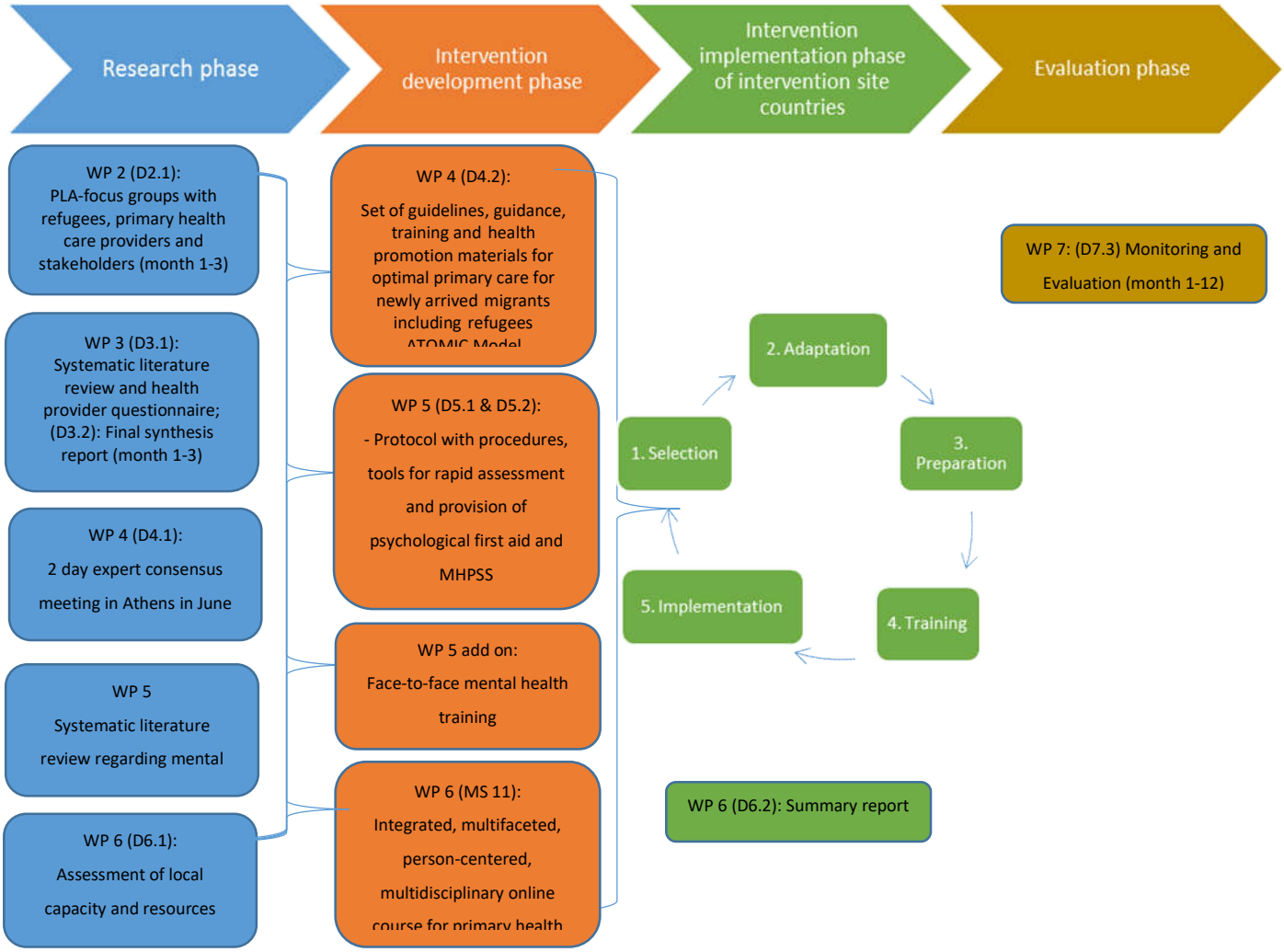
This EUR-HUMAN national report for deliverable 6.2 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Content

Introduction

The national reports will provide input to Deliverable 6.2: Summary report on the interventions that were implemented by the different implementation site countries. Deliverable 6.2 is part of the WP 6 with the aim to enhance and support the primary care workforce through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the Work Packages (WP) 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and D4.2 (WP4), D5.1 and D5.2 (WP5) and D6.1 (WP6) of the current project.

Picture 1: Work process of the EUR-HUMAN project



For the summary report MUW is responsible with the support and input of the intervention site countries and related partners (Greece (UoC), Italy (AUSL 11), Croatia (FFZG), Slovenia (UL), Hungary (UoD) and Austria (MUW)). All intervention countries were responsible for the realization of their tasks and finances regarding the adaptation, preparation, training and implementation of the intervention within their well-defined setting by themselves.

Note:

This summary report 6.2. aims to provide a discerption about the implementation phase of the project.

Tasks 6.10

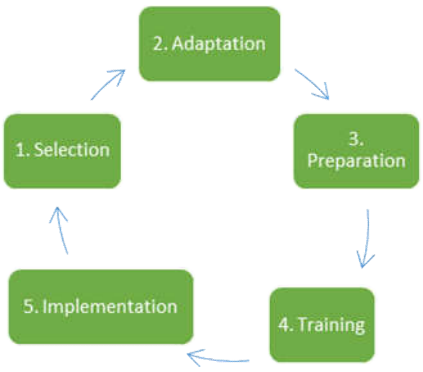
Slovenia has selected, prepared and implemented at least one interventions that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and migrants.

Specific objective for task 6.10

To enhance and support the health care and humanitarian workforce in Slovenia through selecting, preparing and implementing intervention(s) and underlying training(s) which were developed in the WPs 4, 5 and 6 of the EUR-HUMAN project. All the aforementioned are based on the results of D2.1 (WP2), D3.1 (WP3), D4.1 and 4.2 (WP4), D5.1 and 5.2 (WP5) and D6.1 (WP6) of the current project.

Timeline for the different steps of the implementation phase

Picture 2 describes the work cycle for the intervention site partners of the implementation phase. Table 1 gives an overview over the timeline of the implementation phase.



Picture 2: Work cycle for the intervention site partners of the implementation phase

Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

Timeframe	Action	Different steps of the implementation phase
01. July 2016 – 31. Aug 2016	- D 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees has been developed - D 4.2: Development of the ATOMIC Model - D 5.1 & D 5.2: Protocol with procedures, tools for rapid assessment and provision of psychological first aid - English template of the multifaceted, integrated, person-centred, multidisciplinary and needs-based online course has been developed - During this period, we were looking for information on the problem of refugees in Slovenia. We met with representatives of the National institute of public health. We harmonised international protocol and procedures with the Slovenian situation. We've included instructions for vaccination of national Institute of Public Health, instructions concerning the health insurance of refugees which we have got from the Institute for Health Insurance.	Selection
01. Aug – 01. Oct 2016	Particular attention was paid to description the legal aspects regarding the health care of refugees and the legislative principles. We were closely worked with the lawyers and jurists of the Medical Chamber of Slovenia and of the Ministry of Health. Country-specific adaptations of the interventions	Adaptation and inclusion of country specific topics.

	described above. Country-specific context adaptations (such as country specific legal system, epidemiological picture, etc.). Target-group specific context adaptations. Translation (and editing)	
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to eHF)	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)** Updating regarding the EUR-HUMAN Online Course. Finalising the information about the Registration/e-mail procedure. Translation of information regarding the registration and adaptation of it to country specific setting. Developing the Pre-post-Test questions for Modules, and post test questions. Cross-checking and last editing	Preparation
1. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions	Preparation
14. September 2016	Introductory meeting and workshop at Logatec Health Centre. Face-to face-meeting took place in the health unit near to Logatec asylum centre.	Face to face meeting with the GPs, paediatricians, urgent care staff, nurses, district nurses. 23 GPs, paediatricians, nurses, urgent health technicians and paramedics
24. October and	Face to face meeting took place on 24th of October in Izola and the feedback face to face session on 28th of	Face to face

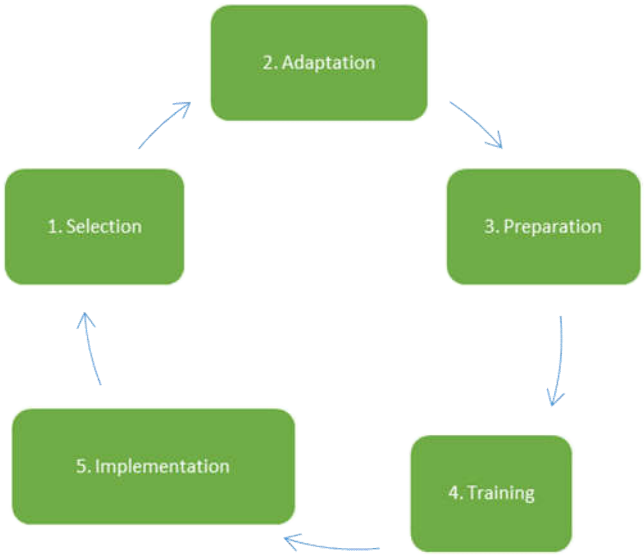
28 November	November 2016 in Izola.	meeting with nurses
1. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s) with the Medical Chamber and the Nurses and Midwives Association of Slovenia. Case number: 623-334 / 16-3 Decision number: 2016-311-311 Date: 21. 11. 2016	Finished
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts	
14.November 2016	Face to face meeting in Ljubljana	Face-to-face training
24. October 2016.	Face-to-face training with invitation to on-line training for nurses near Italian border.	Face-to-face training
29. November 2016	Face-to-face meeting with the representatives of Philanthropy, representatives of organisation Mozaik and Krog and health workers.	Face-to-face meeting
15. Oct. – 5.December 2016	Online-course: • Email-reminders for the participants • Pre- and post-tests • End-evaluation of the online course with questionnaire provided by EFPC and UoL (NOMAD inventory) (WP7)	Training
November 2016	Participants apply the new learned content into their specific health care setting and reflect about it (which will be assessed in the general intervention evaluation by EFPC and UoL)	Implementation
End of October 2016	MUW sends out the template for the national report for D 6.2 to the intervention countries	D 6.2

01. Nov – 30. Nov 2016	Writing the national report about the intervention(s) and sending them to MUW	D 6.2
07.Dec 2016	Preliminary presentation of summary report of D 6.2 (Evaluation meeting in Heraklion)	D 6.2
30. Nov – 23. Dec 2016	Writing the summary report for deliverable 6.2	D 6.2
Dec 2016 **(Deliverable 6.2)**	Uploading deliverable 6.2	D 6.2

Method

Description of the country-specific implementation process in accordance with the five steps of the work cycle in the result section of this template.

Picture 2: Five-step work cycle for the intervention site partners of the implementation phase



Note:

This summary report aims to provide a description of the implementation phase of the project.

Results

1. Description of the selection step

What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention)? Please also indicate how you used the ATOMIC Model.
4. Online course: **a. Description of the intervention and underlying training:** **The online course was prepared by MUW and adapted by the UL Medical Faculty for health care-providers that are involved in primary health care for refugees, asylum seekers and other migrants. The online course is part of WP 6 and has the special aim to support building capacity of the primary health care providers through closing knowledge gaps regarding different issues of primary health care for refugees/asylum seekers and other newly arrived migrants in the respective countries. The course template in English was translated into Slovenian and the content of all eight modules was adapted to the Slovenian context.** **b. Description of the setting where the intervention and training takes place:** **The setting for the online course was home or offices of the participants all over Slovenia with**

individual time management.

c. **Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1), the results of the questionnaire survey from WP3 (D3.1), the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) and how the intervention related to the guidance developed in D4.2*:**

An online course was offered to health care providers in Logatec, Ljubljana, Izola and in North east part of Slovenia.

Detailed description of the target group in this setting (number, profession, etc.):

The list of primary health caregivers and nurses was collected by open call from the Department of Family Medicine of University of Ljubljana and by the field work of Danica Rotar Pavlic, Alem Maksuti, Eva Vičič. The list included 46 general practitioners, nurses, psychiatric specialist, psychology specialist, paediatrician, district nurse, urgent care technicians from different parts of the Slovenia with special interest in migrant care. Therefore, they were considered highly valuable resource to provide feedback on the online course.

5. Face to face training and workshop in LOgatec s the introduction of e-platform training:

a. **Description of the intervention and underlying training:**

The one-day face-to-face training about EUR-HUMAN project was conducted on 14. of September in Logatec (List of participants is included in attachment). Logatec is a city in which one of the few Slovenia's refugee camps is also located and played an important role during the biggest migration flow in 2015. This is why the participants of this event were mostly doctors and other health care staff who had all gathered great experiences through direct contact in working with the migrants. In the first part of the workshop, we organized 2 lectures. In the first one we presented the current literature regarding the provision of health care to migrants and the results of the fieldwork of the EUR-HUMAN project. In the second one we considered the socio-cultural factors that contributed to the migrant crisis and tried to explain how the gravity of the situation they had suffered also might have impacted their mental health status significantly, which must always be taken into account when providing primary health care to

migrants.

In the second part we had a brainstorming session and plenary discussion. Issues were raised about what comes next - how to organise the provision of migrant health care in the future; what constitutes emergency care for migrants and what are the financial aspects of it - who is financing the acute diseases that are not life-threatening but could lead to worsening of health; the problem of non-existing vaccination records of migrants, especially children, who stay in transit countries for only short periods of time - how to manage them and provide not only for their safety but also for the safety of the community.

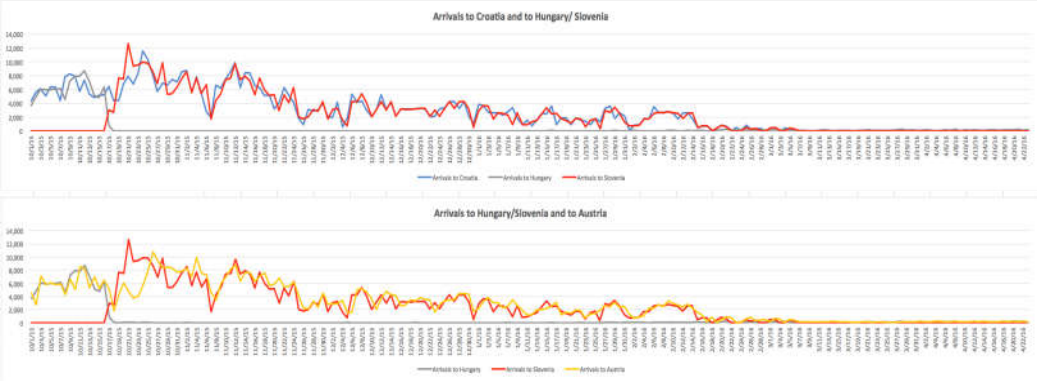
<u>The results of workshop in Logatec:</u> Refugees/migrants are one of the most vulnerable groups in our society, presenting high levels of exposure to traumatic events. The participants agreed that high levels of refugees/migrants required professional psychological distress, but only a small percentage of them received comprehensive mental health provision. Results of the workshop also demonstrated the need health workers to have specific knowledge if they want to be successful in in the treatment of mental illness of refugees/migrants. Our conclusions can be categorized in several broad areas. Firstly, it is important to knowledge of the refugee/migrant culture and community in Slovenia (and Western world in general). Secondly, it is important to know how to communicate effectively with individuals from different cultural/religious background. It turned out that language barrier can be a big problem. People are often suspicious of translators, although in the present case the translators performed outstanding work.

These results could also be understood as guidelines that represent the first step on the road in order to improve professional help seeking in the population of refugees/migrants with mental health problems.

b. Description of why did you choose this intervention for this setting (*there should be a clear rational behind you decision depending on the local situation, the results of WP2 (D2.1) of your country, the results of the questionnaire survey from WP3 (D3.1) for your country, the results from WP 5 (D5.1 & 5.2) as well as the results of WP6 (D6.1) for your country) and how the intervention related to the guidance developed in D4.2*

According to the Slovenian police (date: March 24, 2016) 379 refugees and migrants are temporary or permanent accommodated in Slovenia. They are accommodated in Asylum Centre in Ljubljana (218), in the Center for Aliens in Postojna (45), and in their branch offices in Kotnikova street in Ljubljana (67), and branch offices in Logatec (49) and Vrhnika (0). Since in March 2016 migratory flow was halted, Slovenia did not receive any additional refugees and/or migrants. Below reported figures show daily arrivals from each country from one or more borders. UNHCR estimates are based on the most reliable information available per country, including information from UNHCR border teams, authorities, and humanitarian partners.

Figure 1: Daily estimated refugees and migrants arrivals per country – flows through "Western Balkans Route"



Source: UNHCR (2016)

As the recognized need for capacity building for the provision of health care was the starting point of the EUR-HUMAN project, the consortium members defined that one of the main objectives was to identify, create and evaluate guidelines, training programs and other resources that can be made available for various stakeholders. WP6 has therefore created a multi-faceted and integrated on-line training course encompassing several important topics in primary health care, including mental health. Moreover, in line with the strategy of the EUR-HUMAN project to adapt the tools and resources to the local conditions, the face-to-face training on this specific topic was deemed culturally appropriate to the Slovenian situation.

c. Detailed description of the target group in this setting (number, profession, etc.):

Some doctors from Ljubljana also joined the group of Logatec . The invitations were sent based on field-work to all relevant institutions and organizations. Lea Bombač, MD, and Špela Brecelj,

MD, are two doctors, who are working for Slovenian philanthropic organisation in services for asylum seekers in Ljubljana. The group of primary health care physicians from Logatec health center are interested in this topic, because of the asylum for the families in Logatec.

3. Face to face meeting and the workshop in Ljubljana at the Department of Family medicine, 14th of November 2016

b. Description of the setting where the intervention and training takes place

Department of Family medicine, 14th of November 2016

c. Description of why did you choose this intervention for this setting

The another group of interested professionals was found and formed.

d. Detailed description of the target group in this setting (number, profession, etc.):

Sedina Kalender Smajlovic and Sanela Pivač are two nurses from the Jesenice region, near the Austrian border, who are interested in the area of Migrants. Nina Curk, MD, is psychiatry specialist from Ljubljana, who is interested in the area of migrant and minority health care. Romina Vidmar is a nurse from Ljubljana region. Bernarda Logar Zakrajšek is a psychologist who is working mainly with children in Ljubljana and she was especially interested in mental care because she meets migrant children as well. This group consisted of 5 professionals.

4. The group from North East Region of Slovenia

b. Description of the setting where the intervention and training takes place

This group was formed by e-mail and personal approach by Erika Zelko.

c. Description of why did you choose this intervention for this setting

The other group of interested professionals working near Austrian Hungarian boarder was found and formed.

d. Detailed description of the target group in this setting (number, profession, etc.):

Alenka Simunič, Nejc Halas, Leon Koveš, Staša Kocjančic in Stanislav Malačič are GPs from North Eastern region.

2. Description of the adaptation step

How exactly did you adapt the intervention(s) and underlying training(s) regarding country-specific adaptations, target-group specific adaptations, etc.?

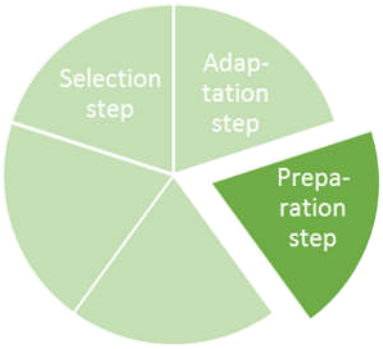
4. Online course

The online module was translated into Slovenian by Lingula, professional language Center from Ljubljana. Dilemmas were discussed with the WP leader as needed. The following adaptations were made:

- **All specific Austrian contents were adapted to the Slovenian specific situation by the help of jurists from Medical Chamber and Ministry of health. Special issues were adapted with the professionals from the Institute of public health of Republic of Slovenia.**
- **Workflow chart was translated into Slovenian language.**
- **Module 1: Specific information about credits for completing the course in Slovenian were included (the Medical Chamber 24 credits, The Chamber of Nurses 25 credits).**

- **Module 2: Chapter Infectious diseases was harmonised with the instructions of national institute of public health.**
- **Module 3 was completely changed to reflect the Slovenian national legal framework by the help of jurist Barbara Galuf from Slovenian Medical Chamber and by the help of Damijan Jagodic, vice-secretary and Ada Čargo , secretary from the Ministry of health.**
- **Module 4: Paragraph Specific Communication Strategies were not adapted since there was no specific need.**
- **Module 5: Links to local resources were provided.**
- **Module 6: Links to local resources were provided.**
- **Module 7: National vaccination recommendation from the Institute of public health was added.**
- **Module 8: Chapter One was slightly changed to reflect the situation in Slovenia; Chapter Prevention and Health Promotion was adapted likewise.**

3. Description of the preparation step



Please, describe the preparation step in detail for each intervention and underlying training.

4. Online course:

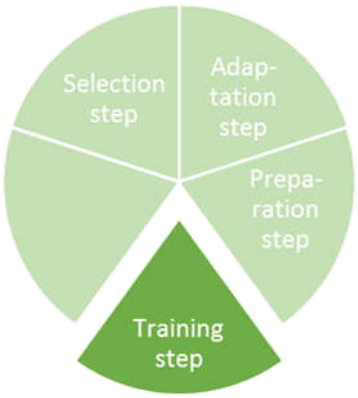
The target groups for the online course were primary health care providers who have experience of working with migrants and refugees. Before the online course, we tried to organise a face to

face meeting with workshop. These were not just the kick of meetings, since participants were also working in small groups and giving us a feedback.

5. Face to face training was conducted in Izola, Ljubljana and Logatec.

The target group were interdisciplinary (GPs, psychologist, psychiatry specialist, nurses, district nurse) with different roles in health care system. Training was introduced by prof. Danica Rotar Pavlic, doc. Erika Zelko, Alem Maksuti, PhD, and Eva Vičič, MD.

4. Description of the training step



Please, describe the underlying training(s) in detail for each intervention and underlying training.
4. Online course: Timeframe of the training. The online course will be available for four weeks, from November 3rd. Learning hours Completing the online course in Slovenian, including pre- and post-tests takes from 15 to 25 hours. Organisation

The course is online on the platform of the organization Health-e-Foundation.

Participants

At this moment (by 2 December 2016) there are 30 health care workers from Slovenia registered in the participants portal of the Health[e] Foundation.

Content

The online course contains 8 modules covering relevant aspects for working in refugee settings, such as acute diseases, sexual and reproductive health, mental health, legal framework, chronic diseases and health promotion.

Location.

Health[e]Foundation participants portal which can be accessed from anywhere with Internet connection

Weaknesses

2 participants had problems with registration. One had problems regarding the module of sexual and reproductive health. One participant mentioned that the translation to Slovenian language could be better.

Strengths

Participants in e-platform course from Ljubljana praised the good opportunity of obtaining information and instructions on how one can cope with the health care of refugees. Many attachments and links were seen and read for the first time. They were amazed how many things were done on the subject of migration! Up to now, this kind of medical documents in Slovenian were scarce. They specially valued and praised the chapter on vaccinations. Some excerpts were printed.

Participants in e-platform from Izola praised the contents of the vaccination and the chapter on jurisdiction and legislation. They found helpful the information on mental health.

5. Face to face training:

Timeframe

The trainings took place on 14 of September in Logatec, on 14th of November in Ljubljana. Face to face meeting took place on 24th of October in Izola and the feedback face to face session on

28th of November 2016 in Izola.

Organisation

The training was organised by the local team of the Slovenian EUR-HUMAN project.

Strengths

The conclusions of meetings in Isola, Ljubljana and Logatec were:

1. Access to medical care has enabled migrant children and pregnant women in the same way as Slovenian citizens. All the others have only the right to emergency medical assistance.

2. Health workers themselves were unfamiliar with the law on the provision of health care for refugees.

3. Migrants themselves are unfamiliar with the health care system in Slovenia and their rights within it.

4. The information flow and communication between stakeholders in the chain of care of refugees should be better.

5. After the completion of the project asylum seekers will receive better care than they were before the project.

6. The current situation is not optimal, but all stakeholders strive to optimize the work within the existing system.

5. Description of the implementation step

Please, describe the implementation phase (participants apply the new learned content into their specific working setting) in detail for each intervention and underlying training.
4. Online course: **No available information - evaluation data pending.** **5. Face-to-face training:** **Participants in e-platform course from Ljubljana praised the good opportunity of obtaining information and instructions on how one can cope with the health care of refugees. Many attachments and links were seen and read for the first time. They were amazed how many things were done on the subject of migration! Up to now, this kind of medical documents in Slovenian were scarce. They specially valued and praised the chapter on vaccinations. Some excerpts were printed.** **Participants in e-platform from Izola praised the contents of the vaccination and the chapter on jurisdiction and legislation. They found helpful the information on mental health.** **Participant from south east region wrote an e-mail in which she underlined the problems around illegal crossings of migrants:" Refugees occasionally cross the Slovenian border illegally. Health workers were called in Dobovo to the train station and to the police station, where they had Albanians who have illegally crossed the border. Healthcare professionals constantly monitor the situation in Turkey and higher. Police officers have tighter control over the entire border, day and night patrols are arranged. On the night of Monday 28th of November to Tuesday they had 7 interventions on, of which they found 10 illegal Turkish immigrants in Slogansko. There was one pregnant woman of 8 months of pregnancy and a half year old child. They swam across the Sotla rever. The pregnant woman was taken by the primary health urgent team to the Hospital in Brežice, the rest of the group slept on the police station in Brežice and have been later returned to Croatia. More and more problems appear by illegal crossings of refugees who also have health problems. Doctors and medical parts staff say that they will not endure another massive transit of refugees."**

Conclusion

All interventions and underlying trainings were fully aligned with the aims of the EUR-HUMAN project. The online course was adapted to the local Slovenian circumstances.

The improvements and progression of knowledge in the group of health workers and professionals were found in the following areas:

1. Health workers became familiar with the legislation on the provision of health care for refugees.

2.Sections about legislation, vaccination and mental health were welcomed and exposed as most useful.

3. After the completion of the project asylum seekers are receiving better care than they were before the project.

4. It would be necessary to appoint a multidisciplinary team that would prepare "clinical path« and continuity forms of health care for migrants within the existing health care system.

Difficulties in dealing with refugees were mainly related to the Slovenian specific organization of the health care system. Refugee women and refugee children are provided with full health care, such as Slovenian citizens. Other refugees with health problems are provided only for urgent medical care. Thus, medical personnel are dealing with difficulties in the care of chronic diseases such as diabetes and heart failure. **Although this problem is not related to online e-platform training, the doctors and nurses often cemented to MF UL team after the online education and reported on actual existing problems in the area of migrant health care.** Psychologist also mentioned the long waiting time for getting job in the group of asylum seekers and their idleness. E-Platform has allowed highly qualified health care knowledge, but this does not solve the fact that the refugees did not have any work, which might lead to mental health problems.

Best regards,

The Slovenian MF UL team!