Periodic/Final Technical Report

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EUR-HUMAN

Title: **EUropean Refugees - HUman Movement and Advisory Network**

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TABLE OF CONTENTS

After finalising your report, please update the Table of contents (right click on the table of content and select "Update Field")

Contents

TABLE OF CONTENTS 2
ACKNOWLEDGEMENTS 3
1. DESCRIPTION OF THE ACTIVITIES CARRIED OUT BY THE BENEFICIARIES AND OVERVIEW OF THE PROGRESS 4
1.1. Description of the activities carried out during the reporting period in line with Annex 1 to the Grant Agreement 4
METHODS AND MEANS 5
1.2. Overview of the project results compared with the objectives of the action in line with the structure of Annex 1 to the Grant Agreement including summary of deliverables and milestones and a summary of project result. (No page limit per workpackage but report shall be concise and readable. Any duplication should be avoided) 15
1.3. Project Results and Visibility 20
1.4. Overview of the evaluation activities and results 30
1.5. Overview of the dissemination activities 38
1.6. Objectives 47
1.7. Description of the activities carried per WP 49
1.8. Follow-up of recommendations and comments from previous review(s) 67
1.9. Deviations from Annex 1 67
1.10. Reasons for deviations from Annex 1 68
1.10.1. Implementation related deviations 68
1.10.2. Unforeseen subcontracting 70
2. REFERENCES 72
3. FURTHER REMARKS 73
APPENDIX 1. *DISSEMINATION OF THE PROJECT* (EXCEPT LEAFLET AND NEWSLETTERS DEVELOPED BY THE EUR-HUMAN TEAM) 73
APPENDIX 2. 78
APPENDIX 3. 79
APPENDIX 4. 82
APPENDIX 5. ABBREVIATIONS 83
APPENDIX 6. DELIVERABLES OF WP1. 84
APPENDIX 7. DELIVERABLES OF WP2. 86
APPENDIX 8. DELIVERABLES OF WP3. 87
APPENDIX 9. DELIVERABLES OF WP4. 89
APPENDIX 10. DELIVERABLES OF WP5. 91
APPENDIX 11. DELIVERABLES OF WP6. 94
APPENDIX 12. DELIVERABLES OF WP7. 96

Remarks:
The report shall be clear and concise. Duplication should be avoided

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1. DESCRIPTION OF THE ACTIVITIES CARRIED OUT BY THE BENEFICIARIES AND OVERVIEW OF THE PROGRESS

1.1. Description of the activities carried out during the reporting period in line with Annex 1 to the Grant Agreement

- Main activities carried out including methods and means

Over the past few years, the international refugee crisis reached a critical point. Many European countries are developing policy to better define their role in supporting refugees entering Europe, and to help address the multiple capacity issues to better address the needs of these vulnerable populations. The EUR-HUMAN Project Proposal was submitted in response to a Call launched under the 3rd Health Programme (Specific Call HP-HA-2015; Project Proposal number 717319). The receiving countries have to prioritise support regarding the health needs of these populations. The level of care to define and address the needs of these populations naturally falls under the primary care level. Additionally, there is ample evidence that strong primary health care (PHC) and the timely provision thereof results in better health outcomes and lower overall costs and burden for the healthcare system. Therefore, the decision was made to select PHC services as the core element to improve capacity in terms of healthcare service delivery to refugees reaching Europe. There are multiple reasons why programs are needed to assess feasibility and acceptability of proposed actions prior to large-scale implementation of such actions. Namely, the unprecedented influx of refugees has created conditions that necessitate optimal resource allocation, high degree of feasibility and acceptability, as well as flexible design, for the successful implementation and high transferability of proposed actions. This is particularly true for first-port-of-entry countries, where austerity had already depleted resources, but, also for transit or longer-term-of-stay countries facing similar challenges and/or additional issues emerging during integration stages. The **EUR-HUMAN** project "*EUropean Refugees - HUman Movement and Advisory Network*" (Specific Call HP-HA-2015; Project Proposal number 717319), is an integrated project under the "3rd Health Programme"for the action of the European Union in the field of health for the period 2014-2020. The duration of the project was 12 months. The overall objective of the EUR-HUMAN project was to enhance the capacity, knowledge and expertise of European Member-States (MSs) which accept refugees and migrants in addressing their health needs and safeguarding them from risks, while at the same time attempting to minimize cross-border health risks. A primary objective of this project was to identify, design and assess interventions to improve PHC delivery for refugees and migrants, the focus of such interventions being vulnerable groups. The target audience of the current project encompasses all healthcare professionals who provide PHC services to refugees and migrants across different settings. The EUR-HUMAN project has focused particularly on strengthening PHC as first-point-of-entry countries for refugees and migrants. In the context of its primary objective, EUR-HUMAN aimed to provide the tools for the provision of good and affordable comprehensive person-centred and integrated care for all ages and all ailments, taking into account the trans-cultural settings and the needs, wishes and expectations of the newly arrived individuals.

METHODS AND MEANS

The EUR-HUMAN project comprised of seven Work Packages (WPs) **(Figure 1)**. WP1 focused on the overall management and coordination of the project. The WP1 leader, for all activities under WP1, was the team at the University of Crete (UoC).

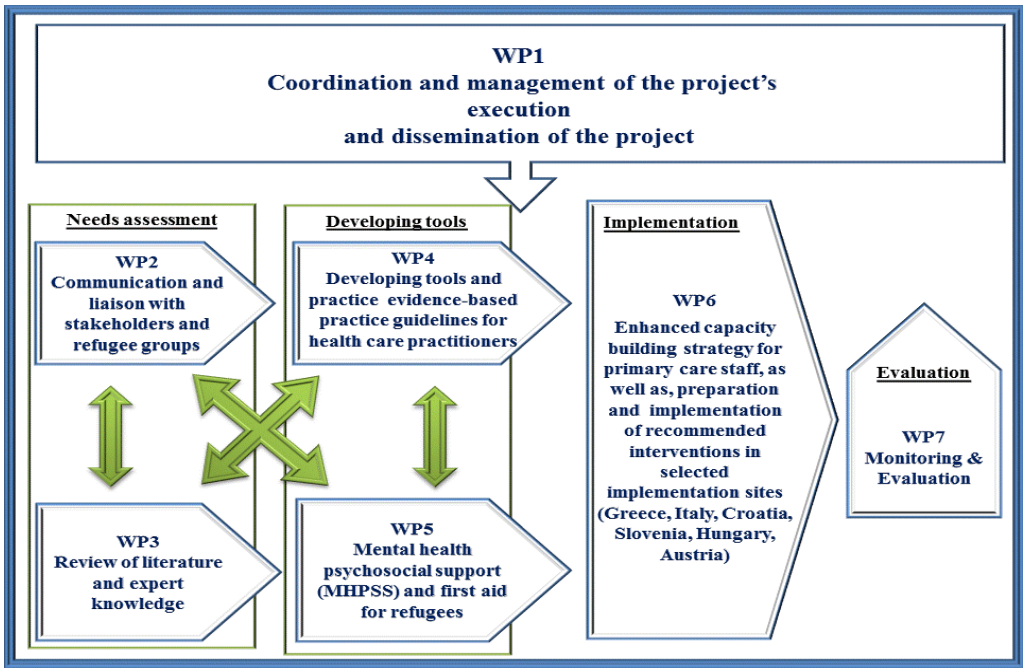

Figure 1: Graphical representation of the WPs of the EUR-HUMAN project

Overview of the project at a glance

1. Establish relevant theoretical inputs from the current research evidence base to underpin the selection of interventions to be combined. Given the relevance of the topic, elements were also extracted from the Chronic Care Model (Ackerman, 1997; DeRiemer, 1998; Walker and Jaranson, 1999)
2. Select and implement actions focusing on person-centred methodological approaches for needs assessment, as for example Participatory and Learning Action (PLA) (O'Reily et al, 2010) → WP2
3. Systematically review the existing literature. Supplement output of systematic review of the body of evidence with online survey of and interviews with experts and professionals. → WP3
4. Establish an Expert Consensus Panel and convene sessions to reach consensus agreement regarding best practices, guidelines, tools and services.→ WP4
5. Development of a model and protocol for rapid assessment of mental health and psychosocial needs of refugees.→ WP5

6. Assess the status of local resources and capacities available regarding PHC for refugees and other migrants. → WP 6
7. Draft evidence-based training material in a modular form appropriate for use by PHC practitioners in seven European languages (English, Greek, German, Italian, Slovenian, Hungarian and Croatian) as well as in Arabic → WP6
8. Deploy educational interventions across settings in six European countries (Greece, Austria, Italy, Hungary, Slovenia and Croatia) → WP6
9. Evaluate interventions utilising an evidence-based, validated approach; tools encompassing a range, including the normalization process theory NoMad (Finch et al, 2013). → WP7
10. Implement a pilot, encompassing interventions deemed most appropriate and lessons learned from interventions across settings, in Greece

WP1 (WP Leader: UoC)

Under WP1 the UoC team coordinated the entire project. Setting up and maintaining communication and dissemination mechanisms project web site, creating a YouTube channel – also functioning as means of training – and Twitter handle accounts, drafting leaflet, newsletters and press releases was performed under this WP. The Kick-off Meeting (KoM), as well as the Steering Committee Meetings (SCMs), and meetings between partners, were all organised and conducted under WP1. In addition, the UoC team organized two Advisory Board Meetings (AdBoards) and disseminated material regarding project output and activities at local, national and international levels. The UoC team organized also meetings and established communication the other projects funded under this particular call, as well as the International Organization of Migration (IOM), to ensure a maximum level of synergy and information exchange, but, also, to ensure duplication was avoided. In addition, the UoC team, in close collaboration with WP4 and WP7 leaders, organised the two-day Expert Consensus Meeting (June 2016; Athens, Greece) and the Project Evaluation Meeting (December 2016; Heraklion, Greece).

WP2 (WP Leader: Radboud UMC)

During WP2 we conducted a qualitative, comparative case study across hotspots, transit centres, intermediate- and longer-stay first-reception centres in seven EU countries (Austria, Croatia, Greece, Hungary, Italy, Slovenia, and the Netherlands) using the PLA research methodology (February-March 2016). The local sites were chosen as they represented points that can be used to map the journey refugees make as the enter and make their way into and across Europe; they do differ in terms of how long and where newly arriving individuals stay **(Table 1)**. Due to the importance of the "PLA - mode of engagement" and the need for mastery of PLA techniques prior to deploying the interventions, steps were taken to ensure the necessary expertise had been acquired. Out of the local teams involved in fieldwork, 16 staff members were

trained during a two-day course (6th and 7th February, 2016; Ljubljana). The training was specifically designed for this project and delivered by staff members of RUMC.

Image 1 PLA training session on 6th and 7th February 2016 in Ljubljana

Table 1: Overview of the settings across countries

Country	Site (location)	Type
Greece	Moria, Lesvos	Hotspot
Slovenia	Šentilj	Transit
Croatia	Slavonski Brod	Transit
Hungary	Bicske	Intermediate
Italy	Villa Pepi and Villa Immacolata	Long-term
Austria	Vienna	Long-term
The Netherlands	Heumensoord, Nijmegen	Long-term

In accordance with the legal requirements, all countries acquired approval by the appropriate Ethics Committees (ECs) prior to the qualitative study **(Table 2)**. The participants were recruited at the local implementation settings. Participant recruitment was performed on the basis of purposive sampling, using a combination of network and snowball sampling strategies. The number of sessions and the number of participants included in the fieldwork depended on the type of centre at the local

sites. Such number was highly dependent of the time available for a certain group of migrants to be able stay and to participate. All participants received a letter (in English, Arabic and Farsi) explaining the purpose and content of the research. Data were generated using PLA-style flexible brainstorm discussions and PLA-style interviews. PLA charts were used throughout to ensure that verbal and visual forms of data were recorded in a consistent manner across all stakeholder groups. All PLA charts were digitalised after each data generation session in order to facilitate data recording, processing and maintenance. Verbal data were recorded on Post-It notes in point form or short phrases rather than in full verbatim quotes.

Table 2: Overview of ethical approval

Country	Approval	Ethics Committee (EC)	Date/File number
Greece	Approval	2nd Health Region of Piraeus and Aegean.	Protocol number: 7496, Date 22-02-2016
Italy	No approval necessary	-	-
Slovenia	Approval	National Ethics Committee	Date 24-03-2016
Croatia	Approval	University of Zagreb, Faculty of Humanities and Social Sciences, Department of Psychology	Date 01-03-2016
Hungary	No approval necessary	-	-
Austria	Approval	Ethics Committee of the Medical University of Vienna	Ethical approval EK Nr: 2181/2015
The Netherlands	No approval necessary	Research Ethics Committee of the Radboud University Nijmegen Medical Centre	2016-2306

WP3 (WP Leader: NIVEL)

WP3: In this WP, the current dynamic and unprecedented situation regarding refugees and other migrants in EU was captured through collecting and analysing all means of information available to researchers. The information and results presented came from a literature search as well as an online survey and interviews with several experts and PHC providers in different EU settings (triangulation). The search strings were entered in 6 databases (***PsychINFO; Sociological Abstracts; Cochrane; Pilots; PubMed; Embase***). In total, 5492 articles were found. After removing duplicate articles a total of 3979 articles remained. Two researchers independently checked all 3979 articles for abstract and title. Additionally, each article was assessed for relevance regarding the EU refugee context. This criterion was added because the

output of WP3 had to be relevant for healthcare providers in the context of the EU. After discussion, consensus was reached on selecting 264 articles for full text screening. All articles were primarily qualitative, descriptive or reporting on research employing mixed methods.

However, to supplement the literature and to provide more up-to-date and hands-on information and practices on refugee care, an online survey was developed and disseminated among professionals and experts in Europe at the different work locations. Items were developed by the members of the review team and exchanged with the EUR-HUMAN group.

Additionally, ten semi-structured interviews were conducted with professionals and experts (May 2016), recommended by the EUR-HUMAN partners, regarding barriers and enablers for implementing care for refugees and other migrants. The majority of interviews were conducted via Skype. The interviews took approximately 30 minutes and were conducted by four different researchers. The interviewees gave informed consent to record the interview. The interviews were transcribed and sent to the respondents for a final check.

WP4 (WP Leader: Radboud UMC)

WP4: The objective of this work package was to define optimal content of PHC and social care services and to identify necessary knowledge, skills, training to provide comprehensive care for refugees and other migrants. Based on the information gathered in WP2, WP3, WP5, and, in part, WP6, the main objective was to reach consensus in terms of the content of what good PHC and social care services encompass to assess and address the health needs of refugees. This applied to newly arrived migrants in first reception centres as well as in transit and longer stay centres. In order to achieve this goal, a stepped consensus procedure was developed. On the 8th and 9th of June 2016 in Athens an expert consensus meeting was organised. A total of thirty (30) experts from fourteen (14) different countries were invited and joined. Consensus during the meeting was initiated by discussions across thematic teams by breakout sessions in smaller groups. With a specific topic being allocated to each team, teams had to come back, report findings and then discuss with all participants in plenary sessions. The thematic teams focused on four **(4) overarching topics** (Linguistic and cultural differences; Continuity of care across sites and countries; PHC team at refugee reception centres; Health promotion information and addressing information needs) and in **5 specific areas (**Acute illnesses and Triage; Infectious Diseases and Vaccinations; Non-communicable diseases; Mental Health; Mother, Child and Reproductive Health Care).

Image 2 Expert consensus meeting, on 8th and 9th of June 2016 in Athens

WP5 (WP Leader: FFZG)

WP5: This WP focused on mental health (MH) and psychosocial needs of refugees and other migrants. First, the *Protocol for early identification* of highly traumatized refugees and other migrants was developed. It includes tools, guidelines and procedures for rapid assessment of MH needs and psychosocial status that can be easily implemented in real settings. It also includes description of interventions based on Psychological First Aid (PFA) that can lead to shorter period of recovery from adverse life experiences and exposure to trauma. This is expected to foster successful integration into hosting societies and decrease social isolation and mental MH risks. The protocol is based on a stepped model of care consiting of *triage* (identification of MH conditions requiring immediate specialist attention), *screening* (identification of individuals who are at increased risk for developing serious MH conditions), *immediate assistance* based on the PFA principles, and *referral* procedure for full MH assessment and care as needed. Short, practical tools guiding these processes are included as a part of the protocl. The protocol was successfully piloted with 123 asylum seekers in the reception centre in Zageb, Croatia.

Second, the *Model of continuity of psychosocial refugee care* was developed that addresses challenges of providing person-centred, integrated and multifaceted support

for refugees and other migrants in the mental health domain. It includes rapid assessment protocol of MH status at the point of entry into EU and describes how to acumulate information about follow-up assessments and received interventions as the refugee individual transits towards the final destination. The model describes how to ensure that information relevant to the PHC is available at each point of contact with the refugee patient in transit countries and at final destinations. Two existing systems for recording health data are presented that can foster information continuity of personal MH data.

To develop both the protocol and the model of continuity of care, initially, key guidelines to mental health and psychological support (MHPSS) were examined. Secondly, over 20 handbooks, manuals and reports focusing on MHPSS in emergencies and refugee crisis were assessed. Finally, a comprehensive search of peer-reviewed studies was conducted in order to identify specifically tools for rapid assessment of MH needs. The procedures described in the rapid assessment protocol and the model of continuity of care be done with children, adolescents and adults.

WP6 (WP Leader: MUW)

WP6: WP6 aim was twofold. Initially, we had to identify and assess the existing situation and the local PHC resources available in six EU countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria). In order to receive this information three (3) different ways were used (narrative literature review/search of grey and scientific literature and reports; (semi-) structured interviews with local PHC providers treating refugees and other migrants and stakeholders involved in the organisation of PHC for refugees; participant observations in refugee camps and centres). This procedure took place April – June 2016. The findings of the report (Del. 6.1) reached the conclusion that there are discrepancies in different settings, the situation is characterized by constant changes and complicated. Results show that the challenges that need be tackled are in different levels (systemic; organizational; provider).

The second aim was to select, prepare and implement an intervention (feasibility study) based on best practice recommendations and tools produced as part of WPs 2, 3, 4, 5, and the first part of WP6, both in existing Early Hosting and First Care centres for refugees (Greece, Italy, and Croatia) and in existing Transit centres and centres for refugees and migrants with uncertain residency status who applied for asylum (Austria, Hungary and Slovenia). 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 (see below).

During WP6, the Austrian team (MUW) developed a comprehensive English template for a multifaceted, integrated, person-centred, multidisciplinary online course for PHC providers on base of the prior findings of the other WPs and in collaboration with expert stakeholders. The online course consists of eight modules, each with several

chapters and pre- as well as post-module-questions for each module. All six countries (Greece, Austria, Italy, Slovenia, Croatia and Hungary) translated and adapted the training material to their country-specific setting and into their own country languages. All countries were able to modify the content according for the country-specific setting and according to the respective needs of the target-group.

Additionally, the MUW team translated the online course into Arabic in order to offer a course for refugees from Arab speaking countries in Austria, who had been health workers in their countries of origin. All intervention site country partners followed a diverse recruitment strategy involving amongst others mailing lists, kick-off events and/or additional training sessions. Each Module (except Module 1, which encompasses the introduction) had pre- and post-test questions in order to evaluate knowledge gained.

Additionally to the online course the UoC team prepared, in collaboration with expert stakeholders, seven stand-alone training lecture videos in the Greek language and on different topics to better support the training of multidisciplinary PHC team. The training lecture videos are available online on the project's YouTube channel. The videos cover seven different topics.

WP7 (WP Leader: EFPC)

WP7: WP7 developed the framework for monitoring and evaluation of the project, while it assessed the accountability of the final results and provided recommendations for health policies and practices. The evaluation of the developed online course followed two approaches:

1. **Assessment of the use of the online course and the learning effect** (ex post/ante questions). Data for this assessment have been generated by HeF, an entity that offer blended learning programs, manages the online course and registers the users and their performance. The data covered the period from the moment the course came online in the various languages until January 3, 2017.
2. **Evaluation survey for feedback among the users of the online course.** These data were collected through an online survey among users (by using the NoMAD questionnaire), which was organised by the WP Leader in the context of WP7 with assistance of the other project partners. The users were invited to take part in the survey, via email. The survey was accessible for users of the course until January 13, 2017.

- Coordination with other projects or activities at European, National and International level

The EUR-HUMAN project collaborated closely with the other EU funded projects and especially with SH-CAPAC (participation on two separate project meetings and providing information on PHC service provision and current state in Greece;

participation of SH-CAPAC members in Expert Consensus and Evaluation Meetings) and CARE projects. The EUR-HUMAN coordinator conducted several teleconferences (TCs) and videoconferences (TCs) (see below) and established a regular communication via email and through meetings to discuss collaboration, present main findings, develop synergies and avoid duplication. Furthermore, the coordinator of EUR-HUMAN participated in two meetings (meeting of the Coordination Committee on Refugees' Health) that took place in Luxemburg (8 July 2016 and 20 January, 2017) as well as in the Preconference Event at the 9th Public Health Conference Vienna 2016 (9th November, 2016). Additionally, the EUR-HUMAN coordinator and the members of the UoC team developed a close collaboration with the IOM. Several TCs were held and communication in tactical base was established (via emails). Furthermore, UoC team participated in the online demonstration of the IOM e-PHR, provided in the discussion with suggestions and comments to improve the IOM e-PHR and based on this, the UoC team developed an electronic health record (offline mode). At national level, the project coordinator and the UoC team was in close collaboration with Greek Ministry of Health, the Greek Ministry of Migration as well as the NGO Médecins du Monde (MdM). One meeting was held in Athens with Greek Minister of Health (Mr. Andreas Xanthos) and also two meetings with the General Secretary of Public Health (Mr. Ioannis Baskozos) in Athens. Additionally, collaboration was established with the Mental Health Commission for Refugees and Migrants running by Greek Ministry of Health via communication with emails and participation in a meeting (12 July 2016 in Athens, Ministry of Health). Additionally, the Greek Ministry of Migration was informed twice and frequent communication by emails with all the aforementioned was established. Members of the EUR-HUMAN consortium participated in European meetings that the other projects organized and held in Ghent, Copenhagen and Granada. Also, members of the consortium participated in other relevant projects such as the two IOM projects (Athens and Lisbon). Finally, the UoC team actively participated in the online Health Policy Platform in the group entitled "*Coordination of the projects related to refugees*"0https://webgate.ec.europa.eu/hpf/network/home/17). The aim is online group was "*to coordinate the actions of all the projects. Public information discussed in this group will be shared in the Agora by the EU Health Policy Platform moderators*". The coordinator of the project actively participated in all teleconferences organized by CHAFEA and DG SANTE and continuously updated the platform with news, newsletters and progress reports of the project.

- Sponsorship

Not applicable.

- Project Coordination (WP 1)

The coordination of the EUR-HUMAN project was the Director and Head of the Clinic of Social and Family Medicine, Head of the Department of Social, School of Medicine, University of Crete.

- Financial management

The UoC coordinated the financial management of the EUR-HUMAN project as the coordinator of the project. The coordination of the financial management was overseen by Prof Christos Lionis, who has extensive experience in participating and coordinating research projects, in collaboration with the financial administrator of the EUR-HUMAN project. The interim state of expenses of the first eight months were presented in internal reports from all beneficiaries on the initiative of Uoc. The final financial reports for the whole period of the project was coordinated by the UoC with the contributions of all partners and submitted to CHAFEA.

1.2. Overview of the project results compared with the objectives of the action in line with the structure of Annex 1 to the Grant Agreement including summary of deliverables and milestones and a summary of project result. (No page limit per workpackage but report shall be concise and readable. Any duplication should be avoided)

Table 3: Summary of EUR-HUMAN deliverables.

Deliverable number	What	By whom	Due date	Delivery date	Comments
D1.1	Final report to CHAFEA	UoC	M12 M14	M12	Draft submitted Submitted
D1.2	Project website	UoC	M1	M1	Submitted
D1.3	Project leaflet	UoC	M3	M3	Submitted
D2.1	Report	RUMC	M3	M4	Submitted
D3.1	Summary preliminary findings	NIVEL	M3	M4	Summited
D3.2	Final synthesis	NIVEL	M4	M12	Submitted
D4.1	Report of expert meeting	RUMC	M5	M7	Submitted
D4.2	Set of guidelines, etc.	RUMC	M6	M7	Submitted
D5.1	Protocol	FFZG	M4	M5	Submitted
D5.2	Model of Integrated Care	FFZG	M6	M8	Submitted
D6.1	Local assessment report	MUW	M6	M7	Submitted
D6.2	Summary report, implementation 6 sites	MUW	M11	M12	Submitted
D7.1	M&E Framework	EFPC	M1	M2	Submitted
D7.2	Interim evaluation	EFPC	M6	M12	Submitted
D7.3	M&E chapter	EFPC	M12 M13	M12	Draft submitted Submitted

Table 4: Overview of EUR-HUMAN Milestones.

WP	Milestone	Expected	Reached
WP1	1.1 Advisory board meeting	(M4)	7-8 June 2016 in Athens (Greece)
WP2	2.1 Local researchers are trained in PLA	(M1)	6-7 February 2016 in Ljubljana (Slovenia)
WP2	2.2 PLA moderated meetings have taken place between researchers and refugees	(M3)	PLA moderated meetings between local staff and refugees took place between February 10th 2016 and March 30th 2016.
WP2	2.3 Report on the views, experiences and expectations of the refugees and the stakeholders	(M4)	(Deliverable 2.1): The synthesis report of aggregated data of all local sites was drafted in April 2016, and finalised on 26th of April 2016.
WP3	3.1 Presentation and discussion of preliminary findings at partner meeting	(M3)	(Deliverable 3.1): April 1st, 2016
WP3	3.2 Final synthesis report available online	(M5)	(Deliverable 3.2): Draft uploaded on May 30th, 2016. Final uploaded on December 27th, 2016
WP4	4.1 Expert meeting	(M5)	7-8 June 2016 in Athens (Greece)
WP4	4.2 Set of guidelines, guidance, tools, training and health promotion materials to support the local sites is available online	(M6)	(Deliverable 4.2): Delivered on July 25th, 2016
WP5	5.1 Protocol for rapid assessment of mental health with procedures, tools and interventions completed	(M4)	Deliverable (5.1): Delivered on April 29th, 2016
WP5	5.2 Model of Integrated Chain of Psychosocial Refugee Care described	(M6)	Deliverable (5.2): Draft delivered on June 30th, 2016
WP6	6.1 Start of development of the capacity building strategies	(M4)	Implementation protocol ready on April 30th, 2016
WP6	6.2 Start of the implementation in the intervention site countries	(M6)	Started on June 13th, 2016
WP6	6.3 EU-wide adaptable curriculum and training material for local primary care professionals would be available via an internet platform and a e-learning module (can be also linked to the project homepage)	(M8)	Final version of the online course available from October 24th until November 30th, 2016
WP7	7.1 Agreement on the monitoring & evaluation framework during kick-off meeting.	(M1)	Delivered on February 4th, 2016
WP7	7.2 Agreement on the final evaluation, conclusions and recommendations in the final report	(M12)	Draft delivered on December 29th, 2016

Summary of deliverables and milestones and a summary of project results

WP1: Coordination and management of the project was intensive, due to the inter-dependence of WPs in terms of content and timing. Next to the formal Steering Committee Meetings, many emails and bilateral exchanges and TC meetings were conducted. A Dissemination Plan was developed from the start of the project, encompassing various actions. The dissemination plan was developed as a rolling plan, since additional opportunities for dissemination were added as they arose. A separate Publication Plan was developed as part of the dissemination actions and the overall Dissemination Plan. For the Publication Plan, an authorship policy with common Terms of Reference (ToR) was developed by the UoC agreed upon by the consortium partners. All partners contributed to the dissemination of the project and of its results in multiple occasions (see below). The Consortium is also in the process of publishing papers in a number of journals. Additionally, the UoC team, in close collaboration with the consortium, developed the "Workflow" which includes three main domains, illustrating how health needs of population groups can be addressed by, health care professionals (see below). ***All milestones and deliverables were reached as planned and on time.***

WP2: This WP aim was to gain insight in the health needs and social problems, as well as the experiences, expectations, wishes and barriers regarding accessing PHC and social services, of refugees and other newly arriving migrants throughout their journey through Europe - from the hotspots via the transit centres to the first longer stay reception centres. The information and insights have been collected through group sessions with refugees in seven (7) countries: Greece, Slovenia, Croatia, Italy, Hungary, Austria and the Netherlands. These sites were chosen so as to represent a variation in contexts and to reflect a part of the journey of refugees. The group sessions were conducted through the PLA research methodology. Local staff members from all intervention sites had to be trained in the application and ground rules of the PLA method. A total of forty-three (43) group sessions were held, with a total of ninety-eight (98) refugee-participants from nine (9) countries and with twenty-five (25) health care workers in Croatia. One site for the PLA sessions has been added to the original plan (Netherlands). In Croatia, sessions with refugees could not be held due to their very fast transit. Therefore, six PLA sessions were held with experienced care providers from various agencies that had been working with refugees in the transit centres. ***All milestones and deliverables have been achieved as planned and in time.***

WP3: This WP aim was to learn from the literature and the experts on measures and interventions and the factors that help or hinder their implementation in European healthcare settings. After the development of a heuristic framework, a systematic search of literature databases and an online survey among experts were done. 81 experts and health professionals responded to the survey. This was followed by interviews with 10 international experts. The original plan was to deliver a report with

an overview of effective interventions that address health needs of refugees. This was delivered. However, in order to facilitate implementation, the WP has delivered also a follow up, a checklist, called "*ATOMiC: Appraisal Tool for Optimizing Migrant Health Care*". It provides practical guidance for improving health care services for oftenvulnerable groups. The checklist helps users – health care professionals, managers, policymakers, implementation advisors – to consider the various contextual and resource factors and to identify priority interventions and issues that require special attention when proceeding with improving the services. ***All milestones and deliverables have been achieved.***

WP4: The overall aim of this WP was to provide a series of support tools for primary care practitioners who work with refugees, in the form of papers, guidelines, training and other materials. An expert meeting was held on June 8 and 9 in Athens and brought together 30 experts from various countries plus 15 Greek officials, representatives of the Ministry of Health, the Ministry of Migration and other relevant organizations. The meeting report with consensus on conclusions and recommendations on Primary Care for refugees/migrants was produced. Thanks to organizational support by WP1, the meeting proceeded smoothly. The delay in deliverable was due to the fact that the expert meeting only could take place after finalizing WP3 and 5, which was foreseen in month 5, so the meeting had to be postponed from month 5 to month 6. ***All milestones and deliverables have been achieved.***

WP5: The overall aim of this WP was to provide a protocol for rapid assessment and provision of psychological first aid (PFA) and mental health psychosocial support (MHPSS). In addition, a Model of continuity of psychosocial refugee care had to be developed. The WP developed the protocol for rapid assessment based on the stepped model of care, described the PFA interventions, and described the Model for continuity of psychosocial refugee care with the focus on ensuring the information continuity of information MH data as the refugee patients transit to their final destination. The protocol for rapid assessment of MH was piloted with 123 asylum seekers despite the fact that wasn't the expected outcomes of the project. The piloting included screening procedure, testing the screening tool in several languages (RHS-13), and establishing the referral pathways (conducted by Croatian team). The screening was based on a validated tool and principles derived from scientific research and practice (described in D5.1). ***All milestones and deliverables have been achieved as planned and in time.***

WP6: The first objective of this WP was to enhance the capacity building of the primary care workforce through the assessment of the existing situation. Another activity of the WP was the development of an online curriculum for local primary care professionals and refugees who are primary care professionals. The second objective was to implement at least one intervention in each of the six participating countries and to evaluate its effectiveness. In each of the six selected countries, Greece, Italy,

Croatia, Slovenia Hungary and Austria, one target group of care providers is selected for training and one intervention is selected for implementation. WP6 has developed a report on the interventions implemented. Based on the results of the data collection phase (WP2-WP6) a portfolio of checklists, guidelines, guidance, tools and training materials for the interventions and underlying trainings was developed (please see below). A comprehensive English template of a multifaceted, integrated, person-centred, multidisciplinary online course (eight (8) Modules) for PHC providers was developed. All six countries (Greece, Austria, Italy, Slovenia, Croatia and Hungary) adapted the training material to their country-specific setting and translated it into their own country language and implemented the training course. However, the MUW team translated the online course also into Arabic, in order to offer a course for refugees from Arab speaking countries in Austria, who had been health workers in their countries of origin. Additionally to the online course and to the Grant Agreement, the UoC team developed and prepared, in collaboration with expert stakeholders, seven training lecture videos in Greek language on different topics (via a YouTube channel: https://www.youtube.com/channel/UCvl3kOrEidGv2XA4zAUs01Q) in order to support the training of multidisciplinary PHC teams. Additionally to the Grant Agreement, the UoC team piloted the intervention by testing the tools, the questionnaires and the procedures in order to enhance capacity building of the European countries that accept and host refugees and migrants. In addition, the UoC team, developed an electronic Health Care Record (e-HCR) based on the IOM personal health records and the existing EPR system. ***All milestones and deliverables have been achieved as planned and in time.***

WP7: The main aim of WP7 was to provide optimal monitoring of the project's progress and key messages deriving from the WPs and the participants' experience and to produce recommendations for health care policies and practices. These emerged as the project was progressing. Furthermore, the monitoring provided a regularly updated overview of adaptations of the activities, outputs and (expected) results and outcomes. This allowed all stakeholders to understand the implementation process and its challenges and to adapt according to local needs, where necessary. Evaluation of the project was conducted towards the end of the twelve (12) month project and contributes to accountability of the project, by assisting the WP coordinators in describing the outputs and results in terms of outcomes and impact. During M1, the Monitoring and Evaluation (M&E) Framework has been agreed with the partners and was used as a tool to communicate with the partners on progress of activities and challenges. The evaluation meeting was held in Heraklion, Crete on December 7. ***All milestones and deliverables have been achieved.***

1.3. Project Results and Visibility

- Major results and key findings, their uptake and future potential use

During the fieldwork in **WP2**, we managed to involve numerous refugees during their journey in so many countries over the same period of time. Our approach enabled us to get a snap shot of the health needs and experiences of refugees with healthcare system in their chain of travel through Europe during the first 3 months of 2016. In contrast with most of the studies conducted among refugees about their health problems in long-stay refugee centres, we also included hotspots, intermediate and transit centres. A new and very important finding of our study is that time pressure is the most difficult barrier in accessing healthcare at hotspots or transit centres something that is relevant for the development of suitable rapid assessment tools (developed in WP3, WP4, and WP5). The results of WP2 had a significant association in providing services to this vulnerable population based on their needs, wishes and preferences. All the results of WP2 assisted us in the development of tools and questionnaires for rapid health assessment, as well as in the development of training material in WP6.

These results are significant because we gained better knowledge on their health needs, wishes, problems and expectations. This was quite important as it supported both health policy makers and the healthcare providers in decision making process. Knowing all the aforementioned, is a key point in health system because it increases service utilisation rates and assist in decision making. Additionally, based on their needs, health policy makers could add or withdraw necessary/unnecessary services and at the same time have the capacity to inform priority setting and primary care planning. All these have a significant impact on decrease of hospitalization, morbidity and mortality. At the same time, available resources are better managed, while healthcare expenditure are decreased. To sum up, knowing health needs, wishes and preferences promote effective and equitable care and in general improve health of this vulnerable population.

The results achieved by **WP3** have a significant impact on improving health status of refugees and other migrants. Initially we found the factors that could help or hinder the implementation of interventions and measures by defining barriers or enablers. Knowing these factors (i.e. values, wishes, beliefs, physical and mental ability, socioeconomic, etc.), enables providers, policy makers and institutions to understand and integrate/abolish these factors into the delivery and structure of the health care systems. The goal is to provide the highest quality of care to every refugee or migrant, regardless of race, ethnicity, cultural background and health literacy. Due to the fact that the present report contributes to our understanding and awareness of factors that influence refugee health care optimization efforts in the EU, the contents of this report

is relevant for a broad audience in different countries for adaptation and utilization. ATOMiC toolkit focuses on the route between appraisal of a promising idea or plan and the decision to proceed with its implementation. The checklist encourages users (health care professionals, managers, policy-makers and implementation advisors) to carefully contemplate recurring implementation factors and identify issues that require special attention when proceeding.

In **WP4**, we found the most rigorous tools, checklists, and guidelines that can help PHC personnel in the provision of care for refugees and migrants (e.g. guidance for the vaccination of children, assessment of malnutrition, and guidelines on sexual violence). All these tools are available in a comprehensive guidance for PHC workers in order to provide optimal primary care. All the tools found, could be used in the European countries after an adaptation to the local context. In D4.2, we provide a simple guidance for adaptation of the tools according local circumstances, the nature and amount of refugees, the composition of the healthcare team, resources in terms of materials, money, housing etc. and based on local collaboration with other healthcare domains (public health services, nationally PHC services, NGOs etc.). One of the main advantages is that most of the tools and guidelines included, are targeting refugees in first reception centres or longer stay reception centre. Additionally, most of the tools could be applied by multidisciplinary teams and not only by physicians. The tools can improve patient-provider relationships, improve the quality of services and are a way of making a comprehensive health assessment. Rapid assessment can identify existing condition and helps in planning, developing and implementing interventions and programmes.

The outputs that **WP5** achieved are significant and their contribution to the European countries is important. Initially, the MH and psychosocial needs of refugees and other migrants were identified both upon their arrival and transit period as well as at their long settlement centres. Additionally, appropriate interventions and services delivered, leading to their shorter period of recovery from incapacitating consequences of adverse life experiences and exposure to trauma were developed and proposed. Applying the proposed protocols, lower health and social services for the hosting societies, lower incidence in domestic violence will be achieved, while integration will be facilitated into hosting societies and decreased risk for radicalization. However, the use of such tools is cost-effective and culturally effective interventions. The goal of these tools is to normalize/improve the patient/refugee situation, providing information to tackle problems and reduce the stigma. The piloting of the MH screening (RHS-13) and referral procedure took place in the reception centre for international protection applicants, Porin, Zagreb (Croatia) and had a threefold objective (establishing trust**;** administering the screener; evaluating the results and immediate assistance (referral if needed)). The need for piloting the procedure of MH screening was recognized from the previous work done in course of the EUR-HUMAN project, where the need for improving MH services was further stressed. 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 MH screening and referral. The implementation facilitated patient-centeredness, compassion, culture-sensitivity and non-discriminative. It is strongly recommended that a systematic MH screening and referral procedure should be integrated into health check-ups/ initial health assessments for all newly arriving refugees and migrants. 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.

The outputs that **WP6** provide are significant and their contribution is of paramount importance. First of all, the consortium provides a portfolio of tools, including comprehensive checklists, guidelines, guidance, tools and training materials to healthcare professionals, PHC providers and policymakers too. These instruments were selected through testing and demonstrated good results can be achieved in terms of in rapidly enhancing capacity building in different European settings. Additionally, these can strength the expertise and the skills of PHC healthcare professionals, thus, enhancing overall capacity for care provision under PHC. Due to the fact that the training material is online and continuously available as stand-along or combined modules, it is possible to train a large number of PHC providers in a comparably brief time period, as well to make it continuously accessible at any place with Internet connection. The material can be downloaded and used even without Internet connection provided video/computer/mobile phone means are available. Additionally, all course material can be also translated in other languages, if and as necessary, and adapted by other European countries affected by the refugees crisis as it can be updated easily and rapidly. The developed training material, promotes skills, knowledge, attitudes and life-long learning while at the same time helps in provision of high quality health services. The pilot implementation of the intervention of all lessons learnt in the training course proves that it is a precious instrument not only for the countries that participated in the project, but for all European countries hosting refugees and other migrants. The Consortium believes the relevance of the overall output extends beyond the borders of Europe and will seek to disseminate results on a global scale. Core elements highlighted and facilitated extend beyond the provision of care for refugees and migrants and go beyond temporal limitations, with skills-based learning, patient-centeredness, compassion, comprehensiveness, well-informed and activated patient as well as decision and self-management support, thus, presenting relevance for all populations, across settings and levels of care.

In summary, **WP7** found that the training procedure was found to be highly acceptable by PHC providers and easy implementable too. Notably, it encompasses the latest information and guidelines regarding refugees and other migrants. Due to the fact that many PHC providers in the field, in different countries emphasised the importance of this training material and expressed very positive feedback, we are

encourage and optimistic that such feedback can help us promote its adoption as a priority item in the agenda of health policymakers, but, also, in the public health/healthcare professional training as part of the curriculum across the spectrum of university and professional training and across training programmes in health sciences. As a conclusion, the current training material could enhance the capacity building in PHC provision.

- Target groups and added value

Given its flexibility and the core elements taking into consideration a person-centred, highly relevant and acceptable to participants and providers approach, EUR-HUMAN is deemed to have high transferability. In more detail, the EUR-HUMAN toolkit can be transferred across settings and in all European countries affected by the current refugee crisis:

- Means of capturing the, wishes, preferences and expectations of refugees and other migrants reaching Europe (WP2);
- Means of establishing and addressing the barriers of providing PHC to these vulnerable populations (WP3);
- A flexible list, i.e., the ATOMiC checklist, to guide implementation decision-making (WP3);
- Multiple tools, that can be used combine or in stand-alone format, for rapid interventions, timely and feasible assessment (WP4);
- A protocol for rapid assessment of MH and the Model of continuity of psychosocial refugee care (WP5);
- Training material for PHC healthcare providers (WP6);
- PHC patient electronic health record (EHR) which is compatible with the IOM personal health records and the existing Greek EPR system for continuity of care (WP1-WP7);
- PHC unit structure and organization (WP1-WP7).

The primary objective of this project was to identify, design and assess interventions to improve PHC delivery for refugees and migrants with a focus on vulnerable groups by developing tools and practice guidelines for the initial healthcare needs assessment of the arriving refugees including mental, psychosocial and physical health and to test of interventions for relevance, acceptability and feasibility in terms of the implementation thereof. The EUR-HUMAN project has a significant impact on three dimensions. Notably, on the quality of the healthcare service provision (a), on the developing competences of PHC providers and of giving them the means and tools to care for these populations, thereby quickly and efficiently increasing capacity in terms of human expertise/resource (b), on providing insights for developing relevant healthcare policy and tools for brokering dialogue with multiple stakeholders (c)). However, it can positively influence the working conditions and satisfaction of

healthcare workers, as well as the interaction and collaboration of the three target groups (refugees; healthcare workers; host communities).

This innovative effort contributed significantly to the development and enhancement of capacity in terms of PHC provision. The project provided a comprehensive health needs assessment and the tools supporting care provision, as well as the mode of services provided, are grounded in a holistic, integrated and compassionate model of health and wellness. The manner of implementation ensures optimal feasibility and high acceptability, facilitating support the delivery of the appropriate, PHC services to refugees upon arrival or during transit.

The educational tools and materials, and the e-training modules that have been developed in the context of this project carry the potential of having an important impact on the training and continuous professional development of PHC healthcare professionals across European settings and for all MSs. Especially, the low-cost of the e-training modules allows easy implementation in a large number of PHC healthcare professionals and to remain accessible, long after the conclusion of the project, while it can be used for multiple purposes serving also the needs of the regional and national training programme for PHC healthcare professionals and/or for informing healthcare professionals practising in settings on different levels of care. Its potential use in undergraduate education is promising and it has been discussed during the evaluation meeting of the project. Additionally, the training material developed by the UoC team via the YouTube channel can potentially be watched anytime, anywhere, by anyone who is interested in the topic, as it is open-access and user- friendly. It could be also used in vocational training of general practitioners in this country and it would be appropriately incorporated within the current plans of primary health care reforming.

The effect of the economic crisis and ensuing austerity on the health and social care, coupled with the refugee crisis and the massive migratory influx, have had – and continue to have – an enormously significant impact on European healthcare systems. Regarding the political context, the European Union have agreed to develop a common immigration policy to ensure that migration to the EU is well managed and integration measures for migrants and their families are improved. Solid PHC produces better health outcomes and lower costs. By promoting robust Community Oriented PHC health status and conditions can be improved for vulnerable populations including refugees and migrants but the health of all European citizens can be safeguarded and protected. Within the EUR-HUMAN project a flowchart, i.e., the “Workflow” was developed to show the ideal process/flowchart of health care for refugees and other migrants when they approach a receiving country. EUR-HUMAN consortium is providing a comprehensive and holistic PHC structure (the so-called “*flowchart”*), which is consisted of three main domains (triage; health assessment, wishes and expectations; health education). Further, the “*Appraisal Tool for Optimizing Migrant Health Care*” (ATOMiC) that was developed by NIVEL can provide practical guidance for improving healthcare services for these vulnerable

groups. The checklist encourages users – health care professionals, managers, policy-makers, implementation advisors – to carefully contemplate these factors and identify issues that require special attention when proceeding, or might even warrant timely reconsideration.

Moreover, we are delivering a useful toolbox to PHC personnel as well as health policy makers for the initial health care needs assessment and rapid MH assessment of needs of the arriving refugees and migrants groups. All the aforementioned, can promote health and improve health related quality of life (HRQoL) for the refugees and their families. The tools that the project has developed could be also utilized in assisting the PHC personnel in performing high quality health care. Last but not least, EU can benefit from the project's results since this knowledge can be transferred to every European country-setting, after adaptation to each specific country and setting.

- Further use of the project results

This is a real momentum on achievement of providing holistic, person-centred, integrated, and compassionate as well as universal health coverage to refugees and other migrants. In the context of social cohesion, progressiveness, prosperity and improvement of solidarity in EU, this project has achieved a lot that could be used and transferred to the other EU countries affected by the refugees' crisis. All these have been achieved despite the challenges the project confronted with as well as the limited timeframe (the project ran only one year). Investing on health of refugees and migrants will also improve economic development and productivity, in a Europe confronting with demographic transition with an increasingly ageing population suffering from chronic and non-communicable diseases and an unstoppable financial crisis. Due to the above, health of this vulnerable population is of paramount significance. Responsibility lies in health policy makers, healthcare providers, stakeholders (local, regional, national and international) not only to cure but to prevent, promote and decrease health gap and literacy.

It has been already mentioned that the training material could be utilized for often purposes and especially in existing improving capacity in primary care in European PHC, to enhance knowledge and skills of health professional, stakeholders, community leaders and people working in NGOs.

- Major problems and lessons learned

As the refugees' crisis nature was so intense during the last two years and still continues to be so, during the project we confronted many more than expected changes, challenges and problems.

- Many EU countries closed their borders and/or constructed fences in their borders;
- The EU-Turkey deal and the involvement of NATO protecting European borders;

- The stuck of plenty refugees in Greece after March the 20th and the EU-Turkey deal;
- The volume of people arriving differs now in comparison to the beginning of the influx;
- The involvement of a plethora of organizations (government and non-government) in managing the current crisis;
- The discrepancies in response of participant countries to this crisis;
- The lack of PHC providers providing healthcare services to refugees and other migrants;
- The rise of xenophobic attitudes, in response to the huge flows of refugees and other migrants as well as some terrorist attacks in European countries;
- Absence of integration approaches by European countries as well as European Union;
- Absence of coherent approach from all EU countries;
- Obstruction of many countries to accept according quota the relocation commitments;

We have learned a lot during the implementation of the current project. Now, we understand much better the health needs, wishes, preferences and expectations of this population. The establishment of interdisciplinary teams along with the utilisation of PLA method enabled us to better understand, theoretically and practically, the dynamics and pragmatics of refugees health needs. Additionally, we know the main factors that enable or hinder PHC services. Having all the aforementioned knowledge, we can design local and national health system provision in a much better way, withdrawing or adding unnecessary/necessary services.

PHC for refugees and other migrants should be person-centred, comprehensive, goal-oriented, minimally disruptive, compassionate, outreaching, integrated within the existing primary health system and other services, and provided by a multidisciplinary team. In all circumstances, the health needs and preferences of the migrant patients are guiding the healthcare process. However, all care providers need to be cultural competent, compassionate and person centred. PHC providers need to be aware of refugees background (country of origin, culture etc.), need to have knowledge of the healthcare system, asylum process and entitlements for different migrant groups as well as of specific tasks in triage, assessment, initial treatment and health promotion. In addition, PHC providers need to collaborate in a multidisciplinary team (including volunteers) as well as to deal with task shifting.

Furthermore, we now know much better that the content of care can/should differ between the first (short stay) reception centres (hot spots and transit countries) and the longer stay centres. However we have learned and present the most suitable and rapid assessment tools as well as recommendations and guidelines that can be used to improve PHC for refugees and other newly arrived migrants in first reception centres as well as in longer stay reception sites.

Additionally, according the results of our project the situation in the respective intervention site countries is highly complex and very dynamic. The lack of staff and resources, the lack of multidisciplinary teams and integrated primary care schemes (Lionis et al., 2009; Tsiachristas et al., 2015), were some of the main lessons learned at different settings. One of the biggest problem found was the lack of trained cultural mediators. This finding is in line with the reported findings of yet another FP7 European Collaborative Project, named RESTORE - "REsearch into implementation STrategies to support patients of different ORigins and language" – No 257258 (further information available on website: http://fp7restore.eu/). We found that clear pathways for (primary) health care for refugees are missing in many intervention site countries. Findings showed that treatment pathways, as well as structures in health care for refugees were to some extent lacking and often unclear responsibilities challenged the health care provision for refugees. For instance, it was reported that there is no standardized initial health assessment in intervention countries and documentation and monitoring structures are often missing. We also learned that there is a lack of information and knowledge regarding flight specific diseases and risk factors and regarding country of origin specific illnesses, by providers. The lack of MH support for refugees who may suffer from post-traumatic stress disorders, while at the same time legal questions on work permission, insurance and ethical aspects were issues of paramount importance. Another aspect was the lack of standardized format for documentation, or the difficult access to medical data records of refugees or asylum seekers, that was mentioned as a barrier in terms of providing health care and especially continuity of care. The results learned fill a huge vacuum as a lot of the instruments (tools, questionnaires, and guidelines) found and/or developed, were tested and showed good results in enhancing capacity building in different European settings. Additionally, these can strength the capacity of PHC providers.

- Future recommendations

The following recommendations could improve the effectiveness and efficiency of the online course.

The educational tools and materials and e-trainings modules that have been prepared and developed within this project with the experiences from a pilot implementation in Greece could have a further impact on the training and continuous professional development of multidisciplinary teams in different European settings. Especially the e-trainings modules are very low in costs and therefore easier to implement and reached a large number of health care professionals. The modules can be translated and adapted by all EU countries affected by the refugee crisis. Below we are proposing some recommendations on three different dimensions.

Recommendations relevant to the on-line course

- Sufficient time and resources need to be available for adaptation and translation of the online course to a country specific setting in order to ensure comprehensiveness of the content;
- Making available a version of the course that can be downloaded and be done offline would potentially make the online course even more accessible in the near future. Participants especially in settings without good Internet facilities might profit from this option;
- Developing an application for smartphones with the training material could also improve accessibility by PHC providers;
- It is proposed the creation of a chat room so participants could interact, discuss and to apply questions. In general, the course would improve by more interactivity;
- An update of the on-line training material, even after the end of the EUR-HUMAN project is necessary on a regular basis. (Former) participants may receive an email informing them about the updates, in order to keep them up-to-date with the newest developments.

- The on-line training material should be advertised by local, regional and national authorities so that more PHC providers can be trained;

- The availability of the online course after the end of the EUR-HUMAN project needs to be assured. Adequate time and resources are needed to maintain, up-date and further supplement the online course.

Recommendations relevant to health policy makers

A brokered demographic dialogue among health policy makers, stakeholders and health care practitioners based on the directions and guidance provided by the RESTORE project (http://fp7restore.eu/) is generally recommended.

Specifications that should be undertaken by the health policy makers include the following:

- Granting permission to all refugees full and equitable access to PHC services regardless their legal status and tackling barriers confronting with;
- Explicitly promoting 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;
- Lobbying on a policy level is needed so as to allow PHC providers to apply the gained knowledge;

- Supporting the introduction of the online training course in other European countries by using the training materials and the implementation guidelines that the project has developed;
- Appropriately using the tools and materials as well as the ATOMIC checklist produced by the EUR-HUMAN project in order to improve the provided healthcare services;
- Considering the provision of healthcare services on multidisciplinary teams;
- Considering to improve continuity of care between different countries and within countries;
- Including the mental health screening as a part of the regular and standard medical check-up of the refugee and other migrants and ensure referral as needed
- Considering the provision of healthcare services to be supported by an electronic patient health record as well as an e-smart card;
- Considering the training material to be adapted at curriculums of Medical Schools as well as at School of Health Sciences.

Recommendations relevant to stakeholders

Stakeholders should take initiatives towards:

- Training takes place as coordinated effort of different stakeholders (local, regional and national) involved care for refugees and other migrants are needed. It is recommended that training providers build on existing structures (community healthcare services, NGOs, other projects, etc.), and lobby for a strengthening of these structures;
- Collaboration and better coordination of different levels of stakeholders with national and international NGOs in order to provide healthcare services according refugees' needs, wishes, preferences and expectations;
- Collaboration with local communities in order to better integrate this vulnerable population;
- Provision of health programmes with specific attention to health literacy, prevention and health promotion;
- Provision of appropriate cultural interpreters in order providing all information in their own language;
- Efforts to be undertaken for better arrangements of refugees within the community and not living in camps and hotspots;
- Further improvement on the recognition of the variations between countries in the organization and delivery of PHC in general and for refugees/migrants specifically and to allow for profound country specific adaptations of any tool or mechanism that supports PHC.
- Granting permission to housing, education and work for their swift integration and social inclusion.

- Dissemination activities during and after the project

Please, see Appendix 1.

- Project website

The project website includes a public part and a protected part (only accessible for project partners). The protected part contains all documents regarding the various WPs. The official link is: http://eur-human.uoc.gr/

1.4. Overview of the evaluation activities and results

- Participant or partner feedback

An important tool for the evaluation is the progress report form. Its aim is to evaluate the progress of all WPs of the EUR-HUMAN project. In the personalized progress report the WP leader has to describe the activities related to his or her WP that have been performed during the period of reporting, and describe their results. The progress report provides insight whether the WP has been implemented and had obtained its results according to plan. Next to the progress reports, also own observations of the evaluator based on the discussion during SC meetings, results presented during other meetings and input from other partners are used for the interim evaluation.

All the results have been achieved according to the plan. All deliverables have been submitted. Some of them were submitted with a delay of few days.

Table 5. The status of deliverables and milestones are summarized

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
WP1	D1.2		D1.3			M1.1						D1.1
WP2		M2.1	M2.2	D2.1 M2.3								
WP3				D3.1 M3.1	M3.2							D3.2
WP4						D4.1 M4.1	D4.2 M4.2					
WP5					D5.1 M5.1	D5.2 M5.2						
WP6				M6.1		D6.1 M6.2		M6.3				D6.2
WP7		D7.1 M7.1					D7.2					D7.3 M7.2

Completed on time →
Completed with a little bit delay →

D=Deliverable
M=Milestone

Deliverable 7.3 is the final evaluation report that fully describes the EUR-HUMAN project and its results (please, see Annex 11). The final result of the project is the delivery of tools, guidelines and other forms of guidance, including a training programme and materials, for primary health care workers in Austria, Croatia, Greece, Hungary, Italy, Slovenia and in Arabic. Specifically, the EUR-HUMAN project intends to involve refugees/migrants who are health professionals themselves.

The objectives of D7.3 report are the following:

- To contribute to the accountability of the project by showing the results of the project.
- To provide key learnings emerging from work packages and participants.
- To produce recommendations for health care policies and practices.

Section I summarises the EUR-HUMAN project, for easy orientation of the reader. Section II contains the evaluation proper of the project. Section III reviews more in detail the activities, deliverables and other results of all the Work Packages of the project (for further information please, see Annex 11).

The preliminary results and analysis of the evaluation were discussed at the evaluation meeting, held in Heraklion Crete, on the 7th of December 2016. The aim of the meeting was to evaluate the whole project and to propose a roadmap to European countries that receive refugees and other migrants. During the meeting each partner presented each intervention sites research activities in each intervention setting. Presentations were made highlighting a number of key themes and findings. These findings were also discussed along with the suggested recommendations. Subsequently, an extensive, fruitful and constructive discussion on the initial results of the evaluation of educational material by trained PHC personnel took place. In addition, were also discussed the final proposals and recommendations, some key issues and the next steps of the project. Thirty-three (33) participants including academicians, experts, and officers from Greece and many European countries. Additionally, four (4) academicians and experts (including members of the Advisory Board of the project and the coordinator of the SH-CAPAC project) who participated via the electronic platform GoToMeeting. The meeting addresses the Rector of the University of Crete Prof. Odysseas Zoras, the Deputy Governor of 7th Health Region Dr. Stelios Dimitrakopoulos, Prof. of School of Medicine Christos Lionis (who is also the coordinator of the project) as well as Dr. Pim de Graaf from European Forum of Primary Health Care responsible also for the current Work Package (WP7).

Image 3 Evaluation meeting in Heraklion, Crete on the 7th of December 2016

Image 4 Evaluation meeting in Heraklion, Crete on the 7th of December 2016

- Process evaluation – Please use indicators specified in Annex 1 to the Grant Agreement)

WP2

Process indicator: Participatory and learning action research of all intervention site countries and transfer of results to WP2 leader.

Target: A list of needs containing an overview of healthcare assessment of the newly arriving refugees, migrants and stakeholders. All implementation sites have completed at least five PLA brokered dialogues meetings per implementation site.

Results: Needs, wishes, preferences of refugees and other migrants have been assessed. 43 group sessions (meetings) in seven (7) countries were held.
Conclusion: The target has been completely achieved.

WP3

Process indicator: Systematic searches of literature databases, online survey and interviews to collect relevant structure and process descriptions from 10-15 international experts on refugees' health care.
Target: Multiple data sources explored and using a systematic methodology.
Results: Search strings were entered in 6 databases and were selected after consensus 264 articles. 81 people (healthcare providers and policy makers) from different settings completed the online survey. Ten (10) semi-structured interviews were held.
Conclusion: The target has been completely achieved.

WP4

Process indicator: WP2 and WP3 results to be discussed with an expert panel of refugees, health care professionals, experts in different fields. Involvement of all intervention site countries in the development of tools and guidelines. Adaption of tools and guidelines to the national and regional situation.
Target: Global organizations, experts in refugees' care and representatives from selected countries to jointly synthesize and integrate the results of the systematic review and the outcomes.
Results: Expert consensus panel on 8-9 June in Athens. All intervention countries participated in the development of tools and guidelines as well as in adapting them. Sixty nine participants took place from fourteen (14) different countries involved in refugees' issues.
Conclusion: The target has been completely achieved.

WP5

Process indicator: Selection of appropriate approaches and methodology regarding rapid assessment of MH and needs for psychological support to be utilized in the implementation settings. Intervention site partners provide input into the draft protocol for rapid assessment, psychological first aid and integrated model of psychosocial refugee care.
Target: Draft document of agreed approaches and methodologies. Draft protocol for rapid assessment, psychological first aid and model of psychosocial refugee care.
Results: Several key guidelines were addressed focusing on overall MH approach and support. Twenty (20) handbooks, manuals and reports focusing on MHPSS in emergencies and refugee care were assessed. Peer review articles were identified and consulted for triage and screening tools. A stepped model of care served to develop the protocol for rapid assessment of MH needs and describe the Model of continuity of psychosocial refugee care were developed. The protocol for rapid assessment of MH needs was piloted with 123 asylum seekers in Zagreb, Croatia.
Conclusion: The target has been completely achieved.

WP6

Process indicator: Identification and assessment of existing capacity of local organizations and development and drafting of a curriculum and training material in English for PHC providers. Preparation and implementation of at least one intervention.

Target: Distribution of training material to partners and establishment of an EU-wide, easy access, low barrier information platform.

Results: The existing situation and the local PHC resources available in six countries (Greece, Italy, Hungary, Croatia, Slovenia and Austria) were identified and assessed by applying three different methods. Additionally, a training material consisting of eight modules was developed. All partners translated and adapted it in their country language and implemented the training.

Conclusion: The target has been completely achieved.

WP7

Process indicator: Involvement of WP leaders in setting the framework for M&E as well as by suppling data for interim and final report.

Target: The participation of WPs leader in timely submitting the interim and final report.

Results: The framework for M&E of the project was developed. All WPs leaders actively participated and both interim and final report were submitted on time.

Conclusion: The target has been completely achieved.

- Output evaluation – Please use indicators specified in Annex 1 to the Grant Agreement)

WP2

Output indicator: At each implementation site PLA brokered dialogues have taken place between refugees and other newly arriving migrants of different background (origin, age, gender etc.), healthcare workers and researchers; the amount of sessions depending of the time needed to get the requested insights.

Target: Introducing a brokered dialogue between stakeholders and focus groups tailored upon refugees of different background. Producing report presenting the output and analysis of the brokered dialogue.

Results: 98 refugees and other migrants participated in a total of 43 sessions. PLA research methodology was used. A report of the brokered dialogue was produced (Del. 2.1).

Conclusion: The target has been completely achieved. Additionally, one more setting was added (in seven countries, six that was initially expected).

WP3

Output indicator: All relevant publications identified and reviewed for findings and recommendations.

Target: A report summarizing key findings. Manuscript of systematic literature review to be submitted to a scientific journal within next period.

Results: A final report on the key findings has been produced (Del. 3.2). The manuscript has not been submitted yet. A first draft is ready and the next period NIVEL team will submit it.

Conclusion: The target has been partially achieved.

WP4

Output indicator: The panel has defined the content and structure of care, a freely accessible low barrier internet platform is established, comprehensive set of training materials to be available and a template for adaptation.

Target: Propose a strategic plan for meeting refugees' healthcare needs and prepare tools and guidance.

Results: The expert consensus panel defined the structure and content of care, all the materials are available and free. In Del. 4.2, we provide a simple guidance for adaptation of the tools according local circumstances, the nature and amount of refugees, the composition of the healthcare team, resources in terms of materials, money, housing etc and based on local collaboration with other healthcare domains (public health services, nationally PHC services, NGOs etc.).

Conclusion: The target has been completely achieved.

WP5

Output indicator: Development of protocol for rapid assessment of MH and psychosocial needs of a refugee / family. Model of integrated psychosocial refugee care and protocol, tools, procedures and interventions adapted and negotiated with the national and local stakeholders.

Target: Protocol agreed by the partners. The model of psychosocial care has been established and approved. Protocol, tools, procedures and interventions adapted and negotiated with local stakeholders.

Results: A protocol for rapid assessment of mental health and psychosocial needs of a refugee/family (both for adolescent and adults), including selected tools, preferred procedures and short time psychosocial interventions at the locations of first hosting as well as appropriate MH and psychosocial interventions at the location / community of final destination was developed. The Model of integrated psychosocial refugee care was also developed. All has been negotiated with PHC providers in Croatia as well as with IOM and NGOs.

Conclusion: The target has been completely achieved.

WP6

Output indicator: Report about the existing primary care workforce capacity and gaps, a curriculum and training materials to be developed and to be available via an EU-

wide website. Finally, a pilot-intervention in a well-defined intervention site emerged from WP 4, 5, or 6 part1 to be implemented in Greece, Slovenia, Austria, Italy, Hungary and Croatia, respectively.
Target: To be achieved and implemented in six settings.
Results: The report about existing primary care force has been produced (Del. 6.1). The training material has been developed and is on-line via HeF platform. All countries implemented at least one intervention (Del. 6.2).
Conclusion: The target has been completely achieved.

WP7
Output indicator: M&E framework and interim and end-report with contributions from WP's.
Target: Preparation of interim and end report.
Results: The M&E framework has been agreed by all partners and finished (Del. 7.1). Both interim and final report were successfully finished (Del. 7.2 and Del. 7.3).
Conclusion: The target has been completely achieved.

- Outcome evaluation – Please use indicators specified in Annex 1 to the Grant Agreement)

WP2
Outcome indicator: Health needs and social needs, experiences and expectations as well as Barriers and facilitators of migrants regarding accessing health care and social services at the site.
Target: Overview of perceived and non-perceived needs, beliefs, preferences and attitudes in terms of comprehensive and holistic care of refugees.
Results: Health needs, wishes, experiences and expectations (in six settings) were recognized. Perceived and non-perceived needs, beliefs, preferences and attitudes in terms of comprehensive and holistic care of refugees were recognized (Del. 2.1).
Conclusion: The target has been completely achieved.

WP3
Outcome indicator: Synthesis of literature and available best practices, focusing on short-term arrival as well as long-term settlement.
Target: A state of the art report on key findings and recommendations to be disseminated to all European stakeholders.
Results: A mailing list has been prepared and the results will be disseminated to all European stakeholders upon CHAFEA final approval.
Conclusion: The target has been partially achieved.

WP4
Outcome indicator: Development of practice guidelines, on which basis intervention sites can be trained, adapt and implement the materials adjusted to their situation, training materials and tools.

Target: Manual with evidence-based practice guidelines and tools for optimum healthcare assessment of refugees needs. State of the art document to be used for the assessment of vulnerable groups including children, women and elderly.
Results: Existing and relevant tools, guidelines, recommendations and implementation strategies were found on six specific issues (Health assessment; Mental health; Reproductive health; Child care; Infectious diseases; Vaccination).
Conclusion: The target has been completely achieved.

WP5
Outcome indicator: Mental health and psychosocial needs of refugees are identified early and appropriate interventions and services delivered.
Target: Lower health and social services costs for the hosting societies.
Results: Development of the Model of integrated psychosocial refugee care which addresses the period from arrival at Early Hosting and First Care Centres upon entry into the EU to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee destinations.
Conclusion: The target has been completely achieved. We also piloted the screening and referral procedure despite the fact that wasn't at the expected outcomes of the project. The RHS-13 instrument as well as the piloted screening procedure was extremely suitable for the screening and referral procedure in the mental health domain.

WP6
Outcome indicator: Primary care professionals and other stakeholders have access to the deliverables 6.1 and 6.2 of this WP and have been alerted to their availability. Refugees, refugees who are health professionals, local health professionals and communities in the intervention sites in each country have been reached with the interventions.
Target: Training material is available via an easily accessible webpage for all European countries. Evaluation of the interventions is completed in month 12.
Results: The training material is on-line. The evaluation of the intervention has been successfully completed (Del. 7.3).
Conclusion: The target has been completely achieved. Refugees in Austria have been trained. Del. 6.1 and Del. 6.2 will be disseminated to PHC personnel and other stakeholders upon CHAFEA approval of them. Additionally to the online course the UoC team prepared, seven training lecture videos in Greek language on different topics. The tools, the questionnaires and the procedures were tested at Kara Tepe hosting centre by UoC team.

WP7
Outcome indicator: Lessons learnt are available for primary care providers in Europe.
Target: Report on relevant lessons learnt are available in 7 languages for primary care providers.

Results: The lessons learned for PHC providers have been produced (D7.3) in English.
Conclusion: All lessons learned will be translated in country language upon CHAFEA approval of the Del. 7.3

1.5. Overview of the dissemination activities

- Please comment on the Strength of the dissemination activities

Since the first moment of the project we tried a large audience to be aware of the current joint action. Our efforts were based on people awareness of our activities and outcomes. One of the main advantages of our dissemination activities was that we tried to inform many target groups involved in refugee's issue (and not only) such as policy makers (both Ministries of Health and Migration), stakeholders (local, regional and national) as well as PHC personnel providing healthcare services in the field. Since the first month of the project, the UoC team created the EUR-HUMAN website as well as the EUR-HUMAN twitter account. Both these means that can reach a large audience, were regularly updated about our aim, activities and key results. However, the consortium developed a short leaflet for Chafea in the beginning of the project and three newsletters in ten (10) languages (English, Greek, German, Croatian, Italian, Hungarian, Slovenian, Dutch, Arabic and Farsi; newsletter Vol. 3 was translated in Arabic). All newsletters were uploaded at the EUR-HUMAN website (http://eur-human.uoc.gr/category/newsletter/), the twitter account of the project, as well as were disseminated to Ministries, Regional and Local authorities and to national and international conferences (further information within Annex 1). One of the main advantages was that the leaflet and newsletters were also translated into the emergent key languages (Arabic and Farsi) of the population in need. The newsletters were disseminated to persons in charge in different camps hosting refugees and migrants in Greece. Both Ministries (Health and Migration) and stakeholders were kindly asked to disseminate them or to bring the responsible people in contact with us. Part of the project's success was that we addressed not only the general population but also tried to embrace PHC practitioners in practical activity. Additionally, NGOs providing healthcare services to this vulnerable population were kept updated during the whole project. The press releases and interviews were published in the media about the beginning of the project, the core meetings and results targeting general population were one of the strengths activities performed.

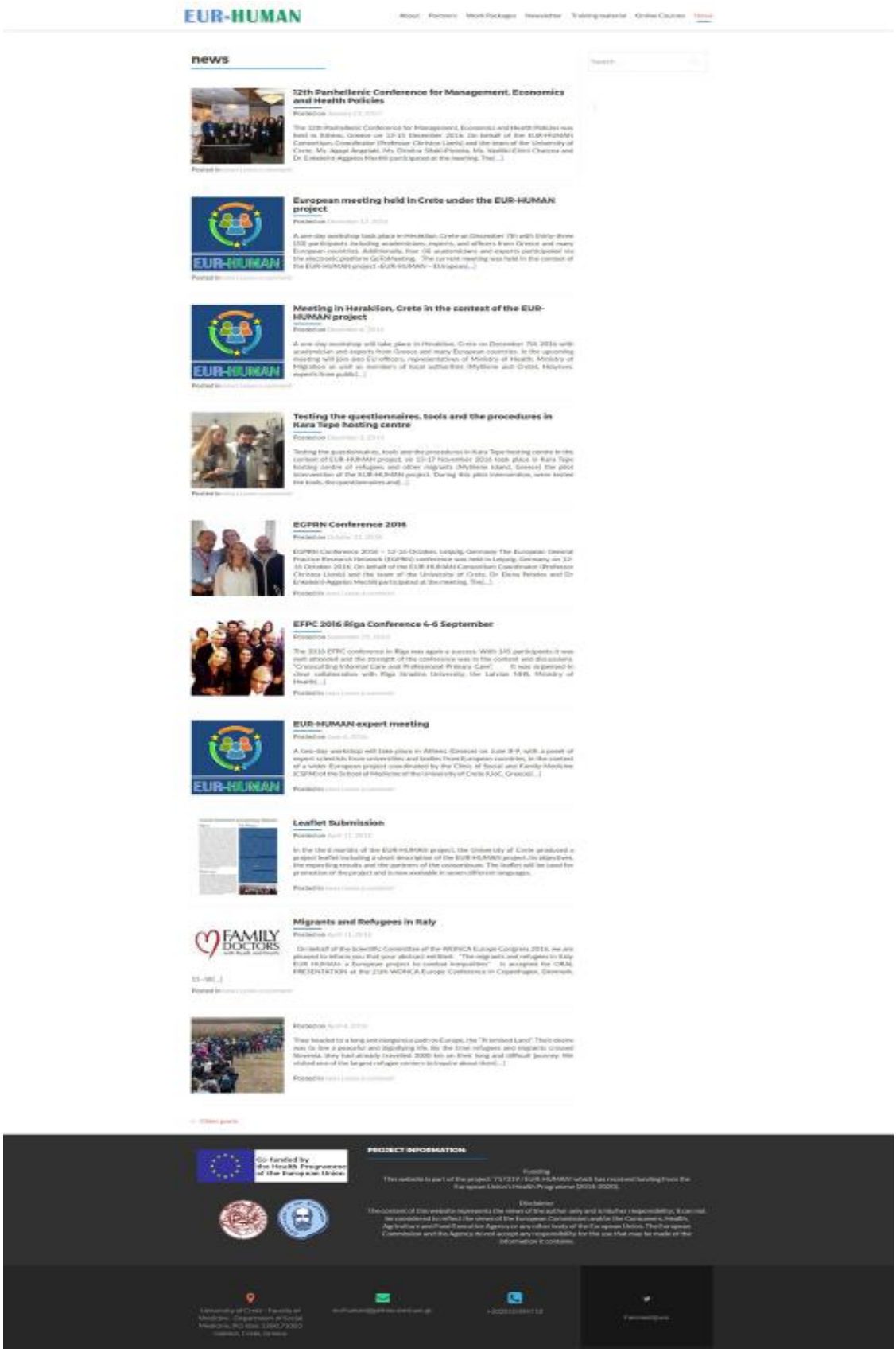

Image 5 Online preview on the News Section in EUR-HUMAN website

However, the project progress was presented in various conferences and workshops both national and international. Moreover, all partners have been and will continue to be ambassadors of the tools and the developed training material and will continue to bring attention in their own country and if feasible, in other countries. The training material developed by the EUR-HUMAN consortium was disseminated to Ministries, stakeholders, NGOs, PHC personnel and to the EUR-HUMAN website and twitter account (further information within Annex 1). Finally, the training material of the project was agreed to be disseminated and advertised by the official website of 2nd Health Region in Greece (the area accepting the core influx of arriving migrants). In conclusion, the aim of the dissemination of the project was not only to raise awareness but also to disseminate for understanding purposes and for underlined the need for further actions.

Image 6 Newsletter Vol 1 (http://eur-human.uoc.gr/newsletter-vol-1/)

EUR-HUMAN

Newsletter
VOL. 2 Spring 2016

EUropean Refugees HUman Movement and Advisory Network

Spring 2016 Newsletter

EUR-HUMAN in context 1
Project Aim & Objectives 1
Expected Final Results 2
Progress Update 2
Next Step 6
Project news 7
Spreading the Word 7
Project Partners 8

EUR-HUMAN in context

The international refugee crisis has reached a critical point. Since the situation is not stable many European countries are developing policy and plan to better define their role in supporting refugees entering Europe. Among refugees who have relocated to European countries, many are challenged with medical issues, social isolation, economic devastation and racial discrimination. **EUR-HUMAN** project "**EU**ropean **R**efugees - **HU**man **M**ovement and Advisory **N**etwork" (Specific Call HP-HA-2015 Project Proposal number 717319), is an integrated project under the Third Programme for the Union's action in the field of health 2014-2020 (duration 12 months).

Aim & Objectives

The overall aim of the **EUR-HUMAN** project is to enhance the capacity, knowledge and expertise of European member states who accept refugees and migrants in addressing their health needs, safeguard them from risks, while at the same time to minimize cross-border health risks. This initiative focuses on addressing the early arrival period, transition and longer-term settlement of refugees in European host countries. A primary objective of this project is to identify, design and assess interventions to improve primary health care delivery for refugees and mi-grants with a focus on vulnerable groups.

Specific Objectives

1. To facilitate sense of coherence and community engagement
2. To undertake a systematic review of existing knowledge from observational and intervention studies to identify suitable tools for needs assessment and effective interventions
3. To arrange an international consensus panel meeting of the approval of tools and evidence based practice guidelines
4. To develop the model and protocol for rapid assessment of mental health and psychosocial needs of refugees and psychosocial care
5. To enhance capacity building for staff in Community Oriented Primary Care centres as well as other existing primary care settings (in 6 countries)
6. To test the feasibility and acceptability of best-practice interventions

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Expected Final Results

The **EUR-HUMAN** project focuses particularly, on strengthening PHC as the first point of entry for refugees and migrants with the objective of providing affordable, comprehensive, person-centred and integrated care for all ages and all ailments. This is attempted by taking into account the trans-cultural setting and the needs, wishes and expectations of the refugees and migrants. A curriculum and training material in English for PHC professionals and refugees who have previously worked in PHC field will be developed. Then an integrated, holistic, patient centred intervention will take place in six European countries. The designed interventions are going to test the feasibility and acceptability of proposed actions prior to large-scale implementation programs.

Progress Update

EUR-HUMAN consists of 7 different work packages which span all the stages of the project. We have made significant progress in these WPs over the past 6 months working on Communication and Liaison with refugees and stakeholders in different countries (WP2), reviewing the literature and conducting interviews with experts and discussion with stakeholders (WP3), finding the best protocols and tools for rapid mental health assessment (WP5), describing the present situation on primary healthcare (PHC) in 6 different countries for refugees/immigrants/asylum seekers (WP6). Finally, based on the above, an expert meeting was held in Athens in order to find the best tools and set of guidelines in order to provide holistic, comprehensive, integrated and person centered PHC services to these vulnerable populations (WP4).

WPs Results

WP2: We conducted a qualitative, comparative case study in hotspots, transit centres, intermediate - and longer- stay first reception centres in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and the Netherlands) using a Participatory Learning and Action (PLA) research methodology. The fieldwork ran from February 2016 until the end of March 2016. To conduct this sessions 16 staff members of local teams involved in the fieldwork were trained during a two-day course that took place on the 6th and 7th of February 2016 in Ljubljana.

WP3: WP3 seeks to learn from literature and experts on measures and interventions and the factors that help or hinder their implementation in European healthcare settings. Except the literature review, an online survey and expert interviews were also conducted. The preliminary evaluation of the existing literature showed high heterogeneity between studies in terms of design. Most of them were cross-sectional and/or descriptive in nature and therefore the assessment of the quality of the provided evidence on the basis of established schemes was, in many cases, a challenge.

WP5: The objective was to build on existing scientific knowledge and expert consensus, while adapting it to current situation. A hierarchical approach was utilized. Firstly, several key guidelines were addressed, focusing on overall approach to mental health and psychological support (MHPSS). Secondly, over 20 handbooks, manuals and reports focusing on more specific MHPSS topics were collected and assessed. Finally, a comprehensive search of peer-reviewed studies was conducted in order to focus specifically on tools for rapid assessment of MH status and needs. In the provision of Mental Health and Psychosocial Support (MHPSS), we propose a stepped model of rapid assessment and care that includes triage, screening and referal. The purpose of the stepped model of assessment and care is to provide MHPSS services on the basis of different levels of individual needs. In the proposed model, both the assessment of mental health (MH) needs and the overall MHPSS provision are integrated in healthcare provision in a seamless manner.

WP4: (initially results): The objective of this work package is to define optimal content of primary healthcare and social care services and identify necessary knowledge, skills, training to provide comprehensive care for refugees and other migrants. Based on the information gathered in WP2, 3, and 5, the **EUR-HUMAN** consortium produced an operational plan with specific actions to optimize the health care offered to refugees and other newly arrived migrants at the first reception centres as well as the longer stay reception centres, the so-called work flow chart (see below figure 1). From WP4 we intend to develop guidance documents/recommendations and to pilot guidance, tools and training for the provision of integrated comprehensive person centred primary care for refugees at the intervention site in hotspots, transit centres and longer stay first reception centres on 1) mental psychological care and Initial assessment/triage, 2) women, maternal and childcare, 3) infectious diseases, 4) chronic and non-communicable diseases, 5) vaccination. During WP4 an expert Consensus meeting was held on 8 -9 June 2016 in Athens at the National School of Public Health (69 participants in total from 14 different countries).

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Project Partners

Coordinator, University of Crete, (UOC), Greece	Stichting Katholieke Universiteit,(RUMC), Nijmegen, Netherlands	The University of Liverpool, (UoL), Liverpool, United Kingdom	Stichting Nederlands Instituut Voor Onderzoek van de Gezondheidszorg (NIVEL), Utrecht, Netherlands
Sveucilište u Zagrebu Filozofski Fakultet (FFZG), Zagreb, Croatia	Medizinische Universitaet Wien (MUW), Vienna, Austria	Univerza v Ljubljani (UL), Ljubljana, Slovenia	European Forum for Primary Care (EFPC), Utrecht, Netherlands
Azienda Unita' Sanitaria Locale Toscana Centro - AUSL 11, Italy	Stichting ARQ (ARQ), Diemen, Netherlands	Debreceni Egyetem (UoD), Debrecen, Hungary	

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Progress Update at a glance

- Kick off meeting 19-20 January Brussels
- Project website D. 1.2 - http://eur-human.uoc.gr/
- Leaflet in 9 languages D. 1.3
- Data collection (interviews with immigrants and refugees at the six implementation countries-PLA sessions) D. 2.1
- Systematic literature review D. 3.1
- Report of Expert Meeting D. 4.1
- Set of guidelines, guidance, training and health promotion materials for pfimal primary care for newly arrived migrants including refugees D4.2
- Model and protocol for rapid assessment of mental health and psychosocial needs of refugees and psychosocial care D. 5.1
- Model of integrated care D5.2
- Identification and assessment of the local situations regarding primary care for refugees and other migrants D. 6.1
- Monitoring and evaluation framework D. 7.1

WPs Key Results

Main health problems: war and journey related

- **Disabilities and injuries** (violence related wounds, burns, frostbites, broken bones, sprained ankles, pain in back and legs, blisters, hypothermia)
- **Mental health problems** (trauma related distress, depression, insomnia, fatigue, anxiety, uncertainty, disorientation)
- **Pregnancy related issues** (dehydration, no medical examinations, privacy, facilities or healthy food)
- **Infectious diseases** (common cold, flu, respiratory, urogenital, eye, scabies)
- **Gastro intestinal problems** and dehydration (diarrhoea, viral gastroenteritis, vomiting and dehydration)
- **Dental problems**
- **Chronic diseases** (not mentioned frequently)

Health care needs and preferences

- **Compassionate attitude of health care workers** (respect, smile, kind word, feeling of being accepted)
- **Bridging linguistic and cultural barriers** (Multilingual health care providers, Involve refugees / migrants as mediators)
- **Information needs** (on healthcare facilities and organisation, on procedures and support)
- **Psychological support** (in most cases (hotspot and transit) enough to just talk about situation, expert mental health care - long-term)
- **Continuity of care**: provide information (about medical history, about care services in the present country or the following countries)

WP3 Key Results

- **General lessons** (refugee or other migrant health care optimization depends on many factors, linked to characteristics of: guidelines, protocols, policies and legislation; health care professionals; particular target groups (refugees and other migrants); professional interactions; incentives and resources; local capacity for change; and social and political context).
- **Mental health /psychosocial care** (e.g., results focus on the training of professionals, refugees/immigrants involvement in the organization of mental and social health care to identify their needs, the absence of continuity of care).
- **Women, maternal and childcare** (e.g., individual barriers of staff and patients, difficulty with communication is seen as a primary issue, lack of knowledge and/or skills of health personnel, lack of a comprehensive monitoring system, social and cultural norms in the community can result in a low uptake of services.
- **Infectious diseases** (e.g., patient factors were identified as major barriers, such as language/communication limitations, psychological and socio-cultural factors, lack of adhere to medication, and migration status.
- **Chronic and non-communicable diseases** (e.g., patient factors and incentives-recourses were identified as frequent barriers, cultural beliefs, forced lifestyle changes, unfamiliarity of patients with healthcare systems, fear of prosecution, passive attitude towards treatment, and language barriers).

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EUR-HUMAN 4 | Spring 2016

WP5 key results

◊ **MH triage (3 steps):**
1. Recognition of behavioural signs that indicate severe distress
2. Rapid assessment and immediate mental health assistance
3. Urgent referral

◊ **Mental health screening:**
4. Recognition of behavioural signs that indicate high levels of distress
5. Applying the MH screening tool
6. Referral to a specialist, for further assessment and treatment, if needed

◊ **Psychological first aid core actions:**
1. Preparation
2. Making first contact
3. Ensuring safety and comfort
4. Helping with stabilization
5. Gathering information on current needs and concerns
6. Providing practical assistance
7. Promoting social support and connectedness
8. Providing information on coping
9. Linking with collaborative services

WP4 key results

Main conclusions and recommendations

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

Important contextual factors

◊ There are different migrant groups with different entitlements to care, undocumented migrants and unaccompanied minors are in need of special attention.
◊ There is a lack of resources and manpower, especially in crowded first reception centres. This challenges the provision of good quality integrated PHC.
◊ Local circumstances will to a high degree determine the extent to which ideal PHC can be implemented. The ATOMIC model, developed by NIVEL (WP3), may play an important role in local decisions on the implementation of interventions.

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EUR-HUMAN 5 | Spring 2016

Recomendations

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

1. All care providers need to be cultural competent, compassionate and person centred.
2. The content of person-centred, comprehensive, goal-oriented, minimal disruptive and compassionate primary health care should involve:
   ◊ Delegating triage to several trained persons within the multidisciplinary team where possible.
   ◊ Working outreaching, proactive to find vulnerably migrants
   ◊ Assessing health needs and personal preferences of the patients at all stages and all sites
   ◊ Applying the disease specific recommendations
3. The organisation of outreaching, integrated primary health care should include:
   ◊ Enabling the composition of multidisciplinary primary health care teams and task shifting
   ◊ Enabling the organisation of person-centred and culturally competent care:
   ◊ Providing quality interpretation service - avoiding informal interpreters wherever possible
   ◊ Providing culturally appropriate health promotion in adequate languages / literacy level
   ◊ Providing necessary (on-line) training on cultural competences and compassionate care
4. Continuity of care should be guaranteed locally and throughout the migrant journey by
   ◊ Improving the continuity of care throughout Europe preferably by an electronic –ICPC/ICD/ATC coded- system.
   ◊ Minimal using the same language in medical patient held reports throughout Europe (prefer English over national Language) and using universal names/codes for diseases/medication/vaccination.

WP6 task 6.1 key results

→ On an organizational level the greatest challenge in all intervention countries appeared to be the lack of staff and resources. Particularly the lack of multidisciplinary teams, including GPs, pediatricians, nurses, psychologists, social workers, cultural mediators, pediatricians and midwifes was found extremely problematic and challenging in terms of adequate health care provision.

→ Clear pathways for (primary) health care for refugees are missing in many intervention site countries (no standardized initial health assessment).

→ Lack of specific guidelines for vulnerable refugees, such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence, was also identified as challenging for health care provision.

→ There was hardly any information on health care skills of refugees.

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EUR-HUMAN 6 | Spring 2016

Next Step

Over next months (July-August 2016), the **EUR-HUMAN** team will develop the intervention based on the results of WP 2, 3, 4 and 5. All concluded WPs including the consensus meeting will guide us to the development of a comprehensive guidance for primary health care workers. In addition, all knowledge will be used to develop an online training platform for Primary Health Care personnel in implementation sites.
The intervention will be implemented between September and October 2016 in existing Early Hosting and First Care Centres for refugees (Greece, Italy, and Croatia) and in existing Transit Centres and centres for refugees and migrants with uncertain residency status who have applied for asylum (Austria, Hungary and Slovenia). The aim of the intervention phase is to test to what extent the multifaceted, integrated, person-centred, and multidisciplinary care intervention and if it is practical, feasible and acceptable in the different setting.

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EUR-HUMAN 7 | Spring 2016

Each **EUR-HUMAN** partner who is responsible for an intervention has to select a multifaceted, integrated, person-centred, and multidisciplinary intervention and underlying training (described in the WP4 results) which is suitable for the local intervention setting and existing needs of the local primary care providers.
After the intervention has been piloted, it will be evaluated and analysed to ascertain the practicality, acceptability, feasibility of its broader implementation and so that it can be adapted for future trials or dissemination. The evaluation process will be finalized during December. We will keep you updated in our next newsletter in Winter 2016/2017.

Project News

The project website is regularly updated with news, so please make sure you log on to keep up to date. Recent items include:
1. Kick-off meeting took place in January 19-20, 2016 in Brussels.
2. Participatory Learning and Action (PLA) training was held on February 6-7 in Ljubljana.
3. Visit of Greek Research Team at First Reception Center of Moria from 27th February to March 3rd.
4. Participation at "Regional Consultation" meeting organized by International Organization for Migration in collaboration with Hellenic Ministry of Health in Athens, on March 8th 2016.
5. The research team of the Clinic of Social and Family Medicine, of Medical School, University of Crete met in Mytilene island with local stakeholders in order to discuss the refugees/migrants issue and also to inform them about the **EUR-HUMAN** project.
6. The experience of volunteer work at the Refugee Centre at Šentilj Slovenia.
7. Presentation of the **EUR-HUMAN** project during the meeting on refugee care organized by the EU commission in Lisbon, on May 13
8. "The migrants and refugees in Italy. **EUR-HUMAN**: a European project to combat inequalities" oral presentation at the 21th WONCA Europe Conference in Copenhagen, Denmark, 15 -18 June 2016.
9. A two-day workshop took place in Athens (Greece) on June 8-9, with a panel of expert scientists from universities and bodies from European countries.

Spreading the Word

◊ Dissemination of EUR-HUMAN project is important and there are a number of ways you can help:
◊ Contact us to arrange free delivery of our project flyer or printed copies of our newsletters and leaflets
◊ Follow us on twitter at https://twitter.com/eur_human
◊ Add a link to EUR-HUMAN website on your own page
◊ Get in touch with us by using the contact form on the project website http://eur-human.uoc.gr/

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EUR-HUMAN

Newsletter
VOL. 3 Winter 2016

EUropean Refugees
HUman Movement and Advisory Network

Winter 2016 Newsletter

EUR-HUMAN at a glance 1
ATOMiC checklist 2
Project overview 3
Core issues 6
Evaluation 6
Preliminary recommendations 7
Spreading the word 7

EUR-HUMAN at a glance

EUR-HUMAN project "EUropean Refugees - HUman Movement and Advisory Network" (Specific Call HP-HA-2015 Project Proposal number 717319), is an integrated project under the Third Programme for the Union's action in the field of health 2014-2020 (duration 12 months). The last years, many Middle East and Sub-Saharan countries are confronted with serious conflicts, riots and political and financial crisis. This have led to an increase of massive migration influx towards Europe. Pre-migration physical or psychological traumas and post-arrival challenges are the main reasons for developing various physical and mental health problems for populations that have experienced war, persecution, displacement, torture, physical danger, separation, detention, hostility and uncertainty.

The overall aim of the EUR-HUMAN project is to enhance the capacity, knowledge and expertise of European member states who accept refugees and migrants in addressing their health needs, safeguard them from risks, while at the same time to minimize cross-border health risks. This initiative focuses on addressing the early arrival period, transition and longer-term settlement of refugees in European host countries. A primary objective of this project is to identify, design and assess interventions to improve primary health care delivery for refugees and mi–grants with a focus on vulnerable groups.

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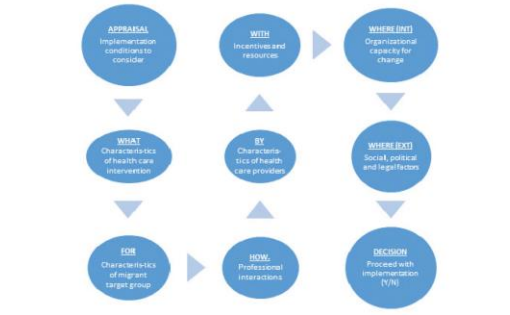
ATOMiC checklist

In the context of the EUR-HUMAN project a plethora of information has been collected to identify success factors and obstacles in the optimization of health care delivery for refugees and other migrants. The "Appraisal Tool for Optimizing Migrant Health Care" (ATOMiC) was developed to provide practical guidance for improving health care services for often vulnerable groups. ATOMiC is based on the findings of a systematic literature review, a survey among health care professionals at different European sites and a series of interviews with international experts. ATOMiC focuses on the route between appraisal of a promising idea or plan and the decision to proceed with its implementation.



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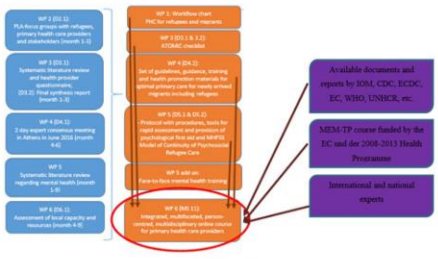
Overview

EUR-HUMAN consists of seven (7) different work packages which span all the stages of the project. We have made significant progress in the last year working on communication and liaison with refugees and stakeholders in different countries (WP2), reviewing the literature and conducting interviews with experts and discussion with stakeholders (WP3), finding the best tools and set of guidelines in collaboration with thirty (30) experts from fourteen (14) different European countries (WP4), developing protocol for rapid mental health assessment (WP5) and describing the present situation on primary healthcare (PHC) in six (6) different countries for refugees and other migrants (WP6). Based on the aforementioned WPs and results, the EUR-HUMAN team developed online training material for PHC personnel in order to provide holistic, comprehensive, integrated and person centered PHC services to these vulnerable populations. The training material initially was developed in English (by MUW team) and after that was translated and adapted by six (6) intervention countries (Austria, Croatia, Greece, Hungary, Italy and Slovenia) according their local situation. However, in Austria the training material was also translated in Arabic in the context of training refugees and other migrants who in their country of origin were health care providers.



Module 1. About the course (consisted of **six** chapters).
Module 2. Health monitoring, acute and infectious diseases and vaccination (consisted of **five** chapters).
Module 3. Legal aspects regarding PHC for refugees and other migrants (consisted **of nine** chapters).
Module 4. Provider – patient interaction (communication and the relevance of culture in medical practice) (consisted of **fifteen** chapters).
Module 5. Mental health and psychological support (consisted of **eight** chapters).
Module 6. Sexual and reproductive health (consisted of **twelve** chapters).
Module 7. Child health (consisted of **nine** chapters).
Module 8. Chronic diseases, health promotion and prevention (consisted of **ten** chapters).

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Module 1 - About this course		Module 2 – Acute diseases		Module 3 - Legal issues	
Pre test score		Pre test score	0 %	Pre test score	40 %
Post test status	1 attempt	Post test status	3 attempts	Post test status	2 attempts
Highest score	100 %	Highest score	90 %	Highest score	12 %

Module 4 – Provider-patient interaction		Module 5 – Mental health		Module 6 – Sexual- and Reproductive Health	
Pre test score	0 %	Pre test score	40 %	Pre test score	20 %
Post test status	1 attempt	Post test status	1 attempt	Post test status	1 attempt
Highest score	40 %	Highest score	100 %	Highest score	40 %

Module 7 – Child health		Module 8 – Chronic diseases and health promotion	
Pre test score	60 %	Pre test score	33 %
Post test status	1 attempt	Post test status	1 attempt
Highest score	33 %	Highest score	66 %

All participating countries decided to choose specific interventions in order to train PHC personnel based on their country specific situation and the results of WP2-WP6. All intervention countries decided to train multi-disciplinary teams that were composed by GPs, nurses, midwives and social workers/health visitors. Additionally to the online training material, the Greek research team in collaboration with seven Greek experts created training material available via a YouTube channel (https://www.youtube.com/channel/UCvl3kOrEidGv2XA4zAUs01Q).
As the training material is on-line, the multidisciplinary teams were trained via their own PC or laptop. Additionally, in some countries (i.e. Croatia or Hungary) PHC personnel were trained face-to-face.

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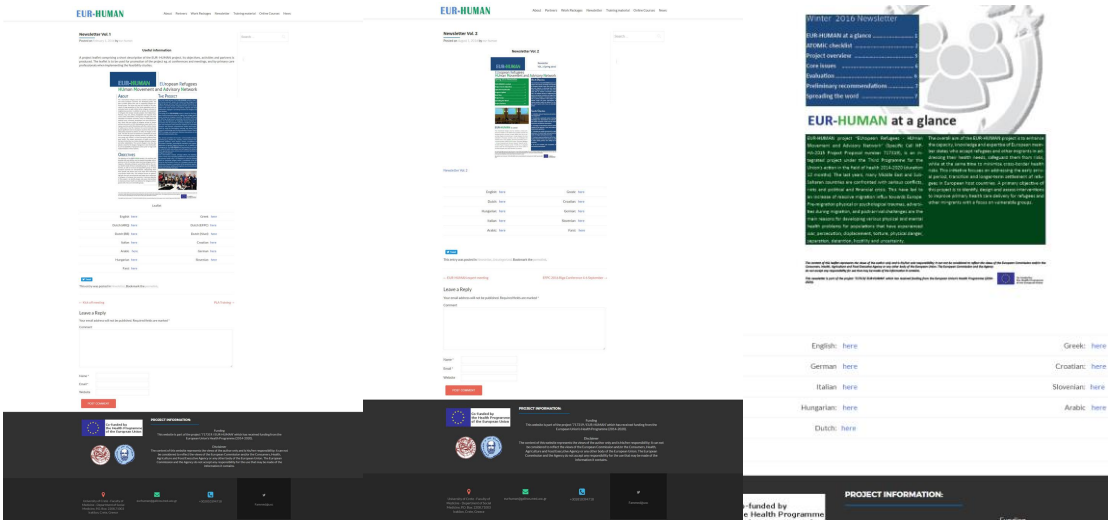

Image 9 Online preview of newsletters Vol 1, 2 and 3

- Please comment on the Weaknesses of the dissemination activities

Despite the limited timeframe of the current project, numerous efforts were also, made to disseminate the work throughout scientific journals, national and international conferences where, progress and the results of the project were reported.

- (if applicable) Update of the plan for dissemination of results

Table 6. Upcoming papers

Title (Type of paper)	**Accountable partner**	**Proposed Journal/s**	**Notes**
The perspective of Primary Health Unit in Greece through the EUR-HUMAN project. **(Correspondence)**	UoC	Lancet Global Health	It has been submitted.
Compassionate care in the wake of the European refugee crisis. **(Debate article)**	UoC	Journal of Compassionate Health Care	A draft has been prepared by UoC team and has been distributed to partners for comments and suggestions.
Refugee crisis in Europe: what are the current health policy needs? Some insights from the EUR-HUMAN project. **(Debate article)**	UoC	BMC International Health and Human Rights	A draft has been prepared by UoC team and has been distributed to partners for comments and suggestions.
Compassionate care and European refugee crisis: do we need much discussion. **(Short report)**	UoC	Journal of Compassionate Health Care	A draft prepared by UoC team is ready and partners are going to receive it within next period.

Views, experiences, wishes and needs of refugees/migrants. The experience of seven European countries. **(Original paper)**	RUMC	Journal of Immigration and Minority Health	A draft prepared by RUMC is ready and partners are working on it.
Implementing a patient-centred PHC services for refugees/migrants. (A feasibility study)	MUW	Canadian Medical Association Journal	A draft is being prepared by MUW WP6 leader
Identifying the factors that influence the implementation of health care improvements for refugees traveling through Europe: A mixed-method study in the context of the European refugee crisis (Original research paper)	NIVEL	Implementation science	A draft is being prepared by NIVEL
The refugees' crisis in Europe. What should change in the education of health care students? (prospective article)	UoC jointly with UoL	BMC Medical Education	It is undergoing discussion.
Tools and guidelines for rapid assessment. What we learnt from the refugees crisis in Europe. Meeting the health care needs of refugees in Europe. (Review article)	RUMC, jointly with UoZ and UoC	American Journal of Evaluation or other.	It is a proposal to all partners and it is under discussion.
Letter to the editor of the BMJ: Experiences gained from EU funded projects.	UoC with coordinators of other EU funded projects	BMJ	It is undergoing discussion.

Table 7. Upcoming conferences

Title	**Accountable partner**	**Conference**	**Notes**
The EUR-HUMAN Project: Providing comprehensive, affordable, compassionate and holistic PHC (PHC) to refugees and migrants	UoC	22nd WONCA Europe Conference	Abstract has been submitted.
Presenting the EUR-HUMAN project.	UoC	7th Public Health Forum	Abstract will be submitted.
Presenting the EUR-HUMAN project.	UoC	10th National and 9th International Nursing Conference	Abstract will be submitted.

The UoC team is planning in April to hold a meeting in order to inform regional and local stakeholders as well as health authorities in Lesvos Island about the project results. We have already discussed this issue with officers of Ministry of Migration as

well as officers at Ministry of Health. At the meeting are expected to be representatives of both Ministries, representatives of Municipality of Lesvos and Regional authorities. However we anticipate representatives of UNCHR and IOM. Director of PEDY Mytilene and representatives of the hospital will also join us. Invitations will be send also to directors of both refugees camps in the island (Kara Tepe and Moria hotspot) and to the NGOs (MDM, MsF, Praksis, Metadrasis etc.). However, representatives of police, fireman and the Orthodox Church will probably be at the meeting.

1.6. Objectives

- List the specific objectives for the project and describe the activities carried out during the reporting period towards the achievement of each listed objective. Provide clear and measurable details.

Specific objectives

1. To facilitate the dialogue between healthcare providers, stakeholders and refugees **(WP2)**
2. To understand better the health and social needs of refugees at the time of their arrival **(WP2)**
3. To learn from literature and experts on suitable measures, interventions and tools, and the factors that help or hinder their implementation in European healthcare settings **(WP3)**
4. To arrange an international consensus panel meeting for the approval of tools and evidence-based practice guidelines relevant to refugee care **(WP4)**
5. To develop a protocol for rapid assessment of MH and model of continuous psychosocial refugee care **(WP5)**
6. To develop teaching capacity to enhance knowledge and skills of primary care providers (in 6 countries) **(WP6)**
7. To test feasibility and acceptability of best-practice interventions **(WP7)**

Table 8. Activities carried

Objective Nr. (WP)	Methods and tools utilized to serve the objectives	Activities carried
Objective nr. 1 and Objective nr. 2 (WP2)	Evidence-based methodological approaches were utilized by the program including: Participatory and Learning Action (PLA)	A qualitative, comparative case study in hotspots, transit centres, intermediate - and longer- stay first reception centres in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and the Netherlands) using the PLA research methodology (February-March 2016).

Objective nr. 3 (WP3)	Systematically review of the existing literature in combination with Interviews with experts	A threefold method was used. Firstly, search strings were conducted in 6 databases. Secondly, ten semi-structured interviews were held in May 2016 with professionals and experts, recommended by the EUR-HUMAN partners and finally an online survey was developed and disseminated among professionals and experts in Europe at the different work locations.
Objective nr. 4 (WP4)	Expert Consensus Panel to reach consensus agreement on best practice guidelines, tools and services.	On the 8th and 9th of June 2016 in Athens an expert consensus meeting was organized and attended by sixty-nine (69) participants from fourteen (14) different countries. Consensus during the meeting was initiated by discussions in small groups that were reported and then discussed in the plenary sessions.
Objective nr. 5 (WP5)	Development of a protocol for rapid assessment of MH (triage and screening) and Model of continuous psychosocial refugee care	We developed a protocol for early identification of highly traumatized refugees and other migrants, including tools, guidelines and procedures for rapid assessment of MH needs and psychosocial status that can be easily implemented in real settings. We described the Model of continuous psychosocial refugee care
Objective nr. 6 (WP6)	Based on the aforementioned method and utilising theoretical inputs from the current research evidence base to underpin the selection of interventions to blend, including documentation retrieved from → Chronic Care Model.	We developed a comprehensive English template of a multifaceted, integrated, person-centred, multidisciplinary online course (consists of eight Modules) for PHC providers. The course was translated and adapted in seven 7 languages (Greek, German, Italian, Hungarian, Slovenian, Croatian and Arabic).
Objective nr. 7 (WP7)	The NOMad questionnaire as well as ex-ante test questions on the training material developed.	To evaluate the training material questions were used before starting each Module as well as when

		PHC personnel finished it. Among the users of the online course, an online survey (the NoMAD questionnaire, derived from Normalisation Process Theory) was circulated in order to assess the course experience, the appreciation of it and to gather respondents' views on the implementation of primary care services for refugees and migrants in their countries. Respondents were asked to identify their profession as well.

1.7. Description of the activities carried per WP

- Work Package 1
- Describe the activities carried out in WP1 during the reporting period giving details of the work carried out by each beneficiary involved. Describe corresponding evaluation activities and results. Describe dissemination activities and their results.

Work package leader for WP1 was the University of Crete (UoC). UoC organized the kick-of meeting on 19th -20th January 2016 in Brussels, and took the initiative for all meetings of the Steering Committee (8 times) and of partner meetings (14 times). UoC team has also regular communication via emails with the other funded projects as well as organized four (4) teleconferences (TCs) together. The coordinator of the project organized also, the two (2) Advisory Board meetings on the 7th and 8th of June 2016 and on the 7th of December 2016. UoC composed the steering committee in cooperation with all partners. UoC had the leading role in writing the final report. All partners contributed to this work package, and all partners were present at all steering committee meetings and partner meetings and contributed actively to the discussions. However, the coordination team created and managed the EUR-HUMAN website. Additionally, the UoC team developed consortium developed a short leaflet for Chafea in the beginning of the project and three newsletters. All deliverables were distributed for addition and comments to all members of the steering committee of the project. The team UoC contribute significantly to the final version of each deliverable with guidance, final additions, comments and editing.

Table 9. Project meetings

Subject	Date
Steering Committee	19/1/2016
Steering Committee	9/2/2016
Steering Committee	16/3/2016
Steering Committee	13/4/2016
Steering Committee	9/6/2016
Steering Committee	21/7/2016
Steering Committee	12/9/2016
Steering Committee	28/11/2016
Advisory Board meeting	9/6/2016
Advisory Board meeting	7/12/2016
TC with WP3 leader	3/2/2016
TC with WP2 leader and Chris Dowrick	5/2/2016
TC with WP2 leader and Chris Dowrick	12/2/2016
TC with Italian partners	12/2/2016
TC with WP2 leader and Chris Dowrick	17/2/2016
TC with Italian partners	7/3/2016
TC with WP2 and WP6 leaders, Chris Dorwick and Dean Ajdukovic	11/3/2016
TC with WP4, WP6 and WP7 leaders	24/3/2016
TC with Arq and Dean Ajdukovic about Blu Dot	30/3/2016
TC with WP4 and WP6 leaders, Chris Dowrick	5/4/2016
TC with WP4 leader and Chris Dowrick	23/5/2016
TC with WP4 leader	30/5/2016
TC with WP6 leader	2/6/2016
TC with WP6 and WP7 leaders	28/6/2016
TC with WP4, WP6 and WP7 leaders and Chris Dowrick	11/7/2016
TC with IOM officer Roumyana Petrova Benedict and Dr. Petelos	31/5/2016
TC with Elena Val (IOM)	25/7/2016
TC with CARE project coordinator	26/7/2016
TC with SH-CAPAC coordinator	13/9/2016

Minutes and records of all of the above meetings were taken and developed.

- Work Package 2

WP2 achieved to respond comprehensively to the first and second objective of the project. We conducted a qualitative, comparative case study in hotspots, transit centres, intermediate - and longer- stay first reception centres in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and the Netherlands) using the PLA research methodology (February-March 2016). The local sites were chosen because they all reflect a part of the journey refugees made through Europe; they differ regarding how long and where newly arriving migrants stay **(Table 1)**. Due to the importance of the "*PLA- mode of engagement*" and the need for mastery of PLA techniques, 16 staff members of local teams involved in the fieldwork were trained during a two-day course (6th and 7th February, 2016 in Ljubljana). The training was specifically designed for this project and delivered by the staff members of Radboudumc, the work package two (2) leaders.

In accordance with the legal requirements, all countries acquired ethical approval. The participants were recruited at the local implementation settings, based on purposive sampling using a combination of network and snowball sampling strategies. The number of sessions and the number of participants included in the fieldwork depends on the type of centre at the local sites and were highly dependent of the time available for a certain group of migrants to stay, and to participate. All participants received a letter (in English, Arabic and Farsi) explaining the purpose and content of the research. Data were generated using PLA-style flexible brainstorm discussions and PLA-style interviews as well as were generated on PLA charts that ensured that verbal and visual forms of data were recorded in a consistent manner across all stakeholder groups. All PLA charts were computerised after each data generation session in order to preserve the data. Verbal data were recorded on Post-It notes in point form or short phrases rather than in full verbatim quotes.

A total of 98 refugees participated in a total of 43 sessions. Variation in gender, age, country of origin and educational attainment was reached throughout sites. **Table 10** provides a summary of the characteristics of the participants. Two third of the participants were male or between 18 and 30 years old. 40% of the participants were refugees from Syria. The second largest group were Afghans (31%). In addition to the sessions with refugees, in Croatia the PLA sessions were held with health care workers or volunteers in the transit centres **(Table 11)**.

Table 10. Characteristics of refugees

Refugees		Total (98)
Gender	Male	65
	Female	33
Age	18-30	66
	31-40	21
	41-50	6
	51-60	3
	60+	2
Country of origin	Syria	39
	Afghanistan	30
	Iraq	12
	Pakistan	6
	Nigeria	4
	Somalia	2
	Gambia	1
	Ghana	1
	Iran	2
	Egypt	1

Table 11. Characteristics of health care workers in Croatia

Health care workers		Total (25)
Gender	Male	9
	Female	16
Age	18-30	9
	31-40	11
	41-50	4
	51-60	1
Length of stay	1-2 months	2
	3-4 months	11
	5-6 months:	11
	periodically:	1

The main health problems reported by refugees and immigrants (in Austria, Croatia, Greece, Hungary, Italy, Netherlands and Slovenia) were related to flight conditions (shooting war) and the journey the refugees had to undertake. During the journey and in the centres (in European countries) travelling and living conditions caused or aggravated injuries, disabilities, and MH problems, as well as common infectious diseases. Furthermore, pregnancies issues were mentioned too (mainly by pregnant women). Additionally, the refugees reported health problems related to the lack of access to adequate healthcare, as for example not treated wounds (lack of doctors or

due to refugees neglecting), dental problems and a lack of continuity of care for chronic diseases and injuries (about medical history and about care services in the present country or the following countries). Many refugees describe a lack of facilities during the journey and in the centre, mainly the amount and quality of food, water, toilets and showers. As about refugees needs, were mentioned compassionate attitude of health care workers, bridging linguistic and cultural barriers, need for information and psychological support.

An element important in terms of data collection and interlinked to the services offered and received too is the main obstacle reported from all sites, namely the linguistic barriers and the cultural differences that had to be taken into consideration and the limitations to the extent this was possible. The lack of qualified interpreters and cultural mediators was, also, reported (mentioned by both refugees and health personnel).

Organisational barriers included increasing uncertainty about the rules of procedures in the centres and lack of clarity about how the healthcare systems work in the country they arrived were also mentioned. The accounts of refugees and healthcare workers revealed important barriers in accessing healthcare related to the specific setting (time pressure is the main barrier). On the other side, many refugees/immigrants reported that their access to health care services was immediate and sometimes was their own rejection to visit a doctor due to their will to leave the country as soon as possible (in Moria's hotspot in Greece).

For all refugees the most important feature was trust and the feeling they were accepted and respected. The main obstacles mentioned at all sites were linguistic or cultural differences. A lack of professional interpreters was mentioned, as was the disadvantages of working with interpreters who were strangers to the refugees concerned and therefore not trusted by them. Cultural differences related mainly to gender issues and to the medical culture in the different countries of origin of the refugees, e.g. the role of primary care in these countries.

Most importantly for all refugees is the way they were approached by healthcare workers. They want to be approached with respect, a smile or kind word, so they have the feeling of being accepted and can build trust with the healthcare provider. These issues were also reported by healthcare workers; in the long-term centre in Heumensoord, Netherlands, it became clear that the expectation about good care differs from what they are used to in their own countries where access to healthcare services was limited.

During the WP2 implementation, all the expected outcomes were achieved. Initially we recognized health needs and social needs as experienced by the refugees and other migrants (in seven countries, additionally to six that was initially expected). However, experiences and expectations of refugees and other migrants regarding accessing

health care and social services at the seven settings as well as barriers and facilitators in accessing health care and social services were recognized too. As a resume, WP2 overviewed the perceived and non-perceived needs, beliefs, preferences and attitudes in terms of comprehensive and holistic care of this vulnerable population.

- Work Package 3

In this WP is described the current situation regarding refugees and other migrants in EU which is both dynamic and unprecedented. The information and results presented came from a literature search as well as an online survey and interviews with several experts and PHC providers in different EU settings (threefold sources). The search strings were entered in six (6) databases (***PsychINFO; Sociological Abstracts; Cochrane; Pilots; PubMed; Embase***). In total, 5492 articles were found. After removing duplicate articles there remained a total of 3979 articles. Two researchers independently, checked all 3979 articles for abstract and title. Additionally, for each article, we checked for relevancy within EU refugee context. This criterion was added because the output of WP3 had to be useful for health care providers in the context of the EU. After discussion, consensus was reached on selecting 264 articles for full text screening. All articles were primarily qualitative, descriptive or mixed methods.

However, to supplement the literature and to provide more up-to-date and hands-on information on refugee care, an online survey was developed and disseminated among professionals and experts in Europe at the different work locations. Items were developed by the members of the review team and exchanged with the EUR-HUMAN group.

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

According **WP3 results**, guidelines, protocols, policy and legislation, need to be tailored to the context were health care is provided and match the local and social reality. A problem is that guidelines are often based on stable circumstances, not chaotic emergency situations where prioritization is needed and the most immediate – often basic – needs are to be addressed first. The included studies point at the necessity to invest in improving the knowledge, skills and attitudes of professionals, particularly in cultural competency and diversity. In many articles ‘lack of knowledge’ is recognized as an obstacle for the provision of high-quality health care as well as communication and interaction skills. Furthermore, it is important that

those who implement services understand the need for those services and feel well equipped/able to deliver those services.

Patients' access to care is challenged by several barriers: legal barriers (eligibility), financial barriers (e.g. the inability to pay for health care), physical barriers (distance to the facilities) language barriers (including illiteracy), cultural barriers (acceptance of services, fear of stigmatisation or social repercussions when making use of services, cultural beliefs), lack of awareness (risk perception, not seeing the need for health services, unawareness about available services and their rights to health care), lack of knowledge, skills and attitude.

As about the results of the on-line survey (81 people completed the survey, 78% health were care provider or health care professional, 22% were involved in policy, management and organizational support), they depends on the participants' country of origin. Transfer countries score different on the factors that help or hinder health care optimization than the countries where most of the asylum requests are submitted. This is probably linked to differences in the health care challenges of the survey that the participants (mostly health care providers) are confronted with. The provision of health care services in transfer countries is chaotic, resources (staff, medication) are in huge absence and there is little time to address the many problems and health issues. However, regardless of the location of the respondent and the health topic, cultural and language issues are recognized as crucial factors for refugee health care.

Experts participating at the interviews suggested international collaboration and coordination, international networks in which information is shared and international consensus on policies is recommended to improve implementation of health care for refugees and other migrants in Europe. The respondents addressed the importance of improving the local infrastructure to handle the large influx of refugees. They argued that bad living conditions, lack of prioritization of certain health issues, lack of political will to address this issue, lack of data lack of resources, unpredictability regarding the numbers of refugees, lack of interpreters and lack of continuity of care are the most important barriers. Additionally, it is argued for more research to enable providing evidence based interventions and measures for refugees and other migrants.

This WP achieved all the expected outcomes. Initially, a comprehensive overview of factors that could help or hinder the implementation of interventions and measures aimed at improving refugee and migrant health care was conducted. In order to enhance health care, the synthesis of literature and available best practices, focusing on short-term arrival as well as long-term settlement, results are presented in a way that are practically useful for health policy makers and healthcare providers. The outcomes of WP3, provide a comprehensive overview of effective interventions to address health needs and risks of refugees and other migrants in European countries, focusing on short-term arrival as well as long-term settlement. All the aforementioned were achieved by using both the existing literature and experts. By taking into

consideration local healthcare systems as well as the position of countries in the cross-European migration and settlement chain recommendations came out. Additionally, in this WP, an implementation decision-making checklist was produced in order to optimize health care for refugees and other migrants: ATOMiC (**Figure 2**).

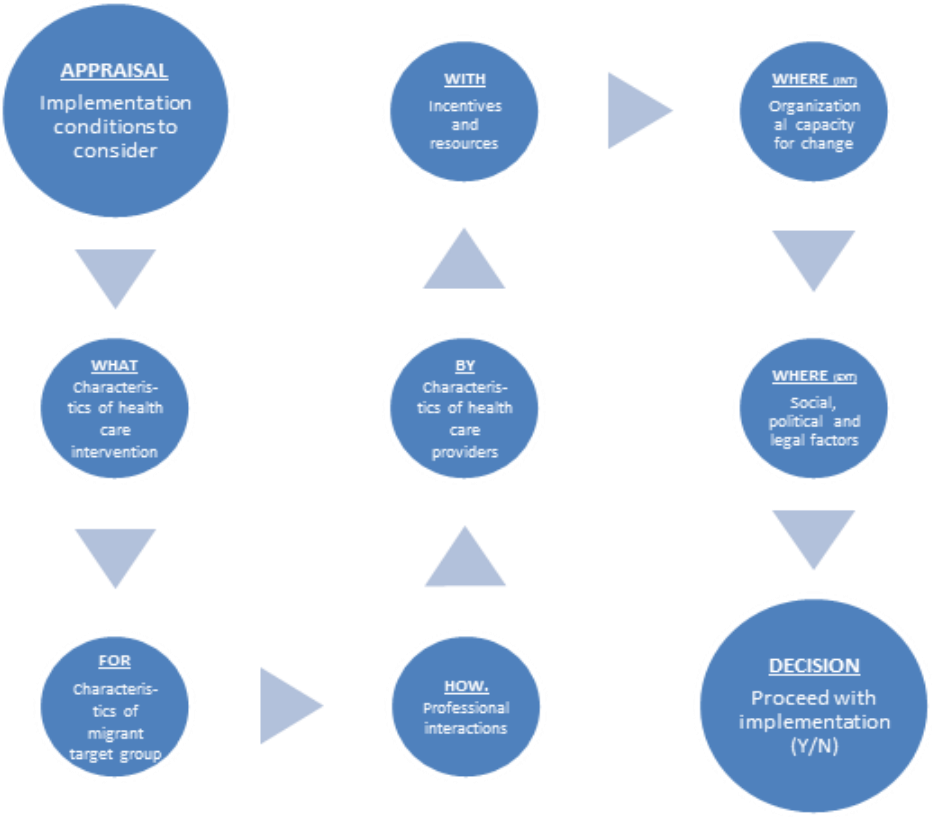

Figure 2 ATOMiC checklist

- Work Package 4

WP4: The objective of this work package was to define optimal content of primary healthcare and social care services and to identify necessary knowledge, skills, training to provide comprehensive care for refugees and other migrants. Based on the information gathered in WP2, WP3, WP5 and part of WP6, the main objective was to reach consensus about the content of good PHC and social care services needed to assess and address the health needs of refugees and other newly arrived migrants in first reception centres as well as in transit and longer stay centres. In order to achieve this goal a stepped consensus procedure was developed. On the 8th and 9th of June 2016 in Athens an expert consensus meeting was organized and attended by sixty-nine (69) participants from fourteen (14) different countries. Consensus during the meeting was initiated by discussions in small groups that were reported and then discussed in the plenary sessions. The discussion took place in four (4) overarching topics (Linguistic and cultural differences; Continuity of care across sites and countries; PHC team at refugee reception centres; Health promotion information and addressing information needs) and in **5 specific areas (**Acute illnesses and Triage;

Infectious Diseases and Vaccinations; Non-communicable diseases; Mental Health; Mother, child and reproductive health care).

According the results of WP4, a collection of existing and relevant tools, guidelines, recommendations and implementation strategies were found. All the material is useful and significant because it can support PHC personnel in providing multifaceted and holistic services to refugees and other migrants. The material can be used not only by physicians but by multidisciplinary teams, who provide services to refugees and other migrants. For all the overarching themes and the specific areas, several tools were found and specified. However, we found guidelines and tools on three (3) overarching issues (Cultural competence in health care; Continuity of care; Information and health promotion) as well as on six (6) specific issues (Health assessment; Mental health; Reproductive health; Child care; Infectious diseases; Vaccination).

Additionally, the EUR-HUMAN team developed the so-called workflow which include three main sectors, illustrating how health needs of population groups can be addressed by, health care professionals (**Figure 3**). Upon refugees and migrants arrival urgent cases are identified and separated from non-urgent cases (first sector). The urgent cases are transferred to other health structures (i.e. hospitals) and the rest of them (without urgent health issues) are transferred to the proposed primary health structure. In the second sector a holistic assessment for all refugees and migrants, of vaccination coverage and of care wishes, preferences and needs concerning chronic illness, mental illness, children, and women with reproductive issues is conducted. In the third sector, in order to reduce health literacy and health gap, health education and promotion activities for all refugees and migrants is conducted.
During WP4, all the expected outcomes were achieved. During the expert consensus meeting that took place, were defined the most suitable guidelines and tools for optimum rapid healthcare assessment both in hotspots, transit and long-term centres. All the tools increase the cultural competence of the health care professional while at the same time are time savings.

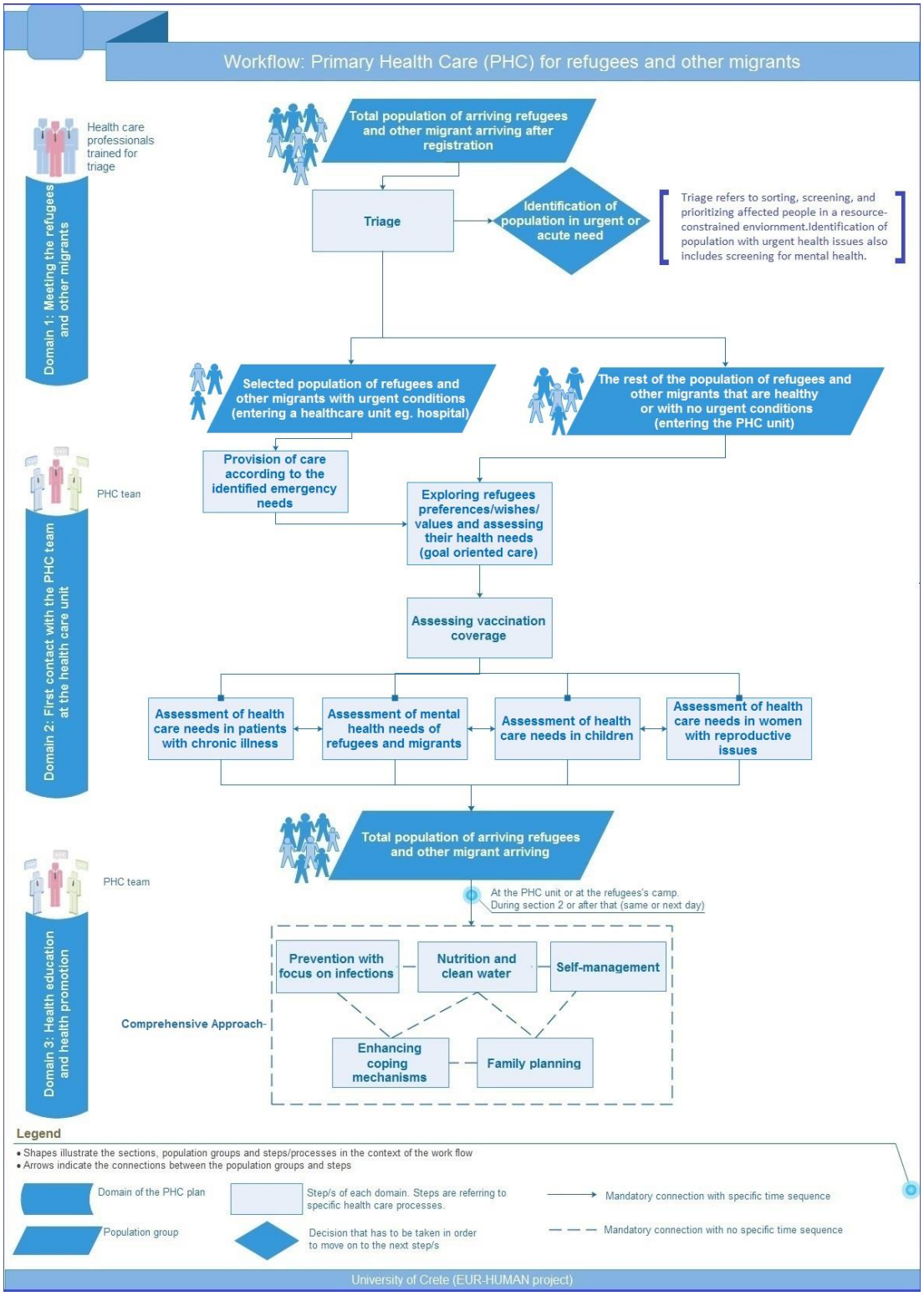

Figure 3. The EUR-HUMAN workflow chart

- Work Package 5

WP5: This WP focused specifically on MH and psychosocial needs of refugees and other migrants. Specifically, the WP objective was to develop a protocol for early identification of highly traumatized refugees and other migrants, including tools,

guidelines and procedures for rapid assessment of MH needs and psychosocial status that can be easily implemented in real settings, and to facilitate early and appropriate interventions and services based on psychological first aid (PFA) leading to shorter period of recovery from adverse life experiences and exposure to trauma. All the aforementioned efforts are expected to foster successful integration into hosting societies and decrease social isolation and risk for internalised oppression. The procedures and services should be comprehensive and practically oriented within the framework of integrated and person-centred primary care.

Initially, several key guidelines for providing assistance in emergencies and to refugees were addressed, focusing on overall approach to mental health and psychological support (MHPSS). Second, over 20 handbooks, manuals and reports focusing on more specific MHPSS topics were collected and assessed. Finally, a comprehensive search of peer-reviewed studies was conducted in order to focus specifically on tools for rapid assessment of MH needs.

In developing the protocol for rapid assessment of MH needs and status of refugees and other migrants we used the stepped model of MH care integrated in overall PHC. Within this model we provided description and tools for *Triage* and *Screening* as a part of the procedure of rapid assessment of MH needs .The *Psychological first aid* (PFA) section we provide and describe the overall supportive response to refugees and migrants in need of psychological support and provide examples of specific and focused steps that can be taken to support them. Furthermore, we provided information how to establish referral pathways for more specialised MH care and propose procedure for successful referral. All the aforementioned procedures can be implemented with refugees and vulnerable groups, both children, adolescents and adults.

Like all other types of health care, MH care starts with identification of people in need. However, MH conditions are typically more difficult to identify. From health care provider perspective, it is difficult to assess such problems since they are usually internally experienced; from patient perspective it is oftentimes difficult to request help for various reasons, most often due to fear of stigmatization. Therefore, identification of MH care needs should be systematic and comprehensive, while in the same time it should also be patient-centred, culture-informed and non-stigmatizing. We have recommended that the screening for MH conditions should be part of the initial health check-up of refugees and other migrants within the PHC service.

MH care for refugees and migrants starts with triage. The purpose of triage is twofold: to recognise urgent, life-threatening conditions and to identify people with immediate health needs. Therefore, the focus in MH triage should be on recognising refugees and migrants whose functioning is so severely impaired that their safety or safety of people around them is endangered. For those migrants and refugees, immediate escort

to a specialist should be ensured. If there are no indications of immediate risk to safety during the triage, but the person is highly distressed (e.g. severe anxiety), immediate help should be provided, based on PFA principles of stabilization, establishing safety, calming, connectedness, self-efficacy and hope. For those refugees and migrants, further referral can be made to MH care specialist, if needed. Triage and elementary PFA should be conducted primarily at hot spots and during transit route, as well as at each contact points with refugees and migrants, since serious MH issues can manifest at different times during resettlement period.

The purpose of MH screening is to identify individuals who are experiencing high level of distress and are more likely to develop serious MH problems and disorders. The focus of screening is on identifying high risks for MH disorders that are common in the refugee population, such as PTSD, anxiety and depression. For refugees and migrants who experience high level of symptoms, immediate help based on PFA principles should be provided together with referral to specialised care provider for full assessment and further care. For others, psychoeducation on MH problems and information about accessing services should be provided if their condition deteriorates. Screening for MH problems should be conducted as a part of any comprehensive health screen. Although the benefits of routine screening are yet to be seen, experts recommend the use of a brief screening instrument due to high levels of distress in refugees and asylum seekers. MH screening (as well as comprehensive health screen) will most likely be conducted at temporary or first hosting locations and at permanent locations in the EU. Based on the model of stepped care, referral to specialised MH services is recommended only in cases where other types of basic interventions and support are not sufficient (**Annex 2**).

During WP5 we developed a protocol for rapid assessment of MH and psychosocial needs of a refugee/family (both for adolescent and adults) which is based on the stepped up care model. It includes several procedures: triage, screening, provisions of PFA, and referral. The protocol include selected tools, description of procedures and short time psychosocial interventions. Interventions can be done at the locations of first hosting as well as at the location / community of final destination.

We piloted the screening and referral procedure despite the fact that wasn't at the expected outcomes of the project. The piloting of the screening (RHS-13) instrument in several languages and referral procedure (conducted by Croatian team with 123 asylum seekers in the reception centre in Zagreb) proved that the procedure and the instrument were highly acceptable to refugees and yielded information on which referrals were made.

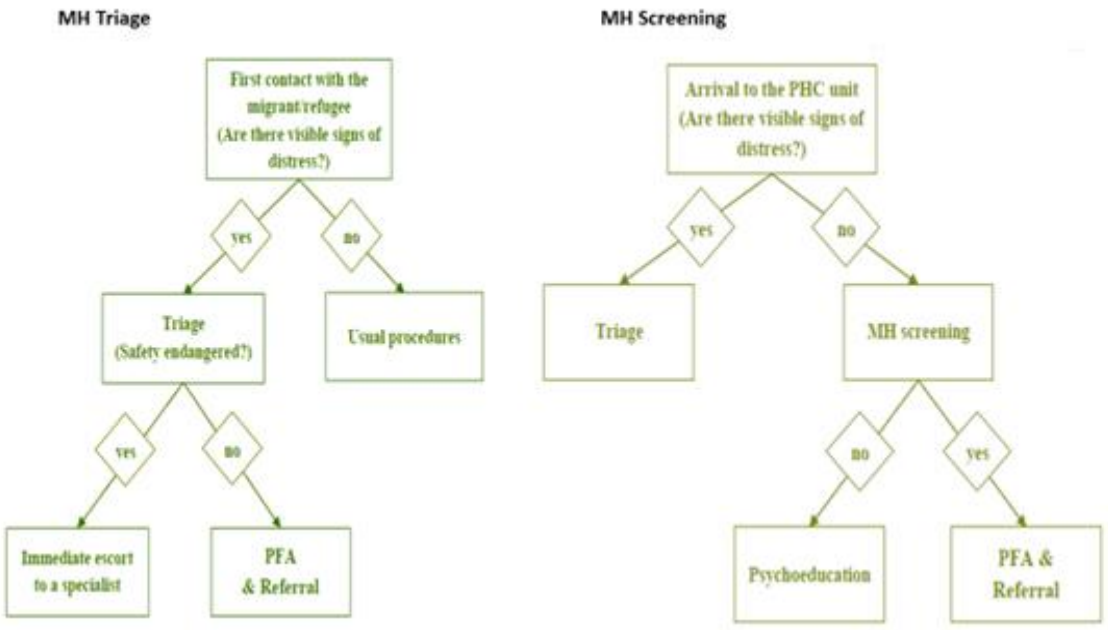

Figure 4. Triage and screening as part of the rapid assessment of mental health protocol

	MH Triage	MH Screening
When	Any contact with the individual	Temporary or long term centres; as a part of comprehensive health check-up
Provider	Trained paraprofessionals and volunteers, professionals	Trained paraprofessionals and volunteers, professionals
Target group	14+	14+
Time to complete	20-30 min	15-20 min
Preconditions	(1) Creating a safe, comfortable and confidential setting; (2) Establishing basic trustful relationship (more information in D5.1, pp 14-15).	(1) Establishing trust (more information in D5.1, p 21); (2) Possibility to offer immediate assistance, if needed; (3) Possibility to offer referral, if needed.

Figure 5. Comparison of MH triage and screening procedures

We also developed and described the Model of integrated psychosocial refugee care which addresses the period from arrival at any point of contact with health service upon entry into the EU, to PHC providers) in communities of refugee destinations. It explains how the information continuity of personal MH records can be achieved and privacy of patient safeguarded. The model describes how the two systems of recording MH data can be used to ensure that PHC providers have access to previously done assessments of MH needs and the interventions received by individual refugee patient.

- Work Package 6

WP6: WP6 aim was twofold. Initially, we had to identify and assess the existing situation and the local PHC resources available in six EU countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria). In order to receive this information three (3) different ways were used (narrative literature review/search of grey and scientific literature and reports; (semi-) structured interviews with local PHC providers treating refugees and other migrants and stakeholders involved in the organisation of PHC for refugees; participant observations in refugee camps and centres). This procedure took place April – June 2016. The findings of the report (Del. 6.1) reached the conclusion that there are discrepancies in different settings, the situation is characterized by constant changes and complicated. Results show that the challenges that need be tackled are in different levels (systemic; organizational; provider).

The second aim was to select, prepare and implement an intervention (feasibility study) based on best practice recommendations and tools produced as part of WPs 2, 3, 4, 5, and first part of WP6 both in existing Early Hosting and First Care centres for refugees (Greece, Italy, and Croatia) and in existing Transit centres and centres for refugees and migrants with uncertain residency status who applied for asylum (Austria, Hungary and Slovenia). 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 10 and figure 6.

Table 10: Portfolio of checklists, guidelines, guidance, tools and training materials of EUR-HUMAN interventions and underlying trainings

Portfolio	Workpackage	Described in detail
Workflow chart: PHC (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 MH of refugees and other migrants	WP5 add-on	Report: Piloting MH screening procedure
Integrated, multifaceted, person-centred, multidisciplinary online course for PHC providers	WP6	Dev. 6.2

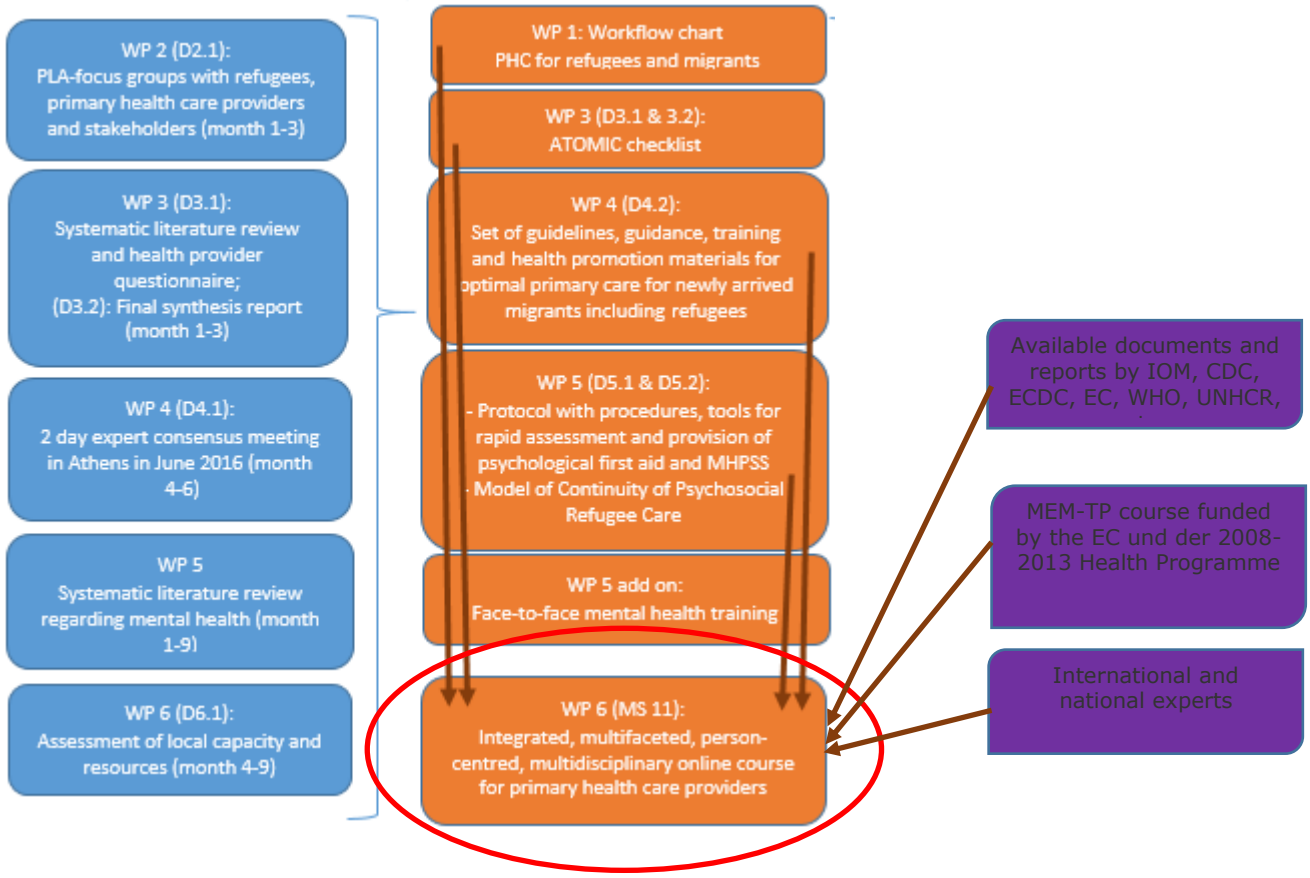

Figure 6: Overview of the influences on the content of the online course

During WP6, the Austrian team developed a comprehensive English template of a multifaceted, integrated, person-centred, multidisciplinary online course for PHC providers. The online course consists of eight modules (**Figure 7**), each with several chapters and pre- as well as post-module-questions for each module (Annex 3). All six countries (Greece, Austria, Italy, Slovenia, Croatia and Hungary) translated and adapted the training material in their own country language. All countries were able to add or delete content that was important or irrelevant for the country-specific setting and the respective needs of the target-group. Additionally, the MUW team translated the online course also into Arabic (available at: http://eur-human.uoc.gr/ekpaidefsi-epangelmation-ygeias/; http://www.healthefoundation.eu/engine?app=hiv&service=classmanager:form:D14&

cmd=new). All intervention site country partners followed a diverse recruitment strategy involving amongst others mailing lists, kick-off events and/or a snowball system.

Additionally to the online course the UoC 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 the project's YouTube channel. The videos cover seven different topics in detail (**Image 10 & Appendix 11**).

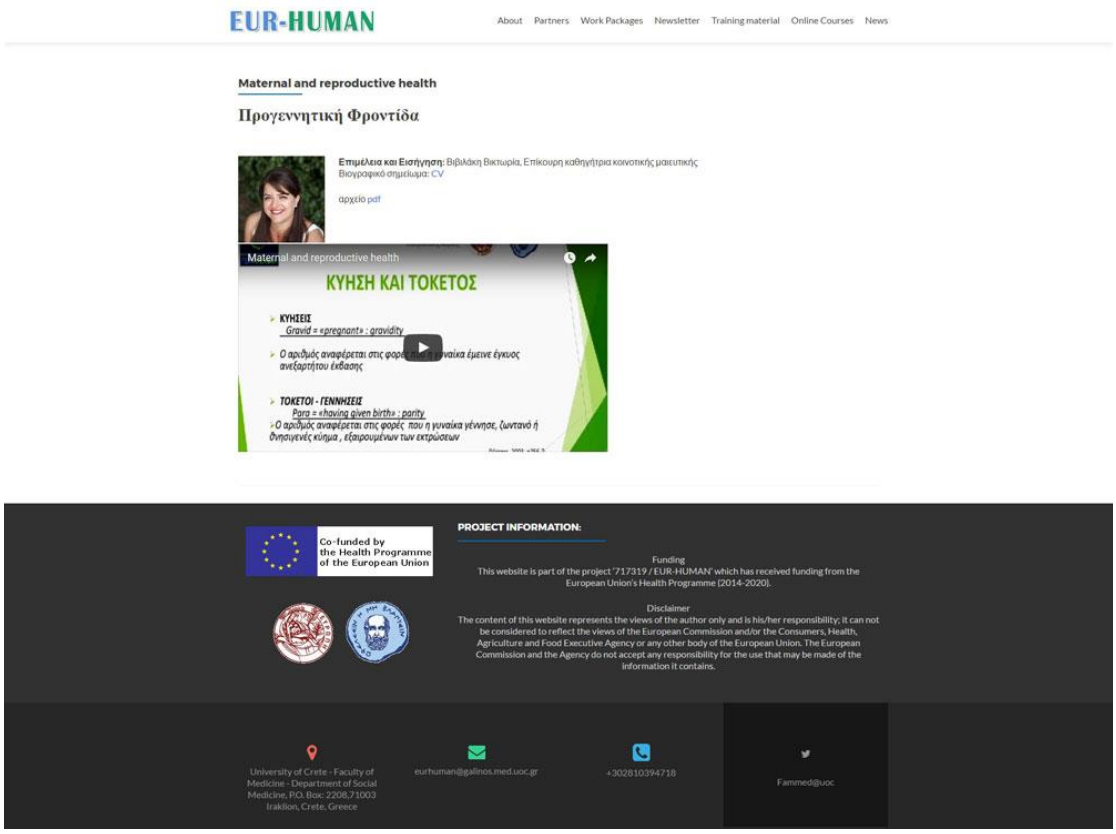

Image 10 Online preview of the online course in Greek language prepared by the UoC team and experts within the website of EUR-HUMAN

In the context of EUR-HUMAN project, on 13th -17th of 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. However, the UoC team, developed an electronic health care record (e-HCR) based on the International Organization of Migration (IOM) personal health records and the existing EPR system. The evaluation of the implementation 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 PHC for refugees such as MH or cultural aspects than they were before the training.

In the context of WP6 were achieved all the expected outcomes and we also went far from them. Initially, we reported the existing primary care workforce capacity, the situation in the field and gaps of local recently involved organizations and primary care professionals. Additionally, we developed a comprehensive, multifaceted, integrated, person-centred and multidisciplinary on-line training material in eight (8) languages in total. The training material is on-line and covers a plethora of topics and is easy accessible via HeF platform. The Greek team also developed additional training material (in Greek language) for PHC providers and which is free and on-line via a YouTube channel (**Figure 8**). However, both Greek and Croatian team tested the tools, the questionnaires and procedures to enhance capacity building in European countries.

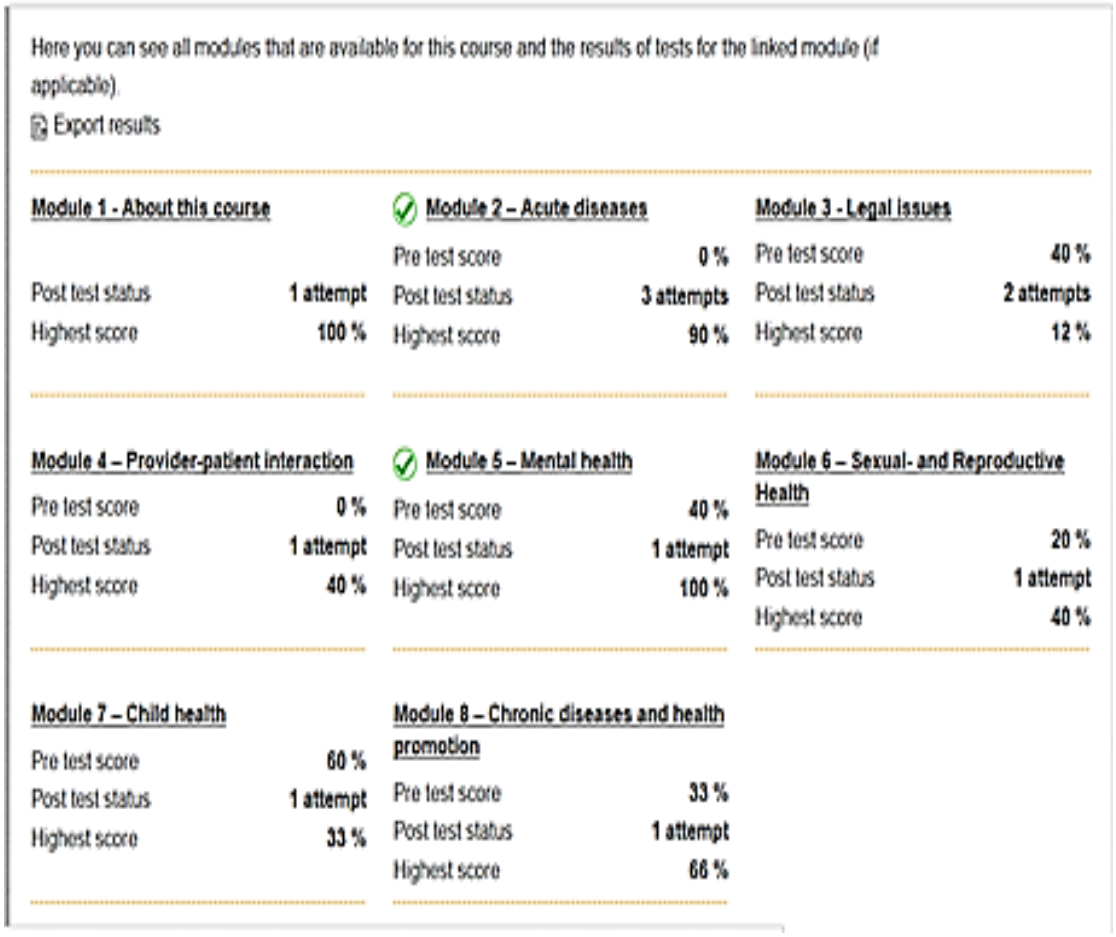

Figure 7: The EUR-HUMAN on-line training material.

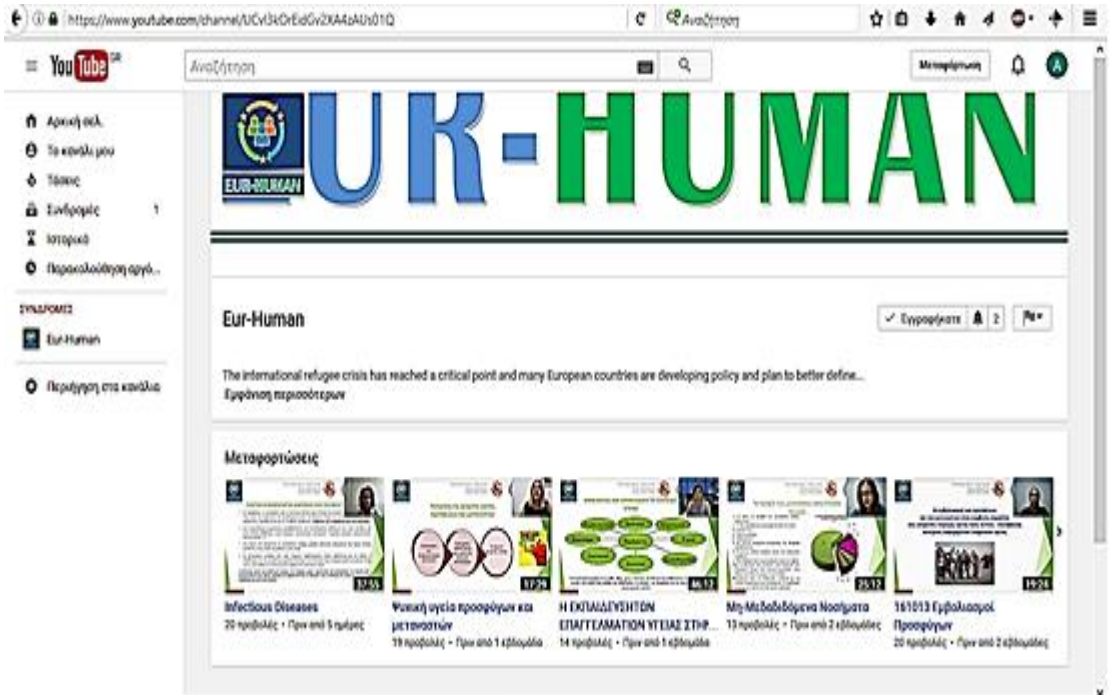

Figure 8: The EUR-HUMAN YouTube channel, available online: (https://www.youtube.com/channel/UCvl3kOrEidGv2XA4zAUs01Q)

- Work Package 7

WP7 was the Monitoring & Evaluation (M&E) package of the project. The main aim of monitoring of the EUR-HUMAN project was to provide support to the consortium members. An important aspect was to prevent overlaps and to strengthen the alignment between the different Work Packages. Monitoring also aimed at learning of all stakeholders. Not only in terms of optimizing the project itself, but also in terms of how best to provide PHC to refugees and migrants, in general. In addition, monitoring and evaluation process provided recommendations to health policy makers. The first month of the project European Forum for PHC (EFPC) who was responsible for this WP developed the M&E framework. Additionally, EFPC jointly with the UoC team organized the evaluation meeting of the project in Crete on December 7th. WP7 results provides the general conclusions and recommendations of the project. The conclusions were on PHC for refugees and other migrants which varies greatly between countries. Provision of appropriate and tailored PHC for migrants/refugees needs training of PHC professionals as the EUR-HUMAN project has developed. The development of local capacity to organize PHC for refugees/migrants is a priority and support to this may be required. As about the training material, it was found to be effective as well as a good tool to pass knowledge. Some key recommendations are the facilitation of mechanism of international coordination and support, in order to enable continuous availability as well as the introduction of the online training course in other European countries (please see in detail recommendations and conclusions of the project in Annex 6 which is the Del. 7.3).

1.8. Follow-up of recommendations and comments from previous review(s)

Not applicable.

1.9. Deviations from Annex 1

- Explain the reasons for deviations from Annex 1, the consequences and the proposed corrective actions

In WP4 the expert consensus meeting was initially planned for month 5th as well as the submission of D4.1 the meeting was held in a month delay. The delay in the expert meeting as well as in deliverable was due to the fact that the expert meeting only could take place after the finalization of WP3 and 5, which was foreseen in month 5, so the meeting had to be postponed from Month 5 to Month 6.

- Explanations for tasks not fully implemented, critical objectives not fully achieved and/or not being on schedule. Explain also the impact on other tasks on the available resources and the planning

All tasks were **fully** completed. Additionally, we implemented a lot of things not included in the Grant Agreement. In WP2 were expected to include six (6) settings in recognizing health needs and social needs as experienced by the refugees and other migrants. One more setting was added (the Netherlands). In WP3, was produced ATOMiC – (Appraisal Tool for Optimizing Migrant Health Care) in order to optimize health care for refugees and other migrants, something that wasn't initially on schedule. In WP5 the Croatian team pilot the screening and referral procedure despite the fact that wasn't at the expected outcomes of the project. The closing of the Balkan Refugee Route in March 2016, required the change of the originally planned location of interventions in Croatia. While the original plan of the WP5 was to focus on the Transit Centre in Slavonski Brod, after it was closed down, the Reception Centre for Asylum Seekers in Zagreb was opened and the project activities concentrated on this location. Additionally to the online course the UoC team prepared, 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. However, the UoC team tested the tools, the questionnaires and the procedures that came out during the project progress. Both the aforementioned wasn't expected outcomes of the grant agreement.

Finally, the EUR-HUMAN team developed the so-called workflow (a holistic PHC structure) which include three main sectors, illustrating how health needs of population groups can be addressed by, health care professionals.

Use of resources in Annex 1 (Description of the Action), especially related to person-months per work package.

In the work plan table the progress of the work over the period months 1- 12 is expressed in person-month per work package.

Workplan Table (actual person-months)									
No	**Beneficiary**	**WP1**	**WP2**	**WP3**	**WP4**	**WP5**	**WP6**	**WP7**	**TOTAL**
1	UOC	**13,58**	4,00	1,00	4,00	3,00	24,20	1,00	50,78
2	RUNMC	3,03	**6,31**	0,22	**6,56**	0,15	1,81	0,98	19,06
3	UoL	0,13	0,09	0,04	0,39	0,05	0,03	0,29	1,02
4	NIVEL	0,04	0,03	**19,40**	0,07	0,00	0,07	0,08	19,69
5	FFZG	3,00	1,50	1,00	1,00	**17,18**	13,40	1,00	38,08
6	MUW	1,60	2,50	0,90	0,90	0,30	**17,30**	0,60	24,10
7	UL	0,30	1,80	0,00	0,10	0,00	3,00	2,00	7,20
8	EFPC	1,60	0,00	0,00	0,00	0,60	0,60	**4,20**	7,00
9	ARQ	2,36	1,06	0,00	3,03	1,97	4,39	0,28	13,09
10	AUSL 11	0,40	0,70	0,00	0,00	0,00	3,50	0,00	4,60
11	UoD	3,00	0,74	0,90	1,08	2,14	12,70	0,50	21,06
TOTAL		29,04	18,73	23,46	17,13	25,39	81,00	10,93	205,68

1.10. Reasons for deviations from Annex 1

1.10.1. Implementation related deviations

- Explain the reasons for deviations from Annex 1, the consequences and the proposed corrective actions

The delay of the expert meeting has as a result the one month delay in submitting D4.1 and D4.2. The expert meeting was held in June and not in May as expected. No correction activities were carried. This delay was due to the fact that WP4 to be finished needed feedback as well as the results of WP3 and WP5 (were expected in month 5). In WP5 the closing of the Transit Centre in Slavonski Brod (Croatia) and opening of the Reception Centre for Asylum Seekers in Zagreb (Croatia) required relocation of project.

- Explain tasks not fully implemented, critical objectives not fully achieved and/or not being on schedule. Explain also the impact on other tasks on the available resources and the planning.

All tasks were fully implemented.

- Explain deviations of the use of resources between actual and planned use of resources in Annex 1 (Description of the Action), especially related to person-months per work **package.**

UOC partner:
In WP1 there was an increase in the effort due to the extra work required for close collaboration with SH-CAPAC project, CARE project and IOM, which was not foreseen in the Grant Agreement. Also, the work in relation to the project website was contracted in-house.
In WP6, there was extra effort required for the UoC team to develop and prepare, in collaboration with expert stakeholders, seven training lecture videos in Greek language on different topics (via a YouTube channel). Moreover, the UoC team made additional efforts to pilot the intervention by testing the tools, the questionnaires and the procedures in order to enhance capacity building of the European countries that accept and host refugees and migrants. In addition, the UoC team, developed an electronic Health Care Record (e-HCR) based on the IOM personal health records and the existing EPR system. The overall budget was not exceeded.

RUNMC partner:
Due to the rather quick start of the project, senior staff was not full time possible. So we chose for a part time solution. Full time senior staff was only possible for the last four months of the project.

UoL partner:
The monthly salaries of the two staff members, Prof Dowrick & Dr van Ginneken are considerably higher than the €1,689.06 quoted in the grant agreement at approx. £12,500 & £6,000 respectively. When the EURO exchange rate for this claim of 0.819480 (ECB average rate over the period 01/01/16 to 31/12/16) is applied this works out at approx. €15,000 & €7,000 per month.

NIVEL partner:
Actual costs vs budget: NIVEL has reported less costs than budgeted in the GA. In person-months there is a small deviation (21,5 PM planned versus 19,6 PM spent), so the work took less time than initially planned. But, the major reason that the costs are lower than budgeted is, that the people who actually worked on EUR-HUMAN were less expensive than the personnel planned.

FFZG partner:
In WP6 due to increased workload of translating and adapting the on-line training materials to what was anticipated, and in WP5 due to developing and implementing the face-to-face training on mental health of refugees and other migrants, as well as piloting the protocol for rapid assessment of MH needs with asylum seekers in Zagreb (Croatia), there was a higher number of person-months was used than planned. However, this costs were not only within the approved budget for FFZG, but given the prudent use of local resources, a substantial part of the budget for the FFZG partner was not spent.

MUW partner:
The PMs for WPs 1, 3 and 7 were as estimated in the GA. For WP2 an additional PM was needed due to the difficulties with the recruitment of the participants for the PLA groups as well as the time needed for analysing the high amount of data (details are stated in the Austrian WP2 report). For WPs 4, 5 and 6 less WPs were needed than estimated. The reason for WPs 4 and 5 were a lower workload than expected; the reason for WP 6 was described before: "As already stated in the amendment the expert who agreed on providing the content of the course an other tasks (he was originally budgeted under personnel costs) was not able to fulfil these tasks due to several private and inter-organizational reasons. Therefore, the core staff of the project at MUW had to take over his duties (particularly Kathryn Hoffmann); a big additional effort. Since the PM costs for the core staff were higher than the calculated costs for the dropped out person, the overall PMs had to be decreased to not exceed the personnel costs too much. In addition, the budget for "other costs" was lower than expected due to the fact that less material for the courses and preparation of the courses was needed. This means that the overall budget does not exceed the budget for MUW stated in the GA, in contrary MUW even used a bit less."

UL partner:
In Slovenia we face a severe shortage of primary care doctors. The primary care doctors, also researchers, were included in the EUR-HUMAN project because of their field work in the refugee camps. They had the best access to refugees, which was reflected in the high percentage of refugees' participation in all project stages. Working with these doctors was the only way to implement the project objectives. Due to the short duration of the project, their full employment on the project was not feasible. The only way to include them in the EUR-HUMAN research project, was a supplementary work. The deviation occurred due to inexact estimation of effort and average cost of person months.

ARQ partner
"The reason Arq Foundation spend 10,91 person months instead of the budgeted 24 person months is largely due to the fact that Arq Foundation expected to need much more hours in developing content for the online course (especially the chapter regarding MHPSS). We delivered our work much more quickly and with less effort than expected."

- Please describe changes to the original planning, their reasoning, which problems occurred and how did you solve them?

The original plan was followed and successfully implemented.

1.10.2. Unforeseen subcontracting

Specify in this section: Not applicable.

- a) the work (the tasks) performed by a subcontractor which may cover only a limited part of the action

Not applicable.

- b) explanation of the circumstances which caused the need for a subcontract, taking into account the specific characteristics of the action

Not applicable.

- c) the confirmation that the subcontractor has been selected ensuring the best value for money or, if appropriate, the lowest price and avoiding any conflict of interests.

Not applicable.

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Further information available in the website: http://fp7restore.eu/.

3. FURTHER REMARKS

- Please state further remarks that you find noteworthy

APPENDIX 1. *DISSEMINATION OF THE PROJECT* (EXCEPT LEAFLET AND NEWSLETTERS DEVELOPED BY THE EUR-HUMAN TEAM)

Newsletters vol 1, 2 and 3 (available online at http://eur-human.uoc.gr/category/newsletter/).

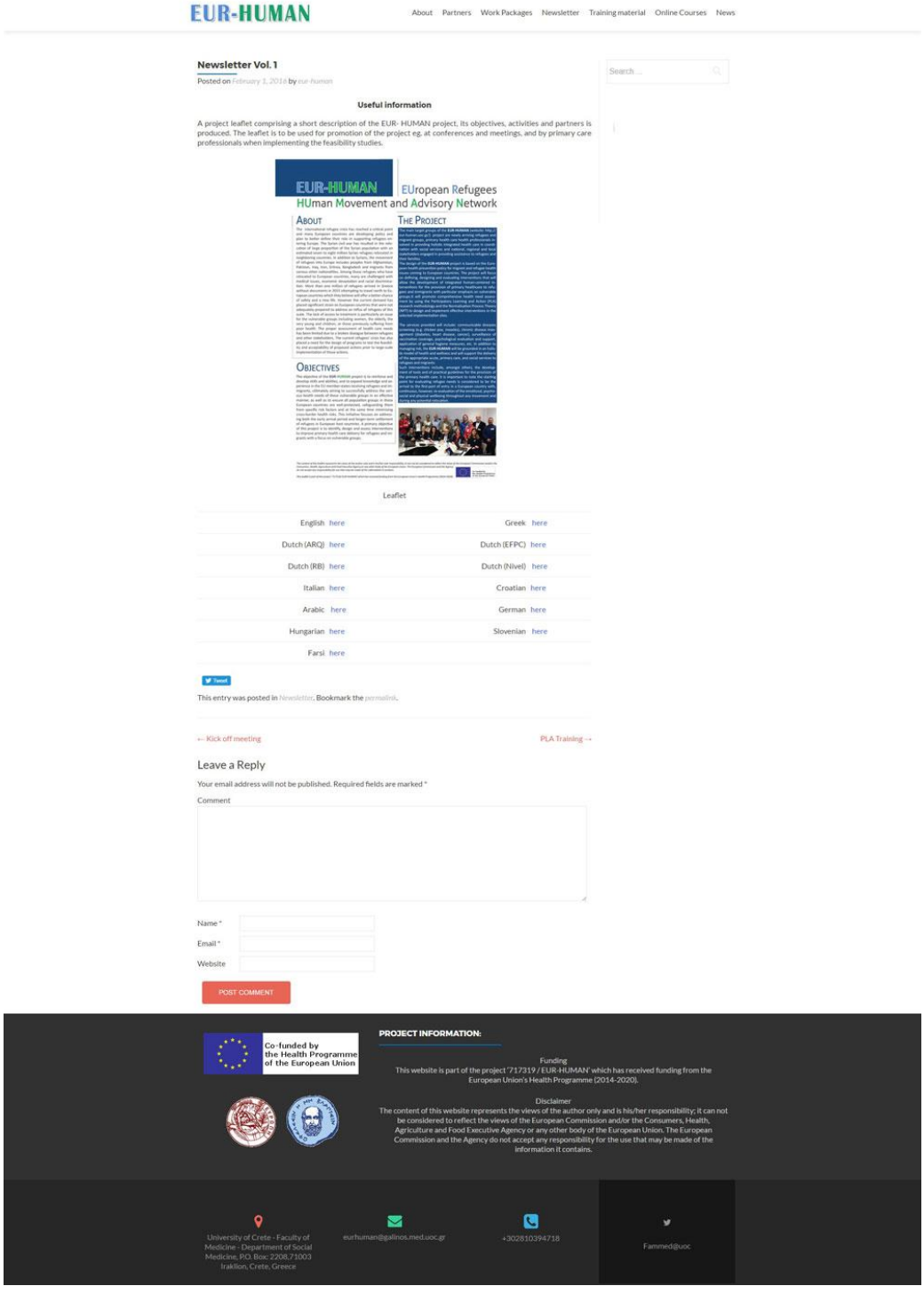

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Table 1: Dissemination of the project in National and International conferences

What	When/where	Who	Budget
Migrants and Refugees in Italy	15 -18 June, 2016 21th WONCA Europe Conference in Copenhagen, Denmark	AUSLTC	AUSLTC
EFPC Conference	4-6 September, 2016 Riga, Latvia	UoC, NIVEL, EFPC, MUW, RANDBOUC,	UoC
EGPRN Conference	12-16 October, Leipzig, Germany	UoC	UoC
6th Panhellenic Congress of Forum: Public Health and Social Medicine. Social Inequalities and Public Health	31 October – 1 November, 2016 Athens, Greece	UoC	UoC
Oral Presentation to a Wider Public (Plenary session	18-10-2016	MUW	MUW
18th Pancretan Medical conference	4-6 November, 2016 Rethymnon, Greece	UoC	UoC
12th Panhellenic Conference for Management, Economics and Health Policies	13-15 December 2016, Athens, Greece	UoC	UoC

***Publications**:*

Peer reviewed Publication; Article/Section in an edited Book or Series; Papers in proceedings of a Conference or Workshop, University Publications/Scientific Monograph; Thesis or Dissertation.

Order Nº	Nº	D.O.I.	Title	Author(s)	Title of the periodical or the series	Number, date or frequency	Publisher	Place of publication	Date of publication	Relevant pages	Open access is/will be provided to this publication	Status	Actions

Other Dissemination Activities:

Publication; Organisation of Conference; Organisation of Workshop; Websites/Applications; Flyers; Press Releases; Articles Published in the Popular Press; Videos; Media Briefings; Presentations; Oral Presentation to a Wider Public; Oral Presentation to Scientific Event; Exhibitions; Thesis; Interviews; Films; TV Clips; Posters.

Nº	Type of activities	Main leader	Title	Date	Place	Type of audience	Size of audience	Countries addressed	Status	Actions
1	Website	UoC Rena Theodosaki, Agapi Angelaki	http://eur-human.uoc.gr/arq-foundation/	30 January 2016	On-line	EU citizens	Public at large	European countries	Completed	
2	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	Meeting with Greek Minister of Health	26 January 2016	Athens, Greece	Minister of Health & his secretariat	2	Greece	Completed	
3	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	Meeting with Greek General Secretariat of Public Health	26 January 2016	Athens, Greece	General Secretariat of Public Health & his secretariat	2	Greece	Completed	
4	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	Meeting with officers at Ministry of Health	12 July 2016	Athens, Greece	Officers of Ministry of Health & members of group tackling Mental Health problems of refugees in Greece	20	Greece	Completed	
5	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	Meeting with officers at Ministry of Migration	20 May 2016	Athens, Greece	Officers of Ministry of Migration	4	Greece	Completed	
6	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	Meeting with officers at Ministry of Migration	9 September 2016	Athens, Greece	Officers of Ministry of Migration	4	Greece	Completed	
7	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	Meeting with officers and stakeholders on the island of Lesvos (Greece)	28 March 2016	Lesvos island, Greece	Deputy Regional Governor, Deputy Mayor, officers, stakeholders, NGOs	25-30	Greece	Completed	
8	Meeting	UoC Enkeleint-Aggelos Mechili	EUR-HUMAN project	31 October 2016	Athens, Greece	Director of MdM Greece	1	Greece	Completed	
9	Meeting	UoC Christos Lionis, Enkeleint-Aggelos Mechili	EUR-HUMAN project	8 March 2016	Athens, Greece	IOM meeting in Athens, national and international officers	45-50	Greece and other European countries	Completed	Presentation
10	Workshop	UoC Christos Lionis,	EUR-HUMAN project	4-6 September 2016	Riga, Latvia	International audience, EU Primary Care professionals, researchers and policy makers	145	More than 25 European countries	Completed	Presentation
11	Conference	UoC Enkeleint-Aggelos Mechili	EUR-HUMAN project	12-16 October, 2016	Leipzig, Germany	EGPRN conference, EU Primary Care professionals and researchers	50-60 people	Many representatives from different European countries	Completed	Presentation
12	Conference	UoC, Enkeleint-Aggelos Mechili	EUR-HUMAN project	31 October – 1 November, 2016	Athens, Greece	Medical students, researchers, policy makers and healthcare providers	100-120	Greece	Completed	Presentation
13	Conference	UoC Enkeleint-Aggelos Mechili	EUR-HUMAN project	4-6 November 2016	Rethymnon, Greece	Greek Primary Care professionals, researchers and policy makers	30-40	Greece	Completed	Presentation
14	Workshop	UoC	Evaluation Meeting EUR-Human	7 December, 2016	Crete, Greece	Researchers, experts and officers	33	Countries included EUR-HUMAN	Completed	
15	Conference	UoC Enkeleint-Aggelos Mechili	EUR-HUMAN project	13-15 December, 2016	Athens, Greece	Primary Care researchers, policy makers and practitioners	80-100	Greece	Completed	Presentation
16	Twitter messages	UoC	Twitter messages about EUR-HUMAN project and refugees issues	During the entire project duration	Social Media	Public at large	EUR-HUMAN followers	Healthcare providers, researchers, academics and organizations		
17	Press Release	UoC	In Greek press as well as at EUR-HUMAN website	During the entire project duration	EUR-HUMAN website and Greek media	Public at large	General population	Greece and European		
18	Mailing lists and phone calls	UoC	Invitation to participate at EUR-HUMAN training process as well as to disseminate it to other interested in	September-October 2016	Emails and phone calls	Health and Migration officers, PHC providers and NGOs directors	5	Greece		
19	Symposium	Radboudumc MvdM	Refugees in Primary Care: what are their needs and how can we care best?	17 June, 2016	Copenhagen	Participants to WONCA Europe conference GP's	250	European		
20	Lecture	Radboudumc MvdM	Healthcare for refugees	21 April, 2016	The Hague	Doctors, member of the regional Medical Association	80	The Netherlands		

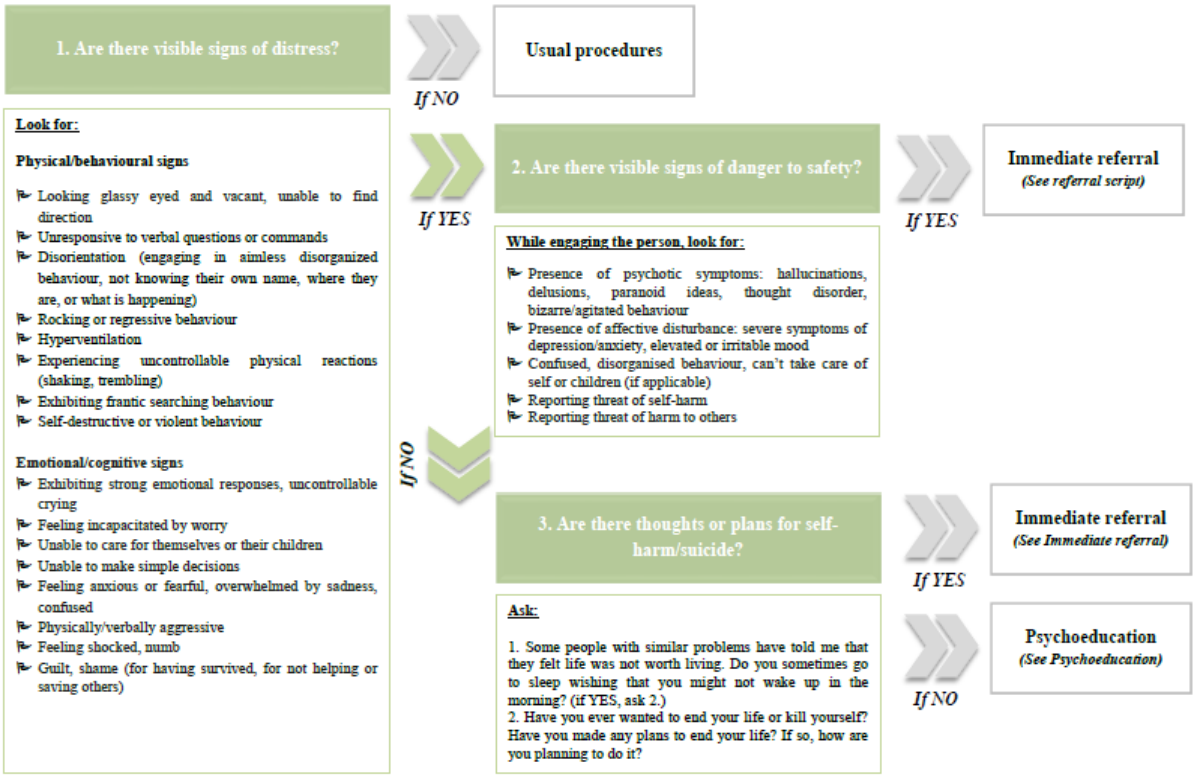
Nº	Type of activities	Main leader	Title	Date	Place	Type of audience	Size of audience	Countries addressed	Status	Actions
21	Lecture	Radboudumc MvdM	The EUR-HUMAN project	18 May, 2016	Lisbon	EU conference refugees	200	Europe		
22	Lecture	Radboudumc MvdM	Healht needs of and care for Refugees	21 June, 2016	Nijmegen	Medical doctors	200	The Netherlands		
23	Lecture	Radboudumc MvdM	Healht needs of and care for Refugees	31	Rotterdam	Global health students	150	Western-Europe		
24	Lecture / workshop	Radboudumc TvL	Health needs of refugees	September, 2016	Riga	EFPC	?	Europe		
25	Keynote lecture	Radboudumc MvdM	Refugees in Primary Care	14 September, 2016	Jerusalem	Young GPs (Vasco da Gama participants)	300			
26	Workshop	Radboudumc MvdM	Refugees in Primary care: how to deliver good PHC	15 September, 2016	Jerusalem	Young GP's	30			
27	Lecture in symposium	Radboudumc MvdM	Health needs of refugees	4 November, 2016	Rio de Janeiro	GPs Wonca World participants	250			
28	Poster	Global Health Center of the Region of Tuscany	Refugees' opinion and expectations on their health status, access and navigation of health and social services	12 May, 2016	Turin	MD, Health and social workers, sociologists, anthropologists	200 people	Italy		poster
29	Organisation of Conference	UoL Chris Dowrick and Nadja van Ginniken	Liverpool Asylum Seeker and Refugee Knowledge Exchange	22 June, 2016	UoL	Mixed academic, policy and NGO	60	UK, Pakistan, Syria, Libya, Somalia, Rwanda		
30	Presentation during annual conference of EFPC	EFPC Diederik Aarendonk	Addressing health care needs of refugees/migrant and designing primary care based intervention in selected European settings: The EUR-HUMAN Project.	3-5 September, 2016	Riga, Latvia	EU Primary Care professionals, researchers and policy makers	145	More than 25 European countries		
31	Workshop	EFPC Pim de Graaf, Diederik Aarendonk, Diana Castro Sandoval	Evaluation Meeting EUR-Human	7 December,2016	Crete, Greece	Researchers, experts and officers	33	Countries included EUR-human		
32	News articles	EFPC Pim de Graaf, Diederik Aarendonk, Diana Castro Sandoval	News items about EUR-HUMAN	During the entire project duration	EFPC two weekly newsflash	Primary Care researchers, policy makers and practitioners	>1000 recipients	Over 30 European countries and beyond		
33	Twitter messages	EFPC Pim de Graaf, Diederik Aarendonk, Diana Castro Sandoval	Twitter messages about EUR-HUMAN	During the entire project duration	Two weekly average	Public at large	1700 followers	European and non-European countries		
34	Oral Presentation to a Wider Public (Plenary session)	MUW Elena Jirovsky, Elisabeth Mayruber, Kathryn Hoffmann	Sichtweisen von Frauen auf der Flucht auf die Gesundheitsversorgung in Österreich – Was sind ihre Erfahrungen und Bedürfnisse?	18 October 2016	Syposium: «Flucht aus Frauenperspektive - bleibt die Gesundheit auf der Strecke?» ("Flight from a women's perspective: is health falling along the wayside?") Wiener Rathaus (Festsaal) (Vienna City Hall; ceremonial hall)	Local government; Social workers; Medical doctors; Aid workers; Volunteers	Approx. 300	Austria	completed	
35	Oral Presentation to a Wider Public (Plenary session)	MUW Elena Jirovsky	„Verbesserung der Gesundheitsversorgung von Flüchtlingen in Europa – Einblicke in ein angewandtes Forschungsprojekt"	03June, 2016	Lecture series: «Facetten von Flucht aus dem Nahen und Mittleren Osten" Summer term 2016 Block 5: (Weiter)Leben im Fluchtkontext – psychologische und gesundheitliche Aspekte University of Vienna, Main building, lecture room 50	Social sciences students; Social workers; Aid workers; Volunteers	60	Austria	completed	
36	Organisation of Workshop	Caritas Vienna); MUW	Kick-off event for online course "EUR-HUMAN: Competency and Safety in Primary Health Care for Refugees" („Kompetenz und Sicherheit in der gesundheitlichen Versorgung von MigrantInnen und Flüchtlingen;"course language: German)"	21 October, 2016	Grüner Salon, *mag* das Hotel, Laufbergergasse 12, 1020 Vienna	General practitioners; Medical doctors of diverse specialties; Midwives; NGOs; MOH Austria	37 (+speakers)	Austria	completed	
37	Organisation of Workshop	MUW Kathryn Hoffmann, Elena Jirovsky, Elisabeth Mayrhuber	Presentation of the EUR-HUMAN project and the online course at the Science lunch of the Centre for Public Health, Med. University of Vienna	15 December2016	Seminar Room 3, Centre für Public Health , Med. University of Vienna, Vienna, Austria	GPs, Psychologists, Epidemiologists, Health economic experts, medical anthropologists	30 (+speakers)	Austria	completed	

Nº	Type of activities	Main leader	Title	Date	Place	Type of audience	Size of audience	Countries addressed	Status	Actions
38	Organisation of Workshop	MUW Kathryn Hoffmann, Elena Jirovsky, Elisabeth Mayrhuber	Kick-off event for online course "EUR-HUMAN: Online Course for (future) Primary Health Care Providers with Flight Experience: Competency and Safety in Primary Health Care for Refugees" (Onlinekurs für (zukünftige) ÄrztInnen mit Fluchterfahrung: Kompetenz und Sicherheit in der gesundheitlichen Versorgung von MigrantInnen und Flüchtlingen;" course language: German, Arabic)	08November, 2016	Festsaal des Amtshaus Neubau 1070 Wien, Hermanngasse 24-26 (ceremonial hall; District town hall 7th district Vienna)	Diverse (future) PHC providers from Arab-speaking countries; Arab-speaking physicians; MOH; District government	20 (+speakers)	Austria	completed	
39	Websites/Applications	MUW Alaa Nadar (volunteer)	Whatsapp group for Arabic speaking doctors; Exchange about course for (future) PHC providers with flight experience; Invitation for the kick-off event (8.11.)	September-December 2016		Refugees with a medical degree from their home countries	Approx. 200		completed	
40	Websites/Applications	MUW Kathryn Hoffmann, Elena Jirovsky, Elisabeth Mayrhuber	Information about the EUR-HUMAN online courses on the department HP		http://allgmed.meduniwien.ac.at/veranstaltungen/single-view/?tx_ttnews%5Btt_news%5D=2631&cHash=1f4f8600624329555dccd722249c4428		Approx. 1800		online	
41	Websites/Applications	MUW	Online DFP-calendar (calendar on CME accredited courses and events).	September to December 2016	www.dfpkalender.at	Medical doctors		Austria	offline	
42	Mailinglists	MUW; Caritas	Invitation to participate in the kick-off meeting for the online course «EUR-HUMAN: Competency and Safety in Primary Health Care for Refugees"	September/October 2016	Email newsletter of the Austrian Society of General Practitioners (ÖGAM); Email newsletter of the Austrian Society of Public Health; Mailing list of Medical Aid for Refugees; Mailing list of Caritas Volunteers	PHC providers		Austria	completed	
43	Mailinglists	MUW	Information about the availability (start date) of the online course «EUR-HUMAN: Competency and Safety in Primary Health Care for Refugees"	October 2016	Email newsletter of the Austrian Society of General Practitioners (ÖGAM); e-mail ist of participants in the kick-off event	GPs; PHC providers	Approx. 1250	Austria	Completed	
44	Flyers	MUW	Info-Sheet and Newsletter EUR-HUMAN	All above face-to-face events				Austria	Completed	
45	Presentation	FFZG Dean Ajduković	Presenting EUR-HUMAN project aims and planned results at a meeting with first responders, health care providers and medical staff in Winter Reception and Transit Centre in Croatia.	03 March, 2016.	Slavonski Brod, Croatia	First responders, health care providers and medical staff.	app. 20			
46	Meeting	FFZG Helena Bakic	Presenting EUR-HUMAN project aims and activities to care providers and coordination staff in the Reception centre for refugees and other migrants "Porin" in Zagreb.	05 May, 2016.	Zagreb, Croatia	Care providers and coordination staff.	app. 20			
47	Meeting	FFZG Dean Ajduković	Participating in regional inter-coordination meetings with representatives of other CHAFEA founded projects from IOM (*Re-Health*), Medecins du Monde (*8 NGOs in 11 Countries for Migrants*) and Croatian institute of public health (*Common Approach for REfugeees and other migrants' health*).	20June, 2016; 31 August, 2016.	Zagreb, Croatia	WP leaders, project assistants.	5-Αυγ			
48	Workshop	FFZG Dean Ajduković and Helena Bakic	Presenting EUR-HUMAN goals and results at the face to face training on mental health of refugees and migrants. EUR-HUMAN leaflet and web-page url was shared with the participants.	04 – 05 November, 2016.	Zagreb, Croatia	Care providers including psychologists, interpreters, GPs and social workers.	32			
49	E-mail	FFZG Helena Bakic	A description of project and web-page url was sent to primary health care providers who were involved in providing care in Winter Reception and Transit Centre in Croatia.	16 November, 2016.	Croatia	Primary health care providers (GPs and nurses)	200			
50	Presentation	FFZG Dean Ajduković	A presentation of Psychological First Aid procedure developed as a part of the project was given to different Red Cross National Societies, including Bosnian, Serbian, Macedonian and Croatian Red Cross.	03 December, 2016.	Zagreb, Croatia	Red Cross staff	35	Croatia, Bosnia Herzegovina, Serbia, Macedonia		
51	Flyer	Dutch partners	Translation of the flyer	24/March, 2016	Diemen	Healthcare professionals			Completed	
52	Flyer	Dutch partners	Translation of the second flyer	17 August,2016	Diemen	Healthcare professionals			Completed	
53	Meeting	Arq Corné Versluis	Meeting with QULI to see if Quli could provide a platform for (online) integrated care	23February, 2016	Diemen	Online professionals			Completed	
54	Meeting	Arq Corné Versluis	Meeting with UNHCR to discuss Blue Dot	04 April, 2016	Dienen	Refugees/migrants			Completed	
55	Meeting	Arq Corné Versluis	Meeting with UNHCR to discuss Blue Dot	08 April, 2016	Diemen	Refugees/migrants			Completed	
56	Meeting	RVO	Meeting with Netherlands Enterprise Agency	19 April, 2016	The Hague	Professionals			Completed	
57	Meeting	Arq Corné Versluis /HEF Judith de Lange	Meeting with HEF to discuss the possibility of implementing the e-learning in the Netherlands	18 October, 2016	Amsterdam	Healthcare professionals			Completed	
58	Presentation	Imre RURIK	Professional refugee care in Hungary. Lesson learnt from the EUR-HUM project.	5 December, 2016	Győr	PHC Staff, local providers in camps	25	Hungary	Completed	

Nº	Type of activities	Main leader	Title	Date	Place	Type of audience	Size of audience	Countries addressed	Status	Actions
59	Presentation	Imre RURIK	Presenting the EUR-HUMAN training material	2 December, 2016	Budapest	PHC and administrative staff of the Immigrational Office	15	Hungary	Completed	
60	Presentation	Imre RURIK	Presenting the EUR-HUMAN training material	3. January, 2017	Budapest	Medical leaders of the Hungarian Army	5	Hungary	Completed	
61	Presentation during NIVEL primary care conference	NIVEL Michel DÜCKERS	Primary care and the European refugees crisis	21 March, 2016	Utrecht, Netherlands	Primary Care professionals, municipalities and regional health authorities	80	Netherlands	Completed	
62	Presentation during annual conference of EFPC	NIVEL Michel DÜCKERS	Barriers and solutions for the optimization of refugee and migrant healthcare in Europe	3-5 September, 2016	Riga, Latvia	EU Primary Care professionals, researchers and policy makers	145	More than 25 European countries	Completed	

APPENDIX 2.

MH Triage tool



MH Screening tool

APPENDIX 3.

Table 2. 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. PHC 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 MH 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, MH support, …)

APPENDIX 4.

Table 3. Overview of the modules of the EUR-HUMAN YouTube channel with training material

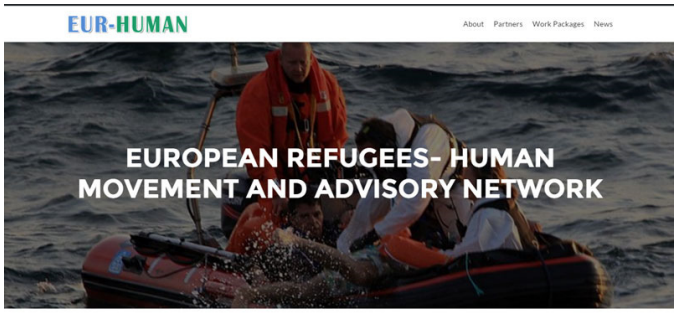
Assessing refugees and other migrants with immediate healthcare needs. Triage upon their arrival
Communicable diseases on refugees and other migrants
Mental health of refugees and other migrants
Provider-patient interaction. Providing cultural appropriate healthcare services
Non-communicable diseases on refugees and other migrants
Vaccination coverage of refugees and other migrants
Maternal and reproductive health

APPENDIX 5. ABBREVIATIONS

ATOMiC	Appraisal Tool for Optimizing Migrant Health Care
e-HCR	Electronic Health Care Record
EU	European Union
EUR-HUMAN	EUropean Refugees - HUman Movement and Advisory NetworK
HRQoL	Health Related Quality of Life
IOM	International Organization of Migration
MH	Mental Health
MHPSS	Mental Health and Psychological Support
M-Ss	Member states
PASR	Psychological Advice and Support points for Refugees
PC	Primary Care
PFA	Psychological First Aid
PHC	Primary Health Care
PLA	Participatory Learning Action
POE	Port of entry
PTSD	Post-traumatic stress disorders
PTSS	Post-traumatic stress
RHS-13	Refugees Health Screening
UoC	University of Crete
WHO	World Health Organization
WP	Work Package

APPENDIX 6. DELIVERABLES OF WP1.

D1.2 Project website.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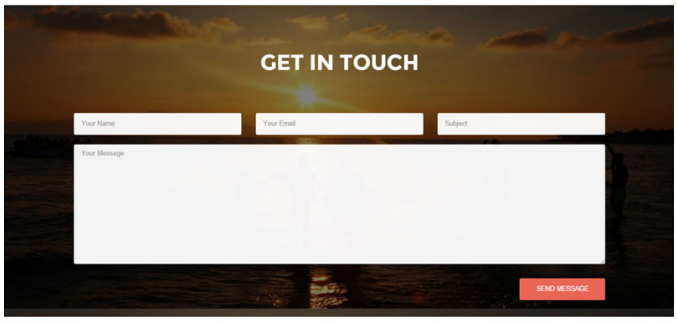
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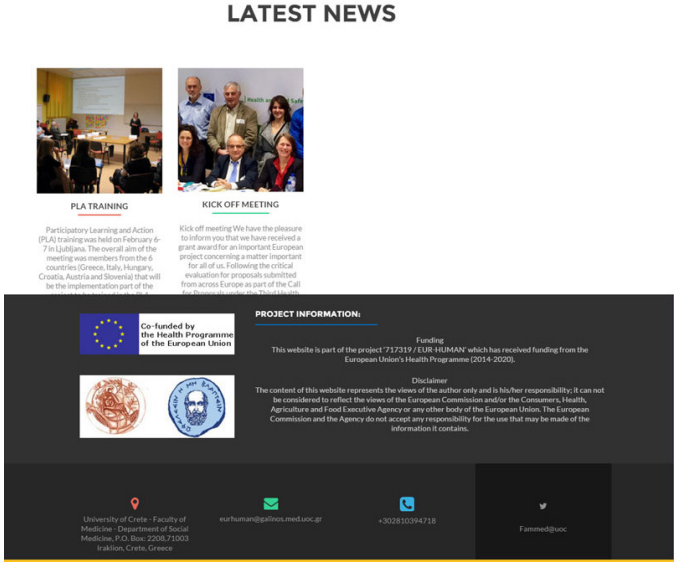
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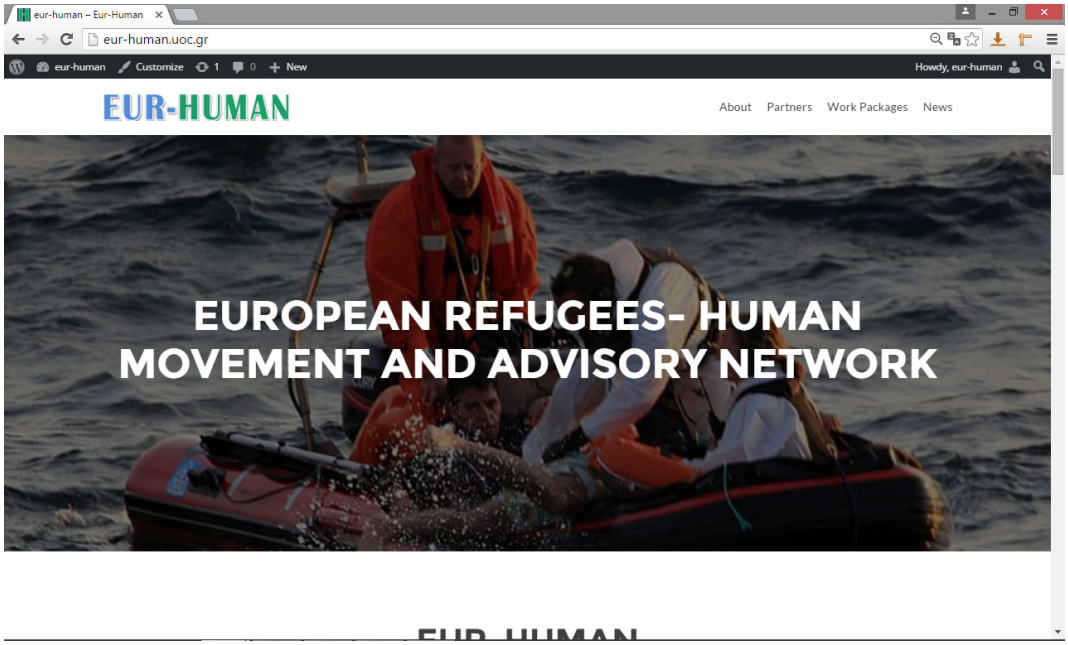
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About
Partners
Work Packages
News
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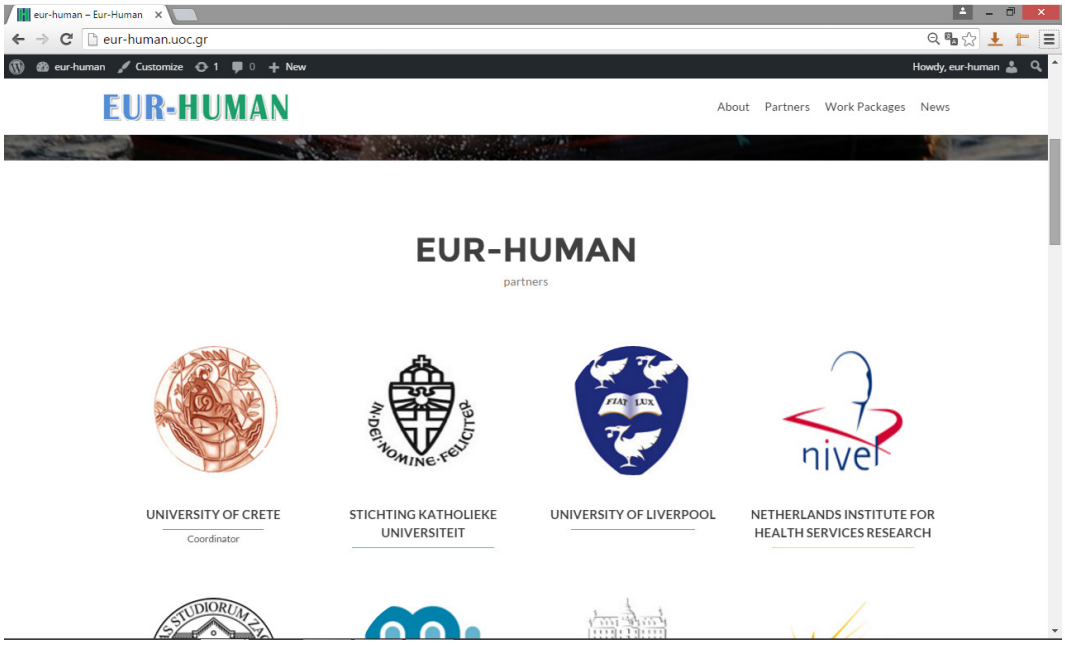
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Partners
Work Packages
News
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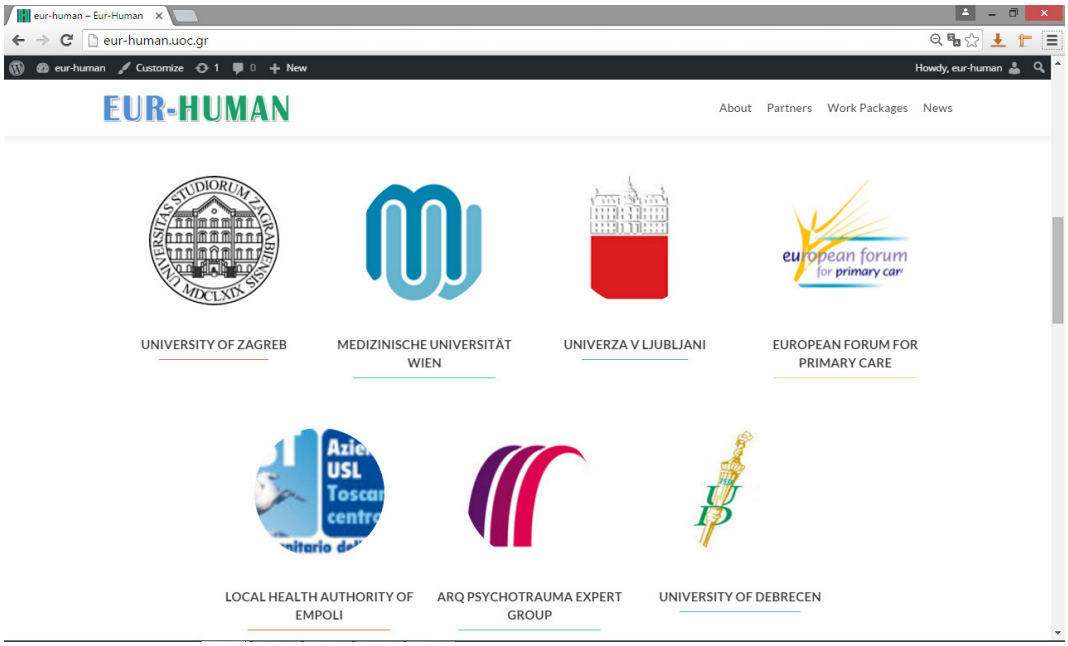
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About
Partners
Work Packages
News
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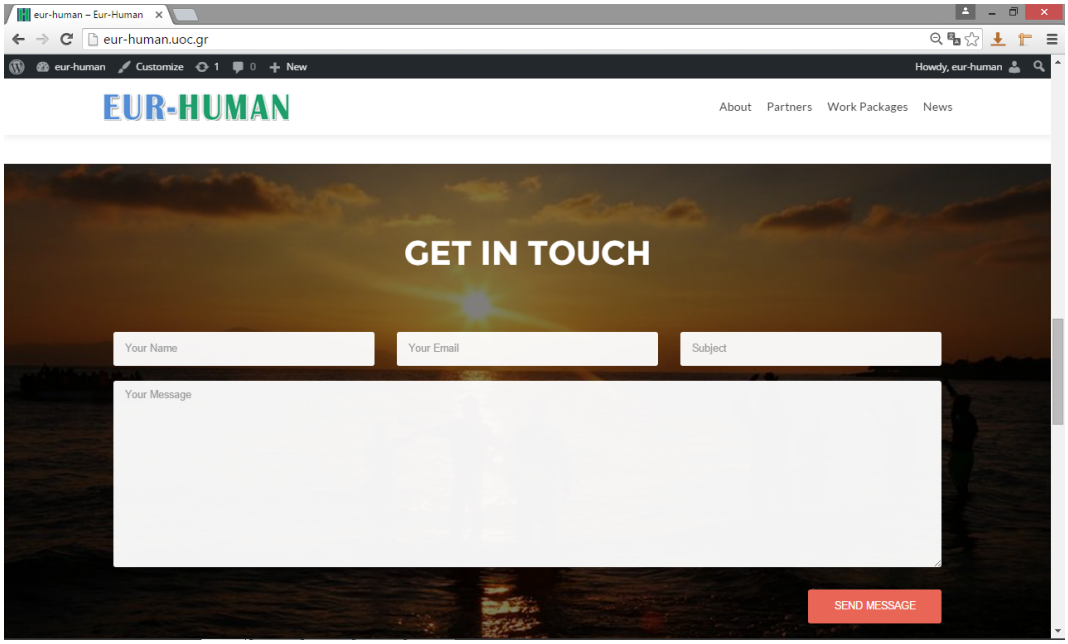
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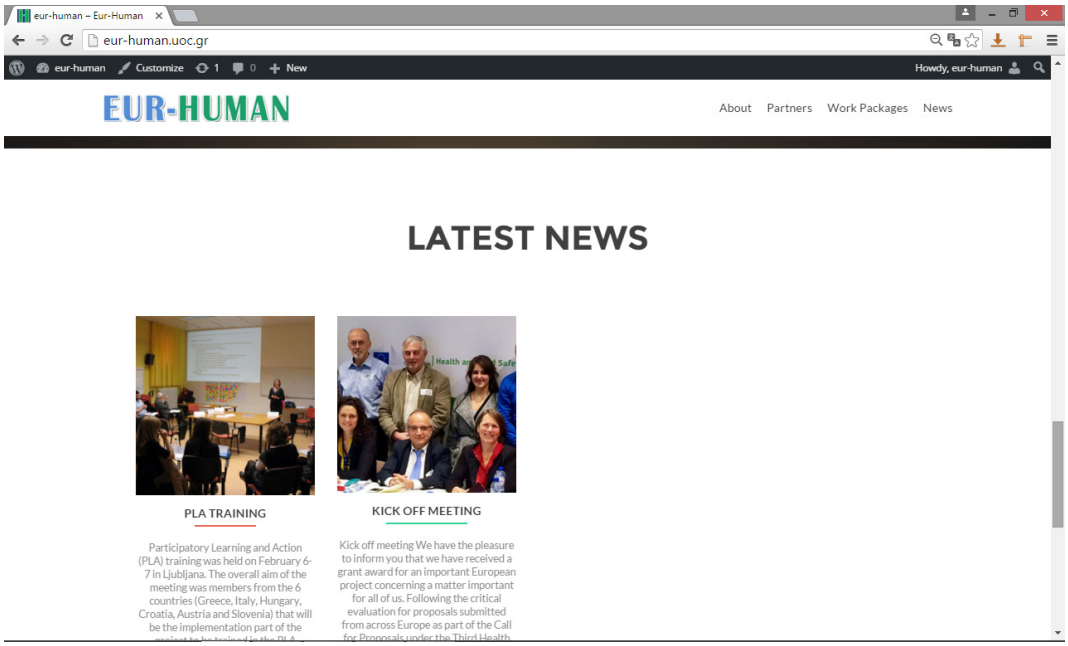
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About
Partners
Work Packages
News
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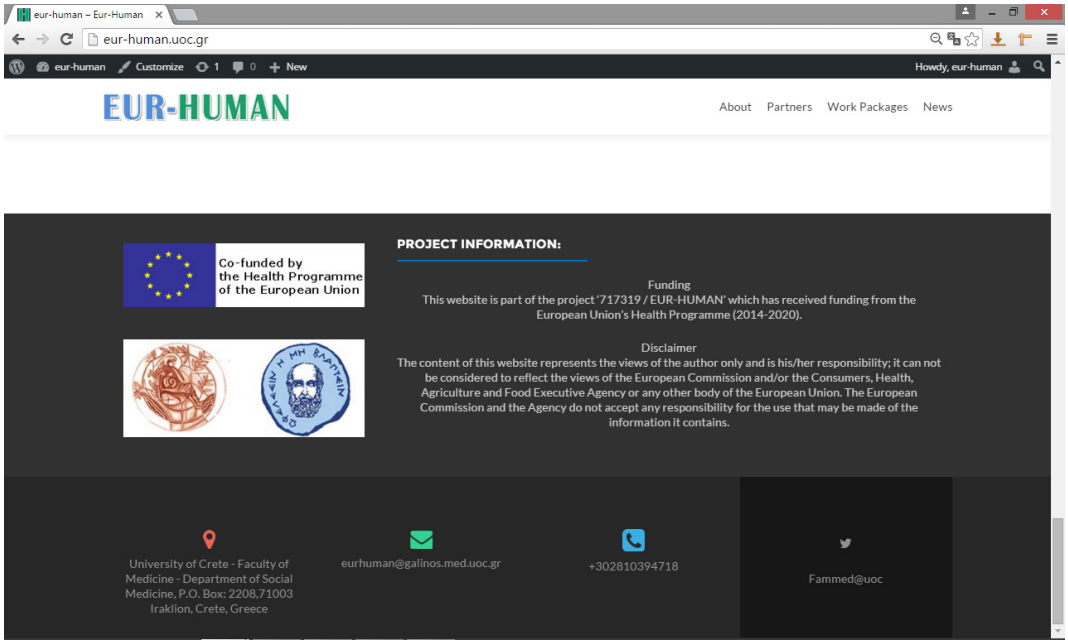
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Partners
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News
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About

EUR-HUMAN

About Partners Work Packages News

About

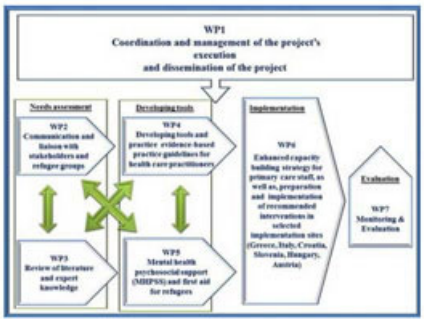
EUropean Refugees-HUman Movement and Advisory Network

Acronym: EUR-HUMAN

Third Programme for the Union's action in the field of health (2014-2020)
Specific Call HP-HA-2015
Duration: 12 months
Grant Amount: 1,320,113 Euros
Co-ordination by the University of Crete (UoC)
Participating countries:
Austria, Croatia, Greece, Italy, Hungary, the Netherlands, Slovenia, UK

The international refugee crisis has reached a critical point and many European countries are developing policy and plan to better define their role in supporting refugees entering Europe. The aim of this proposal is to enhance the capacity of European member states who accept migrants and refugees in addressing their health needs, safeguard them from risks, and minimize cross-border health risks. This initiative will focus on addressing both the early arrival period and longer-term settlement of refugees in European host countries. The existing European and international experience will be systematically reviewed to identify effective interventions to vulnerable groups and tools for the initial health care needs assessment of the arriving refugees including mental, psychosocial and physical health. Established approaches including Participatory and Learning Action and Normalization Process Theory will be used to gain new understanding regarding the needs and opinions of both refugees and stakeholders in regards to the measures needed for health care assessment, and preventive activities including vaccinations, general health hygiene measures, chronic disease management, and psychosocial support. The content of the services that an early or late hosting multi-disciplinary center could offer in the countries that they will accept refugees will be discussed and defined by an international expert panel. Clinical protocols, guidelines together with health education and promotion material and as well as a training programme will be developed for staff serving the refugees and migrants health care centre and tailored protocols and pilot testing in six implementation settings in Greece, Italy, Croatia, Hungary, Austria and Slovenia with contribution from experts and stakeholders from Turkey, Cyprus, Ireland and Belgium. Finally, all these efforts will be evaluated and a final report for implementation in European settings will be produced to guide best practice in this important humanitarian effort.

Graphical presentation of the Work Packages of the EUR-HUMAN project



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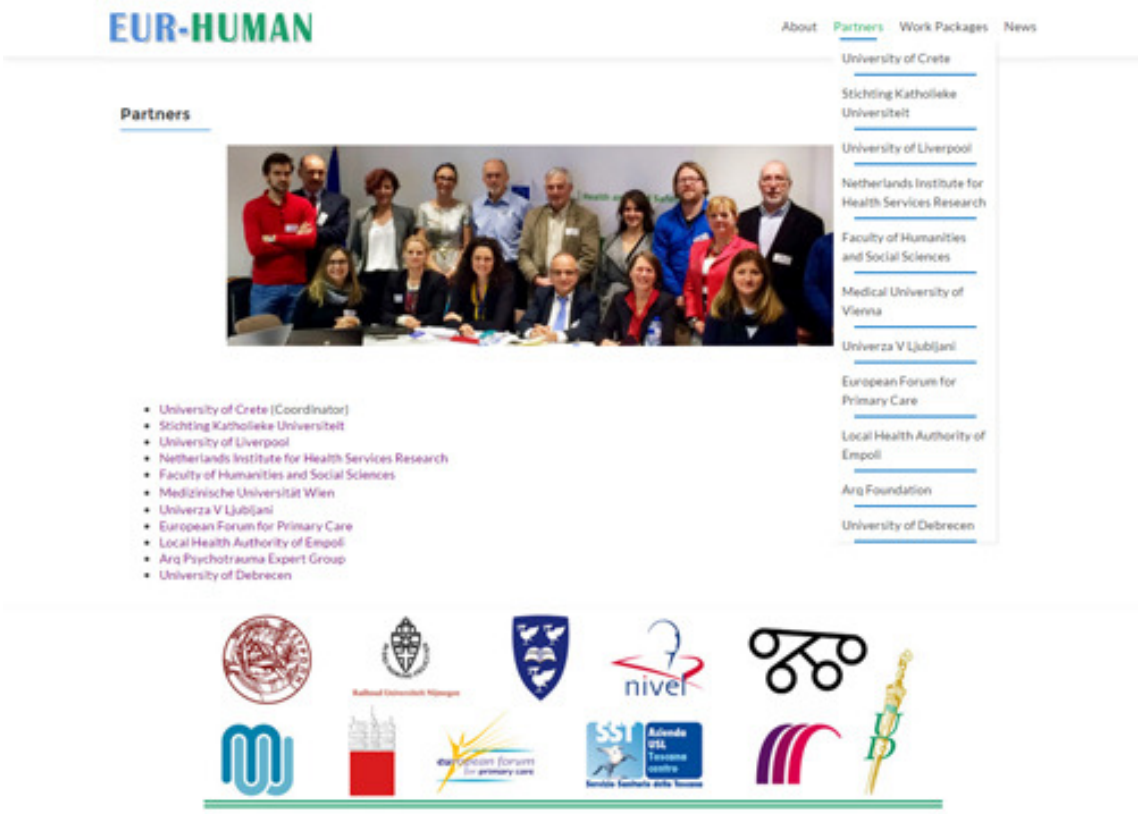
EUR-HUMAN
About
Partners
Work Packages
News
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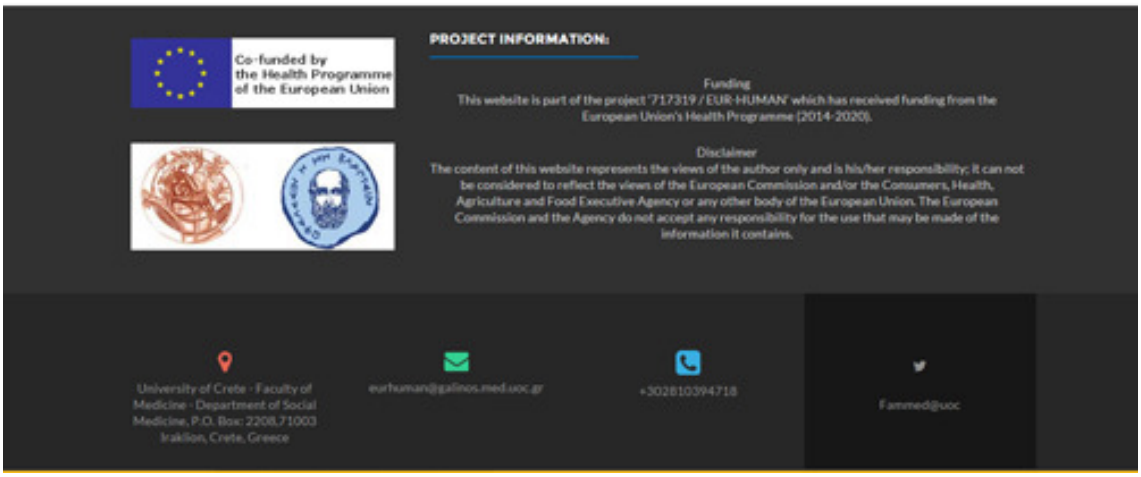
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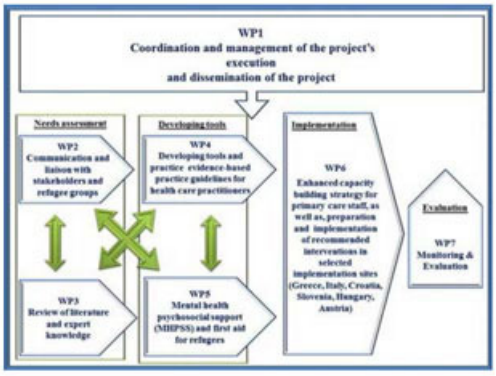
Work Package

Work Packages

Graphical presentation of the Work Packages of the EUR-HUMAN project



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Posted on February 5, 2016

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1 Comment

Kick off meeting

Posted on January 19, 2016

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Leave a comment

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About

The international refugee crisis has reached a critical point and many European countries are developing policy and plan to better define their role in supporting refugees entering Europe. The Syrian civil war has resulted in the relocation of large proportion of the Syrian population with an estimated seven to eight million Syrian refugees relocated in neighboring countries. In addition to Syrians, the movement of refugees into Europe includes peoples from Afghanistan, Pakistan, Iraq, Iran, Eritrea, Bangladesh and migrants from various other nationalities. Among those refugees who have relocated to European countries, many are challenged with medical issues, economic devastation and racial discrimination. More than one million of refugees arrived in Greece without documents in 2015 attempting to travel north to European countries which they believe will offer a better chance of safety and a new life. However the current demand has placed significant strain on European countries that were not adequately prepared to address an influx of refugees of this scale. The lack of access to treatment is particularly an issue for the vulnerable groups including women, the elderly, the very young and children, or those previously suffering from poor health. The proper assessment of health care needs has been limited due to a broken dialogue between refugees and other stakeholders. The current refugees' crisis has also placed a need for the design of programs to test the feasibility and acceptability of proposed actions prior to large-scale implementation of these actions.

Objectives

The objective of the **EUR-HUMAN** project is to reinforce and develop skills and abilities, and to expand knowledge and experience in the EU member-states receiving refugees and immigrants, ultimately aiming to successfully address the various health needs of these vulnerable groups in an effective manner, as well as to ensure all population groups in these European countries are well-protected, safeguarding them from specific risk factors and at the same time minimizing cross-border health risks. This initiative focuses on addressing both the early arrival period and longer-term settlement of refugees in European host countries. A primary objective of this project is to identify, design and assess interventions to improve primary health care delivery for refugees and migrants with a focus on vulnerable groups.

The Project

The main target groups of the **EUR-HUMAN** (website: http://eur-human.uoc.gr/) project are newly arriving refugees and migrant groups, primary health care health professionals involved in providing holistic integrated health care in coordination with social services and national, regional and local stakeholders engaged in providing assistance to refugees and their families.

The design of the **EUR-HUMAN** project is based on the European health prevention policy for migrant and refugee health issues coming to European countries. The project will focus on defining, designing and evaluating interventions that will allow the development of integrated human-centered interventions for the provision of primary healthcare to refugees and immigrants with particular emphasis on vulnerable groups.It will promote comprehensive health need assessment by using the Participatory Learning and Action (PLA) research methodology and the Normalisation Process Theory (NPT) to design and implement effective interventions in the selected implementation sites.

The services provided will include: communicable diseases screening (e.g. chicken pox, measles), chronic disease management (diabetes, heart disease, cancer), surveillance of vaccination coverage, psychological evaluation and support, application of general hygiene measures, etc. In addition to managing risk, the **EUR-HUMAN** will be grounded in an holistic model of health and wellness and will support the delivery of the appropriate acute, primary care, and social services to refugees and migrants.

Such interventions include, amongst others, the development of tools and of practical guidelines for the provision of the primary health care. It is important to note the starting point for evaluating refugee needs is considered to be the arrival to the first-port of entry in a European country with, continuous, however, re-evaluation of the emotional, psychosocial and physical wellbeing throughout any movement and during any potential relocation.

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Results

The results of the project and the pilot implementation of the **EUR-HUMAN** model are expected to be transferrable across EU countries, particularly the main recipient countries through which refugees enter Europe. This is to be achieved through dissemination and knowledge transfer activities, and always taking into consideration the local context.
The **EUR-HUMAN** project will contribute significantly to the development and enchantment of the capacity building for staff in Community Oriented Primary Care Centers as well as other existing primary care settings with regard to refugee and migrants care in EU countries.

Consortium Members

Coordinator, University of Crete, (UOC), Greece	**Stichting Katholieke Universiteit,(RUMC), Nijmegen, Netherlands**	**The University of Liverpool, (UoL), Liverpool, United Kingdom**	**Stichting Nederlands Instituut Yoor Onderzoek van de Gezondheidszorg (NIVEL), Utrecht, the Netherlands**
Sveuciliste u Zagrebu Filozofski Fakultet (FFZG), Zagreb, Croatia	**Medizinische Universitaet Wien (MUW), Vienna, Austria**	**Univerza v Ljubljani (UL), Ljubljana, Slovenia**	**European Forum for Primary Care (EFPC), Utrecht, the Netherlands**
Azienda Unita Sanitaria Locale 11 Empoli (AUSL 11), Empoli, Italy	**Stichting ARQ (ARQ), Diemen, the Netherlands**	**Debreceni Egyetem (UoD), Debrecen, Hungary**	

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Σχετικά

Η διεθνής προσφυγική/μεταναστευτική κρίση έχει φτάσει σε ένα πολύ κρίσιμο σημείο με αποτέλεσμα πολλές ευρωπαϊκές χώρες, να σχεδιάζουν και να αναπτύσσουν πολιτικές με σκοπό να καθορίσουν καλύτερα τον ρόλο τους στη στήριξη των ευάλωτων αυτών πληθυσμών που εισέρχονται στην Ευρώπη. Ο συριακός εμφύλιος πόλεμος είχε μέχρι τώρα ως αποτέλεσμα τη μετεγκατάσταση μεγάλου ποσοστού του πληθυσμού της χώρας. Εκτιμάτε ότι περίπου επτά με οκτώ εκατομμύρια άνθρωποι έχουν μεταναστεύσει σε γειτονικές χώρες. Εκτός από Σύριους, στην Ευρώπη φτάνουν και μετανάστες από το Αφγανιστάν, το Πακιστάν, το Ιράκ, το Ιράν, την Ερυθραία, το Μπαγκλαντές καθώς και από διάφορες άλλες εθνικότητες. Μεταξύ των προσφύγων και μεταναστών που έχουν εγκατασταθεί σε χώρες της Ευρώπης, πολλοί είναι αυτοί που αντιμετωπίζουν προβλήματα υγείας, ή οικονομικά ζητήματα και φυλετικές διακρίσεις.

Περισσότεροι από ένα εκατομμύριο πρόσφυγες και μετανάστες έφτασαν στην Ελλάδα το 2015 προσπαθώντας να ταξιδέψουν προς τις βόρειες ευρωπαϊκές χώρες στις οποίες πιστεύουν ότι θα βρουν μια νέα ευκαιρία για μια καλύτερη και ασφαλέστερη ζωή. Ωστόσο, η τρέχουσα κατάσταση έχει ασκήσει σημαντική πίεση στις ευρωπαϊκές χώρες που δεν ήταν επαρκώς προετοιμασμένες για να αντιμετωπίσουν μια εισροή αυτής της κλίμακας. Η έλλειψη πρόσβασης στις κατάλληλες και απαραίτητες υπηρεσίες υγείας είναι ένα ιδιαίτερο θέμα για τις ευπαθείς ομάδες, συμπεριλαμβανομένων των γυναικών, των ηλικιωμένων, των παιδιών, ή εκείνων που υποφέρουν από χρόνια νοσήματα. Η σωστή αξιολόγηση των αναγκών υγείας υπήρξε περιορισμένη λόγω ενός ελλειμματικού και προβληματικού διαλόγου μεταξύ των προσφύγων, των επαγγελματιών υγείας και των τοπικών φορέων. Η τρέχουσα κρίση έχει αναδείξει την ανάγκη για τον πιλοτικό σχεδιασμό προγραμμάτων για την αξιολόγηση των κατάλληλων παρεμβάσεων πριν αυτές υλοποιηθούν και εφαρμοστούν σε ευρεία κλίμακα.

Στόχος

Στόχος του έργου **EUR-HUMAN** αποτελεί η ενίσχυση ικανοτήτων και δεξιοτήτων, γνώσης και εμπειρίας στις ευρωπαϊκές χώρες κράτη-μέλη της ΕΕ που δέχονται πρόσφυγες και μετανάστες, με σκοπό την αποτελεσματική και ουσιαστική αντιμετώπιση των διαφόρων αναγκών υγείας των ευπαθών αυτών ομάδων, καθώς και την προστασία όλων των πληθυσμιακών ομάδων των ευρωπαϊκών αυτών χωρών από συγκεκριμένους παράγοντες κινδύνου. Η πρωτοβουλία αυτή επικεντρώνεται στην αντιμετώπιση τόσο στη πρώιμη περίοδο άφιξης τους στην Ευρώπη όσο και στη μακροπρόθεσμη εγκατάσταση στις ευρωπαϊκές χώρες που είναι ο τελικός τους προορισμός. Πρωταρχικός στόχος του προγράμματος αυτού είναι να προσδιορίσει, να σχεδιάσει και να αξιολογήσει τις παρεμβάσεις για τη βελτίωση της παρεχόμενης πρωτοβάθμιας φροντίδας υγείας για τους πρόσφυγες και μετανάστες, με έμφαση στις ευάλωτες ομάδες.

Το Πρόγραμμα

Οι ομάδες στόχος του έργου **EUR-HUMAN** (ιστοσελίδα http://eur-human.uoc.gr/) είναι νέο-αφιχθέντες πρόσφυγες και μετανάστες, επαγγελματίες υγείας της πρωτοβάθμιας φροντίδας υγείας που εμπλέκονται στην παροχή ολιστικής και ολοκληρωμένης φροντίδας υγείας καθώς και κοινωνικές υπηρεσίες που ασχολούνται με την παροχή φροντίδας σε εθνικό, περιφερειακό και τοπικό επίπεδο.

Ο σχεδιασμός του προγράμματος **EUR-HUMAN** βασίζεται στην ευρωπαϊκή πολιτική πρόληψης προβλημάτων υγείας που αντιμετωπίζουν οι πρόσφυγες και μετανάστες που μετεγκαθίστανται σε ευρωπαϊκές χώρες. Στόχος του προγράμματος αυτού είναι ο προσδιορισμός, η σχεδίαση και η αξιολόγηση παρεμβάσεων που θα επιτρέψουν την ανάπτυξη ολοκληρωμένων ανθρωποκεντρικών προσεγγίσεων για την παροχή υπηρεσιών πρωτοβάθμιας φροντίδας υγείας σε πρόσφυγες και μετανάστες, εστιάζοντας ιδιαίτερα στις ευάλωτες ομάδες. Η χρήση διεθνών επιστημονικά τεκμηριωμένων τεχνικών όπως το Participatory Learning and Action (PLA) και το Normalization Process Theory (NPT) θα βοηθήσουν σημαντικά να σχεδιαστούν και να εφαρμοστούν αποτελεσματικές παρεμβάσεις στις επιλεγμένες περιοχές εφαρμογής.

Οι παρεχόμενες υπηρεσίες θα περιλαμβάνουν: έλεγχος μεταδοτικών ασθενειών (π.χ. ανεμοβλογιά, ιλαρά), διαχείριση χρόνιων ασθενειών (π.χ διαβήτη, καρδιακές παθήσεις, καρκίνος), την επιτήρηση της εμβολιαστικής κάλυψης, ψυχολογική αξιολόγηση και υποστήριξη, η εφαρμογή των γενικών μέτρων υγιεινής κ.λπ. Εκτός από τη διαχείριση του κινδύνου, το **EUR-HUMAN** έργο θα στηρίζεται στο ολιστικό μοντέλο της υγείας και θα υποστηρίζει την παροχή της κατάλληλης πρωτοβάθμιας περίθαλψης και των κοινωνικών υπηρεσιών προς τους πρόσφυγες και τους μετανάστες. Τέτοιες παρεμβάσεις περιλαμβάνουν μεταξύ άλλων, την ανάπτυξη εργαλείων και πρακτικών κατευθυντήριων γραμμών για την παροχή της Πρωτοβάθμιας Φροντίδας Υγείας. Είναι σημαντικό να σημειωθεί ότι η εκκίνηση για την αξιολόγηση των αναγκών των προσφύγων είναι το σημείο εισόδου σε μια ευρωπαϊκή χώρα με συνεχή, ωστόσο αξιολόγηση της συναισθηματικής, ψυχοκοινωνικής και σωματικής ευεξίας σε κάθε επόμενη χώρα μετάβασης καθώς και στη χώρα τελικού προορισμού.

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Αποτελέσματα

Αναμένεται ότι τα αποτελέσματα και η πιλοτική εφαρμογή του μοντέλου του **EUR-HUMAN** θα αποτελέσουν το αντικείμενο μεταφοράς τεχνογνωσίας σε όλες τις χώρες της ΕΕ, ιδιαιτέρως των κυρίων χωρών εισόδου και υποδοχής προσφύγων, λαμβάνοντας πάντοτε υπόψη τοπικές ιδιαιτερότητες.

Το έργο **EUR-HUMAN** θα συμβάλει σημαντικά στην ανάπτυξη των ικανοτήτων του προσωπικού υγείας που εργάζεται στα κέντρα Πρωτοβάθμιας Φροντίδας Υγείας και παρέχει καθημερινά σε όλες τις Ευρωπαϊκές χώρες υπηρεσίες υγείας στους πληθυσμούς αυτούς.

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Chi Siamo

La crisi internazionale dei rifugiati ha raggiunto un livello critico, e molti paesi europei stanno sviluppando politiche e strategie, per definire in maniera più chiara il loro ruolo nel supporto dei rifugiati che entrano in Europa. La guerra civile siriana ha portato alla ricollocazione di gran parte della popolazione siriana, di cui sette o otto milioni di rifugiati siriani si sono trasferiti nei paesi limitrofi. Oltre ai Siriani, il movimento verso l'Europa dei rifugiati include popoli provenienti da Afghanistan, Pakistan, Iraq, Iran, Eritrea, Bangladesh e migranti di altre nazionalità. Molti dei rifugiati che si sono trasferiti in paesi europei, devono affrontare problemi di salute, disagio economico e discriminazione razziale. Nel 2015, più di un milione di rifugiati sono arrivati in Grecia senza documenti, con l'intento di arrivare verso quei paesi nord-europei, che sono considerati come paesi con maggiore sicurezza, dove cominciare una nuova vita. Tuttavia, l'attuale domanda ha provocato tensioni in quei paesi europei non adeguatamente preparati ad affrontare un afflusso di rifugiati di questa scala. La mancanza di accesso alle cure è un problema soprattutto per i gruppi vulnerabili, tra cui le donne, gli anziani, i più giovani e i bambini, o coloro i quali hanno precedentemente sofferto di scarse condizioni sanitarie. La corretta valutazione dei bisogni di assistenza medica è stata limitata a causa del dialogo interrotto tra rifugiati e le altre parti interessate. L'attuale crisi dei rifugiati ha anche posto la necessità della progettazione di programmi per testare la realizzabilità e l'approvazione delle azioni proposte, prima che vengano implementate su larga scala.

Obiettivi

Gli obiettivi del progetto **EUR-HUMAN** sono il rafforzamento e lo sviluppo di competenze, abilità e conoscenze in quegli Stati membri dell'UE che ricevono rifugiati e immigrati, al fine di affrontare in modo efficace le varie esigenze di salute in questi gruppi a rischio, e garantire che tale popolazione sia ben protetta in questi paesi europei, tutelata da determinati fattori di rischio, riducendo al minimo i rischi per la salute a carattere transfrontaliero. Questa iniziativa si concentra su come affrontare la fase iniziale di arrivo dei rifugiati e il soggiorno a lungo termine nei paesi di accoglienza. Un obiettivo primario di questo progetto è l'identificazione, la progettazione e la valutazione degli interventi atti a migliorare i servizi di assistenza sanitaria di base per i rifugiati e gli immigrati, con una maggiore attenzione ai gruppi vulnerabili.

Progetto

I principali destinatari del progetto EUR-HUMAN (http://eur-human.uoc.gr) sono i rifugiati e i gruppi di migranti arrivati nel periodo recente, e gli operatori sanitari per l'assistenza di base, coinvolti nella fornitura di servizi sanitari integrati e olistici, in coordinamento con i servizi sociali e attori nazionali, regionali e locali impegnati nella fornitura di assistenza ai rifugiati e alle loro famiglie.

Il piano del progetto EUR-HUMAN si basa sulle politiche di prevenzione sanitaria europea per i problemi di salute dei migranti e dei rifugiati che arrivano in Europa. Il progetto si concentrerà sulla definizione, la progettazione e la valutazione degli interventi che permetteranno lo sviluppo di interventi integrati centrati sull'essere umano, per l`erogazione di prestazioni di assistenza sanitaria di base ai rifugiati e immigrati, con particolare attenzione ai gruppi più vulnerabili. Promuoverà una valutazione completa sui bisogni di salute utilizzando il metodo di ricerca del Participatory Learning and Action (PLA) e il Normalisation Process Theory (NPT), atti a progettare e realizzare interventi efficaci nei luoghi selezionati.

I servizi offerti comprendono: lo screening delle malattie trasmissibili (ad esempio, la varicella, morbillo), la gestione delle malattie croniche (diabete, malattie cardiache, cancro), il controllo della copertura vaccinale, valutazione psicologica e sostegno, applicazione delle misure generali di igiene, etc. Oltre alla gestione del rischio, l'EUR-HUMAN si baserà sul modello olistico di salute e benessere, e sosterrà la giusta erogazione dei servizi sanitari secondari, di base, i e servizi sociali ai rifugiati e migranti.

Tali interventi comprendono, inoltre, lo sviluppo di strumenti e di linee guida per la fornitura di assistenza sanitaria di base. È importante notare che il primo punto di accesso ad un paese europeo viene considerato come il punto di partenza per la valutazione dei bisogni dei rifugiati, con un continuo accertamento del benessere emotivo, psico-sociale e fisico, in ogni spostamento e durante ogni potenziale trasferimento.

Il contenuto di questo opuscolo rappresenta il solo punto di vista dell'autore ed è esclusivamente di sua responsabilità; non può essere considerato rispecchiare le opinioni della Commissione europea e/o dell'Agenzia esecutiva per i consumatori, la salute e la sicurezza alimentare (CHAFEA), o di qualsiasi altro organo dell'Unione Europea. La Commissione Europea e l'Agenzia non si assumono alcuna responsabilità per l'uso che potrebbe essere fatto delle informazioni in esso contenute.

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Risultati

I risultati del progetto e dell'implementazione pilota del modello **EUR-HUMAN** sono fatti per essere trasferibili tra tutti i paesi europei, in particolare tra quei paesi utilizzati dai rifugiati per entrare in Europa. Tale obiettivo deve essere raggiunto attraverso un'attività di disseminazione e trasferimento delle conoscenze, sempre tenendo in considerazione il contesto locale.
Il progetto **EUR-HUMAN** contribuirà in modo significativo allo sviluppo della creazione di capacità ("capacity building") per il personale nei Community Oriented Primary Care, così come in altri centri di assistenza di base, per la cura di rifugiati e migranti nei paesi dell'UE.

Membri Del Consorzio

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O Projektu

Međunarodna izbjeglička kriza dosegla je kritičnu razinu zbog čega brojne europske zemlje razvijaju politike i planove kako bi pobliže odredile svoju ulogu u pomoći izbjeglicama koje ulaze u Europu. Sirijski građanski rat rezultirao je premještanjem velikog dijela sirijske populacije, pri čemu se procjenjuje da se sedam do osam milijuna izbjeglica nalazi u susjednim zemljama. Osim Sirijaca, izbjeglički val u Europu uključuje i ljude iz Afganistana, Pakistana, Iraka, Irana, Eritreje, Bangladeša te migrante različitih drugih nacionalnosti. Mnoge izbjeglice koje su otišle u europske zemlje suočene su sa zdravstvenim problemima, ekonomskim osiromašenjem i rasnom diskriminacijom. Više od milijun izbjeglica u 2015. godini pristiglo je bez dokumenata u Grčku s namjerom da otputuju u sjeverne europske zemlje za koje vjeruju da će im pružiti sigurnost i novi početak. Međutim, sadašnji zahtjevi izbjegličke krize čine značajan pritisak na europske zemlje koje nisu bile adekvatno pripremljene za prihvat priljeva izbjeglica u tolikom razmjeru. Nedostatak pristupa zdravstvenoj skrbi predstavlja poseban problem osjetljivim skupinama kao što su žene, stariji ljudi, mala djeca te pojedinci s prethodnim zdravstvenim problemima. Odgovarajuća procjena zdravstvenih potreba do sada je bila ograničena zbog pomanjkanja dijaloga između izbjeglica i ostalih dionika. Sadašnja izbjeglička kriza stvorila je potrebu za razvijanjem programa kojima bi se provjerila izvedivost i prihvatljivost predloženih aktivnosti prije njihove masovne primjene.

Svrha

Svrha **EUR-HUMAN** projekta je razviti i ojačati vještine i sposobnosti te proširiti znanje i iskustvo u državama članicama Europske unije koje primaju izbjeglice i migrante s krajnjim ciljem uspješnog rješavanja različitih zdravstvenih potreba ovih osjetljivih skupina, te osiguravanja da sve populacijske skupine u ovim europskim zemljama budu dobro zbrinute i zaštićene od specifičnih činitelja rizika, a u isto vrijeme minimalizirati prekogranične zdravstvene rizike. Ova inicijativa je usmjerena na pitanja vezana uz prvo razdoblje nakon dolaska te dugoročnog boravka izbjeglica u europskim zemljama koje ih primaju. Primarni cilj ovog projekta je identifikacija, oblikovanje i procjena intervencija za poboljšanje primarne zdravstvene skrbi za izbjeglice i migrante s naglaskom na osjetljive skupine.

Glavne ciljne skupine EUR-HUMAN projekta (web stranica: http://eur-human.uoc.gr) su novo pristigle izbjeglice i skupine migranata, djelatnici primarne zdravstvene zaštite uključeni u pružanje holističke integrirane zdravstvene skrbi u suradnji sa socijalnim službama, te nacionalnim, regionalnim i lokalnim dionicima koji pomažu izbjeglicama i njihovim obiteljima.
Sadržaj EUR-HUMAN projekta temelji se na europskoj politici zdravstvene prevencije za migrante i izbjeglice koji dolaze u europske zemlje. Ovaj projekt će se usmjeriti na definiranje, oblikovanje i evaluaciju intervencija koje će omogućiti razvoj integriranih aktivnosti primarne zdravstvene skrbi za izbjeglice i migrante s posebnim naglaskom na osjetljive skupine. Unaprijedit će sveobuhvatnu procjenu zdravstvenih potreba koristeći istraživačku metodologiju Suradničkog učenja i akcije (PLA) i Teoriju procesa normalizacije (NPT) kako bi se razvile i primijenile učinkovite intervencije u odabranim mjestima provedbe.
Usluge će uključivati: probir za zarazne bolesti (npr.. vodene kozice, ospice), upravljanje kroničnim bolestima (npr. dijabetes, kardiovaskularne bolesti, tumori), nadzor procijepljenosti, psihološku procjenu i podršku, primjenu općih higijenskih mjera, itd. Osim na upravljanju rizicima, EUR-HUMAN projekt temeljit će se na holističkom modelu zdravlja i dobrobiti te će podržavati pružanje primjerene akutne, primarne skrbi i socijalnih usluga izbjeglicama i migrantima.
Takve intervencije uključuju, između ostaloga, razvoj alata i praktičnih smjernica za pružanje primarne zdravstvene skrbi. Važno je naglasiti da se početnom točkom za procjenu potreba izbjeglica smatra njihovo prvo mjesto ulaska u europsku zemlju, pri čemu se njihova emocionalna, psihosocijalna i fizička dobrobit nastavlja procjenjivati tijekom daljnjeg kretanja i mogućeg premještanja.

Izjava o ograničenju odgovornosti : Sadržaj ovog letka odražava poglede samo autora i njegova je isključiva odgovornost; ne može se smatrati da odražava poglede Europske komisije i/ili Izvršne agencije za potrošače, zdravlje, poljoprivredu i hranu, ili bilo kojeg drugog tijela Europske unije. Europska komisija i Agencija ne prihvaćaju odgovornost za upotrebu informacija navedenih u ovom dokumentu
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Rezultati

Očekuje se da će rezultati ovog projekta i preliminarne provedbe **EUR-HUMAN** modela biti primjenjivi u zemljama diljem Europske unije, pogotovo onim zemljama koje predstavljaju glavna mjesta ulaska izbjeglica u Europu. To će se postići kroz širenje i transfer stečenih znanja, uzimajući uvijek u obzir lokalni kontekst.

EUR-HUMAN projekt značajno će pridonijeti napretku i jačanju kapaciteta za razvoj osoblja u centrima primarne zdravstvene skrbi u zajednici kao i drugim postojećim sustavima primarne skrbi o izbjeglicama i migrantima u zemljama EU.

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Het project richt zich met name op vluchtelingen die net in Europa aankomen en de groep die een asielaanvraag indient in het land van vestiging. Een primair doel van het project is het identificeren, ontwikkelen en vaststellen van interventies die de eerstelijns gezondheidzorg voor vluchtelingen en migranten verbeterd, met name voor de genoemde kwetsbare groepen.

Activiteiten

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De resultaten van het **EUR-HUMAN** project zullen in andere EU-lidstaten geïmplementeerd kunnen worden en dan met name in de landen waar vluchtelingen Europa binnenkomen. Dit zal gebeuren door het verspreiden van de opgedane kennis, waarbij natuurlijk gekeken zal worden naar de lokale situatie.

Het **EUR-HUMAN**-project draagt bij aan de kennisontwikkeling van zowel mensen die werkzaam zijn in de zogenaamde wijkerichte eerstelijns zorg als andere eerstelijns zorginstellingen die te maken hebben met de zorg en opvang van vluchtelingen en migranten

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EUR-HUMAN

EUropean Refugees HUman Movement and Advisory Network

Doelgroepen

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Het Projectconsortium Bestaat

Coordinator, University of Crete, (UOC), Greece	**Stichting Katholieke Universiteit,(RUMC), Nijmegen, Netherlands**	**The University of Liverpool, (UoL), Liverpool, United Kingdom**	**Stichting Nederlands Instituut voor Onderzoek van de Gezondheidszorg (NIVEL), Utrecht, the Netherlands**
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Azienda Unita Sanitaria Locale 11 Empoli (AUSL 11), Empoli, Italy	**Stichting ARQ (ARQ), Diemen, the Netherlands**	**Debreceni Egyetem (UoD), Debrecen, Hungary**	

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الموضوع

الأزمة الدولية للاجئين قد وصلت إلى نقطة حرجة، والعديد من الدول الأوروبية عملوا بوضع سياسة وخطة لتحديد أفضل دور لهم في دعم اللاجئين عند دخول أوروبا. وقد أدت الحرب الأهلية السورية في تهجير نسبة كبيرة من الشعب السوري ما يقدر بنحو 7- 8،000،000, اللاجئين السوريين هجروا إلى البلدان المجاورة. بالإضافة إلى السوريين غير اللاجئين ، حركة اللاجئين في أوروبا تشمل الشعوب من مختلف الدول من أفغانستان وباكستان والعراق وإيران وإريتريا وبنغلاديش والمهاجرين من مختلف الجنسيات الأخرى. ومن بين هؤلاء اللاجئين الذين هجروا إلى الدول الأوروبية، والعديد منهم اتحدوا مع قضايا طبية و الدمار الاقتصادي والتمييز العنصري. أكثر من مليون من اللاجئين الذين وصلوا إلى اليونان بدون وثائق لعام 5102 محاولة السفر إلى شمال الدول الأوروبية التي يعتقدون أنها سوف توفر لهم فرصة أفضل للأمن وحياة جديدة. إلا أن الطلب الحالي قد وضعت ضغطا كبيرا على الدول الأوروبية التي لم تكن مستعدة بشكل كاف لمواجهة تدفق اللاجئين بهذا الحجم, وعدم الحصول على العلاج هو القضية على وجه الخصوص الفئات الضعيفة بما في ذلك النساء والشيوخ والشباب والأطفال ،وأولئك الذين يعانون سابقا من حالة صحية سيئة. التقييم السليم للاحتياجات الرعاية الصحية محدود وذلك لكسر الحوار بين اللاجئين وغيرهم من أصحاب المصالح. وقد وضعت أزمة اللاجئين الحالي "أيضا حاجة لتصميم برامج لاختبار عمليه قبول الإجراءات المقترحة قبل تنفيذها على نطاق واسع من هذه الإجراءات.

أهداف المشروع

والهدف من المشروع **NAMUH -RUE** هو تعزيز وتطوير مهاراتهم وقدراتهم، وتوسيع نطاق المعرفة والخبرة في الدول الأعضاء في الاتحاد الأوروبـي المستقبلة للاجئين والمهاجرين، والتي تهدف في نهاية المطاف إلى التصدي بنجاح إلى الاحتياجات الصحية المختلفة لهذه الفئات الضعيفة في طريقه فعاله ، وكذلك لضمان جميع فئات السكان في هذه الدول الأوروبية محمية بشكل جيد، حماية لهم من عوامل الخطر المحددة، وفي الوقت نفسه تقليل المخاطر الصحية عبر الحدود. وتركز هذه المبادرة على معالجة كل فترة وصوله في وقت مبكر والتسوية على المدى الطويل للاجئين في البلدان الأوروبية المضيفة. والهدف الرئيسي من هذا المشروع هو تحديد وتصميم وتقييم التدخلات الرامية إلى تحسين تقديم الرعاية الصحية الأولية للاجئين والمهاجرين مع التركيز على الفئات الضعيفة.

المشروع

الفئات الرئيسية المستهدفة للمشروع **NAMUH -RUE** وصول لاجئين ومجموعات المهاجرين جدد, ومشاركه المهنيين الصحيين في الرعاية الصحية الأولية المتمثلة في تقديم الرعاية الصحية المتكاملة الشاملة بالتنسيق مع الخدمات الاجتماعية والجهات المعنية الوطنية والإقليمية والمحلية العاملة في مجال تقديم المساعدة إلى اللاجئين و الأسر.

ويستند تصميم مشروع RUE الإنسان عن سياسة وقائية الصحية الأوروبية لقضايا المهاجرين والصحية للاجئين القادمين إلى الدول الأوروبية. وسيركز المشروع على تحديد وتصميم وتقييم التدخلات التي من شأنها أن تسمح لتطوير تدخلات محورها الإنسان وذلك لتوفير الرعاية الصحية الأولية المتكاملة للاجئين والمهاجرين مع التركيز بشكل خاص على tI.spuorg الضعيفة وتعزيز تقييم شامل الحاجة الصحية باستخدام التشاركية التعلم والعمل (ALP) منهجية البحث ونظرية التطبيع عملية (TPN) لتصميم وتنفيذ التدخلات الفعالة في المواقع التنفيذية المختارة للمشروع .

الخدمات المقدمة ما يلي: الأمراض المعدية الفرز (مثل جدري الماء، والحصبة)، وإدارة المرض المزمن (داء السكري وأمـراض القلب والسرطان)، ومراقبة التغطية بالتطعيم، والتقييم النفسي والدعم، وتطبيق تدابير الصحة العامة، وما إلى ذلك بالإضافة إلى إدارة المخاطر، وسيعتمد على ORUE-البشر في نموذج الشامل للصحة والعافية تدعم حدة مناسبة، الرعاية الصحية الأولية، والخدمات الاجتماعية للاجئين والمهاجرين.

وتشمل هذه التدخلات، من بين أمور أخرى، وتطوير أدوات ومبادئ توجيهية عملية من أجل توفير الرعاية الصحية الأولية. ومن المهم أن نشير إلى نقطة انطلاق لتقييم احتياجات تعتبر في الوصول إلى أول ميناء للدخول في بلد أوروبي مع حركه اللاجئين المستمر، ومع ذلك، وإعادة تقييم للرفاهية العاطفية والنفسية والجسدية طوال أي حركة و خلال أي نقل محتمل.

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هذه ورقةِ الإعلان جزءُ المشروعِ ' RUE / 913717 ' الذي إستلمَ التمويل مِنْ برنامجِ صحةِ الإتحاد الأوربي (4102-0202).

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النتائج

نتائج المشروع والتنفيذ التجريبي للنموذج الاتحاد الأوروبي الإنسان قد يكون له من المتوقع تحويل عبر دول الاتحاد الأوروبي، هو اذه , أوروبا إلى يدخلون الذين اللاجئين من خلال المداراة التي المستفيدة الرئيسية البلدان الوسيط, ونقل المعرفة، وأخذ داءما في الاعتبار البيئة المحلية, وسياسات مشروع EUR-HUMAN بشكل كبير في تطوير وتحسين الرعاية الأولية القائمة في المجتمع عن غير المرافق الرعاية الصحية الأولية للمهاجرين في دول الاتحاد الأوروبي .

أعضاء الائتلاف

المعهد الهولندي الوطني للبحوث والخدمات الصحية	جامعة ليفربول، (وول)، ليفربول، المملكة المتّحدة	ستيتشتينج كاثوليكي يونيفيرسيتيت ، (آر يو إم سي)، نيجميجين، هولندا	المنسّق، جامعة كريت، (يو أو سي)، اليونان
المنتدى الأوروبي للعناية الأساسية (إي إف بي سي)، وتريتشت، هولندا	-انايلبويل ايبويل ةعماج ايني‌فولس	انيي‌ف ةعماج بطلا ةيلك انيي‌ف-اسمنلا	جامعة زغرب كلية الفلسفة كرواتيا زغرب
	ديبريسيني إجيتيم (وود)، ديبريسين، هنغاريا	ستيتشتينج أي آر كيو (أي آر كيو)، ديمين، هولندا	موقع أزيندا يونيتا سانيتاريا 11 إمبولي (أي يو إس إل 11)، إمبولي، إيطاليا

الاتصال

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لمزيد من المعلومات عن المشروع:

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أستاذ الطب العام والرعاية الصحية الأولية
رئيس عيادة الطب الاجتماعية والأسرة
كلية الطب
جامعة كريت، اليونان
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Aanleiding

De internationale vluchtelingencrisis heeft een kritiek punt bereikt en veel Europese landen ontwikkelen beleid om vluchtelingen beter te ondersteunen. De Syrische burgeroorlog heeft er voor gezorgd dat tussen de zeven en acht miljoen Syriers op de vlucht zijn geslagen. Naast Syriërs, bestaat de vluchtelingenstroom naar Europa met name uit mensen afkomstig uit Afghanistan, Pakistan, Irak, Iran, Eritrea, en Bangladesh.

Vele vluchtelingen die naar Europa zijn getrokken hebben niets meer en kampen daarnaast met medische problemen en discriminatie. In 2015 arriveerden in Griekenland meer dan één miljoen vluchtelingen zonder documenten; zij probeerden naar noorden van Europa te trekken, omdat men dacht daar een betere kans te hebben op het opbouwen van een veilig, nieuw bestaan. De toegenomen stroom vluchtelingen heeft grote druk gezet op Europese landen die veelal niet voorbereid waren op een dergelijke toestroom van vluchtelingen.

Het gebrek aan toegang tot goede zorg is vooral een probleem voor de meest kwetsbare groepen, zoals vrouwen, ouderen, kinderen en degene die al te kampen hadden met een slechte gezondheid. De juiste beoordeling van welke zorg iemand nodig heeft, wordt belemmerd door het ontbreken van een goede dialoog tussen vluchtelingen, zorgverleners en andere belanghebbenden. De huidige vluchtelingencrisis laat ook zien dat bepaalde, voorgestelde (beleid)acties eerst moeten worden onderzocht op haalbaarheid en mate van acceptatie, alvorens wordt overgegaan tot grootschalige implementatie van deze acties.

Doelstelling

Het doel van het **EUR-HUMAN** project is het op een effectieve wijze versterken en ontwikkelen van vaardigheden, capaciteiten en het verspreiden van kennis en ervaring in de EU-lidstaten, die vluchtelingen en immigranten opvangen, over de verschillende zorgnoden vormen van effectieve zorg voor verschillende gezondheidsbehoeften van deze kwetsbare groepen en daarnaast ervoor zorgen dat de verschillende bevolkingsgroepen in Europa goed beschermd zijn tegen grensoverschrijdende gezondheidsrisico's.

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Activiteiten

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De resultaten van het **EUR-HUMAN** project zullen in andere EU-lidstaten geïmplementeerd kunnen worden en dan met name in de landen waar vluchtelingen Europa binnenkomen. Dit zal gebeuren door het verspreiden van de opgedane kennis, waarbij natuurlijk gekeken zal worden naar de lokale situatie.

Het **EUR-HUMAN**-project draagt bij aan de kennisontwikkeling van zowel mensen die werkzaam zijn in de zogenaamde wijkerichte eerstelijns zorg als andere eerstelijns zorginstellingen die te maken hebben met de zorg en opvang van vluchtelingen en migranten

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Doelgroepen

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EUR-HUMAN

EUropean Refugees HUman Movement and Advisory Network

Über

Die internationale Flüchtlingskrise hat einen kritischen Punkt erreicht und viele Europäische Länder arbeiten an Strategien und Plänen, um ihre Rolle bei der Unterstützung der Flüchtlinge, die nach Europa kommen, besser zu definieren. Der Krieg in Syrien hat dazu geführt, dass ein großer Teil der syrischen Bevölkerung geflüchtet ist. Laut Schätzungen befinden sich sieben bis acht Millionen syrische Flüchtlinge in benachbarten Ländern. Zusätzlich zu syrischen Flüchtlingen sind auch Menschen aus Afghanistan, Pakistan, Irak, Iran, Eritrea, und Bangladesch sowie Migranten/innen mit unterschiedlichen anderen Nationalitäten Teil des Flüchtlingsstroms nach Europa. Unter den Flüchtlingen, die sich in Europäischen Ländern angesiedelt haben, stehen viele vor Herausforderungen betreffend medizinischer Probleme, einer schlechten wirtschaftlichen Situation, sowie einer Diskriminierung aufgrund ihrer Herkunft. Über eine Million Flüchtlinge sind im Jahr 2015 ohne Dokumente in Griechenland eingetroffen. Sie strebten danach nach Norden, in Europäische Länder die, wie sie annehmen, bessere Chancen auf Sicherheit und ein neues Leben bieten, weiter zu reisen. Allerdings ergaben sich durch die aktuelle Lage erhebliche Belastungen für Europäische Länder, die nicht ausreichend darauf vorbereitet waren mit einem Flüchtlingszustrom dieses Ausmaßes umzugehen. Der problematische Zugang zur medizinischen Versorgung ist insbesondere ein Problem für vulnerable Gruppen wie Frauen, ältere Personen, sehr junge Personen und Kinder, oder jene Menschen, die zuvor schon von unter einem schlechten Gesundheitszustand gelitten haben. Eine angemessene Beurteilung der Gesundheitsversorgungsbedürfnissen war bisher nur eingeschränkt möglich, da der Dialog zwischen den Flüchtlingen und den anderen betroffenen Gruppen gefehlt hat. Die aktuelle Flüchtlingskrise hat deutlich gemacht, dass es notwendig ist Programme zu entwickeln, die dazu dienen, die Durchführbarkeit und Akzeptanz von vorgeschlagenen Maßnahmen vor einer Implementierung zu testen.

Die Zielsetzung

Die Zielsetzung des **EUR-HUMAN** Projekts ist es Fähigkeiten und Kenntnisse zu stärken und zu entwickeln Wissen und Erfahrungen der EU Mitgliedsstaaten, die Flüchtlinge und Einwanderer aufnehmen, zu erweitern. Letztendlich zielt das Projekt darauf ab die verschiedenen Gesundheitsbedürfnisse vulnerabler Gruppen erfolgreich anzugehen und so zu gewährleisten, dass alle Bevölkerungsgruppen in den Europäischen Ländern gut geschützt sind; dass diese vor spezifischen Risikofaktoren sicher sind und gleichzeitig grenzüberschreitende Gesundheitsrisiken minimiert werden. Diese Initiative schenkt sowohl der frühen Ankunftsperiode als auch der langfristigen Ansiedlung von Flüchtlingen in Europäischen Aufnahmeländern Aufmerksamkeit. Die primäre Zielsetzung des Projektes ist es Interventionen zu identifizieren, zu designen und zu evaluieren, um schlussendlich die primäre Gesundheitsversorgung für Flüchtlinge und Migrant/innen, mit Fokus auf vulnerable Gruppen, zu verbessern.

Projekt

Die wesentliche Zielgruppe des **EUR-HUMAN** (website: http://eur-human.uoc.gr/) sind neu ankommende Flüchtlinge und Migrant/innengruppen, Primärversorgungsfachkräfte, die in die ganzheitlich integrierte Versorgung involviert sind und die in Koordination mit Sozialeinrichtungen und national, regional und lokalen Stakeholdern die Hilfeleistungen für Flüchtlinge und deren Familien anbieten.

Das Design des EUR-HUMAN Projekts basiert auf der Europäischen Gesundheitspräventionspolitik für Gesundheitsfragen von Migrant/innen und Flüchtlingen, die in Europäische Länder kommen. Das Projekt konzentriert sich auf das Definieren, Designen und Evaluieren von Interventionen, die die Entwicklung von ganzheitlichen, auf den Menschen ausgerichteten Interventionen für die primäre Gesundheitsversorgung von Flüchtlinge und Migrant/innen mit besonderem Augenmerk auf vulnerable Gruppen, möglich machen. Es wird die umfassende Erhebungen von Gesundheitsbedürfnissen gefördert, dies geschieht durch die Nutzung der Participatory Leaning and Action (PLA) Forschungsmethode und der Normalisation Process Theory (NPT) um effektive Interventionen in den ausgewählten Implementierungsstandorten zu designen und zu implementieren.

Die angebotenen Leistungen werden folgende Bereiche inkludieren: Screening von Infektionskrankheiten (z.B. Windpocken, Masern), Management von chronischen Krankheiten (Diabetes, Herzerkrankungen, Krebs), Überwachung von Durchimpfungsraten, psychologische Evaluation und Unterstützung, Anwendung von generellen Hygienemaßnahmen, etc. Das EUR-HUMAN Projekt auf einem holistischen Modell von Gesundheit und wird, zusätzlich zum Risikomanagement, geeignete Primärversorgung und soziale Dienstleistungen für Flüchtlinge und Migrant/innen unterstützen.

Derartige Interventionen umfassen unter anderem die Entwicklung von Arbeitsmaterialien und praktischen Leitlinien für die primäre Gesundheitsversorgung. Es ist wichtig darauf hinzuweisen, dass für die Evaluierung von Bedürfnissen von Flüchtlingen die Ankunft am ersten Eintrittspunkt in ein Europäisches Land als Grundlage erachtet wird, es jedoch während jeglicher Weiterreise oder potenzieller Änderung des Aufenthaltsortes der kontinuierlichen Neubeurteilung des emotionalen, psychosozialen und physischen Wohlbefinden bedarf.

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Resultate

Es wird erwartet, dass die Resultate des Projekts und die Pilotimplementierung des **EUR-HUMAN** Models auf andere EU Länder übertragbar sind, insbesondere auf die hauptsächlichen Empfängerländer, durch die die Flüchtlinge nach Europa einreisen. Dies wird durch Dissemination und Wissenstransferaktivitäten und durch die stetige Berücksichtigung des lokalen Kontexts erreicht. Das **EUR-HUMAN** Projekt wird zur Entwicklung und Verbesserung der Leistungsfähigkeit von Personal in Primärversorgungszentren, so wie auch in anderen existierenden Primärversorgungssettings (HausärztInnen) im Hinblick auf die gesundheitliche Versorgung von Flüchtlinge und Migrant/innen in EU Ländern beitragen.

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Célkitűzés

A nemzetközi menekültügyi válság kritikus fejezethez érkezett. Éppen ezért számos európai országban irányelveket és terveket dolgoznak ki, hogy az Európába belépő menekülteket támogatni tudják. A szíriai polgárháború azt eredményezte, hogy a szír lakosság nagy része, körülbelül 7-8 millió ember a szomszédos országokba települt át. Az Európába irányuló menekültáradat a szír bevándorlókon kívül, kiterjed az Afganisztánból, Pakisztánból, Irakból, Iránból, Eritreából, Bangladesből és más nemzetiségű országokból érkező bevándorlókra is. Az Európába áttelepült menekülteknek kihívást jelentenek az egészségügyi problémák, a gazdasági problémák és a faji diszkrimináció kezelése. Több mint egymillió menekült érkezett 2015-ben Görögországba érvényes dokumentumok nélkül, azzal a szándékkal, hogy onnan észak-európai országokba utaznak majd, amelyek szerintük nagyobb biztonságot nyújtanak és ahol majd új életet tudnak kezdeni. Azonban a jelenlegi bevándorlási helyzet, jelentős megterhelést okoz az európai országoknak, amelyek nem voltak megfelelően felkészülve arra, hogy kezelni tudják a beáramló menekültek számának ilyen léptékű növekedését. Az egészségügyi kezelésekhez való hozzáférés hiánya különösen fontos kérdés a sérülékeny csoportok, például a nők, az idősek, a nagyon fiatalok és a gyermekek körében, valamint érinti a korábban is rossz egészségi állapotban lévőket is. A megfelelő egészségügyi felmérést akadályozta a menekültek és a különböző érdekcsoportok közötti elégtelen párbeszéd. A jelenlegi menekültügyi válság szükségessé tette programok megtervezését és a tervezett intézkedések megvalósíthatóságának és elfogadhatóságának tesztelését, mielőtt széles körben alkalmaznák azokat.

Die Zielsetzung

Az **EUR-HUMAN** project célja a készségek és képességek erősítése és fejlesztése. Célul tűzte ki továbbá a menekülteket és a bevándorlókat befogadó EU tagállamok tudásának és tapasztalatának bővítését, végső célja pedig az, hogy sikeresen és hatékony módon kezeljék ezen veszélyeztetett csoportok különböző egészségügyi szükségleteit. Fontos, hogy az ezekben az európai országokban élő populáció összes csoportjának biztosítsák a megfelelő védettséget, valamint megóvják őket a specifikus kockázati tényezőktől és ezzel egyidejűleg csökkentsék a határokon átnyúló egészségügyi kockázatokat. Ez a kezdeményezés kiterjed a menekültek megérkezésének korai szakaszára, valamint az európai befogadó országban való hosszabb távú letelepedésre is vonatkozik. A projekt elsődleges célja az, hogy azonosítsa, megtervezze és felmérje az intézkedések szükségességét, tehát, hogy javítsa a menekültek és bevándorlók egészségügyi alapellátását. Ezen intézkedések középpontjában a veszélyeztetett csoportok állnak.

Projekt

Az **EUR-HUMAN** (honlap: http://eur-human.uoc.gr/) projekt fő célcsoportja az újonnan érkező menekültek és migráns csoportok. Cél, hogy számukra egészségügyi szakemberek által nyújtott integrált egészségügyi alapellátást biztosítsanak, bevonva a holisztikus szemléletű ellátást is. Mindezen szervezetek együttműködve a szociális ellátórendszerrel, valamint a nemzeti, regionális és helyi érdekelt felekkel, közösen tudnak megfelelő segítséget nyújtani a menekültek- és családjaik számára.

Az **EUR-HUMAN** projekt tervezete az európai országokba érkező migránsokra és menekültekre vonatkozó európai egészségügyi megelőzési előírásokra alapul. A projekt középpont-jában az áll, hogy meghatározzák, megtervezzék és értékeljék azokat az intézkedéseket, amelyek lehetővé teszik, hogy fejlesszék az integrált emberközpontú egészségügyi alapellátás biztosítását a menekültek és bevándorlók számára, különös tekintettel a sérülékeny csoportokra. A projekt akképpen mozdítja elő az átfogó egészségügyi igényfelmérést, hogy használja a " Participatory Learning and Action" (PLA) kutatási módszertanát valamint a "Normalizációs Folyamatelmélet"-et (Normalization Process Theory - NPT), hogy hatékony intézkedéseket tervezzen meg és vezessen be a kiválasztott végrehajtási területeken.

Az intézkedések közé tartoznak: a fertőző betegségek szűrése (pl bárányhimlő, kanyaró), a krónikus betegségek kezelése (cukorbetegség, a szívbetegség, rák), a védőoltások meglétének megfigyelése, pszichológiai vizsgálat és támogatás, általános higiéniai intézkedések stb.. A kockázatok kezelésén felül, az **EUR-HUMAN** az egészség és a jólét holisztikus modelljén alapul és támogatja a menekültek és bevándorlók számára nyújtott megfelelő akut, egészségügyi alapellátást és a szociális ellátást.

Ilyen intézkedések közé tartozik, többek között eszközök (tools) és gyakorlati irányelvek (guideline) kifejlesztése az egészségügyi alapellátást nyújtók számára. Fontos megjegyezni, hogy a menekültek szükségleteinek elsődleges meghatározásának az első európai országba történő érkezéskor kell kezdődnie, folyamatosnak kell lennie, mindamellett az érzelmi-, pszichoszociális- és fizikai jólét újraértékelése minden változás és esetleges áthelyezés során vizsgálandó.

Jogi nyilatkozat: *A kiadvány tartalma a szerző véleményét tükrözi, mely kizárólagosan az ő felelőssége; nem hozható összefüggésbe az Európai Bizottság és/vagy CHAFEA — Fogyasztó-, Egészség-, Élelmiszerügyi és Mezőgazdasági Végrehajtó Ügynökség vagy egyéb Európai Uniós szervezet véleményével. Az Európai Bizottság és az Ügynökség nem vállal felelősséget a kiadványban szereplő információk felhasználásáért.*

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Várható Eredmények

Az **EUR-HUMAN** projekt modell eredményei és a pilot-szakasz bevezetése várhatóan alkalmazható lesz az EU-s országokban, különösen a fő fogadó országokban, amelyeken keresztül a menekültek belépnek Európába. Mindezt terjesztéssel és tudásátadással lehet elérni, viszont mindig figyelembe kell venni a helyi viszonyokat.
Az **EUR-HUMAN** projekt jelentősen hozzájárul majd az EU országaiban a közösség-orientált alapellátási központok (Community Oriented Primary Care Centers) illetve a már meglévő alapellátási intézmények csapatának kapacitás- fejlesztéséhez és kiépítéséhez, a menekült- és bevándorló ellátást figyelembe véve.

Konzorcium Tagjai

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APPENDIX 7. DELIVERABLES OF WP2.

D2.1 Report.

Co-funded by the Health Programme of the European Union

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EUR-HUMAN

Report Work package 2

Deliverable 2.1

Communication and liaison with stakeholders and refugees groups

Health needs, views on and experiences with healthcare of refugees and other newly arriving migrants throughout their journey in Europe.

Radboudumc team:

Tessa van Loenen

Maria van den Muijsenbergh

2016/04/26

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Table of Content

List of Contributors 2
Description of WP2 4
Background and general objective of the EUR-HUMAN project 4
Objective of WP2 4
Overview of work in WP2 5
Milestones 6
Deliverable 2.1 6
Timeline 6
Methods 7
Design 7
Methods: Participatory, Learning & Action (PLA) 7
Study setting 8
Recruitment and Sampling 9
Data generation and analysis 10
Ethical approval 11
Results 12
Settings 12
Participants 19
Main health problems 22
Experiences, needs and barriers with health care 25
Discussion and recommendations for further Work packages 38
References 46
List of abbreviations 48
Appendix 49
A1. PLA Training Material 50
A2. Recruitment and fieldwork guide 62
A3. Participation Letter (English) 64
A4. Informed consent (English) 64
A5. Approval Letter of the Dutch Ethical board 66
A6. Topic List 67
A7. Fieldwork evaluation template 70

Description of WP2

Background and general objective of the EUR-HUMAN project

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

The 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 the EUR-HUMAN project is to develop guidance documents/recommendations and to pilot guidance, tools and training for the provision of integrated comprehensive person-centred primary care for refugees at the intervention sites in hotspots, transit centres and longer stay first reception centres.

Objective of WP2

Given the above described aim of the project, Work Package 2 (WP2) seeks to facilitate the sense of coherence and community engagement of all involved (migrants as well as volunteers, primary health care workers and social workers) and to assess with a democratic dialogue the views, wishes, beliefs and attitudes of refugees and other newly arriving migrants.

Interventions, tools and information material can only be appropriate if the needs of the groups at stake, as well as those of the other stakeholders (volunteers, health care workers) are known. In the past some studies have been performed on the health needs of refugees. These studies were performed among asylum seekers who had already reached their country of destination, or were staying in longer stay refugee centres, often outside of Europe (summarized in the systematic review of Hadgkiss (2014) and the WHO health evidence network synthesis report (WHO 2014). However, there is a lack of information on the health needs of refugees and other migrants "on – the – move", at the hotspots, transit centres and during their journey through Europe. In former years there has been substantial groups of refugees passing through Europe (e.g. the people from former Yugoslavia in the 90-ies), but neither at the present scale nor circumstances. The recent waves of migration into Europe presents new health challenges, alongside larger humanitarian issues. In the past, EU authorities have discussed the risk of communicable diseases in refugee centres in member states and the implications for national healthcare, but the scale of movements of people since the summer of 2015 has created unprecedented needs (Jonson 2015). Besides, the largest present group of migrants entering Europe are Syrian refugees, coming from a country with a high standard healthcare system (before the war) and in that way differs from former refugee groups from the Middle-East or Africa. (See figure 1)

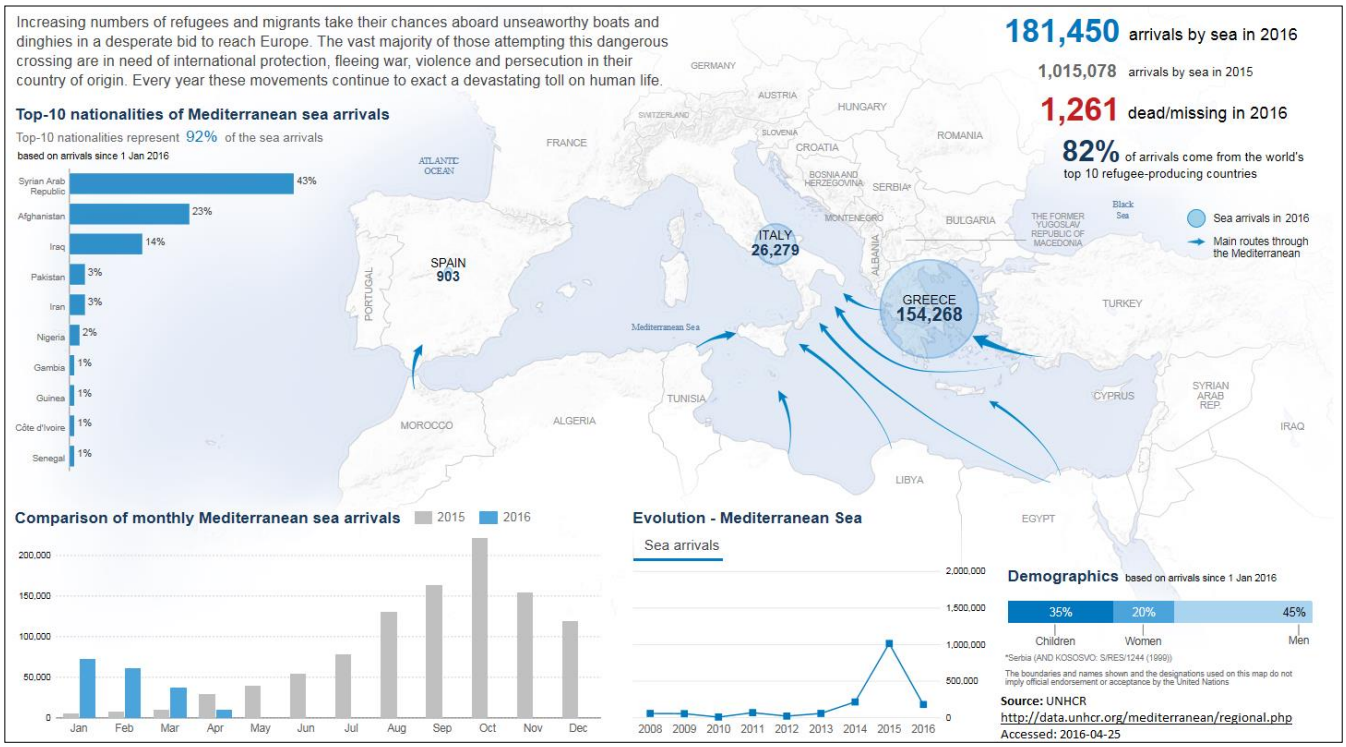


Figure 1. UNHCR: Refugees/Migrants Emergency Response – Mediterranean first months 2016 - 2015

For those reasons, we needed information on the current group of migrants, entering Europe in Greece or Italy, travelling from there (often at high speed) through Croatia, Slovenia, Hungary to Austria (the so called "Western Balkan route") or other countries of final destination in Northern Europe like the Netherlands. Since we wanted get insight into the whole journey, we added fieldwork in the Netherlands – which was not mentioned in the description of work (DOW), but the teams of ARQ and Radboudumc were able to add this work within their budget.

Therefore, the overall aim in WP2 is to gain insight in the health needs and social problems, as well as the experiences, expectations and barriers regarding accessing primary health care and social services, of refugees and other newly arriving migrants ***throughout their journey through Europe - from the hotspots via the transit centres to the first longer stay reception centres***.

The questions we wanted to be answered by our fieldwork were: what are the main health and social problems, as well as the experiences, expectations, wishes and barriers regarding accessing (primary) health care and social services of refugees and other newly arriving migrants throughout their journey through Europe - from the hotspots via the transit centres to the first longer – stay reception centres?

Overview of work in WP2

The Description of Work (p.67) mentions the following tasks in WP2:

Task 2.1: Participatory Learning and Action (PLA) was chosen as the appropriate research methodology, as it uses specific techniques that enable all people to be meaningfully engaged, despite language or educational differences. Local staff members from all intervention sites were trained in the application and ground rules of the PLA method, and were supported in their fieldwork by the Radboudumc team. Members of the local teams of all involved sites were present and very actively involved at this two day training which was attended by in total 16 participants.

Task 2.2: At the intervention sites, by purposive sampling, migrants of different age, gender, educational and geographical backgrounds were recruited to participate in the local stakeholder group. For this step, local research teams had to be sensitive to regulations and governance of the refugee centre, and arrange the necessary permissions to enter the centre and recruit refugees. Local health professionals working in the centre were involved to facilitate the recruitment.
The Radboudumc team developed a detailed instruction for the recruitment, and guidance for the fieldwork (see Appendix A2).

Task 2.3: PLA moderated sessions took place at all involved sites to generate data on views, experiences and expectations of the migrants as well as (in one instance) of other stakeholders regarding health and social needs, access and use of healthcare and social services. The Radboudumc team provided support during the fieldwork and a coding framework for the analysis of the local data.
The *Local teams* coded and analysed the local data resulting in a local report (see for coding and analysis in more detail the methodology section)

Task 2.4: Based on the local reports, the WP leader drafted the present report on the views, experiences and expectations regarding health and social needs and access and use of services of the refugees and other newly arriving migrants as well as of other stakeholders.

Milestones

Milestone 2.1 Local staff members were trained in PLA on February 6th – 7th, 2016.
Milestone 2.2 PLA moderated meetings between local staff and refugees took place between February 10th 2016 and March 30th 2016.
Local reports were all sent to the WP leader by March 30th, 2016.
Milestone 2.3 The synthesis report of aggregated data of all local sites was drafted in April 2016, circulated for comments between all partners and finalised on 26th of April 2016.

Deliverable 2.1

Report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services.

Timeline

6-7 February 2016	Task 2.1 Training in PLA methods **(milestone 2.1)**	Radboudumc, UoC, UoD, UL, FFZG, MUW, AUSLTC, ARQ
1 January – 29 February 2016	Task 2.2 Preparation of the PLA dialogues with migrants	Radboudumc, UoL
15 February- 31 March 2016	Task 2.3 PLA dialogues with refugees at local sites **(milestone 2.2)**	Radboudumc, UoC, UoD, UL, FFZG, MUW, AUSLTC, ARQ
21 March – 31 March 2016	Preliminary summary report of deliverable 2.1 for WP4	Radboudumc
30. April 2016	Final summary report **(deliverable 2.1, milestone 2.3)**	Radboudumc

Methods

Design

We conducted a qualitative, comparative case study in hotspots, transit centres, intermediate - and longer- stay first reception centres in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and the Netherlands) using a Participatory Learning and Action (PLA) research methodology. The fieldwork ran from February 2016 until the end of March 2016.

Methods: Participatory, Learning & Action (PLA)

The PLA research methodology, based on the work of Robert Chambers (Chambers 1987), is a practical approach that enables diverse groups and individuals in a cooperative manner to share, enhance and analyse their knowledge, encouraging them to focus on issues that affect them (O'Reilly 2010).

A PLA 'mode of engagement' promotes reciprocity, mutual respect, co-operation and dialogue in research encounters within and across diverse stakeholder groups. PLA techniques are inclusive, user-friendly and democratic, generating and combining visual and verbal data. This encourages literate and non-literate stakeholders alike to participate. They are seen as 'local experts' who are uniquely knowledgeable about their own lives and conditions (O'Reilly 2016).

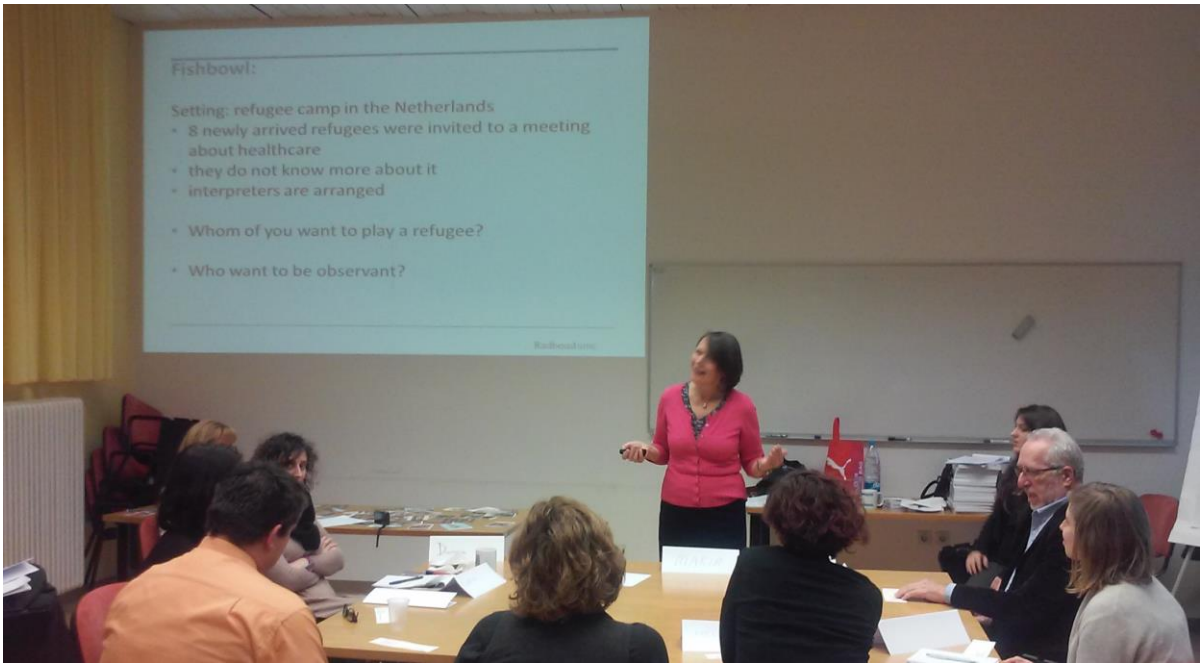
In our fieldwork we used the techniques of the flexible brainstorm and individual interview.

Several key factors may constitute insurmountable barriers to access and meaningful engagement with hard to-reach migrants (O'Reilly 2016). In this study, we had to take account of the following:

- The involved staff members of the local EUR -HUMAN teams' researchers had no familiarity with the languages or cultures of the migrant research participants - interpreters had to be found and used.
- Migrants (particularly at the hotspot and transit centres) were reluctant to participate in the PLA moderated meetings, mainly because of time pressure and other more urgent priorities.
- Migrants and especially refugees may feel uncomfortable in research, and distrustful to the intentions of researchers; our mode of engagement needed to reflect a very open and power-sharing approach from the outset (O'Reilly 2016).
- Among migrants, literacy abilities range from high to low; low literacy must be addressed sensitively.

PLA Training

Because of the above described importance of the "PLA- mode of engagement" and the need for mastery of PLA techniques, 16 staff members of local teams involved in the fieldwork were trained during a two-day course. The training took place on the 6th and 7th of February 2016 at the department of primary care of the University of Ljubljana. The training was specifically designed for this project and delivered by the staff members of Radboudumc, the work package leaders of this WP2, who are experienced in PLA research. For a detailed description of the training, see appendix A1.



PLA training in Ljubljana

Study setting

The fieldwork took place in 7 countries: Greece, Slovenia, Croatia, Italy, Hungary, Austria and the Netherlands. The local sites were chosen because they all reflect a part of the journey refugees make through Europe; they differ regarding how long and where newly arriving migrants stay (table 1).

1. The “hotspot centre” in Lesbos, Greece, where migrants enter Europe – this was before the so called "Turkey deal” came into effect. In the months the fieldwork was carried out, 60% of all migrants arriving in Greece entered via Lesbos.
2. The transit centres in countries where migrants want to pass as soon as possible on their way to final destinations - in our case Croatia and Slovenia.
3. Intermediate -stay first reception centre in Hungary, where after the closing of the borders by Hungary end of 2015, refugees are staying for some months.
4. “Long-term” refugee centre where refugees stay for a long period, to apply for asylum or because they cannot travel further, in our study Italy, Austria and the Netherlands.

Table 1. Overview of the sites

Country	Site (location)	Type
Greece	Moria, Lesvos	Hotspot
Slovenia	Šentilj	Transit
Croatia	Slavonski Brod	Transit
Hungary	Bicske	Intermediate
Italy	Villa Pepi and Villa Immacolata	Long-term
Austria	Vienna	Long-term
The Netherlands	Heumensoord (Nijmegen)	Long-term

Recruitment and Sampling

Our study population consisted of a) newly arriving refugees and other migrants, who were no longer than half a year at the implementation site and did not have permanent staying permits and b) healthcare workers and volunteers involved in the care for these refugees at the implementation sites. For convenience, all migrants or asylum seekers involved in the fieldwork will be referred to as refugees in the present report, although it is possible not all of them eventually will receive a legal refugee status.

PLA sessions with refugees

The participants were recruited at the local implementation sites, based on purposive sampling using a combination of network and snowball sampling strategies. The number of sessions and the number of participants included in the fieldwork depends on the type of centre at the local sites and were highly dependent of the time available for a certain group of migrants to stay, and to participate.

- At the hotspot/transit/intermediate sites it was only feasible to hold **1 session per group**, since the refugees are only there for a few hours. At these sites, more different groups were recruited.
- At sites where refugees stay longer it was sometimes feasible to hold **2-3 sessions per group**.

Per group approximately 5 persons took place. The groups were usually either male or female. In a few cases, mixed groups were used.

Because of these practical limitations, we could not achieve optimal diversity within participants at *every local site*, but instead sought diversity across sites. In this we succeeded: the participants were of different ages (≥18 years), educational attainment, countries of origin, with and without chronic health conditions, with good, bad or without any experiences with medical care in the centre. In a few instances minors were present during the sessions because they accompanied their parents.

PLA sessions with health care workers

In Croatia, the PLA sessions were conducted with healthcare workers. Participants worked in NGO's or were medical staff employed by the ministry of health. Per group approximately 5 persons took place. The groups were mixed female/male and with different ages.

Informed consent

All participants received a letter explaining the purpose and content of the research. The letter was available in English, Arab and Farsi (Appendix A3).

Every participant of the PLA sessions filled in an informed consent form (Appendix A4). The informed consent was user-friendly and specific for the refugee target group. Short sentences and clear language was used. The informed consent forms were available in English, Arab and Farsi. Since refugees are known to be reticence to sign any form, a short version of the consent form was designed. This short consent form has as little references to legal issues as possible. During the PLA meetings, considerable time was taken to explain, orally and personally, the consent procedure, the scope of the study and the confidentiality.

Data generation and analysis

Data were generated using PLA-style flexible brainstorm discussions and PLA-style interviews. This means that the encounter involved a PLA mode of engagement and the use of PLA techniques to encourage interactive data generation (O'Reilly 2016). Interviews were only used when there was a single participant involved/available.

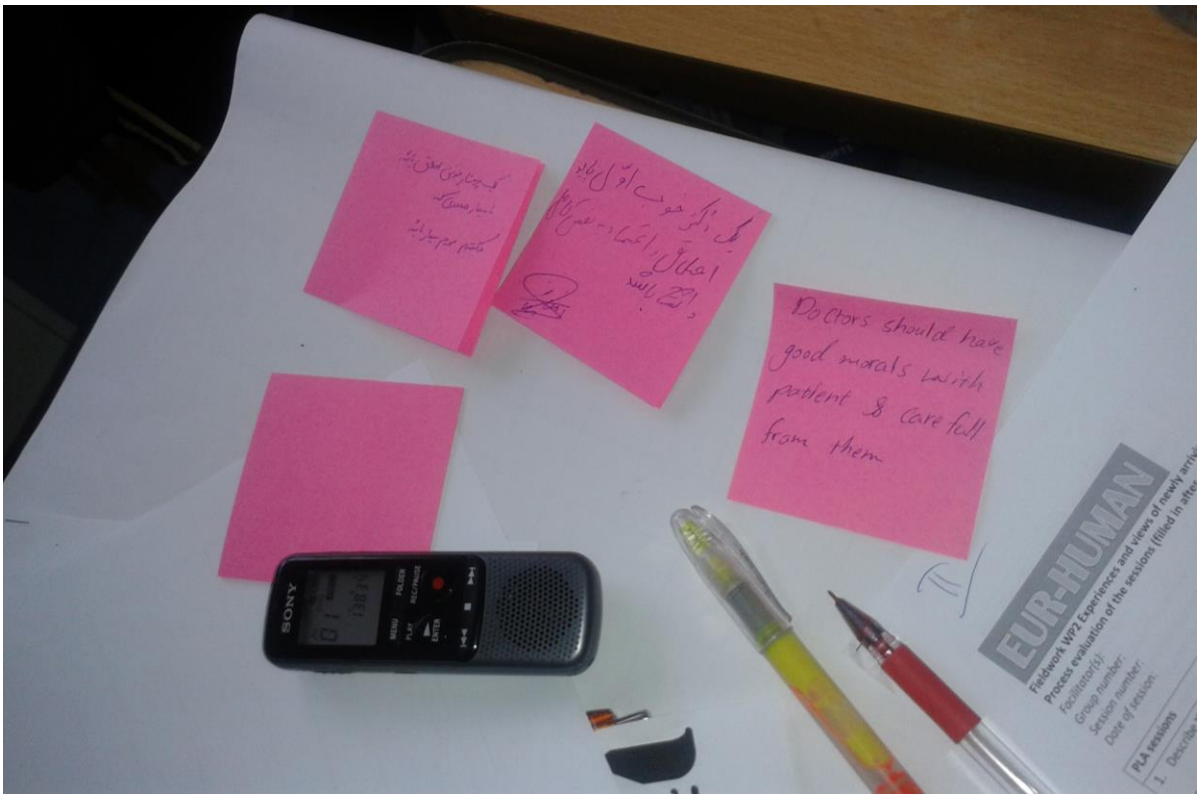
Data were generated on PLA charts that ensured that verbal and visual forms of data were recorded in a consistent manner across all stakeholder groups. All PLA charts were computerised after each data generation session in order to preserve the data. Verbal data were recorded on Post-It notes in point form or short phrases rather than in full verbatim quotes.

As by the nature of the flexible brainstorm and in-depth interviews, topics were brought up by the participants. In addition, to ensure that all relevant aspects of health needs were covered, facilitators could use the topic list that was developed by Radboudumc based on literature and the input of all EUR-HUMAN members (Appendix A6).

Most of the sessions were audio taped and transcribed. In a few sessions, refugees refused to participate if the sessions were audio taped. In those instances, extensive field notes were taken and worked up after the sessions.

All sites analysed their data themselves based on a fieldwork evaluation form and coding framework provided by Radboudumc (Appendix A7). At all sites, several researchers were involved who co-coded and independently analysed at least part of the data.

Radboudumc then completed thematic analysis of all local reports.



Fieldwork in Hungary

Ethical approval

Prior to the start of the fieldwork, all countries acquired ethical approval in accordance with the legal requirements in their country (table 2).

Table 2. Overview of ethical approval

Country	Approval	Ethic committee	Date/Filenumber
Greece	Approval	2nd health region of Piraeus and Aegean. Approval from the governor of 2nd health region	Protocol number: 7496, date 22-02-2016
Italy	No approval necessary	-	-
Slovenia	Approval	National Ethic Committee	24/3/2016
Croatia	Approval	University of Zagreb, Faculty of Humanities and social sciences, Department of Psychology	01March2016
Hungary	No approval necessary	-	-
Austria	Approval	Ethics committee of the Medical University of Vienna	Ethical approval EK Nr: 2181/2015
The Netherlands	No approval necessary	Research ethics committee of the Radboud University Nijmegen Medical Centre	**2016-2306**

Results

Settings

Greece

Site of the fieldwork

The fieldwork in Greece took place in the hotspot of Moria. The hotspot 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. The police, First reception centre (KEPY), Ministry of Interior/Migration, Frontex and the ministry of Defence, are responsible for the management of the hotspot of Moria. There are several national and international NGOs which provide humanitarian support such as: Praxis, Metadrasi, IOM, Médecins Sans Frontières/Doctors Without Borders (MSF), Médecins du Monde (MDM), Danish Refugees Council and Better Days For Moria. The UNHCR is responsible for coordinating all NGOs activities.

Organisation of and entitlements to healthcare for refugees at the hotspot of Moria

There are several facilities on the site. Refugees with need of medical assistance are escorted usually to MDM facilities, which are next to the registration areas. The health care professionals consist of a multidisciplinary team (general practitioners, nurses, psychologists, social worker). The Greek healthcare system provides services to all the documented immigrants/ refugees and the asylum seekers. For all people with emergency needs free services are provided by the public health system regardless their status. Many times refugees/immigrants/asylum seekers are referred from the NGOs doctors to the hospital on the islands (i.e from Moria hotspot to the Mytilene hospital) or to other more specialized structures in the mainland. Due to the increasing number of population in Greece, the Greek parliament is expected to vote a law in May which provides health services to all these people. Health care providers usually come from different parts of Greece to take turns in providing support. The majority of the NGOs at the hotspots hand out hygienic supplies, clothes and food for all refugees/immigrants. The area for unaccompanied minors, which is managed by First Reception, hosts and provides food and some activities to children for maximum 15 days. Afterwards these children go to another public or private institution in Greece until the age of 18, then according to the law they will have the opportunity to apply for asylum or to travel to other European countries.

Between 500-600 persons were registered daily in the hotspot of Moria during the first months of 2016. The Syrian refugees left the hotspot almost immediately further to Western Europe. The rest of them stayed between 3 days to 1 week. The island of Lesbos, accepted around 60% (406,000) of all refugees and immigrants arriving in Greece in 2015.

A total of five PLA sessions were held with a total of 20 people. Four sessions included Afghan refugees and one session was done with Syrian refugees. Interpreters were used to overcome the language barrier (Dari, Arabic, Pashto).

Fieldwork in Moira, Greece

Croatia

Organisation of and entitlements to healthcare for refugees at the transit centres in Croatia

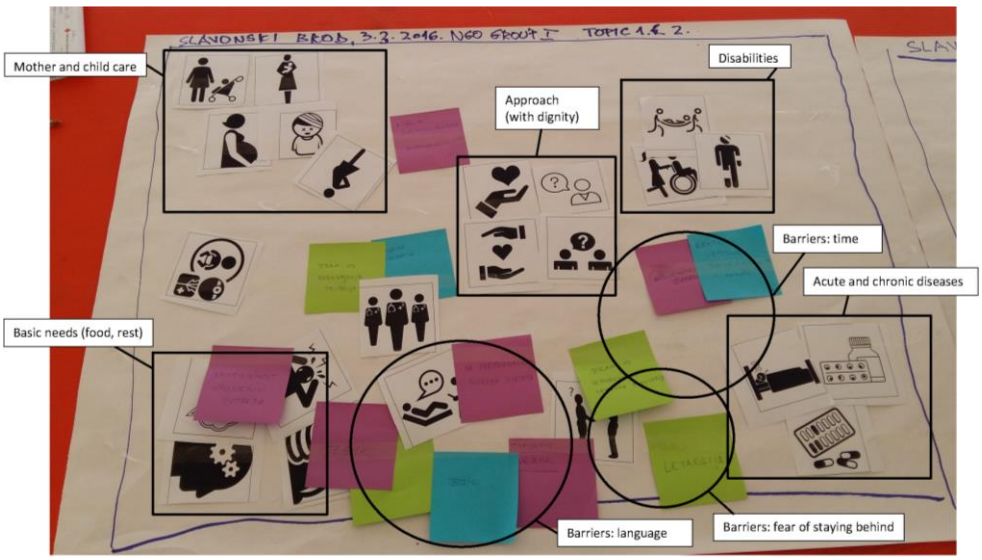
Governmental, international and civil society organizations offered their support to all arriving refugees and migrants during transit in Croatia. In the only transit centre in Croatia since 03 November 2015 (transit centre Slavonski Brod, also the site of the fieldwork), refugees and migrants were entitled to humanitarian assistance (hygienic supplies, clothes and food), as well as medical care. Refugees and migrants in need of medical assistance had access to the stationary ambulance working 24/7. The medical staff consisted of a team of nurses, who were located at the sight daily, and a medical doctor, who rotated every couple of days and came from different parts of Croatia. In addition, refugees and migrants had priority admission right to local hospital, in case of more serious medical conditions. In the Mother and baby centre, mothers with small children had access to paediatric care for children (offered by Magna) and advice regarding child care and breastfeeding. Several tents for longer-term accommodation were available.

Site of the fieldwork

The fieldwork in Croatia took place in the Winter Reception and Transit Centre near Slavonski Brod, a town in eastern part of Croatia. Refugees arrived to the centre by train from Šid, Serbia, and were transported to Dobova, Slovenia. The centre was managed by the operating headquarters of the Republic of Croatia Ministry of the Interior. Other governmental organizations were involved through the Ministry of Health and the Ministry of Social Policies and Youth. There were several national and international NGOs present at the site: ADRA (Slovakia & Croatia), Caritas, IOM, Jesuit refugee service, Magna, Samaritans, Save the Children, and Croatian Red Cross, who were coordinating NGO activities. Overall, there were about 200 volunteers and staff at the site. Up to 4 trains arrived daily, at 07,30 a.m., 15,00 p.m., 19,30 p.m. and 03,00 a.m., and the maximum number of refugees aboard one train was about 900. The map of the transit centre is shown below.

Slavonski Brod. Legend: 1 – the train station; 2 – registration; 3 – ambulance; 4 -distribution tent; 4 – Mother and baby centre; 5 – food distribution; long-term accommodation shaded

It was not possible to include refugees and migrants in the PLA exercise due to very quick transit of refugees through the centre where they remain. Instead, PLA sessions were held with experienced care providers who were asked about the topics related to refugee health. All stakeholder organisations at the transit centre were invited to participate including Croatian Red Cross, MAGNA, ADRA, IOM, UNHCR, UNICEF, Save the Children, Caritas and medical staff. A total of 5 sessions were held; 5 different groups had 1 PLA session. Two groups were with different NGO workers, 1 group with medical staff, 1 with Croatian Red Cross workers and 1 with interpreters.



Picture 1. Fieldwork chart from NGO group, Croatia

Slovenia

Organisation of and entitlements to healthcare for refugees at the transit centres

Health care in transit centres in Slovenia is organized by the nearest primary health centres. Zdravstveni dom Maribor - primary health centre Maribor – organizes health care at Šentilj centre on the daily basis . Zdravstveni dom Brežice (primary health centre Brežice) organizes health care at Dobova centre and Zdravstveni dom Logatec Health centre Logatec provides health care of refugees in centre for people, waiting for asylum in Logatec.

Through the Ministry of Health, commodity reserves were activated to provide medication, sanitary supplies, and medical devices. Furthermore, mobile trauma surgical facilities were put into use. Local health care workers cooperate with the Slovenian Red Cross, Caritas Slovenia, Civil Protection Services, Administration for Civil Protection and Disaster Relief, and foreign organisations and offices.

Site of the fieldwork

Fieldwork was carried out in a transit centre at the border crossing Šentilj. At approximately 12am every day in the first months of 2016 about 800 migrants arrived by train. The Austrian border control authorities let 200 refugees across the border every hour. 200 migrants were transported immediately to the border with Austria, while the remaining 600 migrants were settled in large, heated tents, where they got food, drinks and clothes. The last refugee left Slovenian border at 16 o'clock. Besides a health clinic, which was located away from the tents of migrants, there was a larger tent of Czech military doctors who were trained in surgical procedures.

The refugees were in the centre only for a short period of time (a few hours). Therefore the researchers carried out sessions/interviews with individual refugees or with small groups (max 3). In total 14 sessions/interviews were carried out with 19 refugees. An interpreter was present to overcome the language barrier.

Fieldwork site in Šentilj, Slovenia

Hungary

Organisation of and entitlements to healthcare for refugees in Hungary

The *official* procedure starts at the Hungarian border, supposing the crossing was not *illegal.* At this point, some of the available temporary centre will be assigned for the asylum-seeker. At the moment there are three, of which two in the Western part of Hungary (*Bicske, Vámosszabadi*) and one in South Hungary (*Kiskunhalas*). Refugees, who are registered in the centres, get a card certifying the legal stay in Hungary and a few days later a health-card will be issued. According to recent Hungarian regulations, asylum seekers could achieve two stages in the official process; ***protected*** (allowed to stay for 3 years in Hungary) and ***recognized refugee*** (without limitation). In the official procedure they have to prove the previous pursuit or life-threatening circumstances. Usually this process takes a few months. However, many refugees do not wait, but leave the centres and move forward towards Western Europe, often without informing authorities. Those who become recognized as a refugee, get some financial help to start their lives outside the centre.

Site of the fieldwork

The fieldwork was done in the temporary transit centre at *Bicske*, located 30 km from Budapest. The centre has 903 inhabitants on the capacity of 900 beds. Refugees were transported with buses, provided by the government, from the southern (Serbian) border of Hungary. Usually 2-3 busses arrive daily. The centre follows an "*open-policy*"; refugees can leave when they want. There is a high turnover of inhabitants. People, who are leaving, usually go to Western Europe, mainly towards Austria. There are also people in the centre, who are transported (deported) back from other countries (Switzerland, Sweden etc.). There are families (woman and children) whose men are already working in Hungary. The mean age of the populations staying actually in the centre is low, only a few people were seen above 50 years of age.

The available accommodations in the centre are rooms for 3-4 persons, with a communal kitchen and mainly communal lavatories. Families usually can stay together in one room. Persons who were registered in the centre get some *allowance*; it is cc. 25 EUR/week/persons, a little bit higher for children. In the nearby supermarkets (TESCO, LIDL) every required items could be purchased. There are 3 main *meals* served in the centre. A free *WiFi* is also provided in the centre. It is the most common way of communication between them and with the outside world. There are organized Hungarian language courses for inhabitants, for adults and children as well.

In total 6 sessions were held. Interpreters in Arabic and Farsi were available for translating during the sessions.

Fieldwork site Hungary

Italy

Organisation of and entitlements to healthcare for refugees in Italy

In Italy, there is a legislation allowing the access to healthcare for all, differentially regulated among the diverse legal statuses. All migrants can access the Italian healthcare, through the STP code (Straniero Temporaneamente Presente), which guarantees the access to healthcare for the period preceding the asylum request. After the application, they are registered in the national health system, and they are assigned to a general practitioner (GP).

Site of the fieldwork

The fieldwork was carried out in "Villa Pepi" and "Villa Immacolata". These are facilities in Tuscany where refugees and migrants are located after their arrival. In Villa Pepi there are about 135 people and in Villa Immacolata there are just 4 people. They are managed by Caritas Firenze, like many other facilities of this type in the area. Refugees and migrants stay in these facilities for long periods, between 12 and 18 months, waiting for the documents or the granting of international protection. In the meantime, do some activities such as Italian language courses and job orientation laboratories.
A total of four sessions were held: two different groups (one male and one female) had 2 sessions. Interpreters were used to overcome the language barrier (English, Italian, Urdu).

Austria

Organisation of and entitlements to healthcare for refugees in Austria

In Austria, as soon as it is clear that a refugee is permitted to the asylum procedure, he or she is insured in the common health insurance system and is entitled to receive health care exactly like Austrian citizens. The specific administrative procedures related to health insurance for refugees differ in each of the 9 federal states of Austria. Furthermore, an asylum seeker in Austria receives general basic supplies and a small allowance depending on the individual housing situation. The inclusion in the conventional Austrian health insurance system means that asylum seekers are strictly speaking able to consult any doctor and hospital with the same limitations an Austrian would face in the Austrian insurance system (e.g. regulations concerning cost coverage of drugs, health supplies, and procedures, and waiting time for procedures).

Site of the fieldwork

The centres were the fieldwork took place were in different districts of Vienna and housed 150 to 250 refugees, both single people and families. Either the city of Vienna or private individuals or companies own the buildings and NGOs manage them. People need to check in and check out of the houses in order not to lose the basic provisions. If they stay away more than three nights they lose their place in the house. The refugees stay in the houses until they are granted asylum. After that, they receive a minimal income and can stay anywhere. If food is provided in the house, refugees get an allowance of 40€ per month. If the refugees are responsible for their own meals, the allowance is higher.

In total 6 sessions were held. There was one male and one female group who had three sessions. All participants spoke English.

Fieldwork chart from Austria

The Netherlands

Organisation of and entitlements to healthcare for refugees in first arrival centres in the Netherlands

Migrants who want to apply for asylum have to await the result of their procedure in special asylum seekers centres. In those centres they receive lodging and food, a small weekly allowance as well as a medical insurance. This insurance covers all medical costs that are also covered by the basic health insurance of all Dutch inhabitants. At all asylum seekers centres general practitioners and primary care nurses provide primary care; in the Netherlands general practitioners act as gatekeeper to specialist medical services.

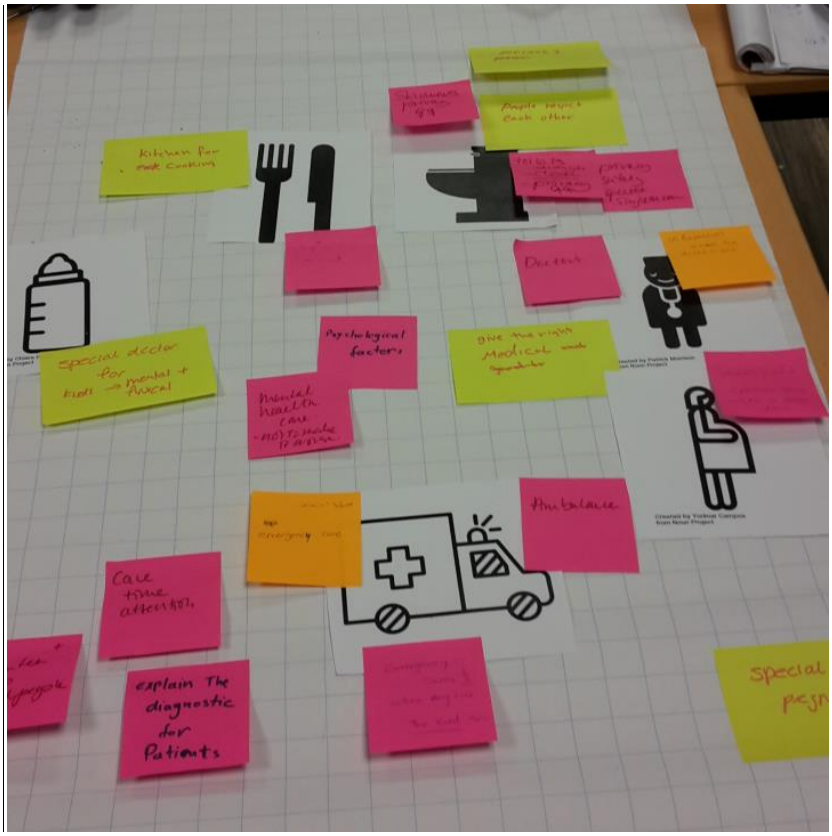
In 2015, the influx of asylum seekers in the Netherlands was larger than expected, and there was not enough room for them in the asylum seekers centres. Therefore, several temporary first reception centres were opened where the asylum seekers had to wait before they could enter the official asylum seekers procedure. In those emergency centres, the migrants were entitled to receive the same medical care as asylum seekers, covered by the same health insurance. However, they did not receive the weekly financial allowance.

One of those temporary first reception centres is Heumensoord, in Nijmegen. Whenever the refugees in Heumensoord need to see a doctor, they have to go to the doctor's post between 09.00 and 10.00 to get an appointment. First there will be an appointment with a nurse, and if necessary with a doctor. When there's need of a doctor after 10.00h, they have to call the "GCA praktijklijn", which is a countrywide phone number for refugees living in asylum seekers centres. A trained nurse or doctor on the phone decides whether and when an appointment is necessary.

Site of the fieldwork

All participants of the fieldwork in the Netherlands were staying at a temporary first – reception centre Heumensoord; with 3000 refugees living there awaiting their asylum procedures. Approximately 100 people per tent, divided in small "rooms" shared with 8 other refugees. Most of the refugees in this centre are still awaiting the start of their procedure, which takes a couple of months. As of may 2016 the centre will close, and refugees will be moved on to asylum centres elsewhere in the Netherlands.

In total 3 sessions were held. Two of them were located at the Radboud University medical centre, and the third was held at Heumensoord. All refugees were from Syria and spoke English. When things were unclear the refugees discussed in Arabic and one of the refugees functioned as a translator. As one participant did not feel comfortable about being audio-taped, extensive field notes were taken instead of making an audiotape.



Picture 2. Fieldwork chart from Heumensoord, the Netherlands

Participants

Figure 2 provides an overview of the fieldwork, the amount of sessions and participants.

A total of 98 refugees participated in a total of 43 sessions. Variation in gender, age, country of origin and educational attainment was reached throughout sites. Table 4 provides a summary of the characteristics of the participants. Two third of the participants were male or between 18 and 30 years old. 40% of the participants were refugees from Syria. The second largest group were Afghans (31%).

Table 4. Characteristics of refugees

Refugees		Total (98)
Gender	Male	65
	Female	33
Age	18-30	66
	31-40	21
	41-50	6
	51-60	3
	60+	2
Country of origin	Syria	39
	Afghanistan	30
	Iraq	12
	Pakistan	6
	Nigeria	4
	Somalia	2
	Gambia	1
	Ghana	1
	Iran	2
	Egypt	1

In addition to the sessions with refugees, in Croatia the PLA sessions were held with health care workers or volunteers in the transit centres. They had different roles in the centres: psychosocial support or counsellor (7), interpreters (5), cultural mediator, nurses (3), emergency unit worker, mobility tracking assistant, administrator, protection associate, organiser, coordinator for urgent interventions, infant and young child feeding consultant, assistant project field manager and a volunteer-distribution of clothing. Although not all of them are providing health care, for convenience they are referred to as health care workers in this report.

Most of the participants have worked 3-4 months (*N* = 11) and 5-6 months (*N* = 11) in transit centres (Opatovac and Slavonski Brod). Other participants had worked for 1-2 months (*N* = 2) or periodically (*N* = 1) in Croatian transit centres (see table 5).

Table 5. Characteristics of health care workers.

Health care workers		Total (25)
Gender	Male	9
	Female	16
Age	18-30	9
	31-40	11
	41-50	4
	51-60	1
Length of stay	1-2 months	2
	3-4 months	11
	5-6 months:	11
	periodically:	1

Figure 2. Overview of the fieldwork

	# of groups	# of sessions per group	Total # of sessions	Total amount of participants	Target groups	Country of origin	Setting	Language barrier	PLA method
Greece	5	1	5	20 (+5 minors)	Refugees	Syria, Afghanistan	Hotspot	Interpreter	Flexible brainstorm
Slovenia	14	1	14	19 (+ 3 minors)	Refugees	Syria, Iraq	Transit	Interpreter	Flexible brainstorm, individually or in pairs
Croatia	5	1	5	25	Health care workers	-	Transit	Interpreter	Flexible brainstorm
Hungary	6	1	6	32	Refugees	Syria, Afghanistan, Iraq, Iran, Pakistan, Egypt	Intermediate stay	Interpreter	Flexible brainstorm, fishbowl, direct ranking
Italy	2	2	4	11	Refugees	Pakistan, Gambia, Nigeria, Ghana, Somalia	Long-term	Interpreter	Flexible brainstorm
Austria	2	3	6	8	Refugees	Afghanistan, Iraq, Syria, Iran, Somalia	Long-term	English speaking participants	Flexible brainstorm
The Netherlands	3	1	3	8	Refugees	Syria	Long-term	English speaking participants	Interview Flexible brainstorm

Main health problems

This section discusses the main health care problems refugees face during their journey or during their stay in the centre. The results reflect the experiences of the participants themselves, their families, other refugees or health care workers.

Most often mentioned health problems were disabilities or injuries, mental health problems, pregnancy related issues, dental problems and chronic conditions.

Disabilities and injuries

The health care workers in Croatia mentioned that there are large numbers of people with physical disabilities, for whom the journey is especially difficult. At other fieldwork sites this feature was not specifically mentioned by the refugees. In general, the involved refugee participants rather spoke about their own problems than about health problems of other refugees.

> *"There are a lot of people with mobility impairments. Whether it is due to different amputations or physical disability, whether it is an older person who has difficulties moving through centre due to long transit."* **(Female, 30, psychosocial support, 3.5 months in the centre, transit, Croatia)**

These physical disabilities and injuries are often weapon or war related, caused by for instance landmines, suicide attacks or mob attacks. Other injuries are often a result from the journey such as burns, frostbites, broken bones, sprained ankles, pain in back and legs due to long walks, blisters, hypothermia and poor hygiene.

> *"Burns occur most often in their journey because they fall asleep by the fire, and frostbites are due to inadequate clothing, footwear and housing*."

And

> *"Blisters from long walking are very often, and in very poor condition; often the whole foot is affected*." **(Female, 30, psychosocial support, 3.5 months in the centre, transit, Croatia)**

> *"broken bones, wounds, that sort of injuries.."* **(Male, 50, Syria, long-term, NL)**

Mental health problems

At all implementation sites mental health problems were mentioned, although the participants told us that for many refugees it is not common to talk about mental health problems. At all sites refugees mentioned distress related to shocking events before or during their journey, depression, insomnia, fatigue, anxiety and uncertainty.

> *"I was so afraid during all this (the journey). I'm still very upset and sad. Even now when something happens, I lose my patience and I feel I have a sore throat. There are moments I lose my voice. I cannot talk and I hardly breathe."* **(Female, 33, Afghanistan, Hotspot, Greece)**

> *"I forget things, and I can't sleep."* **(Male, 21, Afghanistan, Transit, Hungary)**
> *"My life is stressful in the camp, I can't sleep well, I need some sleeping pill. The doctor give me pills."* **(Male, 35, Afghanistan, Transit, Hungary)**

> *"You are watching green window and I'm talking about the bad, a very dark window. I don't know the culture of this country. I don't know the language. Maybe I don't know what I'll get or what they give me. I miss my family and children and all of them. And*

my job and everything. Then I'm alone.[...] I'm thinking about another way." **(Female, 29, Somalia; Long-term, Austria)**

"Some people suffer from depression, or other kind of severe stress episodes. Persistent headache was quite common among migrants, even after a drug treatment." **(Male, 18-30, Pakistan Long-term, Italy)**

In Austria, participants repeatedly mentioned cases of suicide. There were both women and men in the centres who committed or attempted to commit suicide. One of the male participants even talked about attempting or planning his suicide. Sometimes the participants witnessed these attempts:

"Actually I saw it. He is one of my friends. I saw him just cutting his hand. And I told him what are you doing he said no I feel angry. And I said you feel angry why do you do that and I took the knife from his hand. And I started shouting on him: Just give it to me. And he refused to give it to me. I told him I am like your big brother, give it to me and he gave it to me and his hand was just from blood. And actually I found the other friend doing the same thing. (…) Just cutting his hand with the knife and I told him: Why do you do that. And he told I just feel stressed I am thinking. You thinking why do you do that to your body? And there is someone that has just tried to commit suicide." **(Male, 28, Afghanistan, Long-term, Austria)**

In Croatia, the health care workers saw a lot of disoriented people and people who had difficulties with their parenting capacity.

"*The biggest problems start with fatigue, and related to this fatigue is stress. When I look at the people, it seems to me that they do not even know where they are. They seem lost. … They don't know where their belongings are, where their children are."* **(Male, 55, interpreter, >5 months in the centre, transit, Croatia)**

Pregnancy related issues

Pregnant women in transit have almost no medical examinations, and are in fear that something might go wrong with the pregnancy: e.g.

"*There a lot of pregnant women. We often need to take them to the hospital to get an ultrasound check-up, because they are afraid that something is wrong with the child.*" **(Male, 36, medical technician, 3 months in the centre, transit)**

Medical staff emphasize that pregnant women are dehydrated, since they limit their water intake or are under pressure from the family to do so:

"They do not allow them to eat and drink… Their family doesn't let them, so they wouldn't have to use the toilet because they travel a long time." **(Female, 37, nurse, 2 months in the centre, transit)**

Because of this, pregnant women often need infusion (at the dispensary in the transit centre) and ultrasound examinations at the hospital.

Infectious diseases,

Common cold, flu and respiratory complaints

Because of bad weather conditions and the large number of people in small areas, many people have the flu, common cold or respiratory issues. It was a common problem at all sites.

> *"People usually come with airway inflammation, problems in the upper respiratory system. Classic: common cold, sore throat, breathing issues, difficulty swallowing, and most of them, almost 30-40% of our patients have this kind of complaints."* **(Male, 24, organiser, 5 months in the centre, transit, Croatia)**

> *"Like me I live in one room with 13 people (…) If one of us got the flu all the room will get the flu."* **(Male; long-term, Austria)**

Gastro enteritis and dehydration

At all sites people mentioned as frequent problem diarrhoea, viral gastroenteritis, vomiting and dehydration. The participants considered that this was caused by poor nutrition, and travelling in large groups, e.g.:

> "*Throwing up and diarrhoea are also due to travel, the food, always eating canned food, and travelling in large groups where all kind of viruses spread quickly*." **(Female, 30, psychosocial support, 3.5 months in the centre, transit, Croatia)**

> ***"****Like for the food one day in our camp they gave us rotten food. Like 30 people have diarrhoea an all of them."* ***(Male, 28, Afghanistan, Long-term, Austria)***
> ***"*** *(laughing) Diarrhoea"* ***(Male, 26, Iraq, Long-term, Austria)***

In Croatia several of the healthcare workers also stressed poor nutrition as a major health problem, mainly mentioning malnutrition:

> "*They must be sick, I mean, they must be starving for nutrition basics. And from that their conditions can only get worse. I'm wondering where they get vitamins or something. And still we are providing them with sardines. For hygienic or whatever the reasons*." **(Female, 26, assistant project field manager, 2 months in the centre, transit, Croatia)**

Other infections

At all sites various other infections were mentioned, especially scabies, lice and other skin infections, but also varicella in adults::

> *"There's a problem with all these people all together in a small area. It is dangerous to other people. For example somebody had a skin disease which was very contagious, then everybody had this skin disease. This has happened before."* **(Female, 40, Syria, long-term, NL)**

In the long-term centre in Italy as well as in the Netherlands, women had a lot of issues related to eyes irritations as well as urogenital infections:

> *"When we arrived, we have contracted an infection in practically low parts and we were taken to the doctor and the doctor gave us a cream to put under."* ***(Female, 22, Nigeria, long-term, Italy)***

> *"In my tent there was someone with a bacteria in his eye, and his eye was all red. Then the 9 other people in his room also had this infection."* **(Female, 30, Syria, long-term, NL)**

Dental problems

At the hotspot, transit as well as long-term centres, a lot of refugees mentioned dental problems and the lack of good care for such problems.

> *There's also a problem with dental problems. You need to have money on your insurance card, if there's no money left on the card the dentist doesn't do anything. Besides that, they don't repair teeth, they only take them out. I know several people who had 3 teeth removed at the same time."* **(Female, 25-30, Syria, long-term, NL)**

Chronic diseases

Although not frequently, some refugees mentioned problems related to having a chronic disease. As these problems were mainly related to the lack of continuity of care and lack of availability of the right medicines, they are discussed in more detail in the next section of this report.

Experiences, needs and barriers with health care

Experiences and barriers in general

Time pressure

In the hotspot and transit centres, 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 such centres. For instance in Greece, the participants mentioned that they did not want to receive care but want to continue their journey as soon as possible.

> *"I do not want to go to the doctor now. The only thing I want is to leave the centre and to reach Germany. Then I will go to the doctor."* **(Female, 41, Afghanistan, hotspot, Greece)**

In Croatia, when refugees arrive at the centre, they usually have 3-4 hours before they are boarded back on the train to continue their journey. The time period of their stay in this transit centre is too short to provide all the necessary care and on top of that the refugees often refuse help because they are afraid of missing the train or being delayed, separated or left behind in the centre. They are often worried about borders closing.

The problems arising from such time pressure are: difficulty to identify a person's need, establish trust or provide the necessary information.

> *"The lack of time is crucial. A crucial point is that we don't have enough time to establish some kind of trust between us and the person we are talking to. They do not have a sense of when the train will depart or will it leave without them. That creates insecurity: should they go, should they even ask for help… "* **(Male, 32, consultant, 2.5 months in the centre, transit, Croatia)**

> *"I saw someone who probably had a broken ankle, who did not want to be held back, who wanted to get on the train as quickly as possible because he thought that he will get help at the next stop, but they're in pain obviously […] It's a complicated issue because there is help available here in Slavonski Brod, the medical staff will take you to the hospital, they'll help you here, but they're refusing help."* **(Male, 40, volunteer, 5 months in the centre, transit, Croatia)**

Time pressure is also closely related to family pressure. As people are generally concerned about missing the train or being retained, family members can exert pressure on each other not to seek medical help. Sometimes even in high-risk cases, which were seen in Croatia:

> *„I've noticed that parents often do not report chronic diseases of their children or some conditions that are really serious. For example, parents of a child with certain blood vessel malformations which were clearly visible did not want us to change the baby's clothes so we*

would not notice the problem and leave him for treatment. They insisted that the child is sent away to be treated in Germany." **(Female, 44, infant feeding consultant, 6 months in the centre, transit, Croatia)**

"*Sometimes if our doctors want to send the child in the hospital the refugees do not accept it. The baby was in a very bad condition and it had to take the therapy so we told the family that they cannot go. Then they sign a document for the release of the child.*" **(Female, 37, nurse, 2 months in the centre, transit, Croatia)**

„If a woman has some problems, especially if it's about some female issues, but the husband thinks it is not so important… We had a case like that, the husband insisted they continue the journey. "**(Female, 35, coordinator, 4 months in the centre, transit, Croatia)**

Lack of facilities

All refugees describe a lack of facilities during the journey and in the centre, mainly the amount and quality of food, water, toilets and showers. They mention that there are too few facilities for the number of people, especially at border crossings, and that the available facilities are not clean.

For instance, participants in the hotspot in Moira, Greece mentioned lack of dry clothes, accommodation, personal hygiene facilities, water and food, access to legal assistance, medicine and money for transportation. All participants emphasised that they needed a place to sleep. Due to the overcrowded situation in Moira, they often had to sleep outside.

Many refugees mentioned having wet clothes when arriving at the hotspot, due to trip with the boot or bad weather conditions, also some lost their shoes during the trip, forcing them to walk barefoot.

At the other sites similar needs were mentioned:

"It was just not enough water." **(Female, Syria, 32, transit, Slovenia)**

"*We don't have enough water for everybody. We told them that we are saving this for mothers and babies*." **(Female, 44, infant feeding consultant, 6 months in the centre, Transit, Croatia)**

"There were very bad conditions in the centre in Slovenia. People were sleeping outside, it was really cold. Everything (rubbish etc) was being burnt there, so there was a lot of smoke. It was not good for children who for instance have asthma. There was a lack of food, no soap, no clean water." **(Male, 50-55, Syria, long-term, NL)**

"Here in Heumensoord there is also a problem with facilities like toilets and showers. There are not enough toilets and they are not clean. It 'is especially a problem for women and children. With women having their menstruation. How can they change themselves? This is a risk for diseases. There is urine and stool retention – causing problems." **(Male, 50, Syria, long-term, NL)**

Most of the refugees come from countries where squatting lavatories are more common than lavatories with seats. It was mentioned several times that this causes problems in the centres. The toilets were unhygienic because most people did not know how to use them:

"..*And what is important for us: that we did not have this kind of toilets in our country. We are not used to this. And even people in the building where we live. They stand on this. They don't sit because..."* **(Male, 26, Iraq, long-term, Austria)**

***"..** It is not clean"* **(Male, 28, Afghanistan, long-term, Austria)**

Health needs, experiences and barriers in accessing healthcare

Health care resources and access

In the Netherlands, participants reflected on the available healthcare resources during the journey. The refugees illustrate that in every country and every border crossing the Red Cross was available for health care. Some stated that there was no trouble in finding a doctor. However, others did not agree and suggested the opposite with doctors being difficult to find, especially at busy border crossings.

"I didn't experience problems with doctor's along the road. The healthcare was really good, even better than what people are used to in their own countries." ***(Male, 55-65, Syria, Long-term, NL)***

"I don't agree. We need more doctors on the road. Some people lost their medication and need help. I know cases where people needed help and then they said in the next centre there will be a doctor. But then there was none. It's difficult when there are so many people in one spot to find out where the medical help is. Especially at the borders this is really important." **(Male, 25-35, Syria, Long-term, NL)**

In Hungary one of the participants also mentioned the insufficient number of health care providers during the journey.

"… but there were too many of us and not enough health care providers…" **(Male, Iraq, Transit, Hungary)**

In Austria, people who have applied for asylum and are assigned to stay in Vienna receive a health insurance e-card with which they can officially receive health care services. In many cases there is a long waiting period for the e-card. Even though – officially – they are already insured with having an ID card for asylum seekers, sometimes doctor practices do not accept patients who do not have an e-card. People who have e-cards sometimes face the fact these cards have not been activated and people do not receive much needed care until they take an additional administrative step.

***"**If you don't have an e-card, it is very hard to go to the doctor, you know, this and doctor (...) My family, you know, my aunt has diabetes and she meant, they sent us to very, very far diabetes clinic or something and because we didn't have any e-card they just said: „Sorry, we can...* **(Female, 20-25, Iran, Long-term, Austria)**

"..Sorry, we can't have you" **(Female, 30, Syria, Long-term, Austria**

Also in the Netherlands, the refugees in the temporary reception centres, experienced that the healthcare workers applied restrictions to their access to hospital care to which they were referred only in case of severe acute illness.

Continuity of care

Lack of continuity of care was mentioned as a big problem. This related to the lack of information on previous treatment (lack of personal health record), the difficulty to obtain chronic medication during the journey and the lack of knowledge among healthcare workers about care available in the "next" country. In transit centres time pressure added to these difficulties.

In the transit centre in Croatia for instance the healthcare workers noticed that the refugees were not appropriately treated or their treatment was interrupted as they passed from one country to another. This was due to the time pressures during their journey, and the fact that medical and psychosocial staff in the transit centre didn't have enough relevant information about the medical history of their patients or about the care already provided on the way to Croatia. In addition, they lacked information about the care that can be provided in the countries after Croatia, such as Austria, Germany or the Netherlands.

> *"They fell in the sea between Turkey and Greece but were not treated until Croatia so that's why they have serious respiratory problems."* **(Female, 26, coordinator of psychosocial support, 4 months in the centre, transit, Croatia)**

> *"They do not have a medical record that states which medicines they received for example in Greece."* **(Female, 26, mobility tracking assistant, 5 months in the centre, transit, Croatia)**

> *"For example, we have people in here who come with medical reports written in Greek. That's a big problem. First it's a medical report and then it's in Greek letters."* **(Male, 24, organiser/logistic, 5 months in the centre, transit, Croatia)**

> "*Now we send them from country to country to country but we don't really know what is in Germany. We are missing the information." (***Female, 44, infant feeding consultant, 6 months in the centre, transit, Croatia)**

> "*I think that in this situation of transit a coherent system of care from Greece to Austria or Germany would help them a lot.*" **(Female, 26, mobility tracking assistant, 5 months, transit, Croatia)**

When arriving in Hungary, refugees usually do not have medical records. The medical staffs of the centre give a small booklet recording the vaccination administered. For children who attend the local kindergartens and schools, the issue of vaccination is strictly controlled. Also in Italy, participants would appreciate a medical record that collects all data about their health status, vaccinations, treatments, etc. They would positively consider having this medical record always with them, even when travelling across different countries.

> *"It is good because, many people now, likewise me now, maybe most of them doesn't know their group type of blood. But you may be sick, totally sick, you can't utter any word, you can't say anything but through those written information the doctor can understand and treat you..."* **(Male, 24, Nigeria, Long-term, Italy)**

With regard to chronic disease management, there were often not enough medicines in the transit centres in Croatia to provide necessary care. On the other hand, medical staff also mentioned good examples of chronic disease management, such as preparing person specific drugs and instruction to use it.

The refugees in Heumensoord, Netherlands, find it difficult to make sure that they receive the right medical care, since they do not have their personal medical file. One of them explains that he feels

that doctors here don't believe their medical history and therefore treatment is different from what they're used to in their country of origin.

> *"The doctors in Syria have good education and are qualified. When a person has Diabetes Mellitus, doctors here don't believe this and want to do all the investigations all over again."* **(Male, 55-55, Syria, Long-term, NL)**

Many refugees mention that there is a need for some sort of medical health information system. While some argue that it is best to have something that they can take with them on paper of on their phone, others think it is better to have an electronic, digital version since they are a moving population.

> *"It would be good to have an electronic health record."* **(Male, 19, Afghanistan, Hotspot, Greece)**

> *"I think that this can help us very much because we are moving all the time."***(Male, 32, Afghanistan, Hotspot, Greece)**

Regardless how the information is kept, they want information about their treatments.

> *"… we did not get any documentation of the treatment we received…"* **(Male, 26, Syria, transit, Hungary)**

In Slovenia, one of the participants had made a picture of his injury, on his mobile phone and showed it to health care providers in order to create some sort of information continuity.

Information needs

Information needs arise at all sites. Refugees mention in the hotspot and transit centres that they would like information about regulations and procedures, as well as information about care that is provided in the next countries.

In the long-term centres in the Netherlands, Austria and Italy, refugees mention the need for information about how the health care system work in the country they arrived. For instance, how can they get a GP consultation, or what to do in case of an emergency. Moreover, information about payments and insurance is mentioned.

During the sessions, it became clear that some of the participants were illiterate. So, there is not only a need for more information, but also a need for information that can be understood by all refugees even those who cannot read or write. Information should be presented not only in the appropriate language but also by using visual materials, or orally explained.

Psychological support

A lot of refugees cope with mental health problems, resulting in a high need for psychological support. In most cases in the hotspot and transit centres it is enough if refugees can just talk about situation. In some cases and in the long-term centres there is more need for expert mental health care.

In the long-term centres, there was a high awareness of the need for psychological help for children. For instance the children from Syria are traumatised from what they had to go through during the war and the subsequent flight to Europe. For many refugees it was clear that in particular children need psychiatric care:

"But this not just for a man or a woman, a child need that so much. (…) Because they see everything having in the world in our country (…) My child see the father die, his father, my husband his die, Selua and Ibrahim see .. oh my father die. They see him on the earth and … very bad. And now in the night they sleep and wake up and cry and „oooh I need my father" **(Female, 30, Syria, Long-term, Austria)**
" They all have crisis." **(Female, 20-25, Iran, Long-term, Austria)**
" … I need, I need" .. they need help. Every child, not just my child, because they see everything in the way for here or in the country." **(Female, 30, Syria, Long-term, Austria)**

"There are 2-3 cases which concern children who need psychological help. From the GCA there's no psychological help. These are children who arrived here with only one parent and left the rest of their family. These children need special treatment. One child is always crying for its mother. We need to accept that they're here and need help." **(Male, 50, Syria, Long-term, NL)**

In order to provide mental health care, health care workers need to be trained appropriately. Health care workers in Croatia mention this need for training in psychological support for the volunteers and other staff: *"To be able to provide psychological support, training is needed. It should include assessment of vulnerable groups and first psychological aid. They need examples what to do in specific cases; when to discuss some issues and when not, what to say, advise… Interpreters also need this training."* **(Female, 35, psychosocial support, 4 months in the centre, transit, Croatia)**

Even if there is proper psychological support or care available, there is often a cultural barrier in accessing such care. Many refugees mention that it is not common in their culture to go to psychologist or are afraid of being stigmatized:

"Maybe it can be different, if I go to psychologist now, the Somali people who lives there saw me, they will say „Ooooh [Name]., she is crazy". (…) Because of the culture. We don't have this… **(Female, 29, Somalia; long-term, Austria)**

"In Pakistan, it is quite rare going to a psychologist. We don't believe in such thing. The people who have severe mental disorders are usually shipped off to mental hospitals." **(Male, 18-30, Pakistan, Long-term, Italy)**

<u>Mother- and child-care</u>
A lot of pregnancy related needs were mentioned, such as ultrasound examination, care for newly born children, and better nutrition for woman who are pregnant or breastfeeding, more privacy and places to rest.

In Austria, several of the participants (both male and female) were concerned about the fact that many women in the camp were getting pregnant. They thought it ill-advised in the situation that they were in. The discussions in this context mostly turned to the topic of availability of contraception.

"And above the pregnant: You know some families are getting pregnant here because there is no protection. I mean the condom. And people in the office are always joking: Why in this situation they are having a baby. They still don't know if

they stay here or not. They still want to have a baby. And this was the problem that woman had in the AKH." ***(Male, 25, Iran, Long-term, Austria)***

In some of the centre, condoms are only given to families, while in other centre condoms are freely available for everybody:

> ***"*** *Like yes I mean of the protection. Families want to have some privacy so if they give them."* ***(Male, 25, Iran, Long-term, Austria)***
> *"Actually in our camp they give them condoms. (…) Yeah this is no shame from it. They give condom to families for protection in our camp."***(Male, 28, Afghanistan, Long-term, Austria)**
> *"But not in our building. There is no condom. And that is why they are pregnant."* ***(Male, 25, Iran, Long-term, Austria)***

Regarding children, there was a high need for children to have space and toys suitable for them, thus to be able to act childlike:

> *".. There's no place to play that is suitable for them. And there are no toys" .. "They don't have psychological problems yet, but these children will have problems in the future. Right now they are still on a trip/journey. We need to make sure that they are able to play now."* **(Male, 50-55, Syria, Long-term, NL)**

<u>Other needs related to health</u>

The needs as described above are frequently mentioned and at many sites. There are also a lot of needs or preferences mentioned incidentally or regard a specific group:

- Care for people with disabilities : lack of sanitary facilities suitable for them
- Information and facilities for reproductive health, such as sanitary napkins and contraception
- In the long-term centres, it was mentioned that there is a need for speeding up the asylum process. Uncertainty brings a lot of stress in the centres.
-
- Physical activities in the centres where refugees stay for a longer period. When physical activities are organized in the centres, the organizers often only think of men as participants, for instance when soccer games for young men are organized. The female participants complained that there is nothing organized for women.
  "There are too less activities, people get bored. Also there are too many different groups in a small area which gives friction." **(Male, 50-55, Syria, Long-term, NL)**
- Leisure activities can help with distraction.
  "We don't have these possibilities. We are eating and sleeping in the camp. That's what i always.. I have talked to the manager of the building. I said: these people need a little bit rest but not too much rest because they need to go visit some parties/parks. Go for creations." **(Male, 28, Afghanistan, Long-term, Austria)**

Good experiences with accessing healthcare

At all sites, refugees mentioned good experiences with the care they received. For instance a participant in Hungary referred back to his time in Greece:

> *"The Greek centre was the best, when we arrived, we got complete health examination (X-ray, blood examination, dermatological examination). They organised Greek language lessons."* **(Male, 24, Pakistan, Transit, Hungary)**

Other participants also mentioned that they were satisfied with how they were approached and with the health care, for instance they appreciated the childcare.

> *"He (her son) went to great doctor. They treated him very good. They were very professional. And very kind and helpful. Perfect. They were very kind."* **(Female, 35, Syria, Transit, Slovenia)**

In Croatia, the medical staff is satisfied with overall quality and extent of services offered to migrants and refugees such as enough staff, medicines, supplies, emergency vehicle, migrant priority admission to the hospital. Since in Croatia no refugees participated in the fieldwork, we do not know if they would agree.

Many refugees mention that the care they received is better than they are used to in their own country:

> "*I think the medical treatment is much better here, than at home."* **(Male, 30, Iraq, transit, Hungary)**

> *"Yes. What is good here in Austria in the hospitals: Whenever I go to doctors they only take blood and they will not give you any medicine until they find out what is the reason. That is good I think. Because in the society in Iran we lived, whenever we went to doctor to prescribe to give me this medicine."* **(Male, 25, Iran, Long-term, Austria)**

Barriers in accessing healthcare

Organizational barriers

Organisational barriers included increasing uncertainty about the rules of procedures in the centres and lack of clarity about how the healthcare systems work in the country they arrived. For instance, participants in Greece mentioned the lack of information about processes; they thought that it needed to be available the moment they arrive at the country. The rapidly changing political situation and regulations added to the lack of clarity, even for the healthcare workers

> *"A month ago we could tell the people that they will arrive to their destination as soon as they came in Croatia. However, now with the changes in regulations in the last 3 weeks nobody is sure anymore. They ask me "now that I crossed to Croatia, will they let me pass into Slovenia". There is a fear that they will not make it to their final destination. Lately they're not sure because they started to deport migrants from Slovenia and Austria."* **(Male, 55, interpreter, 6 months in the centre, transit, Croatia)**

Many of the organizational problems are due to inadequate information about the functioning, organization and location of the health services.

"There is no dentist here. I don't know how to travel to Budapest and how to find the dentist." **(Male, 28, Iraq, transit, Hungary)**

In Italy refugees mentioned that it was difficult for everyone to navigate within the labyrinth of times, locations and modalities to access medical clinics. This forces them to make use of the emergency department for treatment of acute care or injuries instead of GP care.

In Austria, refugees seem to lack exact information about the health system and what the health insurance actually covers. The lack of information results in people being surprised by bills they receive subsequently. Repeatedly participants talked about the anxiety people have when they are not able to settle the bill for a health care service they utilised, as for instance the transport by an ambulance:

"Another one, she was really sick and then the responsible people they called ambulance and she didn't have insurance number or the e-card and then she went to the hospital they check everything and they give her medicine and… After five month, she gets the bill, six hundred Euro, you have to pay it. And she just gets 10 Euro per week. No food, because they give her the food three times a day but no money. (..) She's crying all the time. She doesn't have six hundred Euros and what then, she don't know what to do it. And this is causing madness or sickness or doing something herself maybe, it can happen." **(Female, 25, Iran, Long-term, Austria)**

<u>Discrimination of country of origin</u>

At the hotspot in Moira, Greece, some of the Afghan participants mentioned that they were discriminated due to their origin, even if their country has been involved in war for 40 years and that they faced closed borders, while the Syrian people had better support (e.g. financial) from some international NGO's. They wished for equal behaviour in all European countries.

"Our voice is being heard by nobody (authorities and population they get in touch) due to our country of origin." **(Male, 59, Afghanistan, Hotspot, Greece)**

<u>Financial barriers</u>

Financial barriers in the hotspots and transit centres were primarily linked to the lack of money and resources necessary to satisfy basic needs.

"The horrible part in this story with the baby is that the mother received the baby food in Greece but she couldn't buy any more. I don't know how long she stayed or how long she travelled from Greece to Croatia, but she had only little food left and was saving it, so she gave her baby infant formula for 3 or 4 times and for the rest she was feeding her with water and sugar. The baby was 3 months old and extremely underweight." **(Female, 44, infant feeding consultant, 6 months in the centre, transit, Croatia)**

"… we had to pay for lots of investigations, it's very expensive." **(Male, 26 Syrian, transit, Hungary)**

In the intermediate and long-term centres refugees describe the lack of financial resources for proper care or problems with insurance or administration. For instance in the Netherlands, refugees describe the following financial problem; in the temporary reception centres, until they enter the asylum seekers procedure, they don't receive pocket money. Since some of the refugees do not have any money, they are not able to pay for medication that is not covered for by the insurance, or for

instance get physiotherapy or regular dental care. The insecurity about the duration of the asylum procedure makes the financial situation more difficult.

> *"We shared our money for someone I know to make sure he could buy the medication he needed, we see that this is happening a lot."* **(Male, 50, Syria, Long-term, NL)**

> *"A lot of people have spent their money already. They expected to be in the centre for maybe 3 months and then they are able to earn money/have a house etc. Nobody expected that it would take this long and now you don't have any idea about how long it will take. We also need to save some money as we are uncertain about how long we'll stay here."* **(Male, 50, Syria, Long-term, NL)**

Experiences, preferences and barriers in contacts with healthcare providers

Importance of trust and positive, compassionate attitude

Most important for all refugees is the way they were approached by health care workers. They want to be approached with respect, a smile or kind word, so they have the feeling of being accepted and can build trust with the health care provider. These issues were also mentioned by the health care workers.

> *" A doctor should be humane and open minded."* **(Male, 38, Iraq, Transit, Hungary)**

> *"We are here to meet their basic needs; needs for food, water, clothing and a sense of security. But all this does not reach them if you do not offer a kind word. In our mother and baby area we always try to smile, play with the child, and try to provide the feeling of being accepted and that these children have a future."* **(Female, 44, infant feeding consultant, >5 months in the centre, transit, Croatia)**

In Austria, refugees made both positive and negative observations about the competencies of health care workers. On the one hand, they experienced compassion, equity and active involvement in the treatment. On the other hand, participants described discrimination, misinformation, carelessness, as well as intentional adherence to speaking only German.

> *"They take care of the people no matter where they are from. What the colour of the skin is. They take care of the health. That is really good."* **(Male, 25, Iran, Long-term, Austria)**

> *"Ah yes we are the same. The language barriers. For example some of the refugees they are not saying all of them are same but some of them they are using their local language. And then Me I know English I can tell my problem and … she wouldn't listen to me. I don't want to say her name but I met a female doctor and then she is using her language. Deutsch. And it was my first time I came here. Now I can understand Deutsch but I can't reply. But at that time I was really shocked. I said please, please doctor I can't understand Deutsch. I know English can you tell me. And she is talking she continued her explanation. And I was really serious… "* ***(Female , 29, Somalia, Long-term, Austria)***

At the other sites, refugees also mention both good and bad experiences with how they were approached and treated.

> *"I went to the doctor now due to my leg injury. Doctors behaved me very well."* **(Male, 19, Afghanistan, Hotspot, Greece)**

Cultural differences: general

Many of the cultural differences are related to male and female relationships. These were mentioned at all sites by both refugees and health care workers, sometimes as a barrier to good care for instance when women do not want to speak to a male doctor.

> *"It is the religion. Women in our country, they don't want to talk about anything, about life. Women can better talk with women doctor."* **(Male, 29, Syria, transit, Slovenia)**

> *"Women do not want to talk about their needs in public. She will not say that she needs sanitary pads or that she's in labour, she will not ask for underwear or publicly say that she has problems with painful breasts. Maybe she will tell it to a female interpreter. If the condition is severe maybe she will tell it to her husband so he can tell it to the interpreter indirectly."* **(Female, 44, infant feeding consultant, 6 months in the centre, transit, Croatia)**

> *"Women often refuse to go to the gynaecologist because they want to be examined only by a female gynaecologist which is difficult to ensure here."* **(Female, 30, coordinator of psychosocial support, 3.5 months in the centre, transit, Croatia)**

> *"If the nurse is female, sometimes men will not let them to administer the injections."* **(Female, 37, nurse, 2 months in the centre, transit, Croatia)**

In Austria, Cultural barriers became particularly apparent in connection with the need for – often male – refugees to translate in situations where it was not culturally appropriate for them to be present:

> *"Because I told the doctor and the person who was helping her to get birth. I told her we are Moslem and there should be some curtain and I could stay with them. But if there is nothing I will not go inside. And she was sitting there: we need you because they don't understand English nor Deutsch. So whenever I was just trying to take your baby out I should tell them what to do. I said: ok I will be there in the room but there should be a cover. And I will stand behind that or sit there and just be there. And that was a new experience for me."* **(Male, 25, Iran, Long-term, Austria)**

In Austria, the female participants preferred female doctors and if possible, they should be from the same geographical/ cultural background.

Other issues were experienced by healthcare workers as cultural differences

> *"We give them clean clothes here, they change their clothes but in the middle of the night or day they all walk around without socks. They are barefoot in shoes. We tell them all the time that they have to wear socks but they're all barefoot here. I think their climate is milder so they probably don't wear socks."* **(Female, 37, nurse, 2 months in the centre, transit, Croatia)**

> "*In the beginning, blankets were distributed in the Opatovac transit refugee centre and everybody was given a blanket. In the meantime we realized that a lot of blankets were thrown away. Than some interpreter who was better informed about that culture told that they take whatever is given to them and if they don't need it they will get rid of it later, rather than refuse to take what is offered to them.*" **(Female, 26, mobility tracking assistant, 5 months, transit, Croatia)**

Cultural differences in healthcare

In the long term centre in Heumensoord, Netherlands, it became clear that the expectation about good care differs from what they are used in their own countries. The health care systems of the Netherlands and Syria differ a lot. In the Netherlands, unlike in Syria, you have no direct access to hospital care: it is the general practitioner who decides if specialist care is necessary and who has to refer the patient to the hospital. In Syria it is possible to go to a specialist directly in an outpatient department or get medication without prescription at the pharmacy. On top of that Dutch doctors are, compared to others quite reluctant in prescribing antibiotics and other medication. Several refugees experience difficulties in dealing with this difference and don't really trust the general doctors with a wait and see policy and prescription of only paracetamol.

> *" We also need specialist doctors, not general doctors. Special care for pregnant women and children. This is important."* **(Female, 25-35, Syria, Long-term, NL**)

> *"I think the medical system in the Netherlands is great, I've seen the Radboud hospital. But in Heumensoord I feel like we're "rats of the laboratory". The people who work at the GCA have no experience with refugees, Syrian people or people from the Middle East. And they have no experience with our cultures."* **(Male, 50, Syria, Long-term, NL)**

> *" I have an example of a child with asthma. The parents know their child has asthma. Normally in Syria this child with an asthma attack will be admitted in a hospital immediately. Here she goes to the doctor and it takes 3 days before they send her to the hospital. She was admitted for 4 days."* **(Male, 55-55, Syria, Long-term, NL)**

Similar issues were also mentioned in the transit centres in Slovenia and Hungary:

> "*We have had better treatment in real medical institutions (buildings) than in tents. We got a specialist there."* **(Female, Syria, 32, transit, Slovenia)**

> *"There are no specialist doctors in the centre, for example gynaecologist. I have to go to another town and I have to pay if I need gynaecologist. "* **(Female, 27, Afghanistan, transit, Hungary)**

Language Barriers

Language barriers were mentioned at all sites both by health care workers and refugees. Problems arise when doctors or other health care workers and refugees do not speak the same language. In some situations health care workers speak English but refugees not. In other situations it is the other way around. In some instances, interpreters are available but this often results into trust issues, especially when it is about mental health problems.

> *"Health workers didn't have interpreter in Serbia and Macedonia. They are speaking a little bit Arabic, but not so much. So this was a problem. Because the doctor couldn't understand. This was a big problem."* **(Female, 32, Syria, transit, Slovenia)**

> *"It is also related to the lack of interpreters who are able to… You know that psychological or psychosocial support should be conducted in a very careful way in order not to increase the psychological stress. So the lack of experience in the interpreter to conduct the clinical interview… It is not a very good idea to have an interpreter between the counsellor and the person. It is better to have the interpreter who can himself provide psychosocial support."* **(Male, 26, psychosocial counsellor, 3 months in the centre, transit, Croatia)**

"There are not enough interpreters at the doctors during the journey, I can't speak languages, so I try to communication with body language." Who speaks languages try to help." **(Male, 24, Pakistan, transit, Hungary)**

"Usually there is no interpreter, we try to communicate with our arms and legs. If there is somebody, who speaks in English, he/she try to interpret." **(Male, 35, Afghanistan, transit, Hungary)**

"There were not enough interpreters at the doctors during the journey; we had problems with the language and understanding each other…" **(Male, 28, Syrian, Transit, Hungary)**

"They are very good [the doctors]. But a special problem we suffered from was that not all of them spoke English. We needed interpreters to talk to them. Not all of them, let's say 70% do not speak English. Only German. Sometimes the nurse came and translated between us." **(Male, 44, Iraq, Long-term, Austria)**

In the Netherlands, when having an appointment with a nurse/doctor there is an interpreter available through the telephone. One of the refugees suggests that it would be better to let the refugees translate themselves. They also suggest a female interpreter for women and that there should be more interpreters available in the centre, not only for medical care.

"I'm a paediatrician and speak good English. Let me help, because these people trust me. .. I'm able to translate and know the taboos. I think I can solve a lot of problems, but I'm just not allowed." **(Male, 50, Syria, Long-term, NL)**

In Italy, the main issue concerning the access to the national healthcare is the language barrier. In fact, all participants were assigned to a general practitioner, with whom they were unable to communicate. Because of this, participants mentioned they preferred to be assigned to a GP with good English communication skills (or other communal languages), or the attendance of a interpreter during their visit.

"For them, the big problem is the language, when they go to the doctor, they can not explain the problem." **(Male, 18-30, Pakistan, long-term, Italy)**

"The doctor did not speak English, did not understand, then at some point spoke in Italian and gave us a sheet to be signed and goodbye." **(Female, 23,Ghana, long-term, Italy)**

"They have communication problems, often when they go to the hospital, often they just they say yes, without really understanding what the doctor said." **(Female, 22, Nigeria, long-term, Italy)**

A female participant in Austria explained that the interpreters who worked in their centre were not capable and not instructed to accompany them to medical facilities. In order to deal with the language barrier and the lack of interpreters, they came up with two solutions. First, those who could speak English or German were asked to accompany others who don't speak these languages (by both their own family members and strangers). Secondly, doctors who speak the mother tongue are

deliberately sought out either by the refugees on their own initiative or with the support of the administration of the centre. This is also preferable for many, as they don't trust the "unofficial" interpreters, who are their fellow housemates. All the Austrian participants were Anglophone and all of them got used to accompanying others to the hospital or to the doctor. They all talked about extreme experiences and difficulties in coping with the enormous responsibilities, as well as the feeling of being overstrained and treated unfairly.

Bridging linguistic and cultural barriers

Overcoming these barriers is mentioned as the main need, both by refugees and health care workers. Multilingual health care providers can help overcoming the language barrier assuring that health care meets the needs of refugees.

> *"We need more experts who are native Arabic speakers, like we have a Syrian psychological counsellor. We also had paediatricians who lived and worked in the EU but come from these countries and are fluent in these languages and this greatly facilitated access to people and information, and sped up the healing process and also providing psychosocial support."* **(Male, 24, organiser, 5 months in the centre, transit, Croatia)**

> *"We need psychological first aid training for interpreters or Arabic training for the psychological support staff because they have a lot of social workers and psychological supporters but none of them speak the language."* **(Male, 40, volunteer - distribution of clothing, 5 months in the centre, transit, Croatia)**

In some instances, it was mentioned as a solution to involve refugees / migrants as mediators. However, this might not be preferable, especially in the hotspots and transits, as it puts enormous pressure and responsibility on the refugees who are translating and can result in trust issues.

Discussion

Main findings

The main health problems mentioned by our participants were related to the flight reasons (shooting war) and the journey the refugees had to undertake. During the journey and in the centres they faced unhealthy living conditions which caused or aggravated injuries, disabilities, mental health problems as well as common infectious diseases. Furthermore, many women worried about the development of pregnancies. Above that, the refugees mentioned health problems related to the lack of access to adequate healthcare: badly treated wounds, dental problems and a lack of continuity of care for chronic diseases and injuries.

The accounts of refugees and healthcare workers revealed important barriers in accessing healthcare related to the specific setting: At the hotspots and transit centres, the enormous time pressure is the main barrier. Due to this, refugees are reluctant to seek help for existing problems. Out of the same reason, health care workers have difficulty to assess the health care needs of the refugees and to build the necessary trust to address those needs, especially if they concern mental health. Participants at the hotspots also mentioned limited available health care facilities and health professionals. However, this problem was apparently not recognised by all participants.

Within the consultations with doctors and nurses, for all refugees the most important feature was trust and the feeling they were accepted and respected. The main obstacles mentioned at all sites

were linguistic or cultural differences. A lack of professional interpreters was mentioned, as was the disadvantages of working with interpreters who were strangers to the refugees concerned and therefore not trusted by them. Cultural differences related mainly to gender issues and to the medical culture in the different countries of origin of the refugees, e.g. the role of primary care in these countries.

Discussion under the light of existing knowledge

Most studies on health problems of refugees are conducted among refugees in long-stay refugee centres or refugees settled in the community (UNHCR 2015a, UNHCR 2015b, Bradby 2015, Hadgkiss 2014, Goosen 2014, Fazel 2005). Comparable to our findings, these studies also indicate the high prevalence of mental health problems. Above that, they mention different health problems that are related to a longer period of residence, such as the high prevalence of diabetes among settled refugees (Pykkonen 2010, Angyamang 2011) and problems related to pregnancy outcomes and reproductive health). Besides, there are health problems among settled refugees that are related to their country of origin, for example the higher prevalence of infectious diseases as tuberculosis, hepatitis B and C, endemic in many countries of origin of refugees.

Our findings on journey-related health problems mentioned by the refugees in our study (e.g. lower limb injuries, common respiratory infections) are supported by the analysis of 3500 consultations by an MSF medical team in Croatia during the last 3 months of 2015 (Escobio et al 2015) , and in the rapid assessment of the ECDC in 2015 (ECDC2015). As in our study, the main groups of refugees seen by teams of MSF were Syrians, Afghan, and Iraqis. The MSF report also mentioned a need for psychosocial services, which correlates with our findings, even though the extreme mobility of the people they treated did not allow a proper assessment of those needs (Escobio et al 2015).

Organisational barriers as well as financial barriers, as reported by our study participants in long-term centres, have been mentioned before (e.g. Hadgkiss 2014, WHO 2015).
The importance of bridging linguistic and cultural differences is well known, as is the importance of trusted interpreters and the disadvantages of family members acting as interpreters (e.g. Flores 2005, van den Muijsenbergh 2013) has been confirmed, which supports calls for (training in) cultural sensitive healthcare (Seeleman 2014)

The suggestion of participants to provide them with a personal medical record is in line with the IOM initiative of such a passport (IOM). However, previous experiments already made negative aspects apparent: for instance, undocumented migrant women were provided with a paper person-held medical record; however, the women in this group were reluctant to use this form of medical record fearing that family members or stranger would get access to confidential information (Schoevers 2011)

A new and very important finding of our study is that time pressure is the most difficult barrier in accessing healthcare at hotspots or transit centres. Especially this finding is relevant for the development of suitable assessment tools. The importance of trust in doctor-patient relationship and of continuity of care has been well documented before (Baker et al 2003), and Primary Care is well placed to provide this trustful, person centred relationship over time (Wonca 2001, WONCA 2015). The challenge in context of health care for refugees is to develop a system that provides a continuity

of care in the various health care contexts with different health care professionals the refugees interact with on their journey by taking into account the known barriers and new findings.

Strength and limitations of the fieldwork

The strength of this fieldwork was that we managed to involve so many, different, refugees during their journey in so many countries over the same period of time. We are not aware of any other study documenting the experiences of migrants undertaken in the difficult circumstances at the hot spots and the transit centres. Our approach enabled us to get a snap shot of the health needs and experiences with healthcare of refugees in their chain of travel through Europe during the first 3 months of 2016.

This approach clearly has its limitations as well: in many places it was not possible to speak at length with the refugees, due to time constraints. Furthermore, not at all fieldwork sites it was feasible to work with interpreters, which led to a high number of English-speaking refugees involved as participants.

Conclusive implications for the development of interventions in EUR-HUMAN

As described in the introduction, the aim of the EUR-HUMAN project is to develop guidance documents/recommendations and to pilot guidance, tools and training for the provision of integrated comprehensive person centred primary care for refugees at the intervention site in hotspots, transit centres and longer stay first reception centres. This study, combined with the results of the review of the literature in WP3, was carried out to provide input for these guidance, tools and training.

From our results we can draw the following conclusions relevant for the choice and development of guidance, tools and training.

1. Because of the time pressure and the large amount of refugees in hotspots and transit centres, it is recommended to use instruments for rapid assessment for both physical and mental health problems in order to identify the population with urgent conditions.
2. Short interventions aiming at identifying as well as treating (acute) mental health problems are needed
3. Considering the variety of stakeholders working together at these sites (volunteers of different NGOs, doctors, nurses, social workers from different background as well as local healthcare providers) it is important to streamlining the health care processes. Actions to improve health care in centres should also target volunteers.
4. Specific attention in guidance of professionals as well as in health promotion materials is needed for (the prevention of) common infections, healthy food, wound care including burning wounds and blisters, pregnancy care , providing care and medication for chronic diseases.
5. At all sites, information on procedures and on the organisation of healthcare should be provided. As many refugees are illiterate, information should not only be provided in writing but should also contain a lot of visual material and be explained orally.
6. To ensure continuity of care across different countries and sites, a person held medical record (like the IOM medical passport) would be very helpful. An electronic based passport would have many advantages above a paper based passport, keeping in mind the wet and crowded travel

circumstances which threaten the confidentiality of medical data that are carried on paper. Considering the fact that many refugees own smart-phones, there is a potential possibility of developing suitable apps for health related purposes.

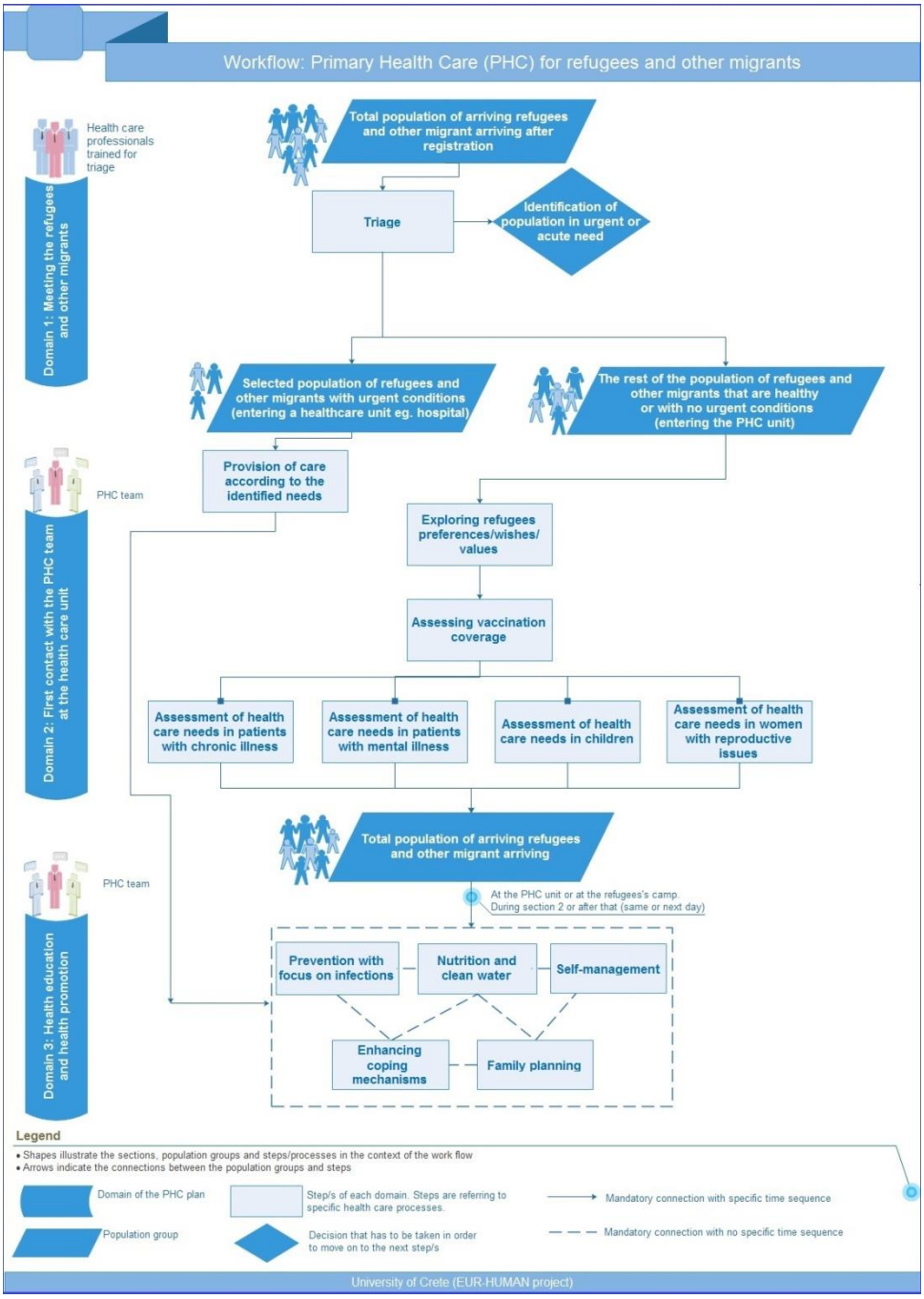
7. An important element of training for professionals should consist of training in culture sensitive and diversity responsive healthcare, including working with interpreters.

Implications and recommendations for the upcoming WPs

The ultimate aim of EUR-HUMAN is to implement 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 for the local population.

An impression of the nature of services PHC will have to provide for refugees is been described in the following diagram of workflow (Figure 3)

Figure 3. Operational plan; workflow of Primary Health Care for Refugees and other migrants



The results of this fieldwork have important implications for the development as well as for the implementation of these interventions, and thus for the next work packages in EUR-HUMAN.
We will describe these implications for each of the following work packages.

Work package 4

Task 4.1.
In this WP an expert consensus meeting is being organized in June 2016 in Athens in order to reach consensus on the content of good and affordable comprehensive person-centred and integrated PHC for refugees and other newly arriving migrants in different settings.
This meeting will be guided by specific questions for the experts, related to the above mentioned operational plan of workflow. From our results the following questions arise:

1. What consequences does the nature of the site (hotspot, transit centre, long stay centre) have for the operational plan regarding availability and access of PHC services, given the time pressure refugees face in hotspots and transit centres and the huge numbers of refugees entering and leaving these places within a very short timeframe ?
2. It might be possible that the workflow will differ, depending on the site (see figure 4)
3. How should we prioritize services and interventions, given the brief encounter and the large numbers?
4. What are the most essential actions always to be taken?
5. What should be the composition of a local PHC team, at the different sites and how could volunteers be involved ensuring good quality of care? Considering the variety of stakeholders working together at these sites (volunteers of different NGOs, doctors, nurses, social workers from different background as well as local healthcare providers) it is important to streamlining the health care processes. Actions to improve health care in centres should also target volunteers.
6. What health promotion issues need to be addressed?
7. How could the continuity of care across sites and countries be guaranteed? What are the pro- and con's of the IOM patient held record ("Medical passport")? What possibilities do mobile phones offer in terms of apps that could be useful, or to transport personal medical data?

Task 4.2.
Based on the consensus on the operational plan, a package will be developed of the most relevant guidance, tools, training and health promotion materials, information and best practices to assess and address the health needs of refugees and newly arrived migrants, especially in transit countries and hot spots of first arrival. Regarding the development of the package our results lead to the following recommendations. The package should contain at least:

- Instruments for rapid assessment for both physical and mental health problems in order to identify the population with urgent conditions, and that can be used also by lay people / volunteers
- Training in cultural competences and on communication with low literate people and across language barriers
- Guidance on information to the refugees about procedures, about the healthcare etc
- Examples of health promotion materials for (the prevention of) common infections, healthy food, wound care including burning wounds and blisters, pregnancy care , providing care and medication for chronic diseases.
- Guidance and tools for the continuity of care

Figure 4. Workflow depending on type of intervention site

Overarching issues across sites			
• Interpreters • Cultural competent healthcare workers • Information provision about (asylum) procedures, health care services • Trust building between providers and refugees			
	Hotspots	**Transit/intermediate**	**Long-term facilities**
	TRIAGE • rapid assessment infections ... • rapid assessment acute illnesses • rapid assessment acute mental health problems	• ... • ...	• screening for tuberculosis... • screening for mental health problems
	• assessment vaccination coverage • brief intervention for mental support, suited for volunteers • ……	• ... • ...	• plan vaccination coverage to standards of country of destination... • referral to specializes mental health care treatment • .....
	• ... • ...	• ... • ... •	• ... • ...

Work package 5:

Wp 5 will develop a protocol for early identification of highly traumatized refugees, including tools and procedures for rapid assessment of mental health needs and psychosocial status that can be easily implemented in real settings, and to facilitate early and appropriate interventions and services leading to shorter period of recovery from adverse life experiences and exposure to trauma.

Wp5 drafted an excellent report describing procedures of rapid assessment of mental health needs within the model of stepped care, overall supportive response to refugees in need of psychological support, specific focused short-term interventions and procedures for successful referral, including interventions targeting children and training and expertise needed for proposed procedures.

Regarding the development of the protocol and training our results lead to the following recommendations;

- Interventions aiming at identifying as well as treating (acute) mental health problems are needed, differentiating between hotspots , transit centres and longer stay centres; this will mean cultural sensitive instruments for Mental health and psychosocial support (MHPSS) in a stepped care model starting at the first sites where refugees enter Europe and stay for a very brief period - assuring continuity of care during their journey - until they finally reach their country of destination where long term care can start. These will include assessment and screening tools, and guidance for support and for referral in acute and chronic problems.
- Especially at the hotspots and transit centres there should be interventions that can be used by lay-people/volunteers.
- There should be guidance on how to work with confidentiality and with language barriers, given the nature of the different sites.

Work package 6:

Wp 6 will guide the choice and implementation of interventions to improve primary health care delivery for refugees, at different sites.

Regarding the choice of sites and interventions as well as the implementation, our results lead to the following recommendations:

- Hot spots and transit centres ask for interventions that are little time consuming, and possible to implement by different healthcare workers and volunteers for a large group of refugees.
- Training in cultural competences and especially communication skills is urgent at all sites.
- Providing information to refugees on procedures, on the organisation of healthcare and health promotion materials is also urgently needed. This information should not only be provided in writing but should also contain a lot of visual material and be explained orally.

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List of abbreviations

ADRA = Adventist Development and Relief Agency

DOW = Description Of Work

ECDC = Centre for Disease Prevention and Control

GCA = Gezondheidscentrum Asielzoekers (Asylum Seekers Health Centre)

GP = general practitioner

IOM = International Organization for Migration

MAGNA = Medical and Nutrition Global Aid

MDM = Médecins du Monde

MSF = Médecins Sans Frontières

NGO = non-governmental organization

PLA = Participatory Learning and Action

STP = Straniero Temporaneamente Presente

UNHCR = United Nations High Commissioner for Refugees

UNICEF = United Nations Children's Fund

WHO = World Health Organization

Appendix

A1. PLA Training Material

A2. Recruitment and fieldwork guide

A3. Informed consent (English)

A4. Participation Letter (English)

A5. Approval Letter of the Ethical board

A6. Topic List

A7. Fieldwork evaluation template

EUR-HUMAN

Radboudumc
university medical center

PLA Training Meeting, February 6th–7th 2016 Ljubljana, Slovenia

Meeting Venue: University of Ljubljana, Faculty of Medicine,

Department of Family Medicine, Poljanski nasip 58, Ljubljana

VENUE address:

University of Ljubljana, Faculty of Medicine,

Department of Family Medicine

Poljanski nasip 58

1000 Ljubljana, Slovenia

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Tessa van Loenen tel: + 31617260636

Co-funded by
the Health Programme
of the European Union

EUR-HUMAN

PLA – TRAINING

February 6 – 7 Medical Faculty Ljubljana

AGENDA

Moderators: Maria van den Muijsenbergh

Tessa van Loenen

SATURDAY February 6th

14.00 hours	Welcome and introductions
14.30 – 15.30	Ground rules and PLA basics (fishbowl exercise)
15.30 – 15.45	Coffee / tea break
15.45 – 17.15	PLA technique 1. Flexible brainstorm (exercise in 1-2 groups)
17.15 – 17.30	Questions
17.30	End of the meeting
19.00	Dinner. Location will be announced during meeting

SUNDAY February 7th

9.00 hours	Start of the meeting
9.15 – 10.15	PLA technique 2. Direct ranking (exercise in 1-2 groups)
10.15 – 10.30	Coffee break
10.30 – 11.30	Information about the fieldwork in EUR-HUMAN
	= stakeholders to be involved / contacted
	= local sites and target Refugee groups
	= recruitment
	= PLA moderated sessions / topic list / how to address mental health issues
	= coding and report
11.30 – 12.00	Questions and discussion
12.00 – 12.30	PLA technique 3. Speed evaluation
12.30	Closing of the meeting

PLA – TRAINING

February 6 – 7 Medical Faculty Ljubljana

Manual

Facilitators: Maria van den Muijsenbergh
Tessa van Loenen

Preparations:

- Make PPTs on PLA and on guidance fieldwork
- copy texts ground rules
- ask Danica for beamer, flipover, coffee/tea /2 rooms / possibility to arrange chairs into circles and at what time we can access the room
- ask Sanne to observe and take notes
- take with us:
    - 4 piles of stickies (M)
    - cards for the icebreaker (M)
    - pictures from internet on healthcare workers and settings (M+T)
    - markers (6x) (M+T)
    - Dutch stroopwafels (Schiphol)
    - present for Danica (Schiphol)
    - nametags (M+T)
    - tape and glue for the walls (M)
    - paperclips 8 different colours (M)

SATURDAY February 6th

13.00	preparing the room arranging chairs, making signs to the room, having coffee / tea and dutch sweet available testing beamer get all materials in place etc name tags	M&T
13.45 -14.00	Welcome in a PLA mode: addressing each participant individual, small talk, offering coffee etc	M &T
14.00 – 14.45	Interactive Ice breaker exercise for introductions • choose a card that illustrates one positive aspect of refugees • 5 minutes to choose and think • Then each participant including T&M 2 minutes to tell their name, affiliation , function/ role in EUR-HUMAN and why they choose that card	M
14.45 – 15.00	General introduction to PLA • short explanation why we took so much time for introductions • introduction to PLA PPT presentation • how we will run the training: we will pretend they are a group of refugees with different background; roles will be distributed (T). We are going to be dividing the group in 2 for some of the exercises • explaining role Sanne (taking notes and observe)	
15.00 – 15.30	Ground rules and PLA basics (fishbowl exercise) • M&T researchers leading a meeting of refugees, not taking enough time, pressing, supposing they can read etc • 8 participants with roles of refugees insight the bowl – the other participants observing	
15.30 – 15.45	Coffee / tea break • distribute roles • put a lot of stickies on the tables as well as pictures on different healthcare workers and settings (pictograms etc)	
15.45 – 16.15	Discussion about observations, ground rules and basic elements of PLA PTT on ground rules and basic attitude of PLA facilitators	
16.15 – 17.15	PLA technique 1. Flexible brainstorm (exercise in 1-2 groups) • short presentation 5 minutes PPt • 2 groups of 8-9 refugees and M&T facilitating. Subject of meeting: refugees have been asked by NGO to come with suggestions how they should arrange (mental) healthcare for the refugees. • Every-one gets pile of stickies, marked personally.	

- Write down your own solutions answers to the question 1 solution per stickie (individually) ;
- if you can not write, choose any pictures or materials and explain what it means
- We will have a flip-over chart sheet on table; ask one participant to draw a circle and a line in the middle. Ask who wants to be the first and explain first sticky. Then discuss and ask if some-one else has something related to this first stickie/ or something completely different. Start looking for themes and make pile, moving stickies around etc. We should end up with various themes.
- Encourage explanations, discussion, grouping, be flexible. Ask if they can identify themes, what does this chart mean, are there gaps now it is all on the board?
- Time keeping. Make sure every-one gets to say something.
- Re-order during discussion. Alarm clock running (perhaps someone has app otherwise alarm clock online

17.15 – 17.30 Plenary Questions T and S taking notes

17.30 End of the meeting

- tape both flipovers to keep
- look at flexible brainstorm and choose 5 often mentioned suggestions and put them with a symbol on a commentary chart
- put the commentary card to the wall
- prepare flipover for evaluation tomorrow
- ask Sanne for debriefing of notes and observations
- discuss necessary adaptations/ improvements for the next day
- close off (ask Danica)
- reorder and clean room - ready for tomorrow

19.00 Dinner at……

SUNDAY February 7th

8.45 prepare last things and presentation

- paperclips on the tables
- flip over on the table
- markers on the table

9.00 hours Start of the meeting

- welcome all participants with coffee
- ask if everybody can stay until the end or planes need to be caught

9.15 – 10.00 PLA technique 2. Direct ranking (exercise in 1-2 groups)

- Mini presentation explaining direct ranking following the commentary chart
- Now every team has to choose one solution. Each individual has equal voting power.
- Go through the commentary charts briefly
- Every-one gets equal nr. of paperclips (calculate). Facilitator asks who wants to start the process of casting votes. Does any-one feel strongly

about one of the three interventions? How many of their paperclips and why. Who goes next same process. Make sure every-one casts votes and gets a change to speak. Every-one casts all his/her votes. Some-one (of the team counts) and writes next to solution. Then we make chart with thermometer.

- Solutions from high to low with spacing (visual).

10.00 – 10.15 Plenary comparing results, questions on the technique

10.15 – 10.30 Coffee break – attach flipover for evaluation to the wall

10.30 – 11.30 Information about the fieldwork in EUR-HUMAN

= local team
= stakeholders to be involved / contacted
= local sites and target Refugee groups
= recruitment
= PLA moderated sessions
= support UoL and RUMC
= coding and report

11.30 – 12.00 Questions and discussion

12.00 – 12.30 PLA technique 3. Speed evaluation

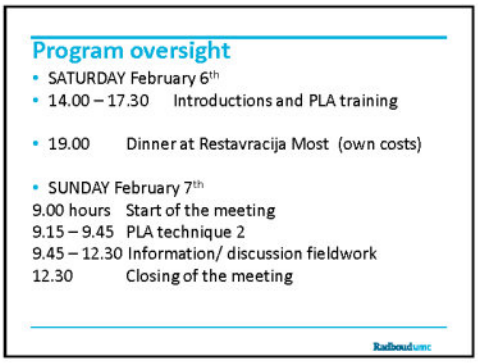
- Have a flip chart ready with at least 8 categories.
- Questions: our own (5) plus ask them if they see any other categories for the evaluation and add on chart

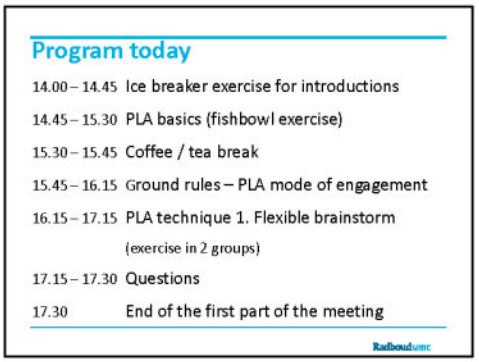
1. Comments on PLA as a research method
2. The used materials
3. Facilitation
4. Actual results
5. Did we meet your expectations

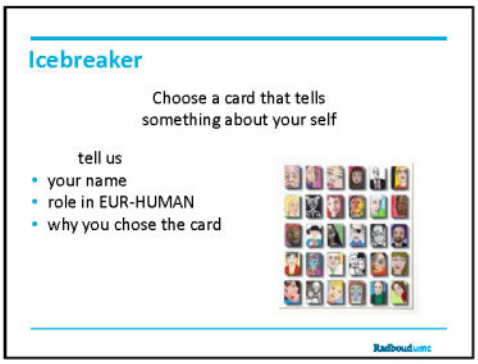
- On stickies on pre-prepared chart : start with first category until no more comments then move on.
- Facilitators move around chart and ask for clarifications, here and there again inviting participants to speak
- Interactive discussion on these key issues

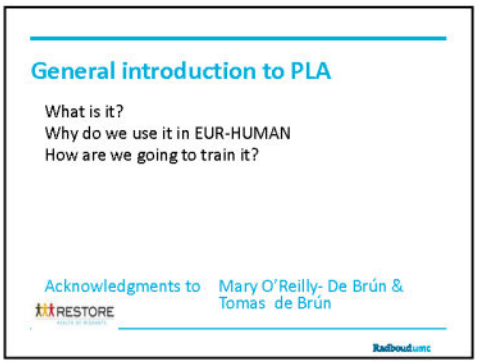
12.30 Closing of the meeting – thanking Danica - cleaning up

Presentation









What is Participatory Learning and Action

"A growing family of approaches and methods to enable ***local people to share, enhance and analyse their knowledge of life and conditions***, and to plan, act and monitor and evaluate"

Chambers 1997

Qualitative research method

Participatory Action Research

Community based participatory research

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In PLA

- Stakeholders are considered to have expert knowledge of their own lives and experiences
  - ✓ **PLA** enables all stakeholders to **participate**, **learn** and **act** in a co-operative and democratic manner to achieve agreed goals
  - ✓ All voices and perspectives count – *culture-sensitive* with mutual respect and equal participation

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In PLA

- Emphasis on *dialogues* to identify problems and to create workable solutions
- Stakeholders are involved as much as possible from start to finish

Chambers, 1994; O'Reilly-de Brún and de Brún, 2010

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PLA mode of engagement

- Creates a safe and positive space for stakeholders from different backgrounds to work in partnership together
- promotes reciprocity and mutual respect
- cultural sensitive – gender issues, language, topics
- facilitator "follows" the group
- much attention to atmosphere and attitude

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PLA researcher – facilitator Essentials

Pay attention to

- Attitude
  - building trust and partnership
- Materials
  - choose and prepare the appropriate materials
- Methods
  - identify most appropriate PLA –technique
  - secure data (and analyse – report)

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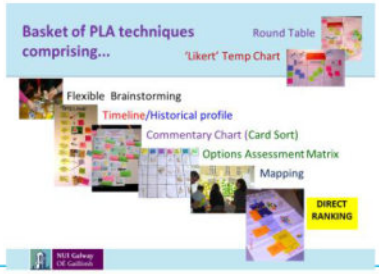

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Why PLA in EUR- HUMAN

- interventions work best as developed with all stakeholders
- as researcher we miss the emic view = the refugees life and context (and experiences healthcare workers in the field)
- refugees on the move are very vulnerable
- questionnaires not feasible because of linguistic and cultural diversity

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How will we train this today?

- Learn by experience:
  you will be part of PLA moderated sessions
- You all get roles as refugees or as observants
- Sanne will observe and take notes about process

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Fishbowl:
the importance of the PLA mode of engagement

- Inner circle participants to a research meeting
- Outer circle critical observants
- Tessa and Maria facilitate the meeting

Questions:
- How did you feel as participant to the meeting?
- What did you see as an observant happening
  - was trust built?
  - did all participants felt included and engaged?

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Fishbowl:

Setting: refugee camp in the Netherlands
- 8 newly arrived refugees were invited to a meeting about healthcare
- they do not know more about it
- interpreters are arranged
- Whom of you want to play a refugee?
- Who want to be observant?

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Key attitude for the PLA mode of engagement

- be relaxed: do not rush!
- build report and trust
  - take time for introductions
  - explain the goal of the meeting
  - explain confidentiality
  - ask consent for audiotaping / Photo's
  - give plenty room for questions
- be respectful and aware of diversity
  - illiteracy / language barrier? – use lots of pictures
  - cultural sensitive pictures
  - always *asks* who wants to do something

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Key features for facilitation in PLA

- Be well prepared (materials, setting, topic)
- Be flexible: go with the flow of the group
  - they are the experts
  - ensure everyone has an equal voice
- Listen and learn
- Embrace mistakes: they lead to unforeseen insights
- It is 90% attitude -10% technique

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Flexible Brainstorm

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Flexible brainstorm

Aim

- To elicit participant perspectives, knowledge & expertise, generating a record of data in a flexible moveable format that can be used to achieve various results.
- In a fast, creative, democratic, way

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Flexible brainstorm

- Generates ideas
- Creates informal atmosphere
- Fluid flexible method
- Good learning tool - participants educate each other
- Strong visual aid
- No pressure to speak
- Empowers and includes all participants

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Flexible brainstorm procedure 1

- Welcome and introduction in PLA mode of engagement – explanation of goal and method
- Facilitator invites participant to draw circle on flipchart sheet on table
- Facilitator invites to discuss the question at stake
- Each participant writes down / chooses a picture each important issue – 1 at 1 sticky
- Each participant in turn is asked to put a sticky / picture on the chart with circle on the table
- Who has something similar? something different?

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Flexible brainstorm procedure 2

- Until all issues are on the flipchart
- Facilitator opens up to new themes all the time etc.
- Participant arrange issues in themes
- Iterative process: go back to new issues / rearranging
- Until no new issues arise and every one is satisfied about the arrangement in themes

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Flexible brainstorm

Result

- Perspectives / idea's
- Shared understanding
- Shows the wealth of knowledge/expertise there is within the group
- Opportunity to fill in gaps
- Flows on to our next step: selection / development of interventions

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Let's do a flexible brainstorm

2 groups : 1 Tessa, 1 Maria

You all are refugees in a camp

Interpreters available

Topic of meeting – question at stake:

"What health care do you need now, in this camp?"

Introduction is performed in PLA mode

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Flexible brainstorm: Data management

- put date, place, name of meeting on flipchart
- take a picture of the chart (and if possible of process)
- tie all stickie's / pictures down and safe as original data
- gather all consent forms and keep
- transcribe audiotape verbatim
- analyse as qualitative data (coding etc)
- ideally: discuss analysis with participants

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Program

- SUNDAY February 7th

9.00 hours	Start of the meeting
9.15 – 10.15	Information and discussion about the fieldwork
10.15 – 10.30	Coffee break
10.30 – 11.20	Information and discussion about the fieldwork
11.20 – 11.30	how to address mental health topics and acute anxiety
11.30 – 12.00	Questions and discussion
12.00 – 12.30	PLA technique 2. Speed evaluation
12.30	Closing of the meeting

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Direct Ranking

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Direct Ranking is a **democratic, inclusive decision-making tool**

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Aim

- To give each stakeholder **'equal voice'** – levels the playing field
- And **equal voting power** (number of votes)
- **Respecting stakeholder expertise**
- **through a visual/tranparent voting procedure**

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Procedure

- Interventions are placed around the chart on table
- Commentary charts on wall
- Each stakeholder gets an equal number of votes (paperclips, buttons etc.)
- Identify top (most suitable)/bottom (least suitable) of chart and draw line in middle (a participant) and write the topic of the ranking
- Globally discussion on the intervention that should be at the top and bottom
- Any participant starts placing first votes and clarifies why. Facilitator 'moves through' participants inviting them to cast votes and explain
- When all votes are cast, one participant counts and writes the number of votes
- Interventions are placed on the line : top one first, then bottom-one and the ones in the middle

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Speed evaluation

to gain insight in the opinions / experiences of the participants on process and content regarding

- time and venue of the meeting
- facilitation
- the way we used materials
- comments on PLA as a research method in general
- comments on PLA as method in Eur human
- the information on the fieldwork
- the discussion on the fieldwork
- did we meet your expectations
- do you feel confident to start the fieldwork
- ? other issues

- Method
  - 1 item on 1 sticky place on the flipchart

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End of the meeting

Hvala zbogom Grazie addio

Ευχαριστίες αντίο

Thank you Good bye

Hvala zbogom

DANKE SCHÖN AUF WIEDERSEHEN

Hartelijk bedankt en tot ziens

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A2. Recruitment and fieldwork guide

Goal

At the intervention sites refugees will be recruited to participate in the local stakeholder group. These groups will participate in PLA moderated sessions in order to generate data on *views*, *experiences* and *expectations* of the refugees regarding their health and social needs, access and use of healthcare and social services.

The number of sessions with each refugee group depends on the sites:

- At the hotspot/transit sites it is only feasible to hold **1 session per group**, since the refugees are only there for a few hours. At these hotspot sites, more groups of refugees will be recruited (approximately 4 groups).
- At sites where refugees stay longer it might be feasible to hold **3 sessions per group**.

Recruitment instruction

Participant groups

- At Hotspot/transit sites 4 groups of approximately 5 persons (1 session per group)
    - 2 groups of female asylum seeker
    - 2 groups of male asylum seekers
- At sites where refugees stay longer 2 groups of approximately 5 persons (3 sessions per group)
    - One group of female asylum seeker
    - One group of male asylum seeker

- Within these groups recruit participants of:
    - Different ages (≥18 years)
    - Different educational attainment
    - Different countries of origin
    - with and without chronic health conditions
    - Preferable with good and without any or with bad experiences with medical care in the camp
    - No staying permits

Location of recruitment

- Participants for the stakeholder group will be recruited within the refugee centre
- Be aware of regulations and governance in the refugee centre and arrange necessary permissions

How to approach the participants

- Purposive sampling; make use of contacts within the centre, e.g. doctors, but make sure also participants are included who do not have contacted a medical service.
- Letter for the participants explaining the purpose and the content of the research. *(example letter in English available)*
- In addition oral explanation; make explicitly clear :
    - that all information is confidential, will not be shared with authorities or doctors
    - that participation will not help them to get a staying permit or whatever other benefits in the camp, but that it intends to help future refugees
    - that they will receive a gift at the end of the sessions

Fieldwork instruction

Ethical approval

In preparation of the fieldwork make sure ethical approval is acquired in accordance with the legal requirements in your country. We provide you with an example letter for you Ethics Committee.

Informed consent

It is very important to obtain an informed consent form of every participant. We have designed a user-friendly format for an informed consent (English and Arab) which you can use as an example. There is also a short consent form available in English and Arab.

We need a digital copy of all the signed consent forms.

For refugees, there might be some reticence to participate. Explain the consent process to participants but don't overwhelm participants with too much information. Take time to explain, orally and personally, the scope of the study and emphasize the confidentiality. Make sure that the informed consent has simple and short sentences and as little as possible references to legal issues.

Language barrier

One of the main problems in this type of research is the language barrier. Within the refugee centre several languages will be spoken. The most common languages probably will be English or Arabic. Either a staff member speaking these languages or a professional interpreter should be available to tackle possible language problems.

Another way to tackle language problems is the use of visual material. Visual materials are information tools that assist a training session by showing the information in picture images.

Location of sessions

- Choose the location for the sessions carefully.
- Make sure the location is safe and discrete.
- Easy to reach
- Provide something to drink and eat

Audiotape

All sessions will be audiotaped and transcribed ad verbatim. Explain that no-one will be identified by name on the tape. The information recorded is confidential, and no one else except the research group will have access to the tapes. You have to store the audiotapes yourself for at least 5 years. A **copy of the transcripts** of the audiotapes should be RADBOUDUMC

Fieldwork reports

We provide a *process evaluation* form with questions about the recruitment and fieldwork processes. Please fill these out.

Coding and Local PLA reports

All the data will be coded and analysed by the local settings. We will provide you with a coding framework.

A3. Participation Letter (English)

Information letter for participation in **EUR-HUMAN**

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of the European Union

Place....Date...

Dear Sir/Madam,

I am [your name], working for the [university/research center]. We want to improve the medical care for refugees like you. For us, it is very important to know what you think about the care that refugees receive, what health problems you or other refugees have, and what care you need.

Therefore, we organize meetings with a group of refugees to talk about their experiences and needs. There is a group for men and a group for women. Each group is led by an experienced interviewer. The meetings will take 2 hours. There will be interpreters to translate for those who cannot speak English. Participants can choose themselves what they want to say and what not. They can leave the meeting at any time they want.

The meetings will be audio taped and later written down in documents. In these documents there will be no names of participants - they are anonymous. The information recorded is confidential, and no one else except the research group will have access to the information.

The results will be used to make training for healthcare workers and information for refugees, and so to improve the healthcare for refugees.

I want to invite you for this meeting because I believe that your views and experiences can teach us more about the care of newly arriving refugees. Your participation in this research is entirely voluntary.

The meeting will take place in [location] on [date]. No one else but the people who take part in the discussion and the interviewer will be present during this meeting.

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following: [contact information]

Thank you in advance.

Kind regards,
[your name]

On behalf of:
[Research Group]

This research has been reviewed and approved by [your ethic committee], which is a committee whose task it is to make sure that research participants are protected from harm.
This letter is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020) The content of this letter can not be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains."

A4. Informed consent (English)

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Consent form participation EUR-HUMAN

Participant consent

PLEASE tick every box

- I have read the information, or it has been read to me. I have asked all questions about the project that I want. All my questions have been answered to my satisfaction.
- I consent voluntarily to participate in the group session about healthcare in the EUR-HUMAN study.
- I consent that the group discussions are audio taped.
- I consent that the audiotapes are being transcribed into written documents. No names of participants are written in these documents (it is anonymous). The tapes and transcripts are stored at a safe location.
- What participants say can be used as anonymous quotations in the reports on the EUR-HUMAN project.

Name of Participant_____

Signature of Participant _____

Date _____

Staff member / person taking consent

- I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the purpose and scope of the study.
- I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability.
- I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Name of person taking the consent_____

Signature of person taking the consent_____

Date _____
Day/month/year

This letter is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020)
The content of this letter can not be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains."

A5. Approval Letter of the Dutch Ethical board

Loenen, Tessa van

Van: Cruysen, Yvonne van der namens Postbus Commissie Mensgebonden Onderzoek
Verzonden: maandag 8 februari 2016 9:40
Aan: Loenen, Tessa van
Onderwerp: 2016-2306

Opvolgingsmarkering: Opvolgen
Markeringsstatus: Voltooid

Titel: European Refugees - Human Movement and Advisory Network
Dossiernummer: 2016-2306

Dear mrs van Loenen,

On behalf of the research ethics committee of the Radboud University Nijmegen Medical Centre I hereby let you know that the abovementioned study doesn't fall within the remit of the Medical Research Involving Human Subjects Act (WMO). Therefore, the study can be carried out (in the Netherlands) without an approval by an accredited research ethics committee and without explicit informed consent of the participants.

Best regards,
Drs. R.B. Keus, Chairman

Research Ethics Committee
Radboud University Nijmegen Medical Centre

Concernstaf Kwaliteit en Veiligheid
Commissie Mensgebonden Onderzoek
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1

A6. Topic List

EUR-HUMAN Radboudumc university medical center

TOPIC LIST fieldwork WP2

Topic list for PLA moderated sessions with refugees and other migrants, to get insight into their views and experiences on health problems, healthcare needs and needs for social care / mental support.

The topic list consist of 2 parts: **Topic #1** and **Topic #2**

Single sessions:
For the single sessions you can use the questions of **topic #1** of the topic list. The emphasis should be on question 2 and 3. But question 1 is a good starting point for the discussion.
If after a few sessions you have the idea that you have heard 'everything' on topic #1, you can choose to start a group with **topic#2.** Try to have at least one group where **topic #2** is discussed.

Multiple sessions:
If a group has multiple sessions, start the 1th sessions with **topic #1.** The emphasis should be on question 2 and 3. But question 1 is a good starting point of the discussion.
In the 2nd and 3th session you can use **topic #2.**

Sessions with NGO's and other stakeholders:
You can use the same topics.

Important remarks for the sessions:

- Guidance has been circulated separately on how to facilitate the discussion, and how to achieve a PLA 'mode of engagement', as well as practical issues as collecting informed consent, audiotaping , data storage etc.
- Very important during each session is attention for ground rules, atmosphere, safety, giving every participant equal opportunity to speak, noting discomfort or anxiety as well as limitations in reading and/or speaking the communal language (as will be discussed during the training).
- Know exactly what you can offer them in terms of acute access to care, to social support, in reward, etc. Make sure you have some contacts with local healthcare / social / psychological workers in case there is an acute need for help.
- Very sensitive topics (like sexual abuse) often can be better addressed by asking if anyone has heard of such a thing, instead of if anyone has experienced this.

1

Topiclist

Note: These are the topics we think are relevant to address – however there has to be room for topics the refugees themselves come up with!

Topics #1

1.What are the main health problems you have experienced so far in your life - at home or during your journey to Europe?

If participants do not mention the following conditions themselves, then please ask if they know people with these conditions:

- *Chronic diseases*
- *Other diseases (focus on communicable diseases)*
- *Mental disorders*
- *Childhood diseases*
- *Pregnancy related issues*
- *Disabilities / Injuries*

2. What experiences do you have with healthcare during your journey / in this centre? What barriers did you encounter if you wanted to see a doctor or if you needed medication?

If participants do not mention any experiences or barriers, you can help them with the following topics

- *administrative and financial hurdles?*
- *language?*
- *cultural/religious barriers?*
- *lack of facilities?*
- *lack of continuous health care*

3. What care would you appreciate for the health problems mentioned before these problems?

To help participants think about all issues, it could be helpful to specify after an introductory broad question (e.g. what healthcare facilities do refugees like you need?)
what is needed in relation with:

- *Acute illness (infections and others)*
- *Injuries*
- *Chronic diseases management and medications' provision*
- *Illness in Children*
- *mother and child care (pregnancy care, delivery and problems with newborns)*
- *Do you want a medical first aid kit for during your journey? If so, what should be in it?*
- *Stress, anxiety: other mental disorder?*
    - *Example questions: we know you all have suffered a lot. And we know many people feel very stressed, or have to think a lot. Sometimes they cannot sleep at all, or are very frightened. Or the cry the whole day. Or just are numb and sad. Or very easily irritated and angry. Do you recognize this? What do these people need, right now on their journey, and when they have reached their final destination?*
- *Sexual and gender based violence : this topic should be addressed only if there is a really confidential atmosphere in the group, and as last questions*

- *Example questions: we know very bad things happen with women in the war, or during the flight. If you have ever heard of such an awful thing, what do you think these women would need? With whom should they speak about this? And the same kind of questions related to torture.*

Related to the kind of services they need, it is important to get information on the following questions:

- What do you need to access care
- How do you get information on access – what kind of information would you want?
- How would you want to deal with language barrier?
- Preference for predictable and coordinated visiting schedule of clinics?
- Where do they find support when they do not feel well mentally? Where do they go to?
- If people have severe mental health problems: do they have access to mental health care facilities? Can they find the way? Would they go there if they had complaints?

Topics #2

1. Health information system

- *Do you want the doctors elsewhere to know your medical history?*
  - *How could this be achieved?*
- *Do you posses any paper or electronic personal health records?*
  - *Medical cards or booklets containing medical history*
  - *Vaccinations booklet*
- *What do you think of a personal health record (show the IOM example)*

2. Competencies of healthcare workers and previous experiences in healthcare

- *What are your preferences and expectations in relation to the care services?*
  - *Sufficient patient-doctor time*
  - *Active involvement in the decision of the therapeutic scheme*
  - *Physicians showing understanding and compassion*
- *What was your experience with the healthcare services in your country?*
  - *First point of contact in case of a health problem*
  - *Accessibility of healthcare services (eg. geographical barriers, insurance policy, private or public healthcare services etc)*
  - *Continuity of healthcare (eg. general practitioner, family physician or other physician)*
  - *Health information sources (eg. healthcare professionals, family, friends, media etc)*

A7. Fieldwork evaluation template

EUR-HUMAN

Fieldwork process evaluation report for WP2
Please complete this form as soon as possible after the last PLA moderated meeting

Evaluation of the preparation, sampling and recruitment
Country:
Staff member:
Date:

Ethical approval procedure	
1. Did you apply for ethical approval? *If not, please explain why not.*	
2. Where did you apply for ethical approval? *Please mention the name and level of the committee (e.g. University, national committee..)*	
3. Did you get ethical approval? *If not, please explain why not?* *if so, can you provide the number of the approval letter*	
4. Where were the any critical assessment points with regard to this study?	

Recruitment	
1. What type of implementation site did you use? (e.g. hotspots, transit camps, long-term camps)	
2. Can you give a description of the implementation site? (e.g. where the site is , how many refugees there are, how long refugees are in these sites..)	
3. Which bodies (professional or authorities) did you involve to support the recruitment?	
4. How did you approach the participants? P lease mention sampling procedure e.g. sampling by convenience, snowball etc.	
5. How many refugees in total were invited to participate in this study?	
6. How many groups of refugees were you able to form?	

1

Fieldwork (overall)	
1. Who were the local staff members involved in the fieldwork? (Students, health care workers,..?)	
2. How many local staff members were facilitating the sessions?	
3. How did you deal with the language barrier? (e.g. bilingual researcher, interpreter)	
4. What was the general feedback from the local staff members on their contact with the refugees?	
5. What problems/difficulties were reported by the local staff member involved in the fieldwork?	
6. In total, how many sessions took place at you site? and how many sessions per group?	

Other	
1. Are there any other issues which you came across during the fieldwork which you think are important for us to know?	

APPENDIX 8. DELIVERABLES OF WP3.

D3.1 Summary preliminary findings.

Ref. Ares(2016)2000509 - 27/04/2016

Version 3.0, April, 2016

EUR-HUMAN

Co-funded by
the Health Programme
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EUR-HUMAN project
WP3: Review of literature and expert knowledge

Deliverable 3.1. Preliminary findings

Promoting the health of refugees and other migrants in the context of short-term arrival and long-term settlement: effective measures and interventions and the factors that promote or hinder their implementation in European health care settings?

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This report 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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Version 3.0, April, 2016

Contents

About this report

1. Background and general objective of the EUR-HUMAN project
2. WP3 objectives
3. Heuristic framework
4. Methods
5. Preliminary findings
6. Practical recommendations
7. Summary and conclusion

References

Version 3.0, April, 2016

About this report

A primary objective of the EUR-HUMAN project is 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 current report, Deliverable 3.1, briefly summarizes the overall status of the third work package (WP3) of the EUR-HUMAN project after three months. The aim of this report is to contribute to the discussion and knowledge exchange between partners of the EUR-HUMAN project. The document gives an overview of the methodology, an example of the early results based on a non-systematic selection of works, and implications formulated against the background of key documents. The report complements the knowledge about the tools and guidelines created in WP4 and WP5. Also, it gives the consortium an opportunity to determine whether the current way of analysing and presenting information is sufficiently informative in the light of the overall objectives of the EUR-HUMAN project and its distinctive WPs.

At the moment the NIVEL-team is screening approximately 250 full-text articles. The preliminary findings are the result of an analysis of selected articles. A heuristic framework is described and partly tested. In a later stadium the partners will assist with the analysis of non-English and non-Dutch documents. An online survey to collect information on best practices is currently being disseminated with help from the partners. Expert interviews are planned to take place by the end of April/beginning of May to verify the findings from the review and surveys .

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

1. Background and general objective of the EUR-HUMAN project

The international refugee crisis has reached a critical point and many European countries are developing policy and plans to better define their role in supporting refugees entering Europe. A primary objective of the EUR-HUMAN project is 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. Tools and practice guidelines are developed for the initial health care needs assessment of arriving refugees (covering their mental, psychosocial and physical health). Intervention models will be tested in the six implementation sites in six different countries. There is a strong need to collect and share information about the most effective structures and programmes to improve health care.

The focus of the EUR-HUMAN project is placed particularly on strengthening primary health care. Primary health care is the first point of entry for refugees and other migrants. 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 an equal service delivery as the local population where appropriate . Additionally, the EUR-HUMAN project aims to positively influence the working conditions and satisfaction of local and refugee health care workers, as well as the interaction and collaboration between three key groups: refugees and other migrants, health care professionals, and host communities.

2. WP3 objectives

In recent years, several initiatives started to synthesize available evidence on effective health care interventions for refugees and other migrants, the core target group of the EUR-HUMAN project. WP3 aims to provide a comprehensive overview of effective interventions to address health needs and risks of refugees and other migrants in European countries, focusing on short-term arrival while anticipating on long-term settlement. Existing knowledge from the literature and experts is collected and synthesized systematically. Practical implications and implementation challenges are addressed, whilst taking into account characteristics of health systems in different countries (including the roles of health care professionals), the position of countries in the cross-European migration and settlement chain, and relevant contextual factors.

One of the primary objectives of WP3 is to bring together knowledge from different sources in a structured way. WP3 and WP2, will provide valuable input to WP4 and WP5 in order to propose an integrated, practical and feasible intervention package for implementation in the context of the project. This intervention package is probably multifaceted but, regardless of its nature and content, it preferably is (a) addressing at least four health domains within the refugee and migrant population: infectious

diseases, mental health and psychosocial problems, women and reproductive health, and chronic illness; (b) feasible for and useful to local health actors and service providers; (c) cross-nationally (and inter-culturally) applicable within the EU; (d) useful in an international "refugee-chain perspective"; (e) based on the strongest available scientific evidence.

The nature of the intervention package is an essential part of the EUR-HUMAN assignment. Special attention is given to the extent to which interventions and measures are applicable to different local European contexts. A good understanding of factors that determine success or failure of an intervention and measure in a particular setting is invaluable for decision-making on the design and composition of the intervention package.

With the ambition to promote the health of refugees and other migrants, especially those coming from Middle East and Africa, in the context of short-term arrival and long-term settlement, objective of WP3 is to learn from literature and experts on measures and interventions and the factors that help or hinder their implementation in European health care settings.

3. Heuristic framework

Before going deeper into the methods in section 4, this section presents the heuristic framework used to analyse the collected material. To enlarge the chance that promising measures and interventions are of practical use within the EUR-HUMAN project, the heuristic framework is comprised of sources in three categories: primary care oriented health care models, evidence-based guidelines, and implementation science models.

Table 3.1. Heuristic framework: sources in three categories

Category	Source
Primary care oriented health care models for refugees and other migrants (§3.1)	● Strategic objectives UN refugee agency UNHCR (UNHCR, 2014) ● Workflow primary health care for refugees and other migrants (EUR-HUMAN, 2016) ● Personal health record and handbook (European Union, IOM, 2015)
Evidence-based guidelines (§3.2)	● ECDC Evidence Based Migrant Health Guideline (Pottie et al., 2011)
Implementation science models (§3.3) *(complementary to the models adopted by WP2, WP4, WP5 and WP6: PLA* and NPT)	● Practical, Robust Implementation and Sustainability Model (PRISM) (Feldstein & Glasgow, 2008) ● Checklist for identifying determinants of practice (Flottorp et al., 2013) ● Community action model (Lavery et al., 2005)

3.1 Primary care oriented health care models for refugees and other migrants

Strategic objectives UNHCR
The UNHCR's "*Regional public health care and nutrition strategy for Syrian refugees"* includes 10 strategic objectives:

1. Support adequate triage, health screening and age-appropriate immunization of new arrivals
2. Support access to comprehensive primary health care (combination of curative and preventive health care, community-based; primary care first base of contact, available for a long term)
3. Decrease morbidity from communicable diseases and outbreaks
4. Support childhood survival and expanded programme for immunization
5. Support integrated prevention and control of non-communicable diseases and mental health
6. Support access to comprehensive reproductive health services
7. Support access to nutrition services (including breast feeding)
8. Support access to secondary and tertiary health care
9. Maintain and expand health information systems including information on access, uptake and coverage of services
10. Coordination (of the decentralized, action-driven approach aimed at health and nutrition; responsibility of Ministries of Health)

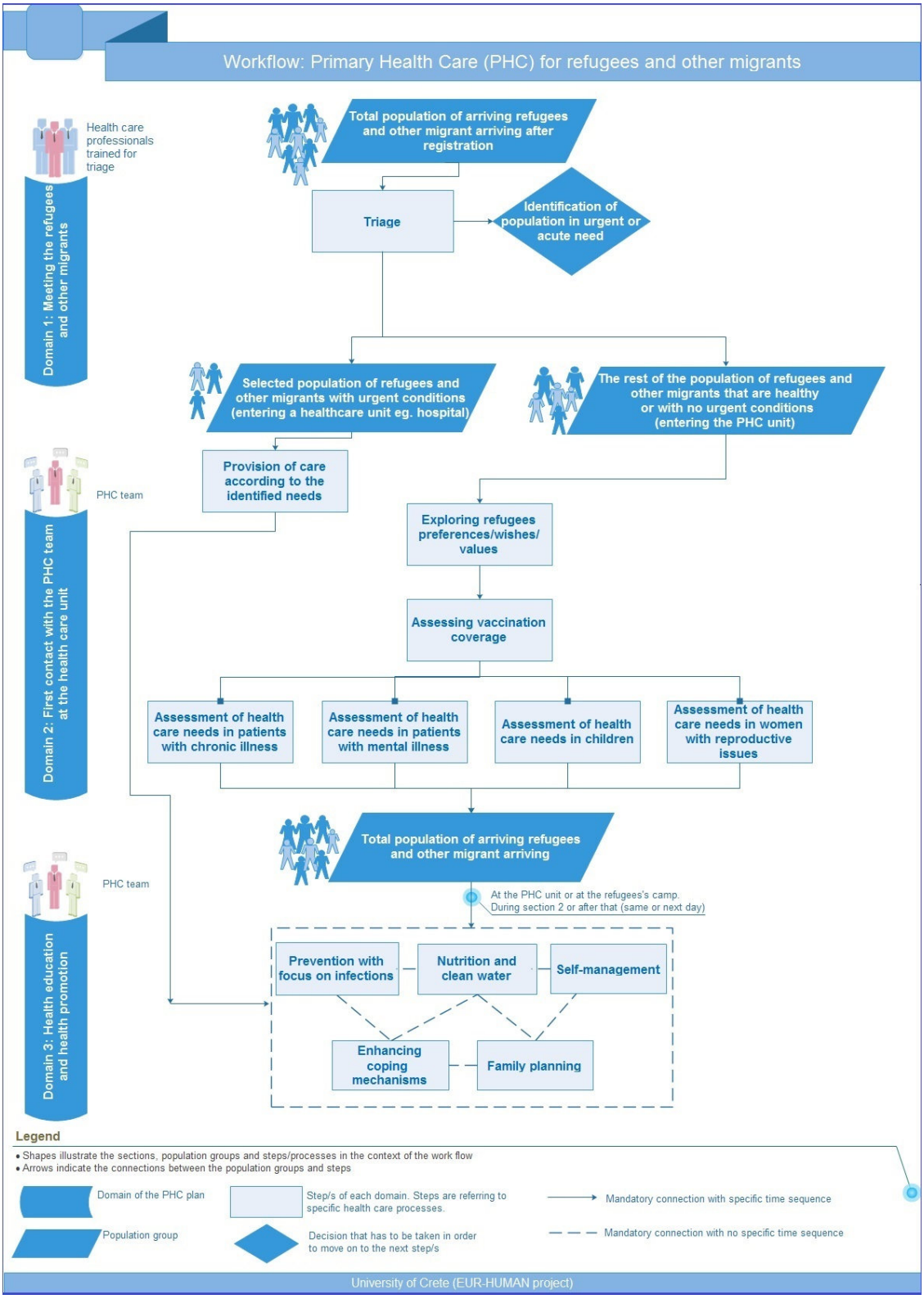
Several core themes and principles of the EUR-HUMAN project are reflected in these objectives: the health themes, the focus on primary care and community-based care, timely detection of risk/vulnerable groups, and a stepped care approach permitting access to more specialized health services where applicable.

Workflow primary health care for refugees and other migrants
Within the EUR-HUMAN project a workflow with three domains is developed, illustrating how health needs of population groups are addressed by, initially, health care professionals trained for triage and later by primary care teams. Figure 3.1 suggests the creation of a primary health care unit at the existing refugees and immigrants hosting centres. In the first domain urgent cases are identified and separated from non-urgent cases. The second domain starts with an assessment of vaccination coverage and followed by an assessment of care needs concerning chronic illness, mental illness, children, and women with reproductive issues. In the third domain a tailored health education and promotion programme is implemented for refugees and other migrants with urgent conditions.

The workflow is applicable to situations in countries where refugees enter the European Union, in transfer countries and in destination countries.

Version 3.0, April, 2016

Figure 3.1. Workflow primary health care for refugees and other migrants



Personal health record and handbook
The 'Personal Health Record' was developed by the Migration Health Division of the International Organization for Migration with the support from the European Commission and the contribution from the European Centre for Disease Prevention and Control. The record is a personal document. It includes in one single document the health data and information that will help the health professionals get a comprehensive view of a person's health status and needs. Refugees and other migrants will have to keep the document with them to help them in further contact with health professionals while traveling through Europe. The medical check is voluntary and the content of this document is confidential. It is covered by European and national regulations on data protection (European Union, IOM 2015).

3.2 Evidence-based guidelines
In recent years, there has been an increase in development of practice guidelines for refugees and other migrants. In the development of the ECDC Evidence-Based Migrant Health Guideline, the authors followed the internationally recognized Appraisal of Guidelines for Research and Evaluation (AGREE; www.agreetrust.org). They selected guideline topics using a literature review, stakeholder engagement and the Delphi process with equity-oriented criteria. A 14-step evidence review process was used to validate tools to appraise the quality of existing systematic reviews, guidelines, randomized trials and other study designs.

The ECDC guidelines are different from other guidelines because the developers insisted on finding evidence for clear benefits before recommending routine interventions (Pottie et al., 2011). For example, in the ECDC guidelines for post-traumatic stress disorder, intimate partner violence and social isolation in pregnancy, the authors recommend not conducting routine screening, but rather remaining alert. With regard to screening for asymptomatic intestinal parasites, they recommend focusing on serologic testing for high burden of disease parasites, rather than traditional testing of stool for ova and parasites.

Although the guidelines are currently being updated they are a convenient point of reference for the data collection in this work package. Table 3.2 provides a summary of evidence-based recommendations for the four health domains, adopted from the original source (Pottie et al., 2011).

Version 3.0, April, 2016

Table 3.2. ECDC Evidence-Based Migrant Health Guideline: Summary of recommendations

ECDC Evidence-Based Migrant Health Guideline: Summary of recommendations
Mental health/psychosocial care *Depression* - If an integrated treatment program is available, screen adults for depression using a systematic clinical inquiry or validated patient health questionnaire (PHQ-9 or equivalent). - Individuals with major depression may present with somatic symptoms (pain, fatigue or other nonspecific symptoms). - Link suspected cases of depression with an integrated treatment program and case management or mental health care. *Post-traumatic stress disorder* - Do not conduct routine screening for exposure to traumatic events, because pushing for disclosure of traumatic events in well-functioning individuals may result in more harm than good. - Be alert for signs and symptoms of post-traumatic stress disorder (unexplained somatic symptoms, sleep disorders or mental health disorders such as depression or panic disorder). *Child maltreatment* - Do not conduct routine screening for child maltreatment. - Be alert for signs and symptoms of child maltreatment during physical and mental examinations, and assess further when reasonable doubt exists or after patient disclosure. - A home visitation program encompassing the first two years of life should be offered to immigrant and refugee mothers living in high-risk conditions, including teenage motherhood, single parent status, social isolation, low socioeconomic status, or living with mental health or drug abuse problems. *Intimate partner violence* - Do not conduct routine screening for intimate partner violence. - Be alert for potential signs and symptoms related to intimate partner violence, and assess further when reasonable doubt exists or after patient disclosure. Note: PHQ-9 = nine-item Patient Health Questionnaire. *Order of listing considers clinical feasibility and quality of evidence.
Women's health *Contraception* - Screen immigrant women of reproductive age for unmet contraceptive needs soon after arrival. - Provide culturally sensitive, patient-centred contraceptive counselling (giving women their method of choice, having contraception on site and fostering a good interpersonal relationship). *Vaccination against human papillomavirus* - Vaccinate 9- to 26-year-old female patients against human papillomavirus . *Cervical cytology* - Screen sexually active women for cervical abnormalities by Papanicolaou (Pap) test. - Information, rapport and access to a female practitioner can improve uptake of screening and follow-up. *Order of listing considers clinical feasibility and quality of evidence.

ECDC Evidence-Based Migrant Health Guideline: Summary of recommendations

Chronic and noncommunicable diseases

Type 2 diabetes mellitus

- Screen immigrants and refugees > 35 years of age from ethnic groups at high risk for type 2 diabetes (those from South Asia, Latin America and Africa) with fasting blood glucose.

Iron-deficiency anemia

- Women: Screen immigrant and refugee women of reproductive age for iron-deficiency anemia (with hemoglobin). If anemia is present, investigate and recommend iron supplementation if appropriate.
- Children: Screen immigrant and refugee children aged one to four years for iron-deficiency anemia (with hemoglobin). If anemia is present, investigate and recommend iron supplementation if appropriate.

Dental disease

- Screen all immigrants for dental pain. Treat pain with nonsteroidal anti-inflammatory drugs and refer patients to a dentist.
- Screen all immigrant children and adults for obvious dental caries and oral disease, and refer to a dentist or oral health specialist if necessary.

Vision health

- Perform age-appropriate screening for visual impairment.
- If presenting vision < 6/12 (with habitual correction in place), refer patients to an optometrist or ophthalmologist for comprehensive ophthalmic evaluation.

*Order of listing considers clinical feasibility and quality of evidence.

Infectious diseases

Measles, mumps and rubella

- Vaccinate all adult immigrants without immunization records using one dose of measles–mumps–rubella vaccine.
- Vaccinate all immigrant children with missing or uncertain vaccination records using age-appropriate vaccination for measles, mumps and rubella.

Diphtheria, pertussis, tetanus and polio

- Vaccinate all adult immigrants without immunization records using a primary series of tetanus, diphtheria and inactivated polio vaccine (three doses), the first of which should include acellular pertussis vaccine.
- Vaccinate all immigrant children with missing or uncertain vaccination records using age-appropriate vaccination for diphtheria, pertussis, tetanus and polio.

Varicella

- Vaccinate all immigrant children < 13 years of age with varicella vaccine without prior serologic testing.
- Screen all immigrants and refugees from tropical countries ≥ 13 years of age for serum varicella antibodies, and vaccinate those found to be susceptible.

Hepatitis B

- Screen adults and children from countries where the seroprevalence of chronic hepatitis B virus infection is moderate or high (i.e., ≥ 2% positive for hepatitis B surface antigen), such as Africa, Asia

ECDC Evidence-Based Migrant Health Guideline: Summary of recommendations

and Eastern Europe, for hepatitis B surface antigen, anti-hepatitis B core antibody and antihepatitis B surface antibody.
- Refer to a specialist if positive for hepatitis B surface antigen (chronic infection). Vaccinate those who are susceptible (negative for all three markers).

Tuberculosis
- Screen children, adolescents < 20 years of age and refugees between 20 and 50 years of age from countries with a high incidence of tuberculosis as soon as possible after their arrival in Canada with a tuberculin skin test. If test results are positive, rule out active tuberculosis and then treat latent tuberculosis infection.
- Carefully monitor for hepatotoxity when isoniazid is used.

HIV
- Screen for HIV, with informed consent, all adolescents and adults from countries where HIV prevalence is greater than 1% (sub-Saharan Africa, parts of the Caribbean and Thailand).
- Link HIV-positive individuals to HIV treatment programs and post-test counselling.

Hepatitis C
- Screen for antibody to hepatitis C virus in all immigrants and refugees from regions with prevalence of disease ≥ 3% (this excludes South Asia, Western Europe, North America, Central America and South America).
- Refer to a hepatologist if test result is positive.

Intestinal parasites
- Strongyloides: Screen refugees newly arriving from Southeast Asia and Africa with serologic tests for Strongyloides, and treat, if positive, with ivermectin.
- Schistosoma: Screen refugees newly arriving from Africa with serologic tests for Schistosoma, and treat, if positive, with praziquantel.

Malaria
- Do not conduct routine screening for malaria.
- Be alert for symptomatic malaria in migrants who have lived or travelled in malaria-endemic regions within the previous three months (suspect malaria if fever is present or person migrated from sub-Saharan Africa). Perform rapid diagnostic testing and thick and thin malaria smears.

*Order of listing considers clinical feasibility and quality of evidence.

(Source: ECDC Evidence Based Migrant Health Guideline; Pottie et al., 2011)

3.3 Implementation science models

Three models play a role in the analysis and the formulation of recommendations aimed at enlarging the success chances of the implementation of measures and interventions on behalf of refugee health care.

PRISM - Practical, Robust Implementation and Sustainability Model

Feldstein et al. (2008) described how a comprehensive model for translating research into practice was developed using concepts from the areas of quality improvement, chronic care, the diffusion of innovations, and measures of the population-based effectiveness of translation. PRISM (the Practical, Robust Implementation and Sustainability Model) evaluates how the health care program or intervention interacts

with the recipients to influence program adoption, implementation, maintenance, reach, and effectiveness. PRISM considers how the program or intervention design, the external environment, the implementation and sustainability infrastructure, and the recipients influence program adoption, implementation, and maintenance (Feldstein et al., 2008).

Checklist for identifying determinants of practice
Flottorp et al. (2013) identified seven dimensions of factors that help or hinder the implementation: (1) characteristics of health care measure or intervention, (2) characteristics of health care providers, (3) characteristics of refugees/migrants, (4) professional interactions, (5) incentives and resources, (6) local capacity for organisational change, (7) particular social, political and legal factors.

Community action model
This cycle-model is not used in WP3 but in the overarching EUR-HUMAN project. At a certain stage interventions and measures are selected and combined with an implementation strategy. The output of the current work package has to be merged within the stepwise approach together with the output of activities in the other WPs.

4. Methods

WP3 seeks to learn from literature and experts on measures and interventions and the factors that help or hinder their implementation in European health care settings. Three data sources are accessed for this purpose, because by focusing solely on the literature it is very likely that valuable, practical information is going to be missed: a scoping review (§4.1), an online survey (§4.2), and expert interviews (§4.3).

4.1 Scoping review
The systematic search of the literature provides insights into the existing scientific evidence for the implementation of assessment tools, intervention strategies and preventive measures in the various health domains of the EUR-HUMAN project. Searches were performed in Pubmed, Embase, Cochrane, PsycINFO, PILOTS and Sociological Abstracts.

Search-strings were formulated in English and are a combination of two building blocks. The first part contains a combination of search terms related to the target group of the EUR-HUMAN project: e.g. refugees, migrants and asylum-seekers. The second part is based on earlier systematic reviews, published in peer reviewed journals such as Implementation Science (e.g. Chaudoir et al., 2013). After elaborately testing the search string the data collection strategy was improved. Additional synonyms were added, in plural and singular forms. Moreover, the search was verified by a review specialist from the Cogis library, which is part of the Dutch national knowledge centre on the psychosocial effects of war, violence, persecution, and humanitarian crises. The search

was mildly adjusted to the interfaces of the databases completed on the 29th of February, 2016. The PubMed search string is included in Table 3.3.

Table 3.3. Example of the search string as it was entered in PubMed

PubMed search string		
#1		
MeSH Terms	refugees	OR
Title/abstract	refugee	OR
Title/abstract	refug*	OR
Title/abstract	“Asylum seeker”	OR
Title/abstract	“Asylum seekers”	OR
Title/abstract	“conflict survivor”	OR
Title/abstract	“conflict survivors”	OR
Title/abstract	migrant	OR
Title/abstract	migrants	OR
Title/abstract	immigrant	OR
Title/abstract	immigrants	OR
Date	26.02.2016	
Time	15:28	
Hits	42698	
#2		
Title/abstract	“diffusion of innovation”	OR
Title/abstract	“diffusion of innovations”	OR
MeSH Terms	“information dissemination”	OR
Title/abstract	dissemination	OR
Title/abstract	disseminate	OR
Title/ abstract	disseminating	OR
Title/abstract	“effectiveness in research”	OR
MeSH Terms	health plan implementation	OR
Title/abstract	implement	OR
Title/abstract	implementation	OR
Title/abstract	implementing	OR
Title/abstract	“knowledge to action”	OR
Title/abstract	“knowledge transfer”	OR
Title/abstract	“knowledge translation”	OR
Title/abstract	“research to practice”	OR
Title/abstract	“scale up”	OR
Title/abstract	“Scaling up”	OR
Title/abstract	“research utilisation”	OR
Title/abstract	“research utilization”	OR
Title/abstract	“technology transfer”	OR
Title/abstract	“translational research”	OR

PubMed search string		
MeSH Terms	practice guidelines as topic	OR
Title/abstract	“practice guideline”	OR
Title/abstract	“practice guidelines”	OR
Title/abstract	“evidence-based medicine”	OR
Date	26.02.2016	
Time	14:09	
Hits	386258	
Combined #1 AND #2		
Date	26.02.2016	
Time	15:29	
Hits	1417	

See Table 3.4 for an overview of search hits in each database. After having checked for duplicates, 3,979 abstracts were included for a first review round. In the first two weeks of March the abstracts were screened by two reviewers.

Table 3.4. Number of hits per database

Database	**Number of hits**	**Date**	**Time (CET)**
Sociological Abstracts	995	26.02.2016	17:13
PILOTS	64	26.02.2016	16:04
Cochrane	66	26.02.2016	16:49
PubMed	1417	26.02.2016	15:29
Embase	2116	26.02.2016	15:56
PsycINFO	861	29.02.2016	15:29

4.2 Online survey

A survey is developed and disseminated among professionals and experts at the different work locations of the partners in Greece, Hungary, Croatia, Italy, Austria and the Netherlands. The survey target group consists out of two types of participants. On the one hand it is important to reach individuals who are involved in facilitating and coordinating the provision of health care for refugees and other migrants. These survey participants can be involved, for instance, in strategy and guideline development, policy-making, legal matters, logistics, capacity planning, and planning of practical support. On the other hand it is crucial that operational professionals and frontline workers with practical experience are consulted: primary health care professionals, social and youth workers, and more specialized care givers including psychologists, psychiatrists, radiologists and testing staff, not volunteers. The personal interaction with refugees and migrants is what distinguishes this second group of professionals from the first one. It is

important that participants from both groups have recent experience with issues, challenges and problems concerning refugees and migrants in Europe. These experience are preferably related to local health care practices, but national and regional experiences are valuable as well. The survey link is accessible in March and April.

4.3 Expert interviews

In addition to the survey and the literature review, expert interviews are conducted to assemble information about the contexts, meaningful structures, process characteristics and challenges of health care for refugees and other migrants on the ground. They are also asked to provide concrete examples of effective interventions that could be used in the current refugee crisis. In consultation with the other partners, NIVEL will invite 10 to 15 international experts (a.o. UNHCR, The Red Cross, Medicins Sans Frontieres and Medicines du Monde) for an individual interview. Interviews will take place by Skype or telephone and will be semi-structured, based on a predefined topic list:

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

Interviews will be recorded with permission from the interviewee. Data will be integrated and analysed according to the principles put forth in “Applied Thematic Analysis” (Guest et al., 2012).

4.4 Data analysis

The included material will be studied by at least two independent reviewers. The partners will be asked to assist with interpreting documents and information in their native language. An overview (in English) will be produced with information on:

- Year the intervention or measure was applied (if available)
- Context (country, refugee or migrant population, type of service provider)
- Evidence strength for effectiveness (applying a hierarchy; e.g. EPOC or PRISMA)
- Description of intervention and measure and its application (single intervention or multi-faceted programme)
- Implementation factors (Flottorp et al., 2013)
- Recommendations for improvement i.e. resolving obstacles

5. Preliminary findings

In this preliminary report preliminary findings on the four thematic areas are presented: mental health/psychosocial care (§5.1), women, maternal and childcare (§5.2), infectious diseases (§5.3), and chronic and non-communicable diseases (§5.4).

This preliminary evaluation showed high heterogeneity between studies in terms of design. Most of them were cross-sectional and/or descriptive in nature and therefore the assessment of the quality of the provided evidence on the basis of established schemes (Gouweloos et al., 2014) was, in many cases, a challenging task. Many of the studies were qualified "weak" and sometimes "moderate". The design of the selected studies is often based on cross-section data. Also, case-reports and non-systematic reviews were found (see Table 4.1 at the end of this section).

Identification and classification of barriers and enablers were based on systematically evaluated criteria for the assessment of factors that prevent or facilitate the implementation of health care professional practice (Flottorp et al., 2013).

5.1 Mental health/psychosocial care

The preliminary findings on the implementation of screening, assessment and treatment of psychosocial problems for refugees and other migrants are based on five articles that were selected on the basis of availability, year and relevancy of the title.

Only a few recent studies deal with Syrian refugees coming to EU. However, valuable lessons can be learned from implementation of psychosocial interventions in refugee camps, for example in South Africa.

<u>Professional level</u>

Most studies identified the training of professionals in cultural sensitive aspects as a core enabler (Watters, 2010, Brugha, 2014, Melle, 2014, Mollica, 2014). The proposed H5 model (Molica, 2014) argues that professionals should know about basic human rights and develop deep listening skills for trauma treatment. Watters (2010) indicates that professionals need to be up to date on the political and legal situation of the receiving country and the country of origin of the refugees. Watters (2010) and Brugha (2014) advise that the mental health services themselves should intrinsically reflect the culture and needs of the refugees they seek to engage with.

<u>Patient level</u>

Importantly, refugees should themselves be involved in the organisation of mental and social health care to clearly identify their needs. General health promotion programs should be made available across refugee camps (Watters, 2010, Brugha, 2014).

Organisational level

Most initiatives of specific refugee services for mental health are organised bottom-up and not structurally financed. This becomes a barrier because this limits the continuity of care for migrants. Mental health care for refugees should be structurally embedded in national mental health care organisations.

Moreover, it is recommended that social care and mental health care are closely integrated as mental health problems and social problems are highly related within refugees. Furthermore, it is argued that a good habitat is essential for mental well-being. Governments should provide appropriate housing, access to employment and other aspects for good habitat (Mollica, 2014).

The focus for psychosocial therapy for refugees is different than within regular patients. Namely, therapy should not be emotional or ego focused, but rather offer more problem solving and practical tools. Basic information on family education and illnesses should be made available in appropriate languages for refugees to understand what mental health care entails. Cognitive behavioural therapy has to be adjusted to the cultural traditions of refugees (Brugha, 2014).

Specialized health care needs to be available for the minority of refugees with severe psychiatric problems. Regarding the screening and assessments, a cross-sectional study from the Netherlands (Melle, 2014) found that GPs underestimated the prevalence of common mental disorders in refugees. Therefore it is needed that GPs are trained in the recognition of common mental disorders in refugees and other migrants.

A longitudinal cohort study in South Africa demonstrated the feasibility of depression screening by using SMS services (Tomita, 2015). Most refugees had access to SMS services and the low rate of incomplete responses and relative ease of use support the feasibility. Biggest challenges were problems with phone network (network delay) and the theft of phones.

Finally, data on screening, assessment and treatment results should be collected systematically (Brugha, 2014).

5.2 Women, maternal and childcare

From the 51 articles selected on the basis of title and abstract for this thematic area six were reviewed for this preliminary study. These specific studies were used to explore the usability of the framework. Studies were conducted in a wide range of settings, from maternity care assistants practising a home-care setting in the Netherlands to infant feeding practices at refugee camps in the Balkans. The target group differs as well; Syrian refugees in Jordan, non-western women in the Netherlands, refugees in Sub-Saharan Africa, African refugees that resettled in Australia, Kosovar refugees at the Balkans and refugees at the Thai-Myanmar border. Even though this clearly challengds

the integration of the findings, general barriers and enablers were identified across settings and formulate general recommendations.

Professional interactions

At the level of individual barriers of staff and patients, difficulty with communication is seen as a primary issue. (Casey, 2015, Boerleider, 2014, Correa-Velez, 2012, Krause, 2015, Borrel, 2001). Therefore it is suggested to make use of appropriate cultural mediator services, translated information and staff that put effort in working towards building a trusting relationship.

Practical issues were identified for the use of cultural mediator services. For example, making sure that the gender and age fits with patient's expectations. Women could for example feel uncomfortable to share sensitive issues with male cultural mediators. Continuity of cultural mediators, which could help building trust and would prevent patients needing to tell their private stories to different cultural mediators. And reserving longer time for consultations when cultural mediator services are used, because that generally takes more time. Another suggestion was to appoint officers (for example social workers) that can form a bridge between service providers and patients. They could assist with the delivery of culturally sensitive information. (Correa-Velez, 2012)

Patients and providers lacked awareness about the availability of services. Therefore they need to be better informed about these services. It is essential to provide information about the health care system, healthy health care practices and to address the needs for health care. Together these could increase the uptake of care (Casey, 2015).

Patient and professional level

An important barrier in the provision of health care is the lack of knowledge and/or skills among health care professionals (Krause, 2015, Borrel, 2001, Hoogenboom, 2015, Correa-Velez, 2012, Casey, 2015). Not having the skill set to provide adequate services and limited knowledge regarding available services, protocols, guidelines, legislation, the needs of refugees and the complex social and medical histories of refugees. Furthermore, cultural sensitivity of practitioners is in need of improvement (Correa-Velez, 2012, Boerleider, 2014) . For example not engaging family in maternal care even though this is part of culture and expected by patients. Furthermore, cultural barriers of practitioners themselves regarding Family Planning services (FP). Resulting in misconceptions about the provision of appropriate care. For example not providing condoms to unmarried women. Therefore, trainings to increase knowledge, skills, and cultural competence are recommended. Especially in regard to issues such as female circumcision, trauma and traditional birthing practices.

A strategy to make care more culturally sensitive is suggested by Boerleider (2014), 'being flexible' in the sense of searching for a compromise between the cultural

practices of patients and protocols when this poses no danger, would enhance practice. And building a trusting relationship with patients and their families (Boerleider, 2014, Correa-Velez, 2012). Several barriers are experienced by patients in accessing reproductive health services. Women face cultural barriers that prevent them from making use of health services (Borrel, 2001, Krause, 2015, Casey, 2015). They tend to comply with cultural norms due to fear of stigma or social repercussions (Krausse, 2015, Casey, 2015). Their limited understanding, knowledge and awareness of available health services and health problems and need for seeking care are resulting in a low uptake of care. Educational programs to inform about health issues and available care can increase acceptability and uptake of care. The provision of translated information and appropriate cultural mediator services could further reduce these barriers.
It was recommended to educate professionals, patients and communities to reduce stigma, raise awareness and increase acceptance and the uptake and provision of services (Casey, 2015, Krause, 2015).

Organisational level

The lack of a comprehensive monitoring system (Casey, 2015, Krause, 2015, Borrel, 2001), insufficient funding (Borrel, 2001, Krause, 2015), limited supply and equipment (Casey, 2015, Hoogenboom, 2015, Krause, 2015, Borrel, 2001), poor coordination, unclear division of roles (Krausse, 2015, Borrel, 2014), lack of capacity in terms of time and resources and staff changes were mentioned as barriers. Borrel (2001) recommends to appoint a lead agency that takes responsibility for a well-functioning monitoring system, this system could increase accountability and enable identification of weak point in implementation. Reproductive health services are recommended to be integrated in general care (Casey, 2015). An enabling environment could motivate staff and influence the perceived quality of health care services by patients (Hoogenboom, 2015). Especially, safeguarding the continuity of carer was mentioned as beneficial (Correa-Velez, 2012, Hoogenboom, 2015). “Continuity of carer increases women satisfaction, trust and confidence and improves communication and enhances women's sense of control and ability to make informed decisions” (Correa-Velez, 2012).

Social, Cultural and Legal barriers and enablers

Social and cultural norms in the community can result in a low uptake of services. For example social sanctions against PLHIV, rape survivors or women that use FP methods. Therefore, communities need to be informed about health benefits of services (Krause, 2015). At the national level policies and legislation need to be in place to support RH services. Implementers are struggling with restrictive national policies or absence of policies. For example the clinical management of rape survivors or female circumcision policy is lacking (Casey, 2015, Krause, 2015). A pre-existing health infrastructure facilitates practices on the ground (Kraus, 2015) As well as the willingness to address reproductive health issues (Krause, 2015, Casey, 2015).

5.3 Infectious diseases

The present preliminary findings for the infectious disease cluster are based on 9 recently published peer-reviewed articles. Five of them involved (at least to some extent) EU countries as setting. The majority of these studies focused on Tuberculosis as health outcome of primary investigation. The primary target group was (but not restricted to) refugees from several (non-western) countries. Time-frame varied from before-arrival at the setting to long-term settlement. Only one study focused specifically on Syrian refugees. There was no restriction regarding basic demographic characteristics (age, gender) of the target groups in most of the examined studies. Among the involved parties were (inter)national expert networks, national and international (health) organizations (WHO, UN, Centre for Disease Prevention), Ministries, local authorities and health care providers.

Guideline factors may act as barriers when there is lack of established international guidelines on screening among migrants, taking into account also the differences between countries receiving immigrants, the number of arriving migrants and their status (e.g refugees, economic migrants). (Kärki et al., 2014). Lack of a broadly accepted treatment protocol and guidelines for disaggregating data collection comprise additional barriers (Riccardo et al., 2012; Cookson et al., 2015). However, implementation of health interventions is strengthened by the availability and accessibility of evidence-based health care practice guidelines (Falla et al., 2013; Nardel et al., 2016) that take into account the time frame between medical screening and patient mobility (Wingate et al., 2015).

A number of patient factors were identified as major barriers, such as language/communication limitations, psychological and socio-cultural factors (Riccardo et al., 2012), lack of adhere to medication (Cookson et al., 2015) and high comorbidity levels among patient groups, which requires additional, costly interventions (Cookson et al., 2015) and migration status (Napoli et al., 2015). Nevertheless, intervention implementation is facilitated and associated costs are lower when screening is targeted only to patients coming from intermediate to high endemic areas (El-Hamad et al., 2014; Wingate et al., 2015); in this case, patient characteristics are acting as enablers.

Social and legal factors as well as incentives and resources were identified as crucial barriers and enablers. Legal restrictions and (health care) user fees (Riccardo et al., 2012), especially for undocumented patient groups (Falla et al., 2013), as well as difficulties in securing an intervention funding source that is stable over time (Cookson et al., 2015) seem to be important obstacles. Measures for the prevention of airborne infections are more difficult to be implemented when are expensive and associated with high maintenance costs or not applicable all year (e.g. because of the local climate) (Nardel et al., 2016). On the contrary, information availability and accessibility appear to be enablers of primary importance. For instance, the initiation of interventions is facilitated by free patient access to primary care (El-Hamad et al., 2014), increased information availability among mobile communities (Riccardo et al., 2012). In addition,

disaggregating data collection to monitor and evaluate health service performance among mobile groups and building trust in public health services (Riccardo et al., 2012). Measures for the prevention of airborne infections are recommended to be widely available and cost-effective in order to facilitate implementation (Nardel, 2016).

Regarding the primary and secondary care setting, will/motivation and skills of health care staff (Storberg et al., 2015) as well as collaboration between health care management and staff on the implementation of the guidelines (Storberg et al., 2015) are positive aspects towards implementation. On the contrary, the fact that referral practice is highly divergent between EU countries (Falla et al., 2013) and cross-border communication between different national health programs is not sufficiently established (Cookson et al., 2015) act as hindering factors. Moreover, health care infrastructure in some EU countries can reduce the capacity for organizational improvements (Storberg et al., 2015).

Legal and political factors such as host country legislation and political decisions that do not favour health care reforms (Napoli et al., 2015; Storberg et al., 2015) can also be important barriers. Furthermore, living in a conflict zone/being internally displaced may result in delayed treatment (Cookson et al., 2015), while social stigma and discrimination towards the target groups constitutes a profound barrier (Kärki et al., 2014 ; Cookson et al., 2015)

5.4 Chronic and noncommunicable diseases

Preliminary findings for the chronic noncommunicable disease cluster are based on 5 recently published articles (only one study performed in the EU). The majority of the examined publications focused on cardiovascular problems and diabetes as health outcomes of primary investigation. In most of the studies, the primary target group was adult refugees with a long-term settlement. Among the involved parties were international organizations (e.g United Nations), National expert societies and health care providers.

Patient factors and incentives-resources were identified as the most frequent barriers and enablers respectively. More specifically, patient factors that hindered the implementation of health programs/interventions were: cultural beliefs (Modesti et al., 2014), forced lifestyle changes (Modesti et al., 2014), unfamiliarity of patients with health care system (Otoukesh et al., 2015), fear of prosecution (in case of undocumented patients) (Otoukesh et al., 2015), passive attitude towards treatment (van de Vijver et al., 2015) and language barriers (Wagner et al., 2015). Nevertheless, similarities/overlap between different target groups (e.g in terms of lifestyle, risk factors, socio-economic status) was considered a facilitating factor towards the application of previously tested interventions on different settings and populations (van de Vijver et al., 2015).

Incentives and resources such as availability and easy access to treatment (Otoukesh et al., 2015; van de Vijver et al., 2015), relevant education for health care providers and low intervention costs (Shahin et al., 2015) seem to play a major role in the implementation of health interventions. However, patients' financial problems as well as lack of registry data and clinical databases to study the clinical profile of the target groups (Modesti et al., 2014) pose as considerable obstacles.

Health care practice guidelines acted as barriers when suggested increased mobility/transportation of patients to different locations (Wagner et al., 2015) and as enablers when being adjusted to patients' cultural background to facilitate acceptance and compliance (Modesti et al., 2014). Involvement and supportive behaviour of health care staff (Shahin et al., 2015) and international partnerships between providers within the framework of cross-cultural multidisciplinary teams (Otoukesh et al., 2015; Wagner et al., 2015).

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

Table 4.1. Methodological quality of studies

author	**year**	**health domain ***	**study design (RCT,CBA,ITS,UBA. mixed)**	**quality**
Boerleider	2014	A	qualitative. 15 interviews	weak
Borrel	2001	A	analysis of practice and policy. No clear method description.	weak
Casey	2015	A	cross-sectional mixed methods study (FDGs, questionnaires and HFA's)	weak
Correa- velez	2012	A	mixed methods. literature review, consultations with key stakeholders, chart audit of hospital use, surveys among patients and hospital staff	weak
Krause	2015	A	3 methods: Key informant interviews(KIIs), health facility assessment(HFAs), focus group discussions (FDGs)	weak
Hoogenboom	2015	A	HFAs (interviews, analysis of maternal records and observations	weak
Watters	2010	B	summary of study	Moderate
Bhrugha	2014	B	guidance document	Weak
Melle	2014	B	cross sectional study	Moderate
Tomita	2015	B	cohort	moderate
Mollica	2014	B	report	weak

author	year	health domain *	study design (RCT,CBA,ITS,UBA. mixed)	quality
Riccardo	2012	C	cross sectional study	weak
Falla	2013	C	cross sectional study	Weak
Kärki	2014	C	cross sectional study	Weak
Hamad	2014	C	longitudinal	Moderate
Cookson	2015	C	case study	Weak
Napoli	2015	C	cross sectional study	Weak
Storberg	2015	C	case study	Weak
Wingate	2015	C	cost-benefit analysis	Weak
Nardel	2016	C	non-systematic review	Weak
Modesti	2015	D	narrative review	Weak
Otoukesk	2015	D	retropsective cohort	Moderate
Shahin	2015	D	narrative review	Weak
Van de Vijver et al	2015	D	protocol	Weak
Wagner	2015	D	review	Weak

* (A) Maternal and child (B) psychosocial (C) Infectious diseases (D) chronic and non-communicable

6. Practical recommendations

General recommendations

The strategic objectives of UNHCR, the flow chart, the IOM health record and handbook, and the evidence-based guidelines serve as a logical and useful framework to optimize health care for refugees and other migrants in European settings. However, the implementation science models point at recurring barriers, in every type of health domain, that must be given attention during the implementation of health care interventions and measures (barriers are encountered in each of the dimensions distinghuished by Flottop et al., 2013).

After having accessed Europe, refugees and migrants are moving towards less vulnerable countries with more favourable health care conditions and capacity, both on the short and on the longer term.[1] Most of the relevant system features and country conditions that influence the quality of health care for refugees and other migrants are exogenous factors; undeniably relevant, but difficult to influence. It is recommended to invest in optimization efforts in local implementation of promising programmes or single interventions and measures and not in large-scale system reform.

Screening actions should be accompanied by an appropriate professional follow-up to those who seem to have severe health problems.

[1] More information can be obtained from the first author (m.duckers@nivel.nl).

Policy-makers

Policy-makers should plan and facilitate local activities in line with a stepped care model, in which primary care professionals form a front-office between refugees and more specialized health care professionals. It is important to promote the safe use of a medical booklet in a paper or a virtual way to ensure that health care professionals in different locations can learn from what is already known. Moreover, they should facilitate the training and education of health care professionals in relation to mental, women and reproductive health issues, infectious diseases, chronic and noncommuncable diseases.

Health care professionals

Health care professionals ought to be aware of cultural norms and stigma in relation to health problems in all the categories addressed in the EUR-HUMAN project. The professional-patient interaction plays a crucial role in the delivery of high-quality health care. Besides taking care of the interests of refugees and other migrants, professionals should take good care of their own well-being, including protective measures against risk of infection. Knowledge and skills must be kept up to date.

Refugees and other migrants

Refugees have a responsibility in taking good care of the health and well-being of themselves, their children and vulnerable relatives and friends, during their journey and arrival in the country of destination. It is in their interest to keep a recent, completed health record accessible, physically or virtually.

Other relevant stakeholders

Researchers should cooperate with health care professionals in the evaluation of interventions and measures and broadly share their findings with other health care professionals, policy-makers and the academic community.

7. Summary and conclusion

This report presented the preliminary findings of WP3. In the first section the background of the EUR-HUMAN project was briefly addressed, followed by a description of the objectives of WP3. Next, a heuristic framework was sketched, based on a combination of three categories of sources, forming a lens to analyse the material collected using the methods described in the fourth section: the scoping review, the online survey and the expert interviews. The studies discussed in section 5 illustrate the suitability of the framework in assessing the contents of the collected material in WP3. In this section the results per health domain were structured according to the dimensions (different types of determinants for implementing changes) distinguished by Flottorp et al. (2013) – information of this sort seems indispensable for any attempt to enhance the health care provision for refugees and other migrants in local settings across Europe. In the previous section some recommendations were listed for different stakeholders. In the final report the list is going to be expanded.

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D3.2 Final synthesis.

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

Deliverable 3.2. Final Synthesis

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

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Contents

About this report

1. Introduction
2. Methods
3. Overview of findings
4. Discussion

Appendix 1. Search terms and flowchart

Appendix 2. Survey items

Appendix 3. List of experts and topic list for interviews

Appendix 4. Detailed description of results

- 4.1 Literature review
- 4.2 Survey
- 4.3 interviews

Appendix 5. Data extraction framework

Appendix 6. Refugee health care optimization checklist: ATOMiC test version

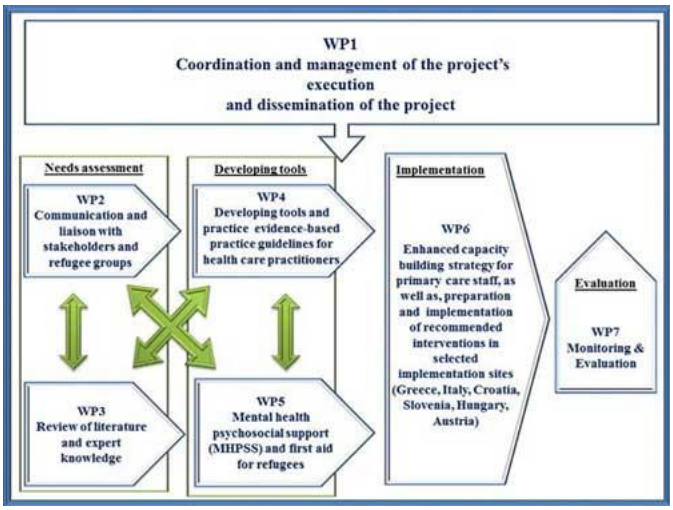
About this report

EUR-HUMAN

In January 2016, with the international refugee crisis in a critical phase, pressuring many European countries to develop policy and plans to better define their role in supporting refugees entering Europe, an international consortium led by University of Crete started the EU-funded EUR-HUMAN project: EUropean Refugees-HUman Movement and Advisory Network. The primary objective of the EUR-HUMAN project was to identify, design and implement interventions to improve primary health care delivery for refugees and other migrants[1] in Europe at hotspots, transit centres and longer stay first reception centres.

The work packages of EUR-HUMAN

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



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

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

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

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

Work package 3

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

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

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

Chapter 1. Focus of work package 3

Objective

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

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

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

Questions

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

(1) What factors help or hinder the implementation of health care interventions for refugees and other migrants in European settings?

(2) What recommendations are provided by the literature, experts and professionals to overcome these barriers and accommodate health care optimization?

Chapter 2. Methods

2.1 Collection and analysis of information from three sources

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

Framework for data extraction

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

2.2 Literature review

Development of search strings

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

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

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

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

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

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

Selection based on full text
The 264 articles were grouped in five main themes and divided among the research team:

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

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

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

2.3 Online survey

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

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

Data analysis

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

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

2.4 Expert interviews

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

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

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

Data analysis

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

Chapter 3. Overview of findings

3.1. Introduction

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

3.2. Main findings from three sources

Literature review

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

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

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

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

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

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

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

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

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

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

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

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

Online survey

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

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

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

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

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

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

Interviews

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Domain A. Legislation, protocols, guidelines, policies

Barriers	Enablers/ strategies to improve implementation
• Unavailability of useful guidelines. • Complexity of guidelines and newness of a guideline. • Adherence to guidelines can be low when the guidelines are considered inappropriate for the target population. For example, when professionals are providing care to patients that are not entitled to it. • A lack of protocols and policies or restrictive legislation can result in the absence of certain services. For example, the treatment of STIs, rape, abortion and HIV. • Weak institutionalisation of policies can also be a barrier for implementation.	• See if already existing guidelines can be simplified, clarified or adjusted. • Summaries of guidelines can also help implementation. • Adjust guidelines to the circumstances in which they are used and to the specific target group. For example, instead of stable practices unstable practices, different health priorities and scarce resources. • Adjust guidelines to level of education of the implementers. Are they untrained, professionals or volunteers? • Make the guidelines more culturally sensitive. • Develop clear guidelines about the following unaddressed topics: entitlement of different migrant groups, about best practices on cross-cultural communication, or the usage of interpreters, or about working with the health surveillance system. • Engage stakeholders in the development of guidelines (e.g. Ministry of Health to increase acceptability). • Accessibility of guidelines. This could be enabled by making guidelines available on the internet. • Government can help to ensure feasibility of policies.

Domain B. Individual professional factors

Barriers	Enablers/ strategies to improve implementation

• Their lack of knowledge and awareness regarding supportive policies, protocols and legislation or available services can result in under usage of services.
• The lack of access to the medical history of patients makes it difficult to provide accurate (follow-up) care.
• The high workload, complex situations in which patients are in need of care but not entitled to it, bureaucracy, fear of stigmatizing patients, and limited support by authorities.
• Cultural norms regarding the provision of certain services can be a barrier for implementation (for example, resulting in professionals not providing condoms to unmarried women).
• Not seeing the need for certain services.
• The fear of losing one's licence when providing care to undocumented migrants.
• Time constraints.
• Language difficulties.
• Attitude can hinder when it is negative, discriminative, arrogant or xenophobe.
	• Make professional aware of the need for providing services.
	• Knowing about specific issues for the target group could enhance practice
	  ○ understanding their needs
	  ○ cultural issues
	  ○ traditional health practices and beliefs
	  ○ common health problems
	  ○ barriers for accessing care (e.g. entitlement)
	  ○ refugee related issues (fleeing experience, current accommodation, status etc.)
	  ○ risk factors and treatment effects for different ethnic groups.
	• Training of professionals is an important factor for enabling implementation
	  ○ Training about above mentioned target group issues
	  ○ Improving cultural competency and awareness of own cultural assumptions
	  ○ Developing skills to negotiate sensitive issues with patients
	  ○ Develop skills for building a trustful relationship with patients
	  ○ Developing an appropriate attitude. Changing attitudes can help implementation: being flexible, creative, supportive, feeling responsible and having patience.
	• Involve stakeholders in the development of training for professionals .
	• Make use of multidisciplinary teams (including psychosocial practitioners) and professionals with a diversity of backgrounds, could reduce language and cultural barriers, increase the acceptance of care, reduce diagnostic mistakes and reduce the barrier for reaching out for psychosocial help.
	• Actively reach out to patients and provide information to patients, to improve acceptance and uptake of services of patients.
	• Involve the family of patients in care when this is expected (for example with pregnancy).

Domain C. Target population factors

Barriers	Enablers/ strategies to improve implementation
• Complex medical and social histories of refugees and other migrants. • Limited knowledge about disease, illness and healthy practices, low awareness of health risks, available services and their rights to health care and how the health system in the host country works. • Limited understanding of language, illiteracy and low educational level. • Different norm and belief systems regarding health practices and health services. • A passive attitude towards treatment. • Legal restrictions (e.g. entitlement issues), distance to the health care facility and lack of transport, inability to cover health care use, lack of required documents and long waiting times can be a barrier in obtaining care. • Lack of trust in health care professionals • Patients seeing health care professionals as migration authority figures, resulting in hiding symptoms, feelings of discrimination, fear of deportation or citizenship refusal, or reluctant to discuss sensitive issues such as HIV. • Fear of being shamed upon when making use of services, fear of stigmatisation or social repercussions from the community. • Lack of privacy when making use of health services. • Lack of a supportive environment to make use of health care services could hinder the uptake of services.	• Providing group training of making use of educational campaigns about the topics mentioned under 'barriers' could increase the acceptability and uptake of the health services. It could guide their expectations of health care. A group approach, in which patients can share their problems, could also increase the social network of patients. • Training material needs to be adjusted to level of understanding of patients. Translated material and interpreters could also lower language barriers. • Professionals need to take into account that patients can have certain expectations that can become a barrier when these are not addressed. For example, that the husband or family is involved in care, or that the health care provider is of similar gender or they expect to be told what to do instead of informed decision making. • Actively involve refugees in development of care. To increase quality, acceptability and effectiveness of services. • Ability to make use of childcare during appointments and flexible walk-in sessions would enable patients to come to appointments.

Domain D. Professional interactions

	Barriers	Enablers/ strategies to improve implementation
Patient-professional interaction	• Language and communication difficulties is one of the most prominent barrier in delivering care to refugees and migrants. • Language and cultural differences, differences in norms and beliefs. • lack of a trusting relationship • time constraints.	• Develop trust and increase patient compliance by involving family, use shared language, use neutral words when discussing sensitive topics, and by being culturally sensitive. • Longer consultation time would enable practice, especially when making use of interpreter services. • Provide translated information to reduce language barriers.
Interpreters cultural mediators	• Informal interpreters, such as family of community members can involve difficulties with confidentiality , fear of gossip, not being familiar with medical vocabulary and withholding information. • Formal interpreter services barriers: limited availability of adequate interpreters, confidentiality issues when a third party is involved in the consultation and logistically challenging in terms of getting translators at the location, high costs and limited time.	• Be aware that the dynamic changes when interpreters are involved in the interaction. • Formal interpreter services are considered a priority when improving refugee and migrant care (Pottie 201). It can increase early diagnosis, prevent miscommunication and misdiagnosis, establish trust and therefore increase the quality of care and patients satisfaction with care. • Making use of phone (or skype) can reduce some of these barriers. • Cultural mediators can help bridging the gap between services and patients. They could help adjust the health services to the needs of refugees and other migrants. Although it is noted that resources are scarce, these services need more investment.
Continuity of care	• Continuity of care is difficult due to mobility of the target population and uncertainty of how long people are there to stay. • Lack of adequate information exchange on different organisational levels and between countries. • Divergent referral practices between EU countries and insufficient patient registration • Limited available information for professionals about how referral of patients need to be arranged. • Lack of coordination between the many different professionals and services involved.	• A medical passport could help information exchange. However, refugees could resist using the passport because of fear that the document would hinder them in reaching their destination country. Therefore it is essential to inform the target population about the risks and benefits of using the medical passport. • Not only transfer of data is needed, follow-up care needs to be available and acceptable for patients. • A well-functioning referral system is essential for follow-up. • Good collaboration is needed. Among others, between reception facilities and health sector to enable tracking refugees in the system and facilitate access to care. • Continuity of staff and interpreters is essential for building trust with patients. • Other strategies mentioned; minimizing the amount of referrals and making someone (for example a casemanager) responsible for keeping overview within the referral system.

Domain E. Incentives and resources

Barriers	Enablers/ strategies to improve implementation
• A lack of resources in terms of time, financial, human workforce, services and equipment are mentioned as prominent barriers for implementation.	• Resource poor countries could increase collaboration with resource full countries to enable implementation.

Domain F. Capacity for organisational change

	Barriers	Enablers/ strategies to improve implementation
Monitoring and evaluation	• Monitoring of refugees and migrant needs is extra. challenged by refugees trying to avoid registration or hiding their health problems because of fear of losing the right to travel to their destination country. • Systematic data collection is currently lacking.	• Monitoring and evaluation in regards to health care needs of refugees and other migrants and health care service delivery is needed to optimize health care provision. To be able to evaluate health service performance, establish quality assurance systems, patient compliance evaluation, cost-efficacy and cost-benefit analysis and develop a strong evidence base. • Systematic data collection needs to be facilitated in terms of financial resources, appropriate data collection systems, expertise and time. Coordination is essential. • More research is needed for developing evidence-based interventions and measures for refugees and other migrants.
Coordination of care		• A clear division of roles and responsibilities • Effective coordination by appointing a leading agency or focal point. • Involvement of stakeholders, such as migrant groups, could optimise migrant friendly care. • Collaboration between partner organisations.
Integration of care		• It is recommended to mainstream migrant care, to reduce stigmatisation and establish acceptance of care. On the one hand separate services, such as NGOs delivering care to refugees or specialized mobile health units can increase access to care, on the other hand these can result in those services not becoming part of the regular health care provision. • The integration of different sectors is seen as important for improving refugee and migrant care. Among others the integration of psychiatric and social services. Some authors and interviewees see mental problems as by product of social problems (literature and interviews). (and mental care as part of regular care?). Integrating reproductive health services into primary

		care services. • The integration of HIV testing into routine care can be improved by normalising this in guidelines. • Commitment of different stakeholders and clear agreements between them is essential • Evidence based advocacy could help establish the integration of care.
Prioritisation and authorisation	• A lack of prioritisation and authorisation are resulting in the unavailability of certain health services.	•

Domain G. Social and political circumstances

Barriers	Enablers/ strategies to improve implementation
• Politics are seen as a major barrier for implementation. Lack of political will to address the health issues and needs of refugees and other migrants result in services being absent or inaccessible for these groups, or NGOs taking over the responsibility of providing care. Possibly resulting in segregated services. • Constantly changing political realities result in problems with adapting services to these new circumstances in time. Therefore, take into account that circumstances change over time and improve the local infrastructure to be able to respond to the large influx of refugees and adjust interventions and measures. • Entitlement and the right to care is mentioned as a crucial barrier in providing and accessing care for these groups. Especially, when transit countries turn into destination countries entitlement for the long term becomes an important issue to discuss. • Living conditions of refugees and other migrants need to be improved. Poor living conditions at reception in the countries currently result in refugees getting ill. Treating migrants the same as the host population, in terms of housing, employment and health services could help prevent the development mental health problems.	• Collaborate and coordinate on an international level. Realise international networks in which information is shared and international consensus on policies is at the centre. • Involve stakeholders, including the government in implementation in order to create social support. • At the community level things can be done to enable implementation. Cultural norms and beliefs in the community and a lack of information about available services can prevent refugees and other migrants from making use of health services. Actively reaching out to the communities and capacity building efforts are essential for implementation and making sustainable change. Community involvement can reduce barriers in the provision and uptake of health services. • Advocacy efforts toward the goal of creating a climate in which health care services can be optimised for refugees and other migrants can enable implementation. • Instead of looking at differences between ethnic groups and organizing health care accordingly, it is suggested to look at what different groups have in common and adjust health care services towards that end. For example, illiteracy or low social-economic capital. Which could also prevent stigmatization of migrant groups.

Chapter 4. Discussion

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

Coherent overview of barriers and enablers

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

The need to make it more practical

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

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

Strength and weaknesses

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

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

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

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

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

Appendix 1. Search terms

PsychINFO

1#
diffusion of innovation.ab. OR diffusion of innovations.ab. OR information dissemination.sh. OR dissemination.ab. OR disseminate.ab. OR disseminating.ab. OR effectiveness in research.ab. OR health plan implementation.ab. OR implement.ab. OR implementation.ab. OR implementing.ab. OR knowledge to action.ab. OR knowledge transfer.ab. OR knowledge translation.ab. OR research to practice.ab. OR scale up.ab. OR scaling up.ab. OR research utilisation.ab. OR research utilization.ab. OR technology transfer.ab. OR translational research.ab. OR practice guidelines as topic.ab. OR practice guideline.ab. OR practice guidelines.ab. OR evidence-based medicine.ab.

29.02.2016
Time 15h27
Hits 120504

AND
2#
refugees.sh. OR refugee.ab. OR asylum seeker.ab. OR asylum seekers.ab. OR conflict survivor.ab. OR conflict survivors.ab. OR immigrant.ab. OR immigrants.ab. OR migrant.ab. OR migrant.ab.

29.02.2016
hits 26089
time 15:28

combined 1# AND #2
29.02.2016
time 15h 29
861 results

Sociological Abstracts

#1
SU(refugees) OR AB,TI(refugee) OR AB,TI(refug*) OR AB,TI("asylum seeker") OR AB,TI("asylum seekers") OR AB,TI("conflict survivor") OR AB,TI("conflict survivors") OR AB,TI(immigrant) OR AB,TI(immigrants)OR AB,TI(migrant) OR AB,TI(migrants)

Date 26.02.2016
Time 17:08
Hits 47,662

#2
AB,TI("diffusion of innovation") OR AB,TI("diffusion of innovations") OR SU(information dissemination) OR AB,TI(dissemination) OR AB,TI(disseminate) OR AB,TI(disseminating) OR AB,TI("effectiveness in research") OR SU(health plan implementation) OR AB,TI(implement) OR AB,TI(implementation) OR AB,TI(implementing) OR AB,TI("knowledge to action") OR AB,TI(knowledge transfer) OR AB,TI("knowledge translation") OR AB,TI("research to practice") OR AB,TI("scale up") OR AB,TI("scaling up") OR AB,TI("research utilisation") OR AB,TI("research utilization") OR AB,TI("technology transfer") OR AB,TI("translational research") OR SU(practice guidelines as topic) OR AB,TI("practice guideline") OR AB,TI("practice guidelines") OR AB,TI("evidence-based medicine")

Date 26.02.2016
Time 17:11
Hits 30,981

Combined #1 and #2
Date 26.02.2016
Time 17:13
Hits 995

Cochrane

1#
Ti,ab,key words: refugee OR refug* OR "asylum seeker" OR "asylum seekers" OR "conflict survivor" OR "conflict survivors" OR immigrant OR immigrants OR migrant OR migrants
OR Refugees mesh

Date 26.02.2016
Time 16:42
Hits 610

AND

2# (OR everywhere)
MeSH health plan implementation
MeSH information dissemination
MeSH Practice guidelines as topic
Ti,ab,key words "diffusion of innovation" OR "diffusion of innovations" OR dissemination OR disseminate OR disseminating OR "effectiveness in research" OR implement OR implementation OR implementing OR "knowledge to action" OR "knowledge transfer" OR "knowledge translation" OR "research to practice" OR "scale up" OR "Scaling up" OR "research utilisation" OR "research utilization" OR "technology transfer" OR "translational research" OR "practice guideline" OR "practice guidelines" OR "evidence-based medicine"

Date 26.02.2016
Time 16:46
Hits 22989

Combined: #1 AND #2

Date: 26.02.2016
Time 16:49
Hits: 66 (1 cochrane review, 62 trials, 3 economic evaluations)

Pilots

su(refugees) OR AB,TI(refugee) OR AB,TI(refug*) OR AB,TI("asylum seeker") OR AB,TI("asylum seekers") OR AB,TI("conflict survivor") AB,TI("conflict survivors") OR AB,TI(immigrant) OR AB,TI(immigrants) OR AB,TI(migrant) OR AB,TI(migrants)
date 26.02.2016
time 15:48
Hits 2,472

AND

#2
AB,TI("diffusion of innovation") OR AB,TI("diffusion of innovations") OR su(information dissemination) OR AB,TI(dissemination) OR AB,TI(disseminate) OR AB,TI(disseminating) OR AB,TI("effectiveness in research") OR su(health plan implementation) OR AB,TI(implement) OR AB,TI(implementation) OR AB,TI(implementing) OR AB,TI("knowledge to action") OR AB,TI(knowledge transfer) OR AB,TI("knowledge translation") OR AB,TI("research to practice") OR AB,TI("scale up") OR AB,TI("scaling up") OR AB,TI("research utilisation") OR AB,TI("research utilization") OR AB,TI("technology transfer") OR AB,TI("translational research") OR su(practice

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

Date 26.02.2016
Time 16:03
Hits 1219

Combined #1 and #2
16:04
Hits: 64 results

PubMed

#1

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

Date 26.02.2016
Time 15:28
Hits42698

#2

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

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

Date 26.02.2016
Time 14:09
Hits 386258

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

Embase

1#
Typing
‘refugee'/exp OR refugees:ab,ti OR refug*:ab,ti OR "asylum seeker":ab,ti OR "asylum seekers":ab,ti OR "conflict survivor":ab,ti OR "conflict survivors":ab,ti OR immigrant:ab,ti OR immigrants:ab,ti migrant:ab,ti OR migrants:ab,ti
Select: with abstract

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

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

#2
2#
Typing:

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

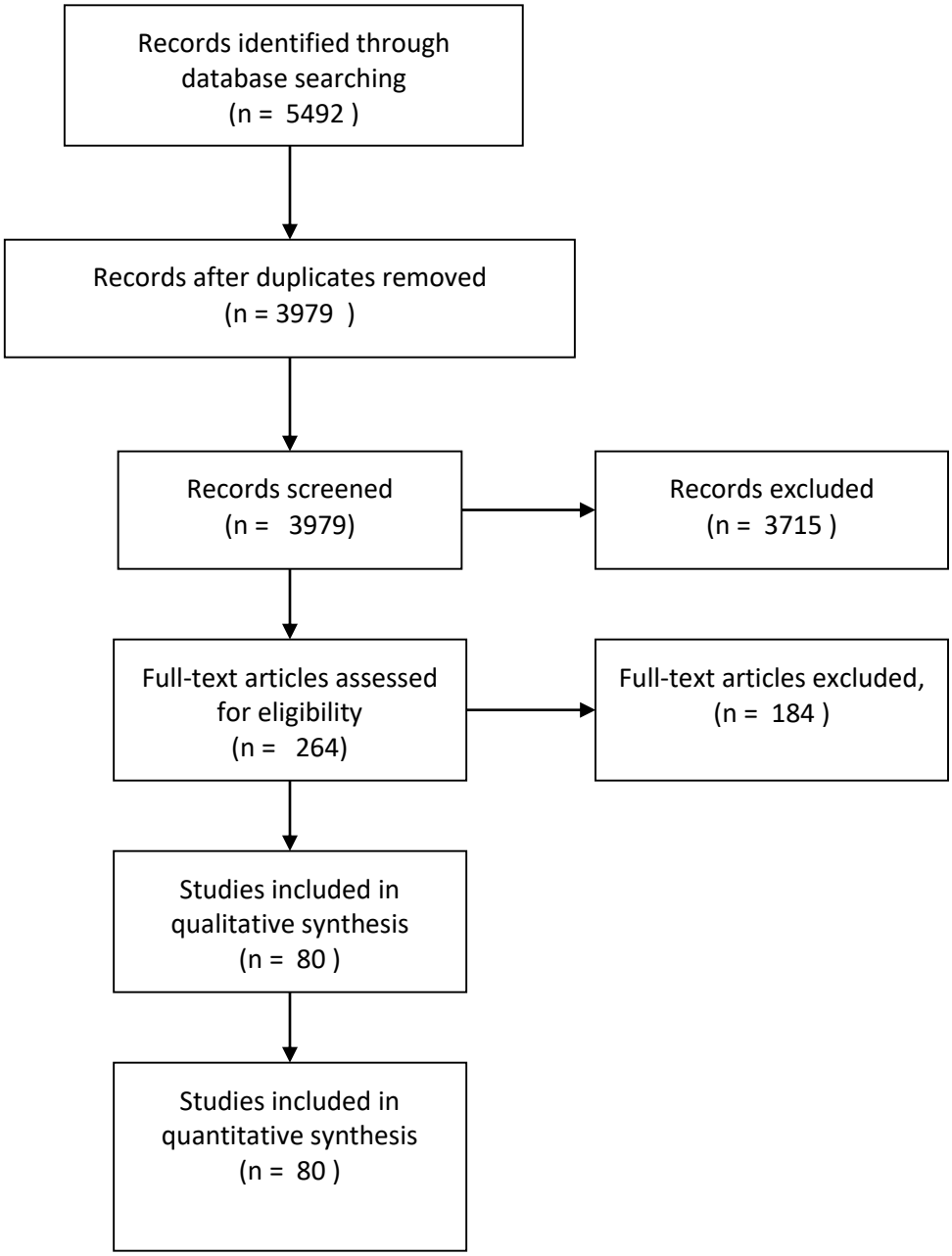
Select: with abstract

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

Date: 26.02.2016
Time 15:54
Hits 569,572

Date 26.02.2016
Time 15:56
Combined: 2116

PRISMA Flow Diagram



Appendix 2. Survey items

EUR-HUMAN SURVEY

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

PURPOSE OF THIS STUDY

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

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

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

INSTRUCTIONS

The survey contains closed and open questions.

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

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

QUESTIONS

1. **How would you describe your primary role in the health care for refugees or migrants?**
   - ○ Policy, management, organizational support
   - ○ Provision of health care/health care professional

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

3. **If possible, please mention particular sites:**

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

	Arrival	Transit	Longstay	How long did your experience last?	N/A
Experience 1					
Experience 2					
Experience 3					
Experience 4					

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

- ☐ Infectious diseases
- ☐ Mental health and emotional maltreatment
- ☐ Chronic and non-communicable diseases
- ☐ Health of women and children
- ☐ Other, please specify

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

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

	Practices	N/A
Best practice/good example: prevention		
Best practice/good example: screening		
Best practice/good example: intervention		
Best practice/good example: other		

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

No

Yes, please specify...

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

No

Yes, please specify...

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

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

☐ Professional interactions

☐ Incentives and resources

☐ Local capacity for organisational change

☐ Particular social, political and legal factors

☐ Other, please specify

☐ None of the above

10. Please explain:

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

Professional interactions

Incentives and resources

Local capacity for organisational change

Particular social, political and legal factors

Other factors

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

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

☐ Characteristics of health care measure or intervention

☐ Characteristics of health care providers

☐ Characteristics of refugee/migrant population

☐ Professional interactions

☐ Incentives and resources

☐ Local capacity for organisational change

☐ Particular social, political and legal factors

☐ Other, please specify

☐ None of the above

12. **Please explain:**

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

Professional interactions

Incentives and resources

Local capacity for organisational change

Particular social, political and legal factors

Other factors

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

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

Characteristics of health care measure or intervention

Characteristics of health care providers

Characteristics of refugee/migrant population

Professional interactions

Incentives and resources

Local capacity for organisational change

Particular social, political and legal factors

Available time for access

Other determinants, namely

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

Document

Document

Document

Document

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

improving refugee and migrant health care in Europe.

Your responses have been registered!
Thank you for taking the time to complete the survey, your input is valuable to us.

Co-funded by
the Health Programme
of the European Union

This survey is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020).
The content of this survey represents the views of the author only and is his/her sole responsibility; it can not be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Appendix 3: Experts and topic list for interview

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

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

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

Appendix 4. Detailed description of results

4.1 Literature review

4.1.1 Introduction

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

4.1.2 Mental health/psychosocial care

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

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

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

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

Professional level

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

Patient factors: lack of trust/fear of stigma

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

Accessibility of care

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

Professional interactions

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

Interpreter services

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

Continuity of care

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

Care for children

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

Organizational change: integration of care

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

Community

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

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

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

4.1.3 Women, maternal and childcare

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

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

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

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

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

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

Selection of articles women, maternal and child care

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

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

Woodland, 2010	Woodland (2010) develops a framework for good practices to promote improved access, equity and quality of care in service delivery for newly arrived refugee children.	state-of-art review	Australia, health care system level

Even though this review takes into account a wide variety of interventions and measurements that take place in different contexts, which clearly challenges the generalizability of the results, lessons can be learned and similar barriers and enabling factors can be identified.

Guidelines, protocols, policy and legislation

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

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

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

Professional level: knowledge, awareness and skills

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

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

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

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

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

Professional level: attitude, beliefs and cultural factors

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

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

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

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

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

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

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

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

Professional level: perceived barriers and other factors

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

Provision of training and information

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

Patient factors

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

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

Patient level: knowledge, awareness and skills

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

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

Patient level: attitude, beliefs and cultural factors

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

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

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

Only one author mentioned the expectation of outcome as a factor for implementation. According to Borrel (2001), the expectations of women altered due to the large distribution of infant feeding products and they became more dependent on these products. One author mentioned motivation of patients as a factor for implementation. According to Casey (2015), patients did not know why they should seek care. Using educational campaigns to inform patients or health providers actively reaching out to patients could overcome this barrier (Casey 2015) Self-efficacy is not mentioned as a factor for implementation. Four authors mentioned patient incentives as a factor for implementation. Moss (2013) sees accessibility of health-care facilities as an enabling factor. The distance to the facility and lack of transport are seen as barriers for accessing health services (Woodland 2010, Casey 2015, Correa-Vales 2012). Long waiting times on the day of the appointments were also experienced as a barrier (Correa-Vales 2012, Krausse 2015). Therefore, Correa-Vales (2012) recommends using 'time management strategies' to reduce waiting times for appointments. Furthermore, patients preferred longer consultation time to discuss their issues with providers (Thierfeleder 2005). Longer time for consultations when interpreters are used (Correa- Vales 2015, Jaeger 2013) and the ability to make use of childcare during the appointments could enable practice (Correa-Vales 2012). Financial constraints (Woodland 2010, Krausse 2015) and a lack of appropriate medicines (Krausse 2015) were perceived as barriers. (Specifically, Krausse (2015) identified a problem with the need of a UNHCR registration card to receive free health care services outside refugee camps). The gender of the provider or interpreter can be perceived as a barrier for patients. Correa-Vales (2012) identified the age and gender of interpreters as a barrier for patients. Krausse (2015) notices that patients preferred female staff and suffered from a lack of privacy when making use of services. Furthermore, a negative attitude of patients towards the services or service providers can also form a barrier for using services (Krausse 2015, Thierfelder 20015) According to Moss (2013) the effectiveness of guidelines are dependent on e.g. the health seeking behaviour of patients. Active patient involvement in health services could increase quality, acceptability and effectiveness of services according to Woodland (2010). He recommends developing strategies to make the inclusion culturally competent. In order to create support it is important that the participants are representative for the refugee group (Woodland 2010). Furthermore, patients' needs need to be taken into account (Jaeger 2013, Thierfelder 2005). Jaeger (2013) sees a 'receptive environment in which privacy is secured, hospital staff has a welcoming approach and respect for the clients culture and where is also taken care of the family of patients', as an enabling factor for realizing migrant friendly care. In regards to FGM in combination with pregnancy, Thierfelder (2005) identified a list of needs. (please see table 3).

Patient level: provision of training and information

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

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

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

Professional interactions: patient-professional interactions

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

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

Interpreter services

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

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

Organizational level: incentives & resources

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

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

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

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

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

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

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

Monitoring and evaluation

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

Division of roles and responsibilities and coordination

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

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

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

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

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

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

Integration of care/continuity of care and staff

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

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

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

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

Byrskog (2015) and Correa-Vales (2012) mention the importance of continuity of care for building a trustful relationship between professionals and patients. According to Correa-Vales (2012) "continuity of carer increases women satisfaction, trust and confidence and improves communication and enhances women's sense of control and ability to make informed decisions" (Correa-Vales 2012). For this not only the continuity of health staff, but also continuity of interpreters is important (Correa-Vales 2012)
Woodland (2010) addresses the difficulty for general practitioners of coordinating care across primary and tertiary services. She advises to build linkages and to link general practitioners with refugee health services to overcome this barrier. Refugee health nurses could effectively assist with the coordination (Woodland 2010). Another enabling strategy Woodland (2010) mentions is to have "specialist clinics linking multiple sub-specialists" (2010:562) Furthermore, Woodland sees the need for "coordination of care across screening providers and medical specialists in the initial period, and routine transfer to primary care for ongoing management" to enable the provision of pediatric care (Woodland 2010)

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

Authority of change and prioritization

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

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

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

Other factors

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

Social context

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

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

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

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

4.1.4 Infectious diseases

Study selection

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

Study characteristics and quality

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

Legislation, protocol, guidelines, policies

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

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

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

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

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

Individual health professional factors

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

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

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

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

Individual patient factors

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

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

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

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

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

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

Professional interactions

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

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

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

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

Incentives and resources

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

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

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

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

Capacity for organizational change

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

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

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

Social context

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

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

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

4.1.5 Chronic and non-communicable diseases

Study selection

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

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

Study characteristics and quality

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

Legislation, protocol, guidelines, policies

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

Individual health professional factors

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

Individual patient factors

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

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

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

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

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

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

Professional interactions

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

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

Incentives & resources

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

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

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

Capacity for organizational change

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

Social context

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

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

4.1.6 General health and implementation studies

Selection of articles

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

Quality of the articles

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

Topics of the articles

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

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

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

Quality of articles

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

Guidelines, protocols, policy and legislation

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

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

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

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

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

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

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

Professional level: knowledge, awareness and skills

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

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

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

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

Professional level: attitude, beliefs and cultural factors

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

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

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

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

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

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

Professional level: perceived barriers and other factors

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

Provision of training and information

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

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

Patient factors: knowledge, awareness and skills

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

Patient factors: attitude, beliefs and cultural factors

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

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

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

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

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

Patient-level: Provision of training and information

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

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

Patient-Professional interactions

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

Interpreter services

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

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

Incentives and resources

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

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

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

Monitoring and evaluation

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

Division of roles and responsibilities and coordination

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

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

Integration of care/ continuity of care and staff

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

Authority of change and prioritization

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

Other

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

Social context

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

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

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

4.2 Online survey

4.2.1 Introduction

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

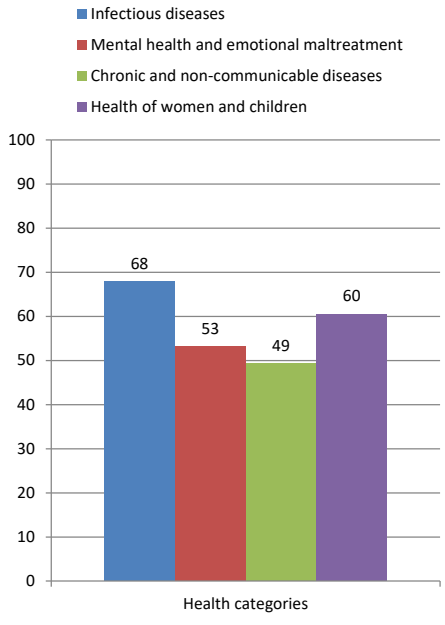
4.2.2 Participants

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

4.2.3 Health categories

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

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



4.2.4 Two country groups

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

Table 4.1. Two country groups

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

4.2.5 Practices

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

[2] Source: http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Five_main_citizenships_of_first_time_asylum_applicants,_4th_quarter_2015.png (accessed 19th of May, 2016)

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

Transfer countries (less than 5.000 first-time asylum requests in Q4 2015)	**Destination countries** (5.000 or more first-time asylum requests in Q4 2015)
Mentioned: - *Nutrition (drinking water, fruit and other food)* - *Clothing* - *Basic hygienic conditions (e.g. disinfecting hands), safety clothes and masks, isolating sick people, and information about hygiene, prevention (e.g. scabies)* - *Screening, testing, medical exam after arrival (malaria, tuberculosis, HIV, chest pains), monitoring of vulnerable groups, (especially women and children)* - *Vaccination* - *Psychological first aid (see WP5)* - *Regular work as a GP* - *Dentistry*	*Mentioned:* - *Information about local health care system* - *Separate healthy from ill people* - *Screening, testing, medical exam after arrival (malaria, tuberculosis, HIV, chest pains), and check-ups (also without apparent symptoms)* - *Vaccination* - *Child care* - *Youth health* - *Pregnancy* - *Sexual health care* - *Drug administration* - *Hypertension* - *Rheumatic problems* - *Dermatologic problems* - *Regular work as a GP* - *Hearing aid services* - *Basic hygienic conditions and information about hygiene* - *Mental health therapy, (targeted) psychotherapy* - *Family/group counselling* - *Multi-family therapy* - *Health education about diabetes* - *Healthy cooking sessions* - *Language learning*

4.2.6 Tools and training

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

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

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

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

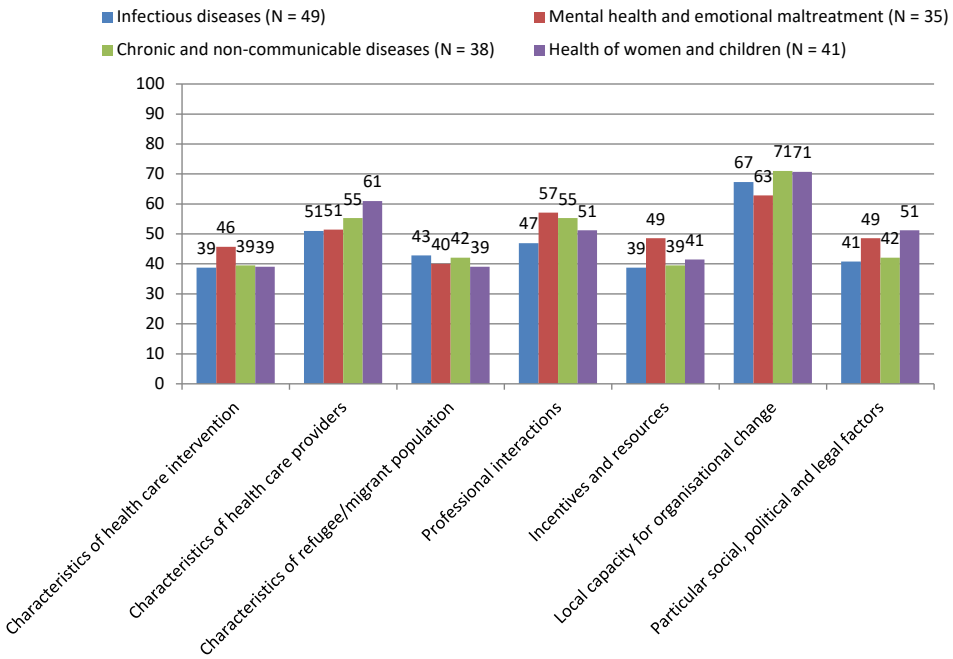
4.2.7 Documents and other resources

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

4.2.8 Relevant determinants for optimization of refugee health care

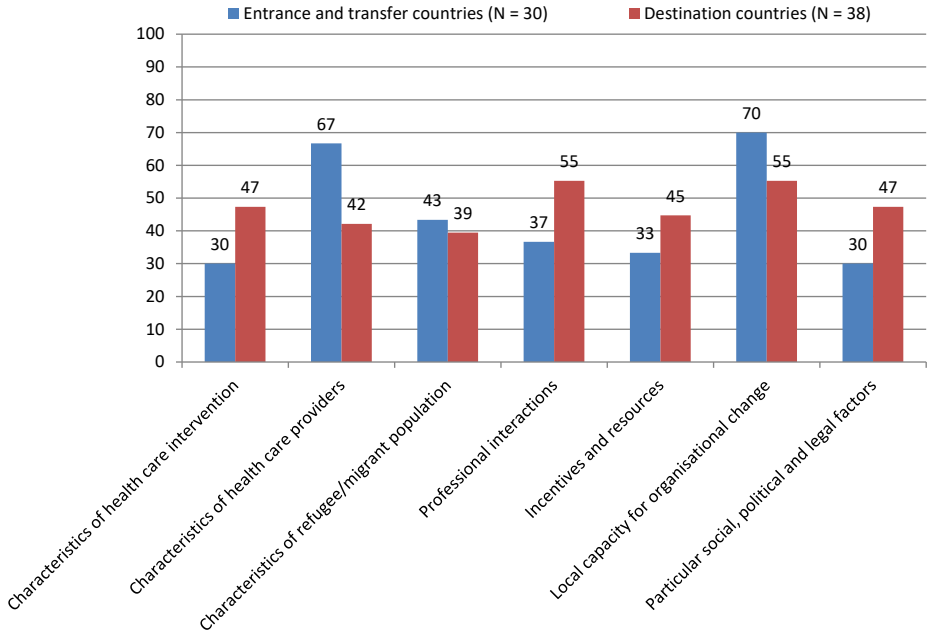
The survey participants could score multiple options in reaction to the questions which factors, in general, help the implementation of health care measures and interventions in their local setting. Although, the factors show some variation between health categories (Figure 4.2), there is a pattern.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

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



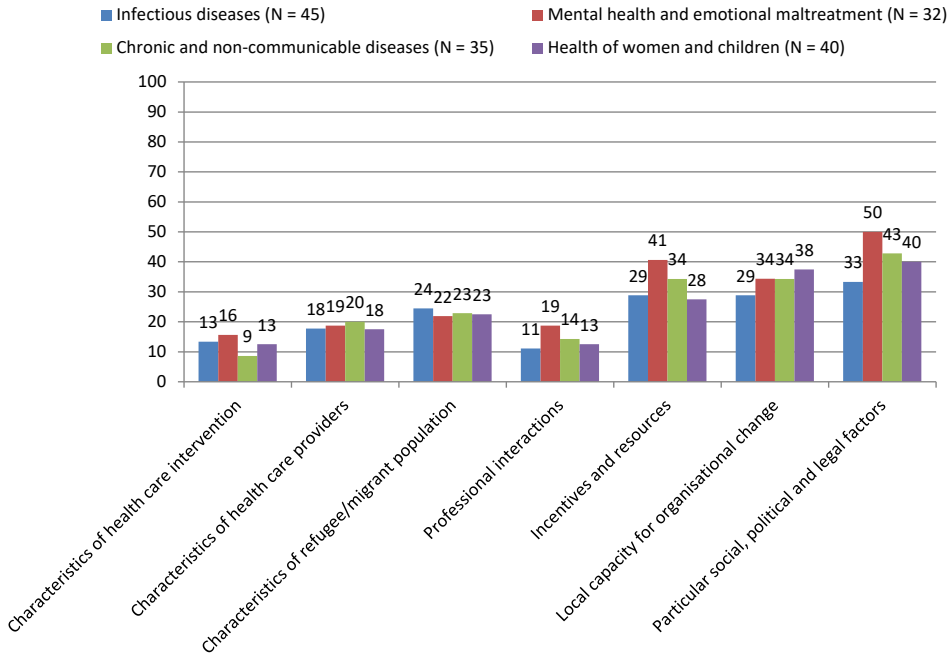
The differences between country groups are similar (Figure 4.3) but point at larger differences between transfer countries on the one hand, and destination countries on the other. Destination countries score higher on characteristics of health care intervention, professional interaction, incentives and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

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



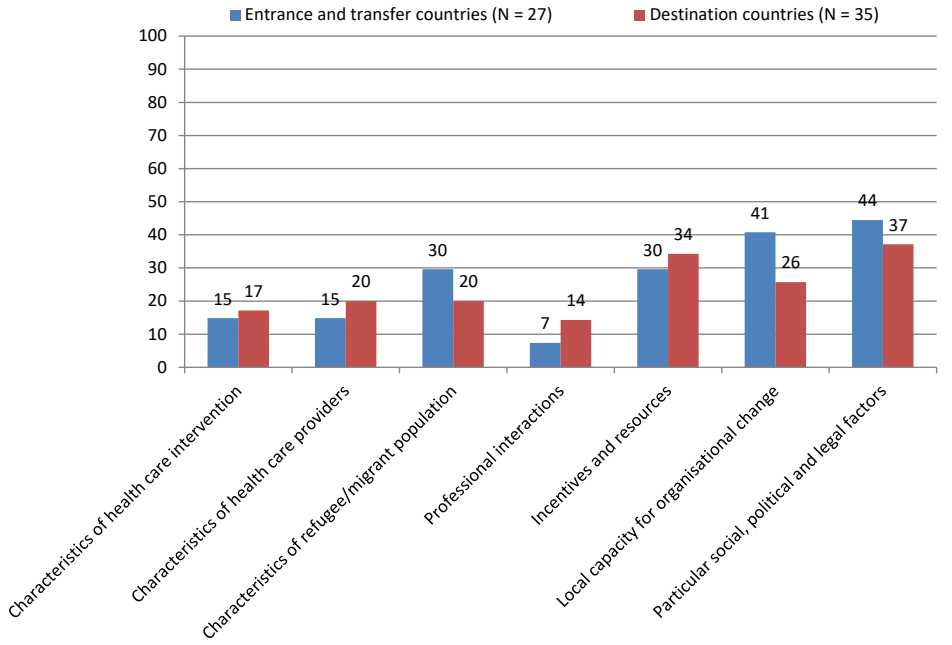
The three factors identified as obstacles most frequently were social, political and legal factors, and local capacity for organizational change, incentives and resources. Respondents active in mental health and emotional maltreatment perceived obstacles in incentives and resources and social, political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

Figure 4.4. Obstacles recognized per health category (%)



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

Figure 4.5. Obstacles recognized per country group (%)



Characteristics of health care intervention

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

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

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

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

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

Characteristics of health care providers

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

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

Characteristics of refugee/migrant population

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

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

Professional interactions

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

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

Incentives and resources

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

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

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

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

Local capacity for organizational change

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

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

> *"Good communication between different types of professionals."*
>
> *"Motivated professionals and high team standards"*
>
> *"Share experiences and skills"*
>
> *"Good communication regarding the organization of medical care in migration centres and collaboration with local clinical centres and public health centres."*
>
> *"We were in touch with hospitals all over the country (…), with hospitals, (…) and clinical specialists."*
>
> *"Caregiving for one patient or vulnerable refugee (children, mothers) involves at least five other professionals, volunteers and so on…"*
>
> *"Interprofessional cooperation (with medical institutions as well as NGOs dealing with housing, social security, legal issues etc.)."*
>
> *"Good cooperation with local organizations in improving the services."*
>
> *"Collaboration with municipalities."*
>
> *"Requires involved local politicians, sympathetic towards refugees."*
>
> *"Support from local Red Cross, civil guard and volunteer organisations."*

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

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

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

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

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

Particular social, political and legal factors

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

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

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

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

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

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

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

In destination countries respondents express their concerns about:

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

4.2.9 Additional thoughts and concerns expressed by participants

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

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

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

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

> *"A more efficient organisation in order to fully use the available staff."*

> *"Coordination between EU countries of refugee and migrant health care."*

> *"Uniform guidelines for screening and preventive measures."*

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

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

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

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

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

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

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

4.3. Expert interviews

4.3.1 Introduction

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

4.3.2 Guidelines, protocols and policies

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

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

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

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

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

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

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

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

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

4.3.3 International and national conditions

Lack of infrastructure

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

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

"We should use WHO data on health profiles per country to plan ahead (5). We can estimate the health needs of the refugees. We can than identify vulnerable people. It must also be used to change our interventions when the demographics of arrivers is changing. There used to come strong young males. No we see pregnant women, children and elderly. (02)"

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

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

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

Poor living conditions

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

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

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

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

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

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

Prioritisation

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

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

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

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

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

Politics

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

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

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

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

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

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

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

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

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

Rights to care and entitlement

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

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

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

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

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

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

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

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

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

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

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

Cultural factors

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

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

Collaboration

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

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

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

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

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

Other

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

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

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

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

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

4.3.4 Resources

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

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

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

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

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

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

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

4.3.5 Organisational level

At the organisational level different factors are identified.

Infrastructure

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

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

Monitoring and evaluation

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

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

Division of roles and responsibilities, coordination & collaboration

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

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

Continuity of care

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

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

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

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

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

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

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

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

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

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

Collaboration

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

Providing culturally sensitive care

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

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

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

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

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

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

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

4.3.6. Professional interactions

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

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

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

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

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

4.3.7. Patient level

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

Knowledge, awareness and perceived need & accessibility of services

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

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

Cultural and language factors

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

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

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

Training and provision of information

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

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

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

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

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

4.3.8. Professional level

At the professional level barriers and enablers could be identified

Knowledge

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

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

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

Cultural competence

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

Attitude

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

Training

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

Other

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

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

APPENDIX 5: Data extraction framework

Domain A. Legislation, protocols, guidelines, policies

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

Domain B. Individual professional factors

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

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

Domain C. Target population factors

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

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

Domain D. Professional interactions

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

Domain E. Incentives and resources

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

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

Domain F. Capacity for organizational change

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

Domain G. Social and political circumstances

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

APPENDIX 6. Refugee health care optimization checklist: ATOMiC test version[3]

ATOMiC – Appraisal Tool for Optimizing Migrant Health Care

Background

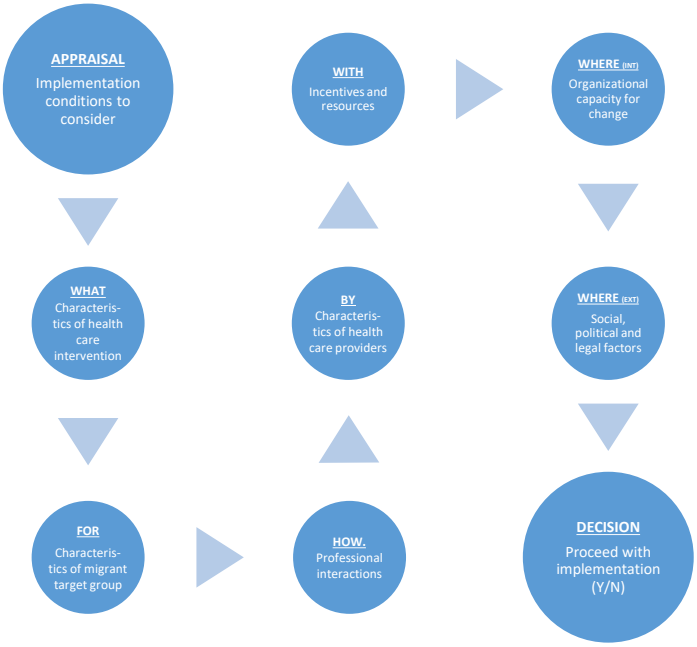
During the last couple of years Europe has been confronted with thousands of refugees and other migrants, entering member states in the south and southeast, and moving further away from conflict and insecurity. In the context of the EUR-HUMAN project a plethora of information has been collected to identify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

How to use this checklist

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

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

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



To think through when shaping the improvement idea

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

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

The checklist

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

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)? *YES / NO / DON'T KNOW / NOT APPLICABLE*
		information about the medical history and relevant personal background of patients? *YES / NO / DON'T KNOW / NOT APPLICABLE*
		language skills, interpreter services or cultural mediation *YES / NO / DON'T KNOW / NOT APPLICABLE*
		protective measures (e.g. vaccination, facemasks, gloves) *YES / NO / DON'T KNOW / NOT APPLICABLE*
		input from other professions or organizations *YES / NO / DON'T KNOW / NOT APPLICABLE*
		additional time for contact or history taking *YES / NO / DON'T KNOW / NOT APPLICABLE*
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) *YES / NO / DON'T KNOW / NOT APPLICABLE*
		language skills *YES / NO / DON'T KNOW / NOT APPLICABLE*
		intercultural competencies *YES / NO / DON'T KNOW / NOT APPLICABLE*
		attitudinal skills (open-minded, tolerance, respect, patience) *YES / NO / DON'T KNOW / NOT APPLICABLE*
		background knowledge and practical experience with the target group *YES / NO / DON'T KNOW / NOT APPLICABLE*
WITH - *Incentives and resources* *'yes' indicates that invest-ments 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 / NO / DON'T KNOW / NOT APPLICABLE*
		education, training and other skill development activities *YES / NO / DON'T KNOW / NOT APPLICABLE*
		medical stock, supportive systems, equipment and technical aids *YES / NO / DON'T KNOW / NOT APPLICABLE*
		evaluation and monitoring capacity *YES / NO / DON'T KNOW / NOT APPLICABLE*
		other (financial) resources *YES / NO / DON'T KNOW / NOT APPLICABLE*
	if the intervention involves screening/testing, it requires investments in	capacity for a timely analysis of the screening/test data *YES / NO / DON'T KNOW / NOT APPLICABLE*
		capacity for a timely follow-up in case of notable risks or problems? *YES / NO / DON'T KNOW / NOT APPLICABLE*
	if the intervention involves therapy or treatment of prevalent problems, it requires investments in	capacity for completing the therapy/treatment including aftercare *YES / NO / DON'T KNOW / NOT APPLICABLE*

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

DISCLAIMER

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

APPENDIX 9. DELIVERABLES OF WP4.

D4.1 Report of expert meeting.

Ref. Ares(2016)3267756 - 08/07/2016

EUR-HUMAN

Expert Consensus Meeting Report Athens, June 8 -9 2016

Deliverable 4.1

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

Disclaimer
"The content of this report represents the views of the authors 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."
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Table of Contents

Executive Summary 4
Section 1: Information and Core Principles EUR-HUMAN project 7
Aim 7
Summary of previous work in EUR-HUMAN 7
Section 2: Consensus Procedure 10
Preparation Phase 10
Meeting in Athens 11
Section 3: Results of the Expert Consensus Meeting 13
Participants 13
Programme Oversight 13
Summary of discussions 14
Day 1: Discussion on Overarching Topics 14
Day 2: Discussion on Specific Topics 20
Section 4: Concluding statements and recommendations 26
General principle 26
Important contextual factors 26
Conclusions and recommendations 26
Section 5: Next Steps 31
Development Guidance and Training 31
Implementation and evaluation of interventions 31
Appendix 1: Agenda Meeting 32
Appendix 2: Participant List 34
Appendix 3: Guidance for groups discussions 37

Executive Summary

The EUR-HUMAN project: aim and previous work

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

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

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

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

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

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

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

Expert consensus procedure

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

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

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

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

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

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

Main conclusions and recommendations

General principle

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

Important contextual factors

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

Recommendations

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

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

2. The content of primary health care should involve:

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

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

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

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

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

Next steps

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

How to read this report?

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

Section 1: Information and Core Principles EUR-HUMAN project

Aim

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

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

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

Summary of previous work in EUR-HUMAN

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

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

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

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

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

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

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

Within this work package a systematic search in different literature databases, an online survey at different European sites and expert interviews were conducted to identify success factors and obstacles in the implementation of tools and interventions to optimize health care for refugees and other migrants in the European context.

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

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

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

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

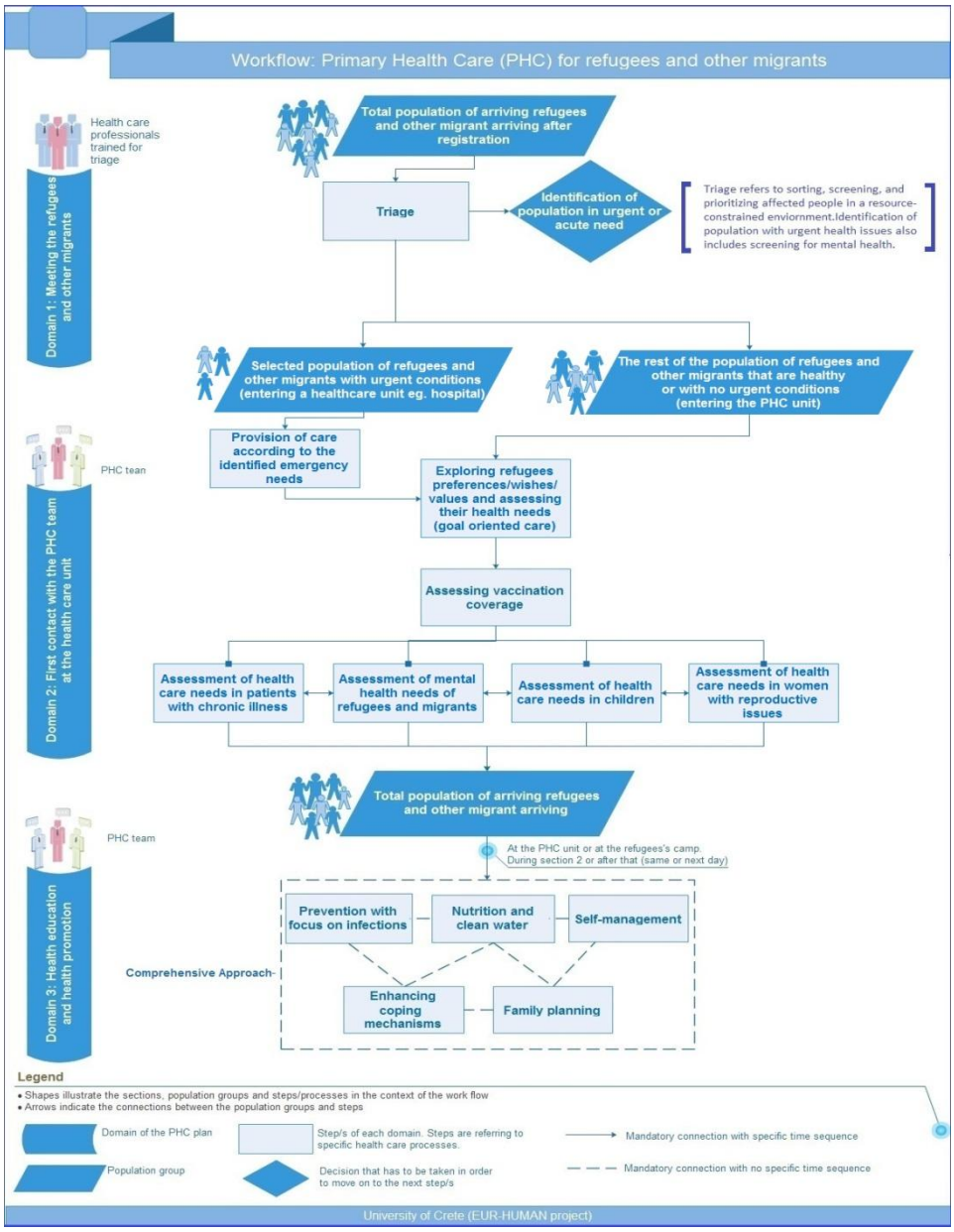
A systematic review of existing knowledge and expert consensus served to formulate the rapid assessment protocol. Key international guidelines, handbooks, manuals and reports were scrutinized, and a comprehensive search of peer-reviewed studies was conducted to identify specific tools for rapid assessment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

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

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

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

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



Section 2: Consensus Procedure

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

Preparation Phase

1. Inviting Experts

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

2. Defining the workflow of PHC and relevant topics

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

3. Selected questions for the experts

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

These include **4 overarching topics**:

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

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

- Acute illnesses and Triage
- Infectious Diseases and Vaccinations

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

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

4. Consultation with consensus meeting participants

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

Meeting in Athens

Aim of the meeting

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

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

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

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

1. Small group discussions

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

Facilitators were instructed to focus on the following:

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

2. Plenary report, discussions and conclusions

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

Report of the expert consensus meeting (D4.1)

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

Section 3: Results of the Expert Consensus Meeting

Participants

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

Programme Oversight

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

Day 1:

Introductions

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

Group discussions

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

General discussion and conclusion

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

Day 2:

Group discussions

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

Plenary discussion

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

Conclusions and first concluding statements

- Professor Christos Lionis gave a summary of the conclusions.

Summary of discussions

Day 1: Discussion on Overarching Topics

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

Group 1: Cultural and linguistic barriers

Facilitators:

Michel Dückers and Marieke van Veldhuizen

Key issues emerging from discussion

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

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

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

Group 2: Continuity of care

Facilitator:

Dean Ajdukovic and Helena Bakic

Key issues emerging from discussion

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

Group 3: Primary health care providers

Facilitator:

Diederik Aarendonk and Nadja van Ginneken

Key issues emerging from discussion

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

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

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

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

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

Group 4. Health promotion and information

Facilitators:

Kathryn Hoffman and Elena Jirovsky

Key issues emerging from small discussion group

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

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

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

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

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

b) Advanced level (destination country)

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

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

Highlights from the plenary discussion

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

Day 2: Discussion on Specific Topics

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

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

Group 1. Acute illnesses and Triage

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

Facilitators:

Michel Dückers and Marieke van Veldhuizen

Key issues emerging from small discussion group

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

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

Additional remarks during plenary session

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

Group 2. Infectious diseases and Vaccinations

Facilitators:

Imre Rurik and László Kolozsvari

Key issues emerging from small discussion group

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

Additional remarks during plenary session

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

Group 3. Non-communicable and chronic conditions

Facilitators:

Diederik Aarendonk and Corné Versluijs

Key Issues emerging from small discussion groups

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

Additional remarks during plenary session

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

Group 4. Mental Health

Facilitators:

Dean Ajdukovic and Helena Bakic

Key Issues emerging from small discussion groups

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

Additional remarks during plenary session

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

Group 5. Mother and child care and reproductive health

Facilitator:

Erika Zelko and Nicole Mascia

Key Issues emerging from small discussion groups

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

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

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

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

Additional remarks during plenary session

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

Closing session

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

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

Next steps in consensus procedure

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

Section 4: Concluding statements and recommendations

General principle

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

Important contextual factors

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

Conclusions and recommendations

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

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

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

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

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

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

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

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

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

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

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

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

d. **Disease specific recommendations:**

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

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

3. Organisation of outreaching, integrated primary health care

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

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

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

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

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

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

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

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

Section 5: Next Steps

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

Development Guidance and Training

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

Implementation and evaluation of interventions

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

Appendix 1: Agenda Meeting

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

Day 1, 8 June 2016

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

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

Day 2, 9 June 2016

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

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

IMPLEMENTATION CHECKLIST
To think through when shaping the improvement idea
IMPLEMENTATION CHECKLIST
To think through when shaping the improvement idea

"Saving lives, Improving Lives"
Vulnerability Indicators
Different stages of a human life
Body
Mind
Emotions
Behaviours

Appendix 3: Guidance for groups discussions

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

Group 1: Cultural and linguistic barriers

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

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

Not to discuss during this session:

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

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

Specific questions:

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

Group 2: Continuity of care

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

Preparation literature:

Personal health record + handbook (IOM)

Introductory remarks:

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

Not to discuss during this session:

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

Topics to discuss:

Appropriate tools and medical records to ensure continuity

Specific questions:

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

Group 3: Primary Health Care Provider

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

Introductory remarks:

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

Not to discuss during this session:

- Specific disease management

Topics to discuss:

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

Decision management tools

Adequate and secure resourcing

Patient safety and quality assessment tools

Specific questions:

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

Group 4: Health promotion and information needs:

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

Introductory remarks:

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

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

Not to discuss during this session:

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

Topics to discuss:

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

Brief behavioural activation to promote health

Specific questions:

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

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

Group 1. Acute illness and triage

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

Introductory remarks:

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

Not to discuss during this session:

- Treatment of different conditions

Topics to discuss:

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

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

Specific questions:

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

Group 2. Infectious diseases

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

Preparation literature:

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

Introductory remarks:

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

Not to discuss during this session:

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

Topics to discuss:

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

Specific questions:

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

Group 3. Vaccination

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

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

Introductory remarks:

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

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

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

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

Not to discuss during this session:

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

Topics to discuss:

Minimum dataset for the refugees vaccination registration

Practical guidelines in assessing and administrating vaccination among refugees

Practical guidelines in administrating and monitoring vaccination uptake

Specific questions:

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

Group 4: Chronic and non-communicable diseases

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

Introductory remarks:

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

Not to discuss during this session:

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

Topics to discuss:

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

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

Interprofessional collaboration and team work in chronic diseases management

Specific questions:

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

Group 5: Mental health

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

Not to discuss during this session:

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

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

Specific questions:

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

Group 6: Reproductive health, mother and childcare

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

Introductory remarks:

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

Not to discuss during this session:

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

Topics to discuss:

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

Specific questions:

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

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

D4.2 Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees.

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EUR-HUMAN

Tools and Guidelines

for optimal primary care for refugees and other newly arrived migrants

Work package 4 title: Developing tools and evidence-based practice guidelines for health care practitioners

Deliverable 4.2: Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees

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Table of Content

EXECUTIVE SUMMARY **3**

SECTION 1. INTRODUCTION, AIMS AND OBJECTIVES **4**

SECTION 2. METHODS **6**

THEORETICAL FRAMEWORK AND LEADING PRINCIPLES. 7
WORKFLOW: STRATEGIC PLAN 8

SECTION 3. THE GUIDANCE **10**

HOW TO USE THIS GUIDANCE 10
OVERVIEW OF GUIDELINES AND TOOLS 11

OVERARCHING TOPICS **12**

CULTURAL COMPETENCE IN HEALTH CARE 13
CONTINUITY OF CARE 19
INFORMATION NEEDS AND HEALTH PROMOTION 20

SPECIFIC ISSUES **21**

1. HEALTH ASSESSMENT 22
2. MENTAL HEALTH 34
3.REPRODUCTIVE HEALTH CARE 45
4. CHILD CARE 51
5. INFECTIOUS DISEASES 53
5. VACCINATION 57

SECTION 4. LIST OF TRAINING MATERIALS **64**

SECTION 5. ADAPTION FOR LOCAL SETTING AND IMPLEMENTATION **67**

ADAPTING THE TOOLS FOR THE LOCAL SETTING 67
IMPLEMENTING INTERVENTIONS: HOW TO CHOOSE 68
ATOMIC – APPRAISAL TOOL FOR OPTIMIZING MIGRANT HEALTH CARE 69

Executive Summary

The EUR-HUMAN project

The European Refugees-Human Movement and Advisory Network project (EUR-HUMAN), running from January to December 2016, aims to enhance the capacity of European member states in addressing refugee health needs in the early arrival period (first reception centres) as well as in transit countries and longer-term settlements (longer stay reception centres in countries of destination). The specific objective of EUR-HUMAN is to develop guidance documents, recommendations and training for the provision of cultural sensitive, integrated comprehensive person-centred primary care for refugees in these settings, and pilot these in interventions in six countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria).

Work package 4

Within work package 4 several tasks were carried out:

1. Based on the results of previous work packages (WP2 health needs, WP3 systematic review, WP5 mental health), relevant guidelines, guidance, training, tools and health promotion materials were gathered.
2. A two-day expert meeting was organised and took place in Athens on the 8th and 9th of June 2016.
3. Based on the outcomes of the expert meeting in Athens a report was drafted on the content of optimal primary health care for refugees (Deliverable 4.1).
4. The current guidance for optimal primary care for refugees was created using all input from work packages 2, 3, 5, and the expert consensus meeting (Deliverable 4.2).

Deliverable 4.2

This guidance (Deliverable 4.2) contains tools, recommendations, guidelines and training materials to support the development of the training for the implementation sites as well as the implementation of these interventions in WP6. It also contains a template for local adaptation and implementation.

The materials described in this guidance can be used to improve primary health care (PHC) for refugees and other newly arrived migrants in first reception centres as well as in longer stay reception sites. It is meant for PHC providers and social workers as well as, in some cases, for the volunteers involved in the assessment of health needs or in the primary healthcare for refugees.

Content of the guidance

The guidance consists of two parts. The first part relates to overarching issues: “cultural competence in health care”, “continuity of care” and “information and health promotion". The second part describes tools and guidelines on six specific issues: health assessment, mental health, reproductive health, child care, infectious diseases and vaccination.

Adaptation and implementation

An important next step is the adaptation of guidelines and tools to the local context of use. This deliverable provides a simple guidance for adaptation, based on the *“PIPOH”* approach: *“Population of interest, the Intervention of interest, the Professions to which the guideline / tool is to be targeted and the Outcomes and Health care setting of interest (PIPOH)”.*

Stakeholders in refugee health care optimization should carefully consider these and other factors identified during the EUR-HUMAN project and are encouraged to work with the ATOMiC checklist *(“Appraisal Tool for Optimizing Migrant Health Care”)* while anticipating the implementation of a particular tool, guideline or other health care improvement, directed at one or more of the potential or actual health issues of refugees and other migrants.

Section 1. Introduction, aims and objectives

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

The European Refugees-Human Movement and Advisory Network (EUR-HUMAN) project, running from January to December 2016, is an EU funded project aiming 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.

The role of work package 4 (WP4) in the project

The work of WP4 has been closely tied to the other WPs in EUR-HUMAN. The aim of the EUR-HUMAN project is to develop guidance documents/recommendations in WP4, and to pilot this guidance, tools and training for the provision of integrated comprehensive person-centred primary care for refugees at the intervention sites in first, short-stay, and reception centres (short stay/first reception centres), transit centres and longer stay reception centres in WP6.

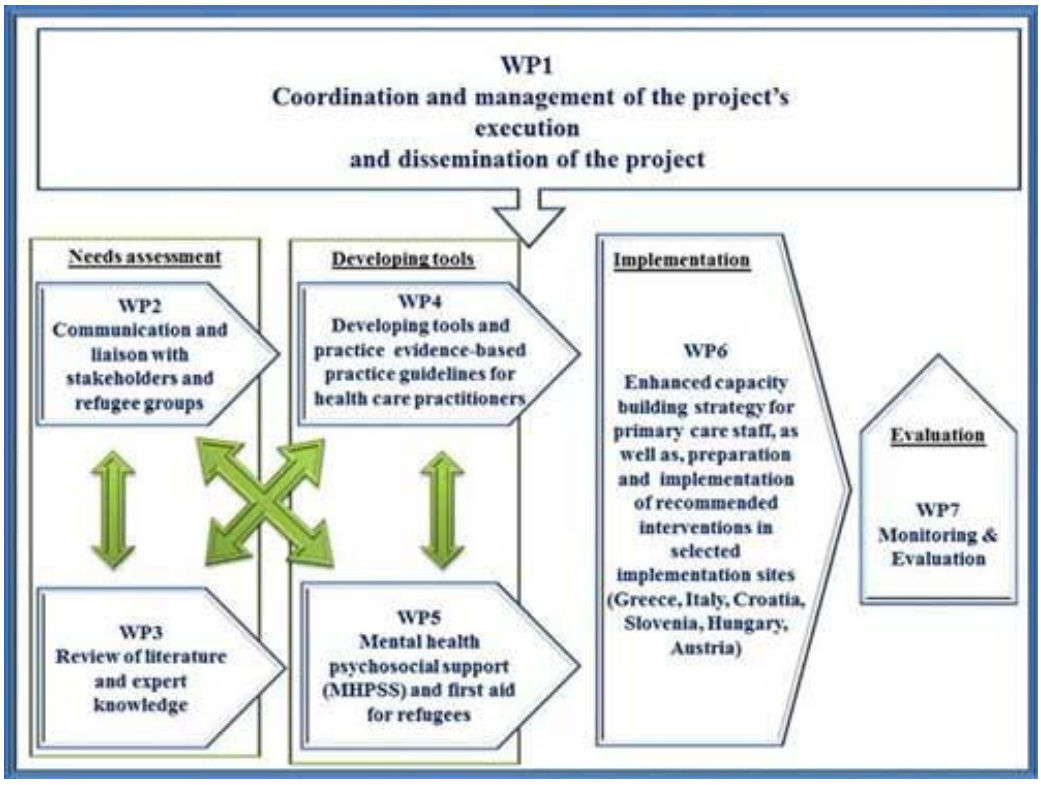


Figure 1 Illustration of the role of WP4 in the project

As the DoW reports, WP 4 will:

- Arrange an international consensus panel meeting for development and approval of best practice guidelines and tools.
- Define the optimal content of healthcare and social services needed to prevent infectious diseases, chronic diseases and further mental health damage in newly arrived migrants; and to provide good care for acute and chronic physical and mental health conditions in concordance with professional standards.
- Identify and define necessary knowledge, skills, training and other support and resources needed for professionals to enable them to provide above mentioned good comprehensive care

The tasks planned and developed in this WP are detailed below:
Task 4.1: Based on results of literature review and the report on health needs (WP2) relevant guidelines, guidance, training and health promotion materials will be gathered;
Task 4.2: Organising and chairing of two-day expert meeting. This meeting took place in Athens on the 8th and 9th of June 2016.
Task 4.3: Drafting a report on the content of optimal primary healthcare for refugees, based on the outcomes of the expert meeting. This report is submitted as Deliverable D4.1
Task 4.4: Produce and provide online a set of guidelines, guidance, training and health promotion materials to support the local sites (Deliverable D4.2).
Task 4.5: Produce a template for local adaptation and implementation of these guidelines, training materials etc. (Deliverable D4.2).

Deliverable 4.2
This guidance (Deliverable 4.2) contains tools, recommendations, guidelines, training materials to support the development of the training that in WP6 the University of Vienna and Arq will provide for the implementation sites as well as the implementation of these interventions in WP6. It therefore also, contains a template for local adaptation and implementation.
The tools, guidelines, recommendations and implementation strategies described in this guidance can be used to improve primary health care (PHC) for refugees and other newly arrived migrants in first reception centres as well as in longer stay reception sites.
This guidance is meant for PHC providers and social workers as well as, in some cases, for the volunteers involved in the assessment of health needs or in the primary healthcare for refugees and other newly arrived migrants.

Section 2 describes the methods used to develop this guidance.
Section 3 provides a description on how to use the guidance. In this section all tools, guidelines and health promotion materials are described. For every tool we give a description on who can use it, in what situation and what the preconditions are. An overview of all tools is provided in the overview table on page 11.
Section 4 provides an overview of relevant existing training materials identified, that can be used in the development of the training in WP6.
Section 5 addresses the implementation of interventions in the local settings. It describes how to adapt tools, guidelines and health promotion materials to the local situation - to the migrant groups in that setting, as well as the organisation of healthcare and provisions in that setting and the national regulations to take into account. In addition it provides guidance on how to choose interventions for implementation.

Section 2. Methods

This guidance was developed using a multi-perspective, stepwise approach, building upon the results of previous work packages.

1. The project started in February with participatory fieldwork among refugees and health care workers in Greece, Italy, Croatia, Slovenia, Hungary, Austria and the Netherlands about their health needs, experiences, wishes and expectations regarding health care and social care throughout the journey through Europe (WP2). Most health problems appeared to be war and journey related: wounds, burns, common infections due to overcrowded reception centres and mental health problems; as most important health needs were mentioned the provision of basic life provisions, care for pregnancy related problems, continuity of care for chronic conditions, compassionate care providers and the provision of information on procedures and health. Refugees face many barriers in accessing health care due to lack of time and linguistic and cultural barriers. (Deliverable 2.1) These insights were used to identify the topics and issues / health problems that needed to be addressed in this guidance.

2. Then a systematic search in different literature databases, an online survey at different European sites and expert interviews were conducted to identify success factors and obstacles in the implementation of tools and interventions to optimize health care for refugees and other migrants in the European context (WP3). The general findings of WP3 point at recurring success factors and implementation obstacles (Deliverable 3.1 and 3.2, see also section 5 of current document).

3. On top of the tools identified in the review, we searched for tools, guidelines and training materials on databases / websites of international organisations as WHO, UNHCR, IOM, EU, ECDC, NGO's and of other current or previous related (EU-funded) projects on healthcare for refugees or other migrants, like MEM-TP, C2Me, Mipex, CARE, SH-CAPAC, Migrant friendly hospitals, Mighealth, Promovac etc.

4. Specific attention is dedicated to mental health, and a protocol for assessment of mental health needs is added. University of Zagreb developed in WP5 a protocol regarding procedures in primary health care that enable rapid assessment of mental health status, provide psychological first aid and ensure referral for specialized care for highly traumatized refugees. (Deliverable 5.1, see also mental health section of current document)

5. The next step was the consultation of international and local experts who discussed, commented and added to all tools, guidelines, recommendations and materials thus far identified. On the 8th and 9th of June 2016 in Athens an expert consensus meeting was organized and attended by sixty-nine (69) participants from fourteen (14) different countries. Consensus during the meeting was initiated by discussions in small groups that were reported and then discussed in the plenary sessions (Deliverable 4.1).

6. The template for local adaptation and implementation was fed by the assessment of the local situation and resources available at the six implementation sites (Deliverable 6.1). It provided us with insights what the PHC providers in these sites need in order to be able to choose and implement the

interventions. It became clear that the situation in the respective intervention site countries is highly complex and very dynamic.

7. Finally, from all sources described here above, we selected the tools, guidelines, training materials and health promotion materials to compose this guidance. All tools, guidelines and materials were assessed independently by three staff members of the RUMC team: a GP trainee (MH), a social scientist (TvL) and an experienced general practitioner/teacher/researcher (MvdM). They were judged upon:

- are they robust or scientific rigorous: either evidence based, or practice based developed and implemented by reliable organisations
- are they feasible in settings with limited time / manpower available
- are they applicable for primary healthcare
- are they specifically applicable for (various groups) of refugees
- are they applicable for the different sites involved in EUR-HUMAN: the short-stay first reception centres (hot-spots), the transit centres and the longer stay reception centres.

<u>This means that NOT included in the guidance are:</u>
- Tools / guidelines on specialist treatment of for instance severe PTSD
- Existing guidelines for Primary Healthcare for specific diseases that are common in all populations, like diabetes, although some of these guidelines will differ when applied to migrants (e.g. the treatment of hypertension in West-African migrants is different from the treatment of the European population)
- Guidelines for the treatment of specific non-communicable diseases that is more prevalent in migrants than in other populations, but not specifically more prevalent among refugees, like hemoglobinopathy.

The current selection of tools, guidance and materials is based on all the above described steps. Most tools and guidance are experience based, only very few evidence based – where this is the case we mention this. The original source of the tool / guideline is mentioned in the description of the tool.

Theoretical framework and leading principles.

The choice of tools, guidelines and other materials is guided by the following vision on primary health care that was confirmed by the experts during the expert consensus meeting in Athens:

Primary health care for refugees and other migrants should be equitable, accessible and affordable for all patients according to their needs, person-centred, cultural sensitive, comprehensive, goal-oriented, minimally disruptive, compassionate, outreaching, integrated within the existing primary health system and other services, and provided by a multidisciplinary team[1].

The guidance has its basis in the strategic plan of the workflow of healthcare in reception centres.

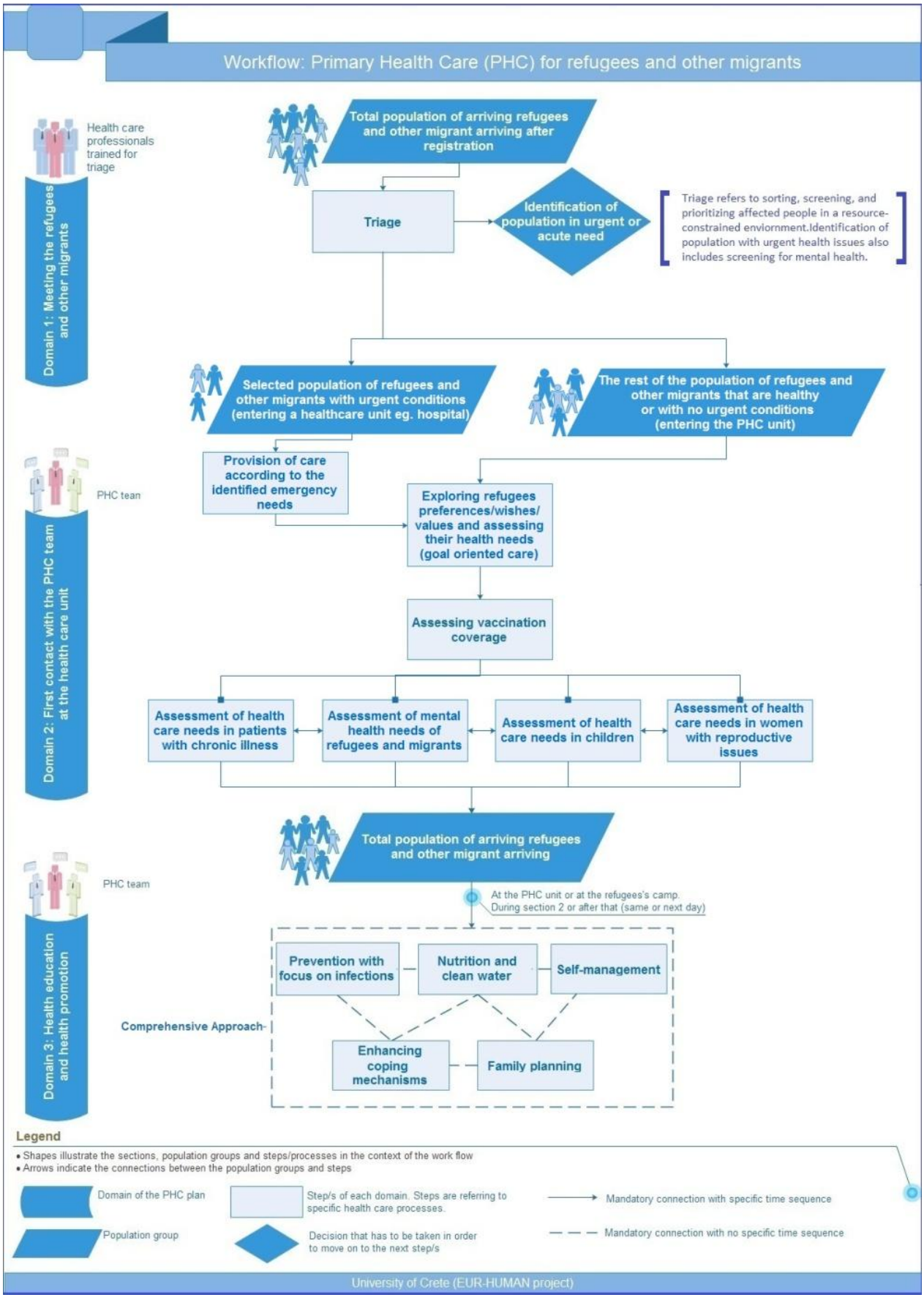
[1] *European Commission (2014). Expert Panel of Effective Ways of Investigating in Health.*

Workflow: strategic plan

Within the EUR-HUMAN project a workflow with three domains is developed, illustrating how health needs of population groups can be addressed by, health care professionals (figure 2). In the **first domain** urgent cases are identified and separated from non-urgent cases. The **second domain** covers assessment for all refugees and migrants, of vaccination coverage and of care needs concerning chronic illness, mental illness, children, and women with reproductive issues. In the **third domain** a health education and promotion activities for all refugees and migrants take place.

This workflow is applicable to situations in countries were refugees enter the European Unions and in destination countries (in first arrival centres-short stay/first reception centres, in transit and permanent centres for refugees / immigrant).

Figure 2 Strategic plan



Section 3. The guidance

How to use this guidance

In this guidance a collection of existing and relevant tools, guidelines, recommendations and implementation strategies can be found to support primary health care for refugees and other newly arrived migrants. The guidance is divided into two parts; one describing overarching issues and one concerning specific issues. Each section starts with some general recommendations that were obtained from the expert consensus meeting in Athens (see methods section). Then, a set of relevant tools and guidelines are presented.

This guidance is meant for workers in primary healthcare on the spot: primary healthcare doctors, nurses, social workers, volunteers and refugees with a background in health care services involved in provision of PHC services. They could use it during consultation when they need some practical tool or checklist. Furthermore, it could also be utilized for training and educational purposes.
For a quick use in practice, the following steps will lead you to the tool or checklist you need:

1. The overview of guidelines and tools shows all available tools in a glance. In this overview you can click on the tool to directly link you to its description.
   Instruction:
   - Look at the overview
   - In the overview you can find 3 overarching themes (Cultural competence, continuity of care and health information and promotion) and 6 specific issues.
   - For every overarching theme or specific issue several tools are specified.
   - Decide which tool or guidelines you are interested in.
   - Click on the tool or guidelines you are interested in.
   - You will be directed to the related tool or guidelines
   - Below each page you can find a [→ back to overview] link. Clicking on it will direct you to the overview of guidelines and tools.
   - For some tools/manuals only URLs are provided and you will need an internet connection to access them.

2. Each tool contains a description of:
   - *Domain*: Domain 1, 2 or 3 of the strategic plan (see page 6 for a description).
   - *Location*: This can be at short stay/first reception centre sites or longer stay reception centres.
   - *Issue:* Target area of the tool.
   - *Provider:* A description on who can use the tool/guideline/training.
   - *Type:* Tool/checklist/protocol/questionnaire/guideline/information/training.
   - *Developed by:* a description of who developed the tool, including the reference
   - *Description:* A short description of the tool is provided.

Overview of guidelines and tools

Overarching Issues: across sites		Page number:
Cultural competence in health care	- Organisation - Trained health care workers - Working with interpreters	13 13 14
Continuity of care	- Organisation - Informational continuity	19 19
Information and health promotion	- Information for health care providers - Information for refugees	20 20
Specific Issues:	**Tools:**	**Page number:**

Health assessment	- Organisation
	  ○ Emergency health kit
	- Triage/emergency assessment
	  ○ Triage/red flags
	  ○ Screening form for refugees
	  ○ ABCDE
	  ○ Initial general health assessment for longer stay reception centres
	  ○ Nutritional state screening
	- Treatment and referral
	  ○ Nursing intervention guide
		23
		23
		24
		24
		25
		28
		30
		
		32
		33
		33

Mental health	- Mental health triage - Mental health screening - Refugee health screener	35 38 41

Reproductive health	- Organisation
	  ○ Minimal service package reproductive health
	- Sexual violence
	  ○ Assessment gender based violence
	  ○ Female genital cutting
	  ○ Care for victims of sexual violence
		46
		46
		47
		47
		48
		49

Child care	- Unaccompanied children - Trauma risk in children	51 52
Infectious diseases	- Infectious diseases screening	54

Vaccination	- List of vaccinations to consider
	- Delivery of immunization
	  ○ How to hold children when immunising
	  ○ Injection techniques
	- Promotion material on vaccination
	  ○ Information for health care workers and refugees
	  ○ Information on hepatitis screening
		57
		59
		59
		60
		62
		62
		63

Overarching topics

1. Cultural competence in health care
2. Continuity of care
3. Information and health promotion

→ Back to overview

Cultural competence in health care

Organisation:

1. Enable the composition of multidisciplinary primary health care teams

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

2. Guarantee a safe and confidential environment

- install separate toilets for women close to accommodation to reduce sexual violence
- introduce volunteers from migrant communities as navigator (to help with feeling of safety and trust)
- provide separate examination rooms

Trained health care workers:

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

a. an *attitude* enabling the building of a trustful relationship
   i. awareness of the own personal background (gender, culture, language)
   ii. awareness of the personal context of the migrant patient (language, educational level, culture, migrant status)
   iii. ability to provide compassionate care
   iv. awareness of signs of compassion fatigue

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

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

→ Back to overview

Useful links on compassionate care

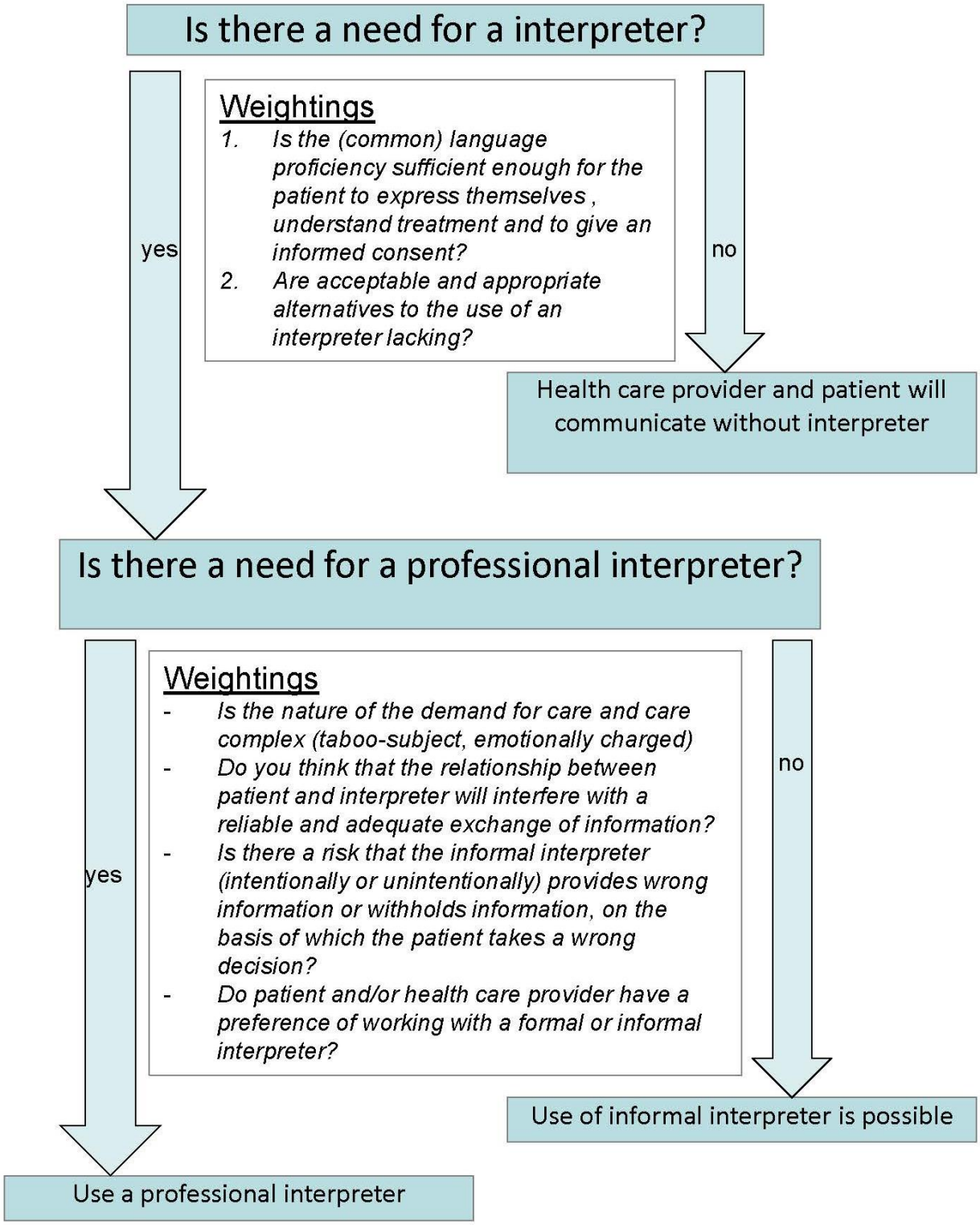
Issue:	Measuring your compassion
Title:	DISPOSITIONAL POSITIVE EMOTIONS SCALE (DPES) –COMPASSION SUBSCALE.
Description	The compassion subscale of the DPES is a 5-item questionnaire for health care practitioners that measures a dispositional tendency to feel compassion toward people in general.
URL:	http://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/CompassionandCompassionateLove-DISPOSITIONALPOSITIVEEMOTIONSSCALE.pdf
Developed by:	Fetzer institute

Issue:	Measuring compassionate care
Title:	Compassionate Care Assessment Tool (CCAT)©
Description	A 28-item tool that can be filled in by refugees
URL:	http://internationaljournalofcaringsciences.org/docs/6.%20Burnell%20Compassionate%20Care%20Tool.pdf
Developed by:	Burnell, L., Agan, D.L. Compassionate care can it be defined and measured? The development of the compassionate care assessment tool. Int J Caring Sci. Volume 6, Issue 2, Pages 180-187

Working with interpreters:

- Minimise the use of informal interpreters (family and friends) as much as possible
- Only use informal interpreters in case of emergency and highlight the following information:
  - privacy
  - their role in interpreting
  - why certain questions are asked
- Never use children for interpreting
- Consider the seating arrangements – an equilateral triangle usually works best.
- Ensure that you use the same interpreter for the duration of your work with a client.
- Try and speak slowly and clearly and in short segments, because the interpreter has to remember what you have said and then interpret it.

The flowchart on the next page can help you decide whether to use a professional interpreter.



Source: *Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg [Dutch]*
http://www.knmg.nl/Publicaties/KNMGpublicatie/142783/Kwaliteitsnorm-tolkgebruik-bij-anderstaligen-in-de-zorg.htm

There is an ethical code for interpreters (NCIHC code) and a standard for practice:
For more information: http://www.ncihc.org/ethics-and-standards-of-practice

NCIHC

Code of Ethics for Interpreters in Health Care

- The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing relevant requirements regarding disclosure.
- The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.
- The interpreter strives to maintain impartiality and refrains from counseling, advising or projecting personal biases or beliefs.
- The interpreter maintains the boundaries of the professional role, refraining from personal involvement.
- The interpreter continuously strives to develop awareness of his/her own and other (including biomedical) cultures encountered in the performance of their professional duties.
- The interpreter treats all parties with respect.
- When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.
- The interpreter strives to continually further his/her knowledge and skills.
- The interpreter must at all times act in a professional and ethical manner.

→ Back to overview

Standards for practice (NCIHC):

Accuracy	1. The interpreter renders all messages accurately and completely, without adding, omitting, or substituting. 2. The interpreter replicates the register, style, and tone of the speaker. 3. The interpreter advises parties that everything said will be interpreted. 4. The interpreter manages the flow of communication. 5. The interpreter corrects errors in interpretation. 6. The interpreter maintains transparency.
Confidentiality	7. The interpreter maintains confidentiality and does not disclose information outside the treating team, except with the patient's consent or if required by law. 8. The interpreter protects written patient information in his or her possession.
Impartiality	9. The interpreter does not allow personal judgments or cultural values to influence objectivity. 10. The interpreter discloses potential conflicts of interest, withdrawing from assignments if necessary.
Respect	11. The interpreter uses professional, culturally appropriate ways of showing respect. 12. The interpreter promotes direct communication among all parties in the encounter 13. The interpreter promotes patient autonomy
Cultural awareness	14. The interpreter strives to understand the cultures associated with the languages he or she interprets, including biomedical culture. 15. The interpreter alerts all parties to any significant cultural misunderstanding that arises.
Role boundaries	16. The interpreter limits personal involvement with all parties during the interpreting assignment. 17. The interpreter limits his or her professional activity to interpreting within an encounter. 18. The interpreter with an additional role adheres to all interpreting standards of practice while interpreting.
Professionalism	19. The interpreter is honest and ethical in all business practices. 20. The interpreter is prepared for all assignments. 21. The interpreter discloses skill limitations with respect to particular assignments. 22. The interpreter avoids sight translation, especially of complex or critical documents, if he or she lacks sight translation skills. 23. The interpreter is accountable for professional performance. 24 The interpreter advocates for working conditions that support quality interpreting. 25. The interpreter shows respect for professionals with whom he or she works. 26. The interpreter acts in a manner befitting the dignity of the profession and appropriate to the setting.
Professional development	27. The interpreter continues to develop language and cultural knowledge and interpreting skills. 28. The interpreter seeks feedback to improve his or her performance. 29. The interpreter supports the professional development of fellow interpreters. 30. The interpreter participates in organizations and activities that contribute to the development of the profession.
Advocacy	31. The interpreter may speak out to protect an individual from serious harm. 32. The interpreter may advocate on behalf of a party or group to correct mistreatment or abuse.

→ Back to overview

Other useful links

Issue:	List with most frequently asked questions in emergency situation.
Title:	Basic language emergency kit
Description	The Basic Language Emergency Kit helps healthcare providers communicate with refugees/migrants in emergency situations. List with most frequently asked questions in emergency situation. Available in 17 languages: English, Arabic, Bulgarian, Chinese, Croatian, Dutch, French, German, Greek, Lithuanian, Polish, Portuguese, Romanian, Russian, Spanish, Turkish, Ukrainian.
URL:	http://www.takecareproject.eu/en-2
Developed by:	Take care project

Issue:	Glossary
Title:	Word Fan
Description	A word fan including words relevant for health care. Available in 17 languages: English, Arabic, Bulgarian, Chinese, Croatian, Dutch, French, German, Greek, Lithuanian, Polish, Portuguese, Romanian, Russian, Spanish, Turkish, Ukrainian.
URL:	http://www.takecareproject.eu/upload/docs/GLOSSARY.pdf
Developed by:	Take care project

Issue:	Guideline for primary care in low resource countries
Title:	Prevention and control of non-communicable diseases
Description	The primary goal of the guideline is to improve the quality of care and the outcome in people with type 2 diabetes or asthma / COPD in low-resource settings. It recommends a set of basic interventions to integrate management of diabetes into primary health care. It will serve as basis for development of simple algorithms for use by health care staff in primary care in low-resource settings, to reduce the risk of acute and chronic complications of diabetes.
URL:	https://www.medbox.org/clinical-guidelines/listing
Developed by:	WHO

→ Back to overview

Continuity of care

Organisation

- Have one organisation in charge of coordination of all care by different providers.
- Make clear **what** services are available for **which** groups of refugees/migrants and by **whom** it is provided.
- Appoint a medical coordinator.
- Appoint a navigator (for instance a volunteer) that will help refugees to navigate through the system.

Informational continuity:

- Refugees are a moving population, it is important that health care providers in other countries can read the medical documentation as well. Therefore, write in English (not only in national language) in medical records since health care providers in other countries need to read it as well.
- Use universal (international codes) for diseases/medication and vaccination.

Useful links

Issue:	Medication indexed according to name and ATC code
Title:	ATC/DDD Index 2016
Description	A searchable version of the complete ATC index with DDD. You can find ATC codes and DDDs for substance name and/or ATC levels.
URL:	http://www.whocc.no/atc_ddd_index/
Developed by:	WHO collaborating centre for drug statistics and methodology

Issue:	Personal health record
Title:	IOM personal health record and handbook
Description	It includes in one single document the health data and information that will help the health professionals get a comprehensive view of refugees health status and needs. IOM is currently working on a electronic version.
URL:	http://ec.europa.eu/dgs/health_food-safety/docs/personal_health_record_english.pdf http://ec.europa.eu/dgs/health_food-safety/docs/personal_health_handbook_english.pdf
Developed by:	IOM

Issue:	Codes for vaccines
Title:	Vaccine nomenclature: the three-letter code.
Description	Description of three letter code for vaccines
URL:	http://www.ncbi.nlm.nih.gov/pubmed/10618552
Developed by:	Maurer W.Vaccine nomenclature: the three-letter code. OMCL Vaccine Nomenclature Drafting Group. Vaccine. 2000 Feb 14;18(15):1539-42.

Information needs and health promotion

Information for health care workers:

Every health care worker should at least be aware of the following knowledge:

- Political and legal situation of the receiving country and country of origin.
- Asylum process and entitlements of different migrant groups.
- Healthcare system information.
- Information on particular risks, needs and problems of refugee/migrant groups at the local sites.

Information for refugees:

- Provide information on basic human rights.
- Make sure all information is culturally appropriate.
- Make sure information also fit needs of illiterate: use visual material and oral explanation.
- The following information should (at least) be available for refugees:
    - Hygiene
    - Sanitation
    - Malnutrition
    - Healthcare system information

Useful links

Issue:	Health care system information
Title:	Migration integration policy index: Mipex
Description	This website provides information on how countries are promoting integration of immigrants.
URL:	http://www.mipex.eu/
Developed by:	MIPEX project

Issue:	Clinical guidelines for several diseases
Title:	MEDbox
Description	On this webpage you can find information and clinical guidelines on many diseases
URL:	https://www.medbox.org/clinical-guidelines/listing
Developed by:	Depending on the guideline

Issue:	Health promotion
Title:	Patient information on several diseases/issues
Description	Information available in English, Arabic, German, Russian, Spanish and Turkish
URL:	http://www.patienten-information.de/kurzinformationen/uebersetzungen
Developed by:	AZQ

→ Back to overview

Specific issues

1. Health Assessment
2. Mental Health
3. Reproductive Health care
4. Child care
5. Infectious diseases
6. Vaccination

1. Health assessment

Refugees arrive in short stay/first reception centres often exhausted and with many journey and violence related health problems, sometimes critically ill or wounded. When large groups arrive, a triage system, assessing who are first in need of care is urgent.

General recommendations

- The initial assessment should be done by a **multidisciplinary team** that contain accredited quality workers including the following:
  - Doctor
  - Nurse
  - Midwife
  - Social worker
  - Mental health worker
  - 'Navigator' or volunteer or CHW
  - Interpreter (well trained, not informal)
  - If available a dietician
- Enable task shifting and joint triaging.
- Make sure there are enough rooms available to provide confidential environment.

→ Back to overview

Organisation

Emergency Health Kit

Domain:	1 and 2
Issue:	General healthcare
Location	Short stay/first reception centres (early phase of crisis situations)
Provider:	UN agencies and international and nongovernmental organizations responding to large-scale emergencies
Developed by	WHO
Includes:	Manual , 72 pages
Features:	Provides a manual for the necessary medication and medical devices in large scale emergencies
URL:	http://www.who.int/medicines/publications/emergencyhealthkit2011/en/

Description:

The concept of the emergency health kit has been adopted by many organizations and national authorities as a reliable, standardized, affordable and quickly available source of the essential medicines and medical devices (renewable and equipment) urgently needed in a disaster situation. Its content is based on the health needs of 10 000 people for a period of three months. This document provides background information on the composition and use of the emergency health kit.

- Chapter 1 describes supply needs in emergency situations and is intended as a general introduction for health administrators and field officers.
- Chapter 2 explains the selection of medicines and medical devices – renewable and equipment – that are included in the kit, and also provides more technical details intended for prescribers.
- Chapter 3 describes the composition of the kit, which consists of basic and supplementary units.

Triage/red flags

Domain:	1
Issue:	Red flags checklist
Location	Short stay/first reception centre and longer stay reception centre
Provider:	Health care workers in triage
Developed by	EUR-HUMAN
Includes:	Quick checklist for red flags and vulnerable groups

Red flag symptoms or signs	yes	no
Shock or coma or hypoglycaemia		
Fever		
Cough		
Acute injury -trauma		
Haemorrhage		
Dyspnoea		
Respiratory rate (high-low)		
Short breathiness		
Signs of dehydration		
Signs of starvation		
Delirium		
Suicidal ideation/ thoughts of self-harm		
Diarrhoea		
Vomiting		
Scabies		
Burns or frostbites		
Wet clothes- torn apart		
Bruises –signs of surgery (esp. children)		
Special groups		
Pregnancy or carrying an infant		
Disabled/handicapped		
Unaccompanied children		
Chronically ill		

Screening form for refugees

Domain:	1 and 2
Issue:	Anamnesis/screening
Location	Short stay/first reception centre and longer stay reception centre
Provider:	Refugees can fill in themselves
Developed by	Landkreis Führt, (2015)
Includes:	Questionnaire for triage
URL:	https://www.medbox.org/anamnesis-screening/toolboxes/listing

Description:

A short form (2 pages) for anamnesis/triage of red flags that refugees can fill in themselves or health care providers can fill in for them. Available in English, Arabic, Farsi, Kurdish, Croatian, Serbian, Georgian, Macedonian.

Date of examination: Language: Englisch

Number/day:

Questionnaire for the initial examination for asylum seekers

Please present the completed questionnaire when undergoing the initial examination!

First and last name:.....

Date of birth:.....

1. Do you or your children suffer from looseness and/or ☐ yes ☐ no
   vomiting? ☐ yes ☐ no
   If yes, since when? ☐ 1-2 days
   ☐ 1-4 weeks
   ☐ More than 4 weeks

2. Do you suffer from breathlessness when resting and/or ☐ yes ☐ no
   under stress? ☐ yes ☐ no

3. Do you suffer from cough? ☐ yes ☐ no
   With secretion? ☐
   Without secretion? ☐

4. Do you or your children suffer from fever or do you have yes no
   the suspicion of an acute infectious disease with fever? ☐ ☐

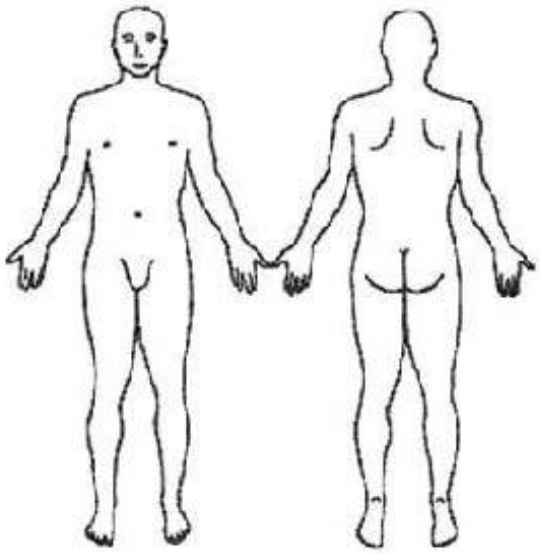
5. Do you or your children have yellow-coloured skin, yes no
   and/or eyes? ☐ ☐

6. Do you or your children have conspicuous skin alterations? yes no
   ☐ ☐
   Hydrous bladders/blisters ☐
   Purulent pustules ☐
   Blury/spread discolorations ☐
   Ulcers/wounds ☐
   Papules ☐
   Wheals ☐
   Haemorrhages ☐
   Itching ☐
   .....☐

→ Back to overview

If so, where? **(Please mark on the figure using *)**

		yes	no
7.	Do you or your children have tumours under Your skin, for example at your neck, armpit or inguinal region? If so, where? **(Please mark on the figure using *)**	☐	☐
8.	Have you unintentionally lost weight, recently?	☐	☐
9.	Do you or your children currently suffer or have suffered from tuberculosis?	☐	☐
10.	Do you or your children suffer from chronic diseases? If yes, which diseases?	☐	☐



....

Date Signature

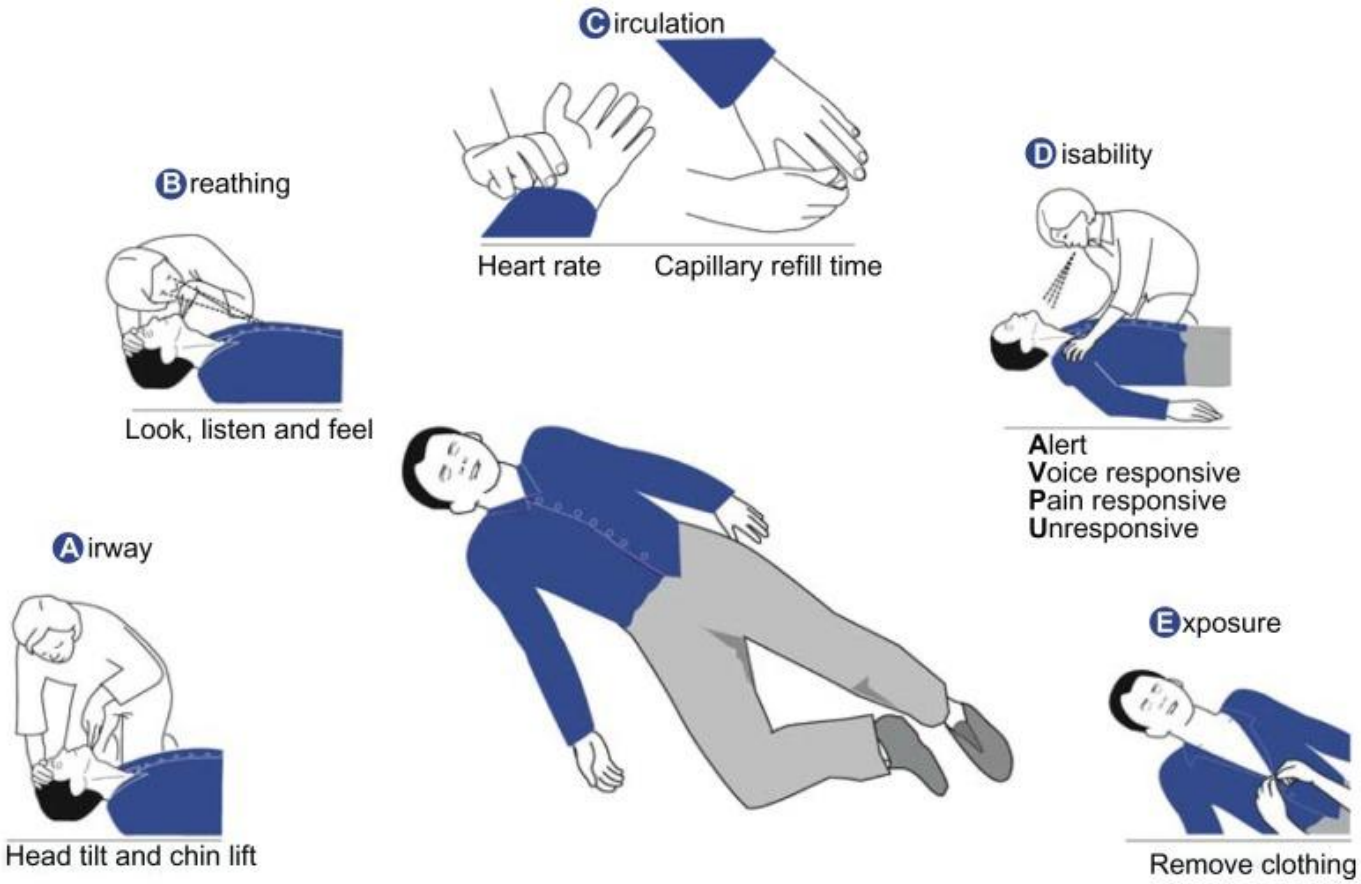
ABCDE or ATLS (advanced trauma life support):

Domain:	1
Issue:	First health assessment
Location:	Short stay/first reception centre and emergency situation in longer stay reception centres
Provider:	Health care provider (GP)
Target group:	general population
Developed by	Thim T, Krarup NHV, Grove EL, Rohde CV, Løfgren B. Initial assessment and treatment with the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach. *International Journal of General Medicine*. 2012;5:117-121. doi:10.2147/IJGM.S28478.
Includes:	Tool
URL:	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3273374/

Description

The Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach is an approach for the immediate assessment and treatment of critically ill or injured patients.

	Assessment	Treatment
A – Airways	Voice Breath sounds	Head tilt and chin lift *Oxygen (15 l min^{-1}) Suction*
B – Breathing	Respiratory rate (12–20 min^{-1}) Chest wall movements Chest percussion *Lung auscultation* *Pulse oximetry (97%–100%)*	Seat comfortably Rescue breaths *Inhaled medications* *Bag-mask ventilation* *Decompress tension pneumothorax*
C – Circulation	Skin color, sweating Capillary refill time (<2 s) Palpate pulse rate (60–100 min^{-1}) *Heart auscultation* *Blood pressure (systolic 100–140 mmHg)* *Electrocardiography monitoring*	Stop bleeding Elevate legs *Intravenous access* *Infuse saline*
D – Disability	Level of consciousness – AVPU • Alert • Voice responsive • Pain responsive • Unresponsive Limb movements Pupillary light reflexes *Blood glucose*	Treat Airway, Breathing, and Circulation problems Recovery position Glucose for hypoglycemia
E – Exposure	Expose skin Temperature	Treat suspected cause


Circulation
Heart rate
Capillary refill time
Breathing
Look, listen and feel
Disability
Alert
Voice responsive
Pain responsive
Unresponsive
Airway
Head tilt and chin lift
Exposure
Remove clothing

Initial general health assessment in longer stay reception centres

Domain:	3
Issue:	Intake for news patients in practice
Location	Short stay/first reception centre and longer stay reception centres
Provider:	Healthcare workers
Developed by	Pharos, translated by EUR-HUMAN
Includes:	List of issues to discuss with new patients

Contextual information

- Country of origin
  - Place of Birth
  - Which ethnic group
  - How long in the current country
  - Reason of migration
- Living conditions
  - Permanent address (asylum seeker centre, homeless)
  - Resident
- Family/ Social support
  - Marital status
  - Current residential situation
  - Children
  - Family circumstances in current country and country of origin
  - Social environment, Social support (Family, Friends)
  - Person of contact/volunteer (name)
- Religion (accompanying customs)
- Education
  - Current work
  - Work in country of origin
  - Educational background
- Language
  - Mother tongue
  - Western European languages
  - Interpreter necessary?
  - Reading ability in what language/script
- Life Events
  - Migration history / refugee claim
  - Moving (how many times)
  - Loss family/friends
  - Physical / sexual violence
  - Detention / arrest

Medical information

- Medical history
  - Hospitalisation / operations
  - Severe or longer stay reception centres illnesses
- Chronic / recurrent conditions
- Infectious diseases
  - TBC screening, Status hepatitis B en C, HIV

→ Back to overview

  - Vaccinations
- Medications
- Allergies
- Intoxication
  - Smoking, alcohol, drugs
- Family medical history

Explanation

The issues described above are a guideline for the introductory interview with new migrants. Awareness of the history and cultural background of the patient will help create a bond of trust essential for the therapeutical relationship. This knowledge will also help recognizing culture-related complaints and find the best treatment for the patients.

Recommendations:

- Take the time to build trust.
- Asking about sensitive information only when trust is established.
- It is advised to first give attention to the reason the patient is coming to the consult before asking background information.
- Be aware of migrant health literacy.

Practical tips to assess health literacy:

- Ask patient to write his/her own name, date of birth and phone-number.
- Ask about the number of years they went to school.
- Ask whether they have difficulties to fill in medical forms.

➔ In case of low literacy:

- Take the time for the consultation and speak slowly.
- Avoid use of medical terminology.
- Use audiovisual aids.
- Avoid giving to much information.
- Ask patient to summarize the conversation.

Nutritional state screening

Domain:	2
Issue:	MUST tool for malnutrition
Location	Short stay/first reception centre and longer stay reception centres
Provider:	Health care provider
Target group:	Adults
Developed by	Bapen
Includes:	Tool
Conditions:	Availability to measure weight and height
URL:	http://www.bapen.org.uk/pdfs/must/must_full.pdf

Description

This tool contains a five step screening to identify adults at risk for malnutrition and under nutrition.

Steps:

1. Measure height and weight to get a BMI score.
2. Note percentage unplanned weight loss.
3. Establish acute disease effect.
4. Add scores obtained from step 1-3 together.

Use management guidelines to develop care plan.

Treatment and referral

Nursing intervention guide to health problems

Domain:	1,2,3
Issue:	General health
Location	Short stay/first reception centre, Longer stay reception centres
Provider:	Nurses
Target group:	General population
Developed by	Castelldefels Agents de Salut (CASAP)
Includes:	Manual, 120 pages
URL:	http://www.casap.cat/wp-content/uploads/2014/08/HealthProblems_nursing_interventions_guide_adults.pdf

Description

Within this guide 23 health problems solvable by nurses and 18 emergency possible interventions are described. For every health problem a brief definition is provided. Secondly it describes an algorithm of actuation which includes the history, assessment, intervention, alert causes and revisiting criteria. Finally, a third section includes most common nursing diagnoses NANDA (North American nursing Diagnosis Association) for each common health problem and possible nursing interventions-NIC (nursing Interventions Classification).

Information on the following health problems can be found:

Acute health problems	**Urgent health problems**
- Oral thrush - Emergency contraception - Burn - Anxiety attack - Diarrhea - Blood pressure elevation - Epistaxis - Wound - Herpes - Dermal lesion of skin folds - Sore throat - Backache - Toothache - Distress when urinating - Animal bite - Stye - Bite - Mosquito bite - Allergic reaction - Respiratory symptoms in upper airways - Sprained ankle - Trauma - Whitlows	- Aggressions - Cardiac arrest - Seizures - Heatstroke - Severe abdominal pain - Chest pain - Fever > 39º - Intoxications - Serious eye injury - Intense headache - Dizziness - Drowning - Loss of conscience - Gastrointestinal bleeding - Traumatic brain injury - Severe trauma - Vomiting - Anaphylactic shock

2. Mental health

General recommendations

Short stay/first reception centre:

- Perform triage as crisis response: assess dysfunctional level of distress and self- and other-harm and provide urgent referral for specialist care if necessary.
- Consider involving trained non-specialist health personnel and allied staff and trained volunteers.
- Think of the appropriateness of the health worker: in terms of the gender, age etc.
- Include assessment of mental health problems in general physical assessment.

Longer stay reception centres:

- Assess for delayed crisis cases.
- Screen for mental health conditions (recommended instrument RHS-15).
- Consider involving trained non-specialist health personnel and allied staff and trained volunteers.
- Think of the appropriateness of the health worker: in terms of the gender, age etc.
- Provide referral for specialist full MH assessment and care as needed for those who score above cut-off.
- Provide psychological first aid to those who score bellow cut-off but have symptoms and monitor changes.
- Link with PC in countries (depends on country which do MHC in PC and which don't but at least physical health of those with mental illness should be looked after).

→ Back to overview

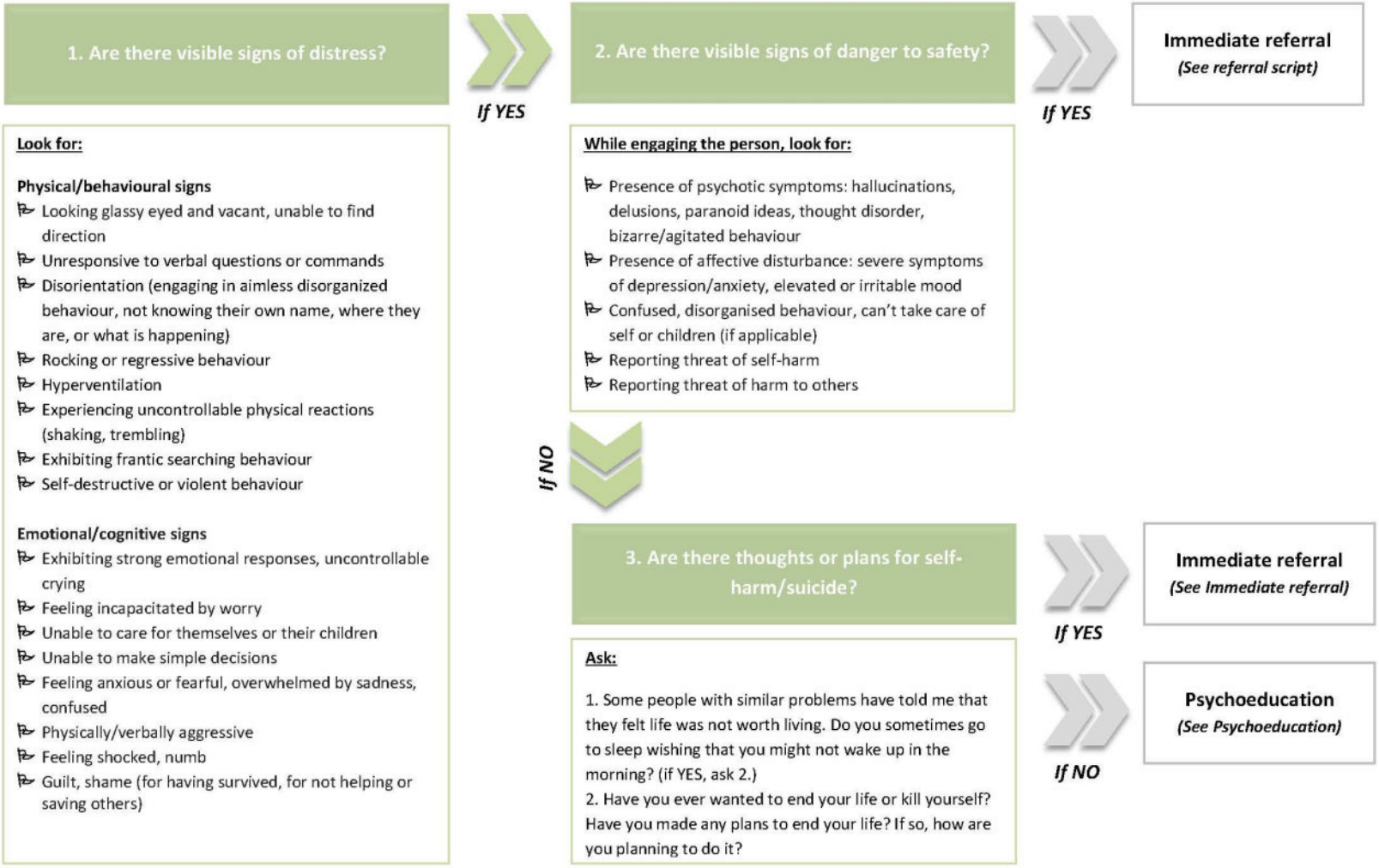
Mental health triage

Mental health triage tool

Domain:	1
Issue:	Mental health triage
Location	Short stay/first reception centre and longer stay reception centres At any contact with individual (not only first contact)
Provider:	Trained paraprofessionals and volunteers, professionals
Target group:	Young adults/Adults (16+)
Developed by	Developed within the EUR-HUMAN project (WP5, University of Zagreb)
Type:	Tool
Time:	20-30 min.
Conditions:	(1) Creating a safe, comfortable and confidential setting; (2) Establishing basic trustful relationship (more information in Deliverable 5.1, pp 14-15).

Description: The purpose of MH triage tool is to guide the care providers in recognising refugees and migrants who are dysfunctional and/or at immediate risk, defined as threat to personal safety of the affected people, or threat to safety of people around them. MH triage consists of recognising behavioural signs that indicate severe distress, conducting rapid assessment of immediate risk and providing referral and psychoeducation. Details on MH triage procedure can be found in Deliverable 5.1, pp 11-17.

MH Triage tool



→ Back to overview

Immediate referral[1]

Inform

- ✓ Explain to the person that you are worried about him/her harming himself/herself and that you have a professional duty to act in the interest of preventing that.

Take precautions

- ✓ Remove means of self-harm.
- ✓ Create secure environment while waiting – if possible, offer separate, quiet room.
- ✓ Do not leave the person alone – assign a staff or family member to ensure safety.

Refer

- ✓ Immediately consult mental health specialist and ensure escort to that specialist. If it is not possible to ensure immediate escort to specialist, ensure safe environment and make appointment as soon as possible.

Psychoeducation[2]

Normalise

- ✓ A lot of people experience sadness, worries, bad memories and feel stress when they go through terrible life events

Explain

- ✓ Experiencing stressful life events affects body and mind.
- ✓ Typical physical reactions ("body symptoms") are sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.
- ✓ Typical emotional and behavioural reactions ("mind symptoms") are anxiety, watchfulness and poor concentration, and negative feelings such as guild, sadness and anger.
- ✓ Some people become disoriented, have intrusive memories and avoid being reminded of the thing that happened. Others may isolate themselves or increase intake of alcohol, medicine or drugs.

Encourage

- ✓ It is important to find ways of dealing with reactions to stressful life events.
- ✓ It may help to:
  Remember that these reactions are expected after terrible experiences.
  Allow yourself to feel sad and grieve.
  Maintain daily routines and do things that normally give you pleasure.
  Eat healthy foods, get sleep and exercise if possible.
  Socialize with other people instead of withdrawing.
  Seek support and assistance.
  Accept assistance that is offered.

Offer support

- ✓ If you start/continue feeling like this, and it persists over several weeks, seek help (*give contact where the person can do that!*).

[1] based on http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
[2] based on http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf

→ Back to overview

Mental health screening

Mental health screening tool

Domain:	2,3
Issue:	Mental health screening
Location	Short stay/first reception centre and longer stay reception centres
Provider:	Trained paraprofessionals and volunteers, professionals
Target group:	14+
Developed by	Developed within the EUR-HUMAN project (WP5, University of Zagreb)
Type:	Tool
Time:	20-30 min.
Conditions:	(1) Establishing trust (more information in Deliverable 5.1, p 21); (2) Possibility to offer immediate assistance, if needed; (3) Possibility to offer referral, if needed.

Description: The purpose of mental health (MH) screening tool is to guide the care providers through the process of MH screening. The purpose of screening is to identify individuals who are experiencing heightened distress and who are more likely to develop more serious MH conditions. MH screening should be conducted as a part of comprehensive health screening, either in temporary or longer stay reception centres. If MH screening indicates possibility of developing more serious MH conditions ("positive screen"), care providers should make appropriate referral. Details on MH screening procedure can be found in Deliverable 5.1, pp 19-24.

→ Back to overview

MH Screening tool

→ Back to overview

Referral script[3]

✓ Offer referral. You can use the following script[4]:

"From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. In *(state country)*, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time. I would like to connect you to a counsellor. This is a type of healthcare worker who will listen to you and provide help and support. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?"

✓ Make an appointment for the refugee.
✓ Proactively address potential barriers: ask the refugee if there are any obstacles that need to be addressed (e.g. money, transport, child care).
✓ Follow-up with the refugee after appointment.

Psychoeducation[5]

Normalise

✓ A lot of people experience sadness, worries, bad memories and feel stress when they go through terrible life events.

Explain

✓ Experiencing stressful life events affects body and mind.
✓ Typical physical reactions ("body symptoms") are sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.
✓ Typical emotional and behavioural reactions ("mind symptoms") are anxiety, watchfulness and poor concentration, and negative feelings such as guild, sadness and anger.
✓ Some people become disoriented, have intrusive memories and avoid being reminded of the thing that happened. Others may isolate themselves or increase intake of alcohol, medicine or drugs.

Encourage

✓ It is important to find ways of dealing with reactions to stressful life events.
✓ It may help to:
Remember that these reactions are expected after terrible experiences.
Allow yourself to feel sad and grieve.
Maintain daily routines and do things that normally give you pleasure.
Eat healthy foods, get sleep and exercise if possible.
Socialize with other people instead of withdrawing.
Seek support and assistance.

Accept assistance that is offered.

Offer support

✓ If you continue or start feeling like this, and it persists over several weeks, seek help (*give contact where the person can do that!*).

[3] based on http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
[4] taken from http://www.lcsnw.org/pathways/pdf/RefugeeHealthScreener.pdf
[5] based on http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf

→ Back to overview

Refugee health screener

Domain:	2 and 3
Issue:	Refugee health screener-15 (RHS 15)
Location	Temporary or longer stay reception centres
Provider:	Self-administered/Trained paraprofessionals and volunteers, professionals
Target group:	14+
Developed by	Hollifield M, Toolson EC, Verbillis-Kolp S, et al. Effective screening for emotional distress in refugees: The Refugee Health Screener. *The Journal of nervous and mental disease*. 2016. doi:10.1097/NMD.0000000000000469.
Type:	Checklist, 13 items
Evidence:	Validated scale for newly arrived refugees, sensitivity 0.82-0.96, specificity 0.86-0.91 with a cut-off point of >11.
Time:	15 minutes
Conditions:	(1) Establishing trust (more information in D5.1, p 21); (2) Ability to offer immediate assistance, if needed; (3) Ability to offer referral, if needed.
URL:	http://www.lcsnw.org/pathways/

Description:

RHS-13 (a shorter version of RHS15) is a screening tool assessing PTSD, anxiety and depression symptom intensity. The scale consists of 13 questions with five possible answers (0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely). It can be used as quick assessment of the probable risk of having or developing PTSD, anxiety or depression (cut-off score ≥ 11). This instrument was specifically designed for and validated on newly arrived refugees and migrants with items derived from existing and valid instruments used on similar populations. It is translated in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); can be administered in relatively short amount of time; is easily understandable for people of different educational levels and can be administered for persons from age 14.

→ Back to overview

ID#

DATE

REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

CHECK ONE: ☐ POSITIVE ☐ NEGATIVE ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

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→ Back to overview

Refugee Health Screener-15 Arabic Version (page 1/2)

PATHWAYS TO WELLNESS

تعليمات: باستخدام المقياس الموجود بجانب كل عرض من الأعراض، يرجى الإشارة إلى درجة مضايقة كل عرض لك على مدى الشهر الماضي. ضع دائرة في العمود المناسب. إذا لم يكن العرض مضايقاً لك خلال الشهر الماضي، فضع دائرة في عمود «لا شيء على الإطلاق».

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

لا شيء على الإطلاق NOT AT ALL	قليلاً A LITTLE BIT	معتدلاً MODERATELY	كثيرا QUITE A BIT	إلى أقصى حد EXTREMELY	
0	1	2	3	4	.1 آلام في العضلات والعظام والمفاصل Muscle, bone, joint pains
0	1	2	3	4	.2 الشعور بالكآبة معظم الاوقات Feeling down, sad, or blue most of the time
0	1	2	3	4	.3 كثرة التفكير Too much thinking or too many thoughts
0	1	2	3	4	.4 الشعور بعدم القدرة على المساعدة (الشعور بالعجز) Feeling helpless
0	1	2	3	4	.5 رعب مباغت بدون سبب Suddenly scared for no reason
0	1	2	3	4	.6 إغماء أو دوخة أو ضعف Faintness, dizziness, or weakness
0	1	2	3	4	.7 عصبية أو ارتجاف داخلي Nervousness or shakiness inside
0	1	2	3	4	.8 عدم الشعور بالسكينة و عدم القدرة على الثبات Feeling restless, can't sit still
0	1	2	3	4	.9 البكاء بسهولة Crying easily

Refugee Health Screener-15 Arabic Version (page 2/2)

PATHWAYS TO WELLNESS

التجارب التالية يمكن ان تكون تجارب مؤلمة متعلقة بالحرب او الهجرة, كم مرة شعرت بالاعراض تالية خلال شهر الماضي:
The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

إلى أقصى حد EXTREMELY	كثيرا QUITE A BIT	معتدلا MODERATELY	قليلاً A LITTLE BIT	لا شيء على الإطلاق NOT AT ALL	
4	3	2	1	0	10. هل عانيت من استعادة تذكرك لهذه الصدمة بخيالك أو تمثيلها أو الشعور كأنها تحدث مرة أخرى؟ Had the experience of reliving the trauma; acting or feeling as if it were happening again?
4	3	2	1	0	11. هل عانيت من ردود فعل بدنية (على سبيل المثال، كثرة تصبب العرق، سرعة دقات القلب) عندما تمّ تذكيرك بالصدمة؟ Been having physical reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?
4	3	2	1	0	12. هل شعرت بانعدام المشاعر (على سبيل المثال، تشعر بالحزن ولكنك لا تستطيع البكاء، أو غير قادر على الإحساس بمشاعر الحب)؟ Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?
4	3	2	1	0	13. الآختلاج و سرعة الآجفال (مثال على ذلك، تشعر أن هناك شخص يمشي ورائك) Been jumpier, more easily startled (for example, when someone walks up behind you)?

CHECK ONE: ☐ POSITIVE ☐ NEGATIVE ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

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→ Back to overview

3. Reproductive health care

General recommendations: Organisation

Short stay/first reception centre

- Identify pregnant women.
- Provide adequate care for pregnant women, preferably by midwife.
- Identify victims of sexual violence for immediate initial examination by doctor and provision of psychological first aid.
- Provide culturally appropriate information on pregnancy, contraception, women's rights.
- Make available all contraceptives, including post-natal IUD's, in line with national guidelines.
- Secure the provision of sufficient hygiene pads.

Longer stay reception centres

- Provide perinatal care as per national guidelines.
- Be aware of sexual violence as cause of delayed PTSD.
- Refer victims of sexual violence for MH support.
- Provide (more in-depth) culturally appropriate information on contraception, breastfeeding and on women's rights in that country.

Useful links

Issue:	Organization of reproductive health
Title:	field manual on reproductive care in humanitarian setting
Description	Although the target group are officers and managers there is loads of important information for service providers. We highly recommend to read this document.
URL:	http://www.who.int/reproductivehealth/publications/emergencies/field_manual_rh_humanitarian_settings.pdf?ua=1
Developed by:	WHO

→ Back to overview

Minimum Initial Service Package (MISP) for reproductive health

Domain:	1, 2
Issue:	Sexual and reproductive health
Location	Short stay/first reception centre, also helpful for longer stay reception centres
Provider:	Mainly humanitarian workers in emergency response settings
Target group:	People in crisis settings
Developed by	Women's Refugee Commission
Type:	E-learning, cheat sheets
Time:	4 hours
Conditions:	Computer
Features:	Teaching humanitarian workers skills and knowledge for implementing reproductive health care needs in emergency settings. Free of charge, certificate after completion of the e-learning. Available in English, French, Spanish.
Link:	http://misp.iawg.net/

Description

The Minimum Initial Service Package (MISP) for reproductive health (RH) is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; and plan for comprehensive RH services.

Additional priority activities of the MISP include making contraceptives available to meet demand, syndromic treatment for sexually transmitted infections (STIs) and ensuring antiretrovirals (ARVs) for continuing users. The MISP distance learning module aims to increase humanitarian actors' knowledge of these priority RH services to initiate at the onset of a crisis and to scale up for equitable coverage throughout protracted crises and recovery, while planning for comprehensive RH services and implementing them as soon as possible.

The e-learning consists of 8 chapters with a quiz at the end and a post-test. After obtaining a score of at least 80% for the post-test, participants will automatically receive a certificate of completion which can be printed out directly.

Sexual violence

Assessment Gender based violence

Domain:	3
Issue:	**ASIST-GBV: Assessment screen to identify survivors toolkit for gender based violence**
Location:	Longer stay reception centres
Provider:	PHC workers
Target group:	Refugees and internally displaced females/girls (IDPs)
Developed by:	Vu, A., Wirtz, A. , Pham, K., Singh,S. Rubenstein, L., Glass, N. & N. Perrin (2016) Psychometric properties and reliability of the Assessment Screen to Identify Survivors Toolkit for Gender Based Violence (ASISTGBV): results from humanitarian settings in Ethiopia and Colombia. Conflict and Health 10:1
Type:	8 item questionnaire
Evidence:	Validated in Ethiopian refugees and IDP Colombian women (1 qualitative study, Cronbachs α=0.77)
Time:	5 minutes
URL:	**http://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0068-7**

Description:

"Refugees and internally displaced persons who are affected by armed-conflict are at increased vulnerability to some forms of sexual violence or other types of gender-based violence. A validated screening tool will help service providers identify GBV survivors and refer them to appropriate GBV services. Vu et al developed the 8-item ASIST-GBV screening tool from qualitative research that included individual interviews and focus groups with GBV refugee and IDP survivors."

Tool:

GBV Screening Question Items:
1. In the past year, have you been threatened with physical or sexual violence by someone in your home or outside of your home?
2. In the past year, have you been hit, punched, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt by someone in your home or outside of your house?
3. In the past year, were you forced to have sex against your will?
4. In the past year, were you forced to have sex to be able to eat, have shelter, or have sex for essential services (such as protection or school) because you or someone in your family would be in physical danger if you refused?
5. In the past year, were you physically forced or made to feel that you had to become pregnant against your will?
6. In the past year, were you coerced or forced into marriage?
7. In the past year, were you coerced or forced to have an abortion?
If yes to any of items 1 to 7, the woman has screened positive for gender-based violence. If positive screen, please ask:
8. Would you like to talk to someone or learn more about services for women who have experienced gender-based violence?

More information on prevention of Sexual and gender based Violence can be found at: https://emergency.unhcr.org/entry/60283/sexual-and-gender-based-violence-sgbv-prevention-and-response

→ Back to overview

Female genital cutting

Domain:	3
Issue:	Female genital Cutting
Location	Longer stay reception centres
Provider:	Primary care Physician
Target group:	Women
Developed by	Adelaide A. Hearst, Alexandra M. Molnar, Female Genital Cutting: An Evidence-Based Approach to Clinical Management for the Primary Care Physician, Mayo Clinic Proceedings, Volume 88, Issue 6, June 2013, Pages 618-629
Includes:	Guidelines
URL:	http://www.ncbi.nlm.nih.gov/pubmed/23726401

Description

This article gives an overview of the social and cultural context, the geography, types, complications and their management of female genital cutting. In addition it provides a guideline for discussing female genital cutting with patients.

Guidelines for discussing female genital cutting with patients.

Category	Questions
Basic history	Please share your experience with being circumcised. Where was it done? By whom? What was your age at circumcision?
Community/context	Do you know anyone who is not circumcised? Do you talk about circumcision with other women? Your daughters? What do you talk about?
Beliefs	What do you think is good about being circumcised? What do you think is bad about being circumcised? Does your religion recommend circumcision? Does your culture recommend it?
Problems	Do you have any pain/discomfort/problems because of your circumcision? Are there other problems? What medical help would you like for any of the problems?
Treatment	As a woman who has been circumcised, what kind of care did you get in the past? How is this different than the care that you've received here? What would be your preference?
Plans/concerns	How would you feel about raising your daughters in [country] without being circumcised? How do you think your daughter would feel if she is not circumcised? How do you think your daughter's future husband would feel if your daughter is not circumcised?
Difficult scenarios	Do you hope to be able to circumcise your daughter? Are you aware of the laws relating to circumcision in [country]?

Guideline for care for victims of sexual violence:

Domain:	1,2,3
Issue:	Guidelines for medico-legal care for victims of sexual violence
Location	Short stay/first reception centre and longer stay reception centres
Provider:	Health care providers
Developed by	WHO
Includes:	Guideline, manual
URL:	http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

Description

To build health workers' capacity to respond to cases of sexual assault in a sensitive and comprehensive manner, WHO has developed the *Guidelines for medico-legal care for victims of sexual violence.* The aim of these guidelines is to improve professional health services for all victims of sexual violence by providing:

- health care workers with the knowledge and skills that are necessary for the management of victims of sexual violence;
- standards for the provision of both health care and forensic services to victims of sexual violence;
- guidance on the establishment of health and forensic services for victims of sexual violence.

Health professionals can use the guidelines as a day-to-day service document and/or as a tool to guide the development of health services for victims of sexual violence. The guidelines can also be used to prepare in-service training courses on sexual violence for health care practitioners and other members of multidisciplinary teams.

The guidelines will be useful for a range of professionals who provide care for victims of sexual violence: health service facility managers, medico-legal specialists, doctors and nurses with forensic training, district medical officers, police surgeons, gynaecologists, emergency room physicians and nurses, general practitioners, and mental health professionals. At a second level, the guidelines are of relevance to policy-makers in charge of health service planning and professional training within health ministries, and policy-makers with responsibility for developing guidelines for university curricula in the areas of medicine and public health.

See next page for an example on how to deal with victims of sexual violence.

Dealing with victims of sexual violence: useful techniques

You may find the following strategies and techniques helpful when dealing with victims of sexual violence:

- Greet the patient by name. Use her preferred name. Make her your central focus.
- Introduce yourself to the patient and tell her your role, i.e. physician, nurse, health worker.
- Aim for an attitude of respectful, quiet professionalism within the boundaries of your patient's culture.
- Have a calm demeanour. A victim who has been frightened and has experienced fear wants to be in the company of people who are not frightened.
- Be unhurried. Give time.
- Maintain eye contact as much as is culturally appropriate.
- Be empathetic and non-judgmental as your patient recounts her experiences

THE FEELING	SOME WAYS TO RESPOND
Hopelessness	Say, "You are a valuable person."
Despair	Focus on the strategies and resourcefulness that the person used to survive.
Powerlessness and loss of control	Say, "You have choices and options today in how to proceed."
Flashbacks	Say, "These will resolve with the healing process."
Disturbed sleep	Say, "This will improve with the healing process."
Denial	Say, "I'm taking what you have told me seriously. I will be here if you need help in the future."
Guilt and self-blame	Say, "You are not to blame for what happened to you. The person who assaulted you is responsible for the violence."
Shame	Say, "There is no loss of honour in being assaulted. You are an honourable person."
Fear	Emphasize, "You are safe now." You can say, "That must have been very frightening for you."
Numbness	Say, "This is a common reaction to severe trauma. You will feel again. All in good time."
Mood swings	Explain that these are common and should resolve with the healing process.
Anger	A legitimate feeling and avenues can be found for its safe expression. Assist the patient in experiencing those feelings. For example, "You sound very angry."
Anxiety	Tell the patient that these symptoms will ease with the use of the appropriate stress management techniques and offer to explain these techniques.
Helplessness	Say, "It sounds as if you were feeling helpless. We are here to help you."

→ Back to overview

4. Child care

General recommendations

- Be aware that apparent developmental delay in children can be a result of PTSD/abuse etc.
- Provide adequate psychological care and assessment for these children.

Unaccompanied children

Domain:	2,3
Issue:	Unaccompanied children
Location	Short stay/first reception centre and longer stay reception centres
Provider:	All
Target group:	Children
Developed by	Connect project
Includes:	Tools
URL:	http://www.connectproject.eu/tools.html

Description

The connect project developed practical tools which can be used by different actors across EU member states. They address specific aspects of how actors address the situation of unaccompanied children. The following tools are available:

- Who's responsible: a Tool to strengthen cooperation between actors involved in the protection system for unaccompanied Migrant Children.
- Local cooperation for unaccompanied children: a tool to assess and improve reception conditions.
- Standards to ensure that unaccompanied migrant children are able to fully participate: a tool to assist actors in legal and judicial proceedings.
- The right to be heard and participation of unaccompanied children.
- Working with the unaccompanied child: a tool to support the collection of children's views on protection and reception services.

Trauma risk in children

Domain:	3
Issue:	Trauma risk in children
Location	Longer stay reception centres
Provider:	Primary health care provider
Target group:	Children
Developed by	National child traumatic stress network
Includes:	Toolkit
URL:	http://learn.nctsn.org/mod/book/view.php?id=4518&chapterid=16

Description

The Refugee Services Toolkit (RST) is a web-based tool designed to help service system providers understand the experience of refugee children and families, identify the needs associated with their mental health, and ensure that they are connected with the most appropriate available interventions. The mental health and general well-being of refugee children and families can be impacted by multiple factors including their experience of trauma; stressors such as resettlement, acculturation, and social isolation; and strengths they may have that could contribute to resilience. Providers can use community resources and supports to build resilience and reduce stress in refugee families.

5. Infectious diseases

General recommendation

Short stay/first reception centre

- Follow ECDC or national / international guidelines for screening and treating infectious diseases.
- Do not screen asymptomatic persons with high risk for Hep B/C HIV.
- Use rapid testing for symptomatic / high risk (TB, HIV, malaria etc.).
- Provide information on hygiene and prevention of communicable diseases.

Longer stay reception centres

- Follow ECDC or national/international guidelines for screening and treating infectious diseases.
- Test asymptomatic persons with high risk for Hepatitis B/C or HIV , even if treatment is not available.

Infectious diseases screening

Domain:	1,2,3
Issue:	Infectious diseases
Location	Short stay/first reception centre, longer stay reception centres
Provider:	PHC professionals
Target group:	Refugees, migrants
Developed by	ECDC
Type:	Information 6 pages Table: Infectious diseases to consider according to country of origin Table: Infectious diseases to consider for differential diagnosis during clinical examination
Conditions:	Knowledge of infectious diseases
URL:	http://ecdc.europa.eu/en/publications/Publications/Infectious-diseases-of-specific-relevance-to-newly-arrived-migrants-in-EU-EEA.pdf

Description

The document consists of information regarding:

1. Infectious diseases to consider in overcrowded settings
2. Infectious diseases to consider according to migrants originated from Syria, Iraq, Afghanistan, Eritrea and Somalia (table 1)
3. Infectious diseases to consider for differential diagnosis during clinical examination (table 2)

Diseases to consider in overcrowding settings:

- Relapsing fever due to Borrelia recurrentis,
- Trench fever due to Bartonella quintana
- Epidemic typhus due to Rickettsia prowazekii
- Murine typhus
- Scabies
- Meningococcal disease
- Measles
- Varicella
- Influenza

Table 1. Infectious diseases to consider according to country of origin

Disease	Indicator	Syria	Afghanistan	Iraq	Eritrea	Somalia
Diphtheria [3]	Cases reported to WHO in 2012, 2013, 2014	0, 0, and NA	0, 0, 0	3, 4, and 5	8, 0 and NA	65, 7 and NA
Typhoid fever	Risk of typhoid	✓	✓	✓	✓	✓
Cholera*	Risk	No recent outbreak	Recurrent outbreaks	On-going outbreak in Baghdad Babylon, Najaf, Qadisiyyah, and Muthanna.	NA	Recurrent outbreaks
Hepatitis A†	Risk	High endemicity	NA	High endemicity	High endemicity	High endemicity
Hepatitis E‡	Risk	NA	NA	High endemicity	NA	High endemicity
Helminthiasis§	Risk of soil transmitted helminthiasis (ascaris, whipworm, hookworm)	+	++	+	++	++
	Risk of urinary schistosomiasis	✓	Non-endemic country	✓	✓	✓
Leishmaniasis**	Risk of cutaneous leishmaniasis	✓	✓	✓	✓	✓
	Risk of visceral leishmaniasis	✓	✓	✓	✓	✓
Hepatitis B††	Prevalence of chronic hepatitis B	Intermediate prevalence: 5.6%	High prevalence: 10.5%	Low prevalence: 1.3%	High prevalence: 15.5%	High prevalence: 12.4%
Hepatitis C‡‡	Prevalence	High prevalence: 3.1%	High prevalence: 1.1%	High prevalence: 3.2%	High prevalence: 1%	NA
HIV	Prevalence	Low	NA	Low	Low	Low
Malaria§§	Risk of malaria	Malaria-free	Risk of *P. vivax* >> *P. falciparum*	Malaria-free	Risk *of P. falciparum* >> *P. vivax*	Risk *of P. falciparum*
Measles*	Incidence per 100 000 in 2013 and 2014	1.84 and 2.68	1.41 and 1.75	2.09 and 3.02	0.77 and 0.02	2.17 and 9.12
Polio***	Cases reported to WHO in 2012, 2013 and 2014	0, 35 and NA	46, 17, and 28	0, 0, and 2	0, 0, and 0	1, 195 and 5
Tuberculosis†††	Incidence/100 000	Low: 17	High: 189	Low: 25	High: 40 to 499	High: 285
Antimicrobial resistance	Risk of carriage of multidrug-resistance Gram-negative bacteria	NA	NA	NA	NA	NA
Rabies	Risk level for humans contracting rabies	High	High	High	High	High

* World Health Organization. Global Health Atlas. [Internet] Available from: http://apps.who.int/globalatlas/

† World Health Organization. The Global Prevalence of Hepatitis A Virus Infection and Susceptibility: A Systematic Review. 2010. [Internet] Available from: http://apps.who.int/iris/bitstream/10665/70180/1/WHO_IVB_10.01_eng.pdf

‡ WHO. The Global Prevalence of Hepatitis E Virus Infection and Susceptibility: A Systematic Review Available from: http://apps.who.int/iris/bitstream/10665/70513/1/WHO_IVB_10.14_eng.pdf

§ World Health Organization. Intestinal worms – Epidemiology. 2015. [Internet] Available from: http://www.who.int/intestinal_worms/epidemiology/en/

** Alvar J, Vélez ID, Bern C, Herrero M, Desjeux P, Cano J, et al. Leishmaniasis - Worldwide and Global Estimates of Its Incidence. PLoS One 2012;7(5): e35671. [Internet] [cited 18 November 2015] Available from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0035671

†† Prevalence of chronic hepatitis B among foreign-born persons living in the United States by country of origin. Kowdley KV et al. Hepatology. 2012. Available from: http://onlinelibrary.wiley.com/doi/10.1002/hep.24804/epdf

‡‡ Global epidemiology and genotype distribution of the hepatitis C virus infection. Gower E et al. J Hepatology. 2014. Available from: http://www.sciencedirect.com/science/article/pii/S0168827814005261

§§ World Health Organization and WHO Regional Office for the Eastern Mediterranean (WHO-EMRO). Country profiles: Syria and Iraq. [Internet] [cited 18 November 2015]. Available from: http://www.emro.who.int/malaria/countries/ Country profiles: Afghanistan, Eritrea and Somalia. [Internet] [cited 18 November 2015]. Available from: http://www.who.int/malaria/publications/country-profiles/en/

*** Global Polio Eradication Initiative. Polio this week. 17 November 2016. [Internet]. Available from: http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx

††† World Health Organization Regional Office for the Eastern Mediterranean. WHO Eastern Mediterranean Region: Framework for health information systems and core indicators for monitoring health situation and health system performance. [Internet] [cited 18 November 2015]. Available from: http://applications.emro.who.int/dsaf/EMROPUB_2014_EN_1792.pdf?ua=1

→ Back to overview

Table 2. Diseases to be considered† for differential diagnosis among migrant populations

Clinical presentation	Differential diagnosis to consider
Fever	Typhoid fever Malaria Louse-borne diseases Visceral leishmaniasis Amoebic abscess Arboviruses
Respiratory symptoms	Tuberculosis Influenza
Gastrointestinal symptoms	Cholera Typhoid fever Shigellosis Amoebic colitis Helminthiasis: ascaris, whipworm, hookworm
Sores	Scabies Cutaneous leishmaniasis Cutaneous diphtheria
Skin rash	Measles Rubella Louse-borne diseases
Meningitis or other neurological symptoms	Rabies Invasive bacterial diseases (*Neisseria meningitidis, Haemophilus influenza type b and Streptococci pneumoniae*) Polio Dengue and other arboviruses

† This list identifies diseases to be considered in addition to the more common causes of the clinical presentations among resident EU populations.

5. Vaccination

List of vaccinations

Domain:	1,2,3
Issue:	Infectious diseases
Location	Short stay/first reception centre, longer stay reception centres
Provider:	PHC professionals
Target group:	Refugees, migrants
Developed by	ECDC
Includes:	Information on vaccination
URL:	http://ecdc.europa.eu/en/publications/Publications/Infectious-diseases-of-specific-relevance-to-newly-arrived-migrants-in-EU-EEA.pdf

Description

Review of vaccination status

Vaccination status for all migrants should be assessed using available documentation. Supplementary vaccination should be offered as needed according to the national immunisation guidelines of the hosting EU/EEA country. Information on country-specific immunisation programmes can be obtained through the ECDC (EU/EEA countries) or WHO (all countries) websites.

If no or uncertain documentation exists, the individual should be considered as unvaccinated. For best protection of the individual, administer and document first doses of the vaccine series listed below as early as possible following entry to or registration in a host country, preferably within 14 days, especially for the priority vaccines. The vaccine series can then be continued or supplemented with additional vaccines at the place of longer stay reception centres residence in accordance with the national guidelines of the host country.

Priority should be given to protection against easily transmitted and/or serious infectious diseases such as measles, rubella, diphtheria, tetanus, pertussis, polio, Hib (<6 years unless otherwise indicated in country-specific recommendations) and hepatitis B (with or without screening, according to national guidelines). When possible, combination vaccines should be used to facilitate vaccination. If there is a vaccine shortage, prioritise children but aim for at least one dose of dT-IPV-containing vaccine in adults.

Additional vaccinations should be considered for protection against the following diseases depending on living conditions, season and epidemiological situation:

- Invasive meningococcal disease (disease common in densely-populated settings such as refugee camps or reception centres, vaccine included in many EU routine programmes);
- Varicella (disease common in crowded settings and migrants are highly susceptible – vaccine included in some EU routine programmes);
- Invasive pneumococcal disease (vaccine included in many EU routine programmes);
- Influenza (disease common in crowded settings during influenza season – vaccine included for all children in some EU routine programmes and for risk groups, including the elderly, in all EU routine programmes).

→ Back to overview

Table 3. Vaccinations to be offered in the absence of documented evidence of prior vaccination

Disease/age group	Children and adolescents (<18 years)	Adults (> 18 years)
Priority vaccinations		
Measles, mumps, rubella	Administer to individuals ≥ 9 months of age. Two doses of MMR* should be administered at least one month apart but preferably longer according to national guidelines. Measles vaccine provided before 12 months of age does not induce protection in all and should be repeated after 12 months of age.	Administer one or two doses of MMR to all individuals, according to national guidelines*
Diphtheria, tetanus, pertussis, polio, Hib	Administer to individuals ≥ 2 months, three doses of DTaP-IPV-Hib (Hib-component only for children <6 years unless other country-specific recommendations) containing vaccines at least one month apart, followed by a booster dose according to national guidelines. Pentavalent- and hexavalent combination vaccines are authorised up to six years of age.	Administer to all adults, three doses of TdaP-IPV- ** containing vaccines according to national guidelines
To be considered		
Hepatitis B	Administer to individuals ≥ 2 months, three doses according to national guidelines*** Administer to new-born infants of HBsAg-positive mothers within 24 hours of birth, according to national guidelines	Administer to all adults, with or without previous screening, according to national guidelines
Meningococcal disease	National guidelines for meningococcal vaccines against serogroups A, B, C, W135 and Y should be followed, unless the epidemiological situation suggests otherwise.	
Pneumococcal disease	Administer to individuals ≥ 2 months with 1–3 doses of conjugate vaccine at least one month apart, according to national guidelines	Administer to individuals ≥ 65 years, according to national guidelines.
Varicella	National guidelines should be followed unless the epidemiological situation suggests otherwise. If used, administer to individuals ≥ 11 months of age, two doses of varicella at least one month apart, but preferably longer.	National guidelines should be followed unless the epidemiological situation suggests otherwise. Consider vaccinating non-immune non-pregnant women of childbearing age.
Influenza	National guidelines should be followed unless the epidemiological situation suggests otherwise. Consider vaccinating risk groups over six months of age ahead of and during influenza season.	National guidelines should be followed unless the epidemiological situation suggests otherwise. Consider vaccinating risk groups, including pregnant women, ahead of and during influenza season.
Tuberculosis	Administer BCG according to national guidelines. Re-vaccination with BCG is not recommended.	BCG is generally not recommended for adults, unless specific reasons suggest otherwise.

* MMR vaccine is contra-indicated in immunocompromised individuals and during pregnancy. Pregnancy should be avoided for one month after MMR vaccination.

** If there is a vaccine shortage administer at least one dose of vaccine containing acellular pertussis-component.

*** Testing for hepatitis B virus infection (HBsAg) could be done before the vaccine is administered.

→ Back to overview

How to hold children:

Domain:	1, 2, 3
Issue:	Injection of children
Location	Short stay/first reception centre and longer stay reception centres
Provider:	Health care provider
Target group:	Children
Developed by	California Department of Public Health Immunization Branch
Includes:	Description how parents can hold their child for immunization
URL:	http://www.eziz.org/assets/docs/IMM-720ES.pdf

COMFORTING RESTRAINT

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• **The method:**

This method involves the parent in embracing the child and controlling all four limbs. It avoids "holding down" or overpowering the child, but it helps you steady and control the limb of the injection site.

• **For infants and toddlers:**

Have parent hold the child on parent's lap.

1. One of the child's arms embraces the parent's back and is held under the parent's arm.
2. The other arm is controlled by the parent's arm and hand. For infants, the parent can control both arms with one hand.
3. Both legs are anchored with the child's feet held firmly between the parent's thighs, and controlled by the parent's other arm.

• **For kindergarten and older children:**

Hold the child on parent's lap or have the child stand in front of the seated parent.

1. Parent's arms embrace the child during the process.
2. Both legs are firmly between parent's legs.

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IMM-720ES (9/07)

Injection techniques:

Domain:	1, 2, 3
Issue:	How to Administer Intramuscular and Subcutaneous Vaccine Injections
Location	Short stay/first reception centre and longer stay reception centres
Provider:	Health care provider
Developed by	Immunization action coalition
Includes:	Guideline
URL:	http://www.immunize.org/catg.d/p2020.pdf

How to Administer Intramuscular and Subcutaneous Vaccine Injections

Administration by the Intramuscular (IM) Route

Administer these vaccines via IM route

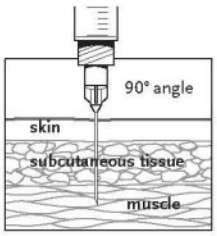
- Diphtheria-tetanus-pertussis (DTaP, Tdap)
- Diphtheria-tetanus (DT, Td)
- *Haemophilus influenzae* type b (Hib)
- Hepatitis A (HepA)
- Hepatitis B (HepB)
- Human papillomavirus (HPV)
- Inactivated influenza (IIV)
- Meningococcal serogroup B (MenB)
- Quadrivalent meningococcal conjugate (MenACWY [MCV4])
- Pneumococcal conjugate (PCV13)

Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPSV23) vaccines either IM or Subcut.

PATIENT AGE	INJECTION SITE	NEEDLE SIZE
Newborn (0–28 days)	Anterolateral thigh muscle	⅝"* (22–25 gauge)
Infant (1–12 months)	Anterolateral thigh muscle	1"* (22–25 gauge)
Toddler (1–2 years)	Anterolateral thigh muscle	1–1¼" (22–25 gauge)
	Alternate site: Deltoid muscle of arm if muscle mass is adequate	⅝–1"* (22–25 gauge)
Children (3–18 years)	Deltoid muscle (upper arm)	⅝–1"* (22–25 gauge)
	Alternate site: Anterolateral thigh muscle	1–1¼" (22–25 gauge)
Adults 19 years and older	Deltoid muscle (upper arm)	1–1½"*† (22–25 gauge)
	Alternate site: Anterolateral thigh muscle	1–1½" (22–25 gauge)

* A ⅝" needle usually is adequate for neonates (first 28 days of life), preterm infants, and children ages 1 through 18 years if the skin is stretched flat between the thumb and forefinger and the needle is inserted at a 90° angle to the skin.

† A ⅝" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90° angle; a 1" needle is sufficient in patients weighing 130–152 lbs (60–70 kg); a 1–1½" needle is recommended in women weighing 153–200 lbs (70–90 kg) and men weighing 153–260 lbs (70–118 kg); a 1½" needle is recommended in women weighing more than 200 lbs (91 kg) or men weighing more than 260 lbs (118 kg).



Needle insertion

Use a needle long enough to reach deep into the muscle.

Insert needle at a 90° angle to the skin with a quick thrust.

(Before administering an injection of vaccine, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.¶)

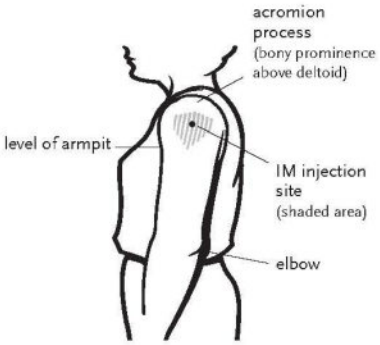
Multiple injections given in the same extremity should be separated by a minimum of 1", if possible.

¶ CDC. "ACIP General Recommendations on Immunization" at www.immunize.org/acip

Intramuscular (IM) injection site for infants and toddlers

Insert needle at a 90° angle into the anterolateral thigh muscle.

Intramuscular (IM) injection site for children and adults



Give in the central and thickest portion of the deltoid muscle – above the level of the armpit and approximately 2–3 fingerbreadths (~2") below the acromion process. See the diagram. To avoid causing an injury, do not inject too high (near the acromion process) or too low.

→ Back to overview

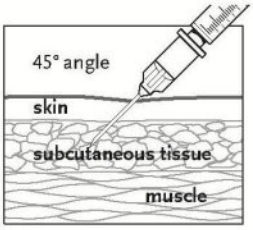
Administration by the Subcutaneous (Subcut) Route

Administer these vaccines via Subcut route

- Measles, mumps, and rubella (MMR)
- Meningococcal polysaccharide (MPSV4)
- Varicella (VAR)
- Zoster (shingles [ZOS])

Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPSV23) vaccines either IM or Subcut.

PATIENT AGE	INJECTION SITE	NEEDLE SIZE
Birth to 12 months	Fatty tissue overlying the anterolateral thigh muscle	5/8" (23–25 gauge)
12 months and older	Fatty tissue overlying the anterolateral thigh muscle or fatty tissue over triceps	5/8" (23–25 gauge)



Needle insertion

Pinch up on subcutaneous tissue to prevent injection into muscle.

Insert needle at 45° angle to the skin.

(Before administering an injection of vaccine, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.*)

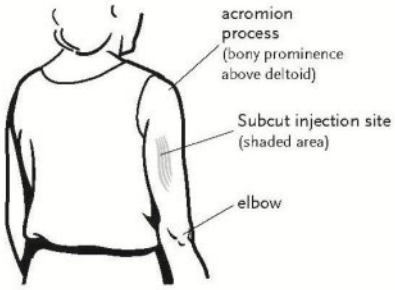
Multiple injections given in the same extremity should be separated by a minimum of 1".

* CDC. "ACIP General Recommendations on Immunization" at www.immunize.org/acip

Subcutaneous (Subcut) injection site for infants

Insert needle at a 45° angle into fatty tissue of the anterolateral thigh. Make sure you pinch up on subcutaneous tissue to prevent injection into the muscle.

Subcutaneous (Subcut) injection site for children (after the 1st birthday) and adults



Insert needle at a 45° angle into the fatty tissue overlying the triceps muscle. Make sure you pinch up on the subcutaneous tissue to prevent injection into the muscle.

Immunization Action Coalition • Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org
www.immunize.org/catg.d/p2020.pdf • Item #P2020 (12/15)

Promotion material on vaccination

Information for health care workers and refugees

Domain:	1,2,3
Issue:	Promotion material for vaccination
Location	Short stay/first reception centre and Long - term
Provider:	Health care providers involved in vaccination
Target group:	Migrants
Developed by	PROMOVAX
Includes:	Information material on vaccination for health care workers and refugees Immunization record
URL:	http://www.promovax.eu/toolkits/

Description:

For health care workers:

http://www.promovax.eu/toolkits/HCW_english_web.pdf

This toolkit will give insight and knowledge about migrant immunization needs. It is designed to help health care providers assess the immunization needs of migrant patients. The information is available in English, Croatian, German, Greek, Hungarian, Italian, Norwegian and Polish. The following information can be found:

- Who should be offered vaccinations
- How to deal with missing or incomplete vaccination records
- Assessing a migrants risk of exposure to vaccine preventable diseases and immunization needs
- Schedules for paediatric and adult vaccinations
- How to increase vaccination rates among migrants
- Several case examples
- Vaccination recommendation in addition to those recommended by age for workers at rick of occupationally acquired vaccine preventable diseases

Immunization record:

The project provides a clear assessment form for migrant's risk of exposure to vaccine preventable diseases and a practical immunization record for adults and children. This information is also available in English, Croatian, German, Greek, Hungarian, Italian, Norwegian and Polish.

http://www.promovax.eu/toolkits/HCW_english_forms_web.pdf

For Refugees/migrants

The toolkit also provides information for refugees on why vaccinations are necessary, which diseases to prevent, securing the safety of vaccinations, some myths and facts and information on where to get vaccinated. It also includes a copy of the immunization record. The information is available in English, Albanian, Arabic, Bosnian, Bulgarian, Chinese, Nepali, Polish, Romanian, Russian, Somali, and Ukrainian.

http://www.promovax.eu/index.php/promovax/toolkits/too2

Information on Hepatitis screening

Domain:	3
Issue:	Information on hepatitis B and C screening
Location	Longer stay reception centres
Provider:	Health care professionals involved in Hepatitis screening
Target group:	Refugees/migrants
Developed by	HEPscreen
Includes:	Website with information and videos
URL:	http://hepscreen.eu/

Description

The general objective of EU HEPscreen is to assess, describe and communicate to public health professionals the tools and conditions necessary for implementing successful screening programmes for hepatitis B and C among migrants in the European Union.

It provides the following:

- Information about the epidemiology of Hepatitis: http://hepscreen.eu/health-challenge/epidemiology/
- A tool to assess the burden of hepatitis in your area: http://hepscreen.eu/health-challenge/epidemiology/estimate-the-burden/ available in English, German, Spanish, France, and Italian.
- A movie about different ways of screening
- Leaflet for people who are offered viral hepatitis screening. It is available in 42 languages. http://hepscreen.eu/what-can-we-do-about-it/pre-test-information/multi-language-builder/
- Pre-test Discussion checklist. This checklist can be used before offering testing and helps to secure informed choice, improve acceptance of screening, raise awareness and improve knowledge. Available in English, Italian, France, Spanish and German. http://hepscreen.eu/what-can-we-do-about-it/pre-test-information/pre-test-discussion-check-list/

Section 4. List of training materials

Issue:	Health services for migrants
Title:	Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
Description	4 different modules and 2 additional modules available. The content of the modules include: Sensitivity and awareness of cultural and other forms of diversity, knowledge about migrants, ethnic minorities and their health, professionals skills and knowledge applications. The additional modules concern target groups and specific health concerns.
URL:	http://www.mem-tp.org/
Developed by:	Project MEM-TP

Issue:	Quality health care delivery for migrants
Title:	Training materials development: review of existing training materials
Description	This systematic review describes several existing trainings in the context of migrant care.
URL:	http://www.mem-tp.org/pluginfile.php/873/mod_resource/content/4/MEM-TP%20WP2%20Final.pdf
Developed by:	Migrant & ethnic minorities training packages (MEM-TP)

Issue:	Care for children and families
Title:	Refugee and immigrant health
Description	This module will explore concepts related to immigration, health and healthcare. In this module you will learn about the challenges associated with resettlement and examine factors that may affect the health and healthcare experiences of refugees and new immigrants
URL:	http://www.sickkids.ca/tclhinculturalcompetence/modules/Refugee-and-Immigrant-Health/player.html
Developed by:	SickKids

Issue:	Cultural mediators
Title:	Training of cultural mediators utilizing new social networking software
Description	A training platform into which existing social networking applications, modern adult education methodologies and specifically designed content and services will be integrated to assist those working in the field of cultural mediation to identify and articulate the knowledge, skills and competencies necessary to function in a professional manner.
URL:	http://www.sonetor-project.eu/
Developed by:	SONETOR project

Issue:	Language barriers
Title:	TRICC - Training Intercultural and Bilingual Competencies in Health and Social Care
Description	This international handbook contains a description of all training given in the five countries. In addition to this, each country has published their national handbook of good practice, in their native language.
URL:	http://www.tricc-eu.net/products.html
Developed by:	TRICC project

Issue:	Interpreting
Title:	Interpreting in a Refugee context
Description	A self-study module for interpreters: The module assists interpreters in understanding how the two or more languages that they speak differ from one another, and why it is sometimes difficult to correctly translate one language into another. It also trains interpreters on the various techniques they can use to help people who cannot understand each other while, at the same time, making themselves unobtrusive. Further, it advises interpreters on the difference between professional and unprofessional behaviour, and the impact of both on the institution for which they are working and its clients. The module also includes basic information about how interpreters can take care of themselves, since interpreting in a refugee-interview context can be demanding and possibly dangerous.
URL:	http://www.unhcr.org/4d947e2c9.pdf
Developed by:	UNHCR

Issue:	Cultural barriers
Title:	Culturally appropriate teaching in medicine
Description	The aim of the course is to provide teachers with the knowledge and skills to review or improve their practice in teaching diversity issues to students.
URL:	https://www.coursesites.com/webapps/Bb-sites-course-creation-BBLEARN/courseHomepage.htmlx?course_id=_378358_1
Developed by:	C2ME

Issue:	Patients with limited English proficiency
Title:	TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module
Description	The TeamSTEPPS® Limited English Proficiency module is designed to help you develop and deploy a customized plan to train your staff in teamwork skills and lead a medical teamwork improvement initiative in your organization from initial concept development through to sustainment of positive changes. This evidence-based module will provide insight into the core concepts of teamwork as they are applied to your work with patients who have difficulty communicating in English.
URL:	http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/lep/
Developed by:	TeamSTEPPS® / AHRQ

→ Back to overview

Issue:	Mental health
Title:	Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians
Description	Culture, context and mental health and psychosocial wellbeing of Syrians. An e learning program for mental health, psychosocial and humanitarian aid staff working with Syrians Affected by Armed conflict.
URL:	http://www.healthefoundation.eu/courses/refugeecare
Developed by:	Health[e]foundation

Issue:	Sexual and gender based violence
Title:	Make it work!: Training Manual for sexual health promotion and prevention of sexual and gender-based violence in the European reception & asylum sector.
Description	The "Make it Work!"-manual is primarily designed for professionals and/or residents who wish to set up SGBV prevention activities or to develop an SGBV prevention policy in their asylum or reception centre. However, with slight adaptations of wording in the exercises, it can easily be used in any other intercultural setting where prevention of SGBV is at stake.
URL:	http://icrhb.org/publication/sgbv-senperforto-make-it-work-training-manual
Developed by:	Frans, E. and Keygnaert, I. (2009) Make it Work! Prevention of SGBV in the European Reception and Asylum Sector. Academia Press, Ghent.

Issue:	Sexual and reproductive health
Title:	Minimum Initial Service Package (MISP) for reproductive health (RH), e-learning
Description	Teaching humanitarian workers skills and knowledge for implementing reproductive health care needs in emergency settings. Free of charge, certificate after completion of the e-learning. Available in English, French, Spanish.
URL:	http://misp.iawg.net/
Developed by:	Women's Refugee Commission

Section 5. Adaption for local setting and Implementation

Adapting the tools for the local setting

An important and necessary step is the adaptation of guidelines and tools to the local context of use (Harrison 2010[2]). Although preferably guidelines and tools are evaluated and customized to fit local circumstances through an active, systematic and participatory process (Harrison 2010), this procedure will not be feasible within the context of the EUR-HUMAN project. Therefore we provide here a simple guidance for adaptation, based on the *"PIPOH"* approach: *"Population of interest, the Intervention of interest, the Professions to which the guideline / tool is to be targeted and the Outcomes and Health care setting of interest (PIPOH)".*

The applicability and the feasibility of the tools are depending on the setting and country you are working in, the nature and amount of refugees you see each day, the composition of your healthcare team, resources in terms of materials, money, housing etc and on your local collaboration with other healthcare domains, like public health, regular Primary Health, hospitals as well as the collaboration with volunteers and NGO's.
Therefore tools and guidelines in this guidance will often need adaptation to your own local setting.
Although most tools and guidelines included are targeting refugees in first reception centres or longer stay reception centre, some tools originally are meant for another setting (e.g. regular Primary care setting). Besides, some are directed to health care doctors where nurses could also do (part of) the work and they most of them are in English.

For this adaptation the following issues have to be taken into account:

a. The **P**opulation of interest:

- What population is targeted in the guideline / tool and how compares this to the local setting?
- What group of migrants are visiting the site in question?
    - newly arriving refugees / asylum seekers
    - refugees already staying a longer time in safe surroundings (e.g. in longer stay reception centres)
    - other migrant groups
- What ethnic backgrounds?
- What specific cultural issues to be taken into account?
- What languages are spoken?
- What can be said about the literacy level of the male and female refugees involved?
- What gender / age / group is being targeted?
- What does this mean of adaptation?

b. The **I**ntervention of interest:

- is the intervention (guideline / tool) suitable for the local PHC team / local migrant groups / setting
- If not: can it be adapted to fit this, or not.

[2] Harrison MB, Légaré F, Graham ID, Fervers B. Adapting clinical practice guidelines to local context and assessing barriers to their use. Canadian Medical Association Journal. 2010 Feb 9;182(2):E78-84.

c. The Professions targeted:

- What professions are targeted by the guideline / tool and are these congruent with the composition of the local PHC team? Or should the tool / guideline be adapted for
    - primary health care doctors
    - other doctors
    - nurses
    - social workers
    - other health care professionals
    - volunteers

d. The Outcomes aimed for

- Does the goal targeted by the tool / guideline fit in the goal of the local health care. E.g. if a tool is meant for referring people to specialist care, but no specialist care is available, the tool should be adapted.

e. The **H**ealthcare setting targeted

- Is this congruent with the local setting, or should be the tool / guideline be adapted to this local setting.
    - regular primary care
    - emergency situations
    - asylum seekers centres and if so, short stay/first reception centres or longer stay reception centre
    - what national / ethnic or cultural background?

Translation

At least all tools will need to be translated to your own language if people will use them who do not understand English very well.

The health promotion materials will have to be translated to the languages of the migrants you are seeing, adjusted to cultural approach as well as to different literacy levels.

Implementing interventions: how to choose

Local circumstances will to a high degree determine the extent to which ideal PHC can be implemented. A first test version of a practical checklist to assist local decision-making on the implementation of interventions was developed in the context of WP3 by the NIVEL team.

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

consideration. Finally, results stress the importance of monitoring and evaluating the needs of refugees as well as implementation of health services.

Practical guidance

Stakeholders in refugee health care optimization should carefully consider these and other factors identified during the EUR-HUMAN project and are encouraged to work with the ATOMiC checklist *("Appraisal Tool for Optimizing Migrant Health Care")* while anticipating the implementation of a particular tool, guideline or other health care improvement, directed at one or more of the potential or actual health issues of refugees and other migrants. Users of the tool are encouraged to consider relevant factors, to optimize them where possible or to explore alternative ideas.

ATOMiC – Appraisal Tool for Optimizing Migrant Health Care

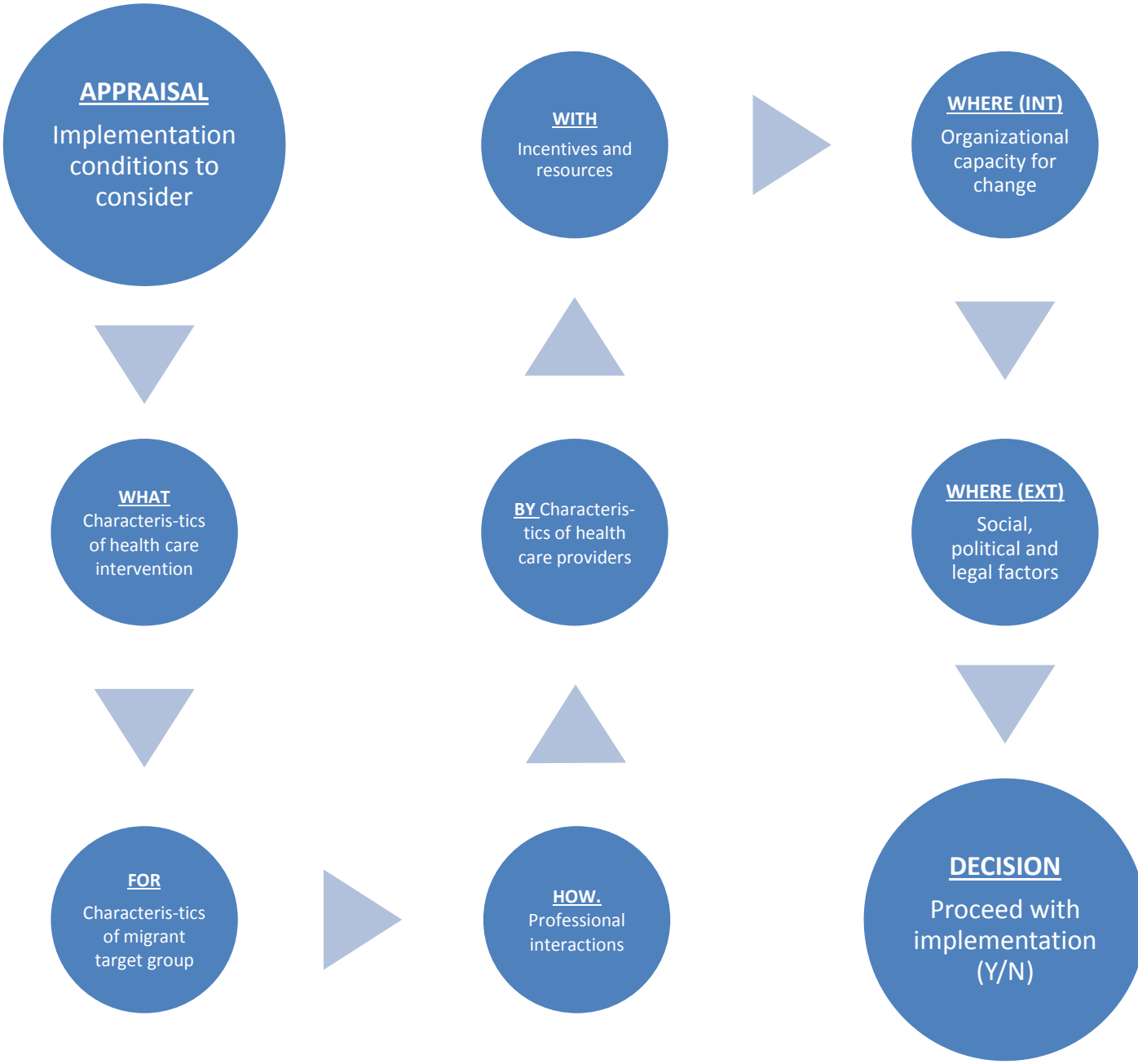
Background

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

How to use this checklist

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

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



To think through when shaping the improvement idea

We recommend you select only a few improvement topics at one time (to protect professional workload, scarce resources and organizational capacity for change)

Pick an improvement topic or intervention related to a prioritized concern in your local health care setting (popular interventions might seem attractive, but when an intervention tackles a more pressing local problem, the sense of urgency and the readiness for change are likely to be bigger).

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

The checklist

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

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)? *YES / NO / DON'T KNOW / NOT APPLICABLE*
		information about the medical history and relevant personal background of patients? *YES / NO / DON'T KNOW / NOT APPLICABLE*
		language skills, interpreter services or cultural mediation *YES / NO / DON'T KNOW / NOT APPLICABLE*
		protective measures (e.g. vaccination, facemasks, gloves) *YES / NO / DON'T KNOW / NOT APPLICABLE*
		input from other professions or organizations *YES / NO / DON'T KNOW / NOT APPLICABLE*
		additional time for contact or history taking *YES / NO / DON'T KNOW / NOT APPLICABLE*
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) *YES / NO / DON'T KNOW / NOT APPLICABLE*
		language skills *YES / NO / DON'T KNOW / NOT APPLICABLE*
		intercultural competencies *YES / NO / DON'T KNOW / NOT APPLICABLE*
		attitudinal skills (open-minded, tolerance, respect, patience) *YES / NO / DON'T KNOW / NOT APPLICABLE*
		background knowledge and practical experience with the target group *YES / NO / DON'T KNOW / NOT APPLICABLE*
WITH - *Incentives and resources* *'yes' indicates that invest-ments 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 / NO / DON'T KNOW / NOT APPLICABLE*
		education, training and other skill development activities *YES / NO / DON'T KNOW / NOT APPLICABLE*
		medical stock, supportive systems, equipment and technical aids *YES / NO / DON'T KNOW / NOT APPLICABLE*
		evaluation and monitoring capacity *YES / NO / DON'T KNOW / NOT APPLICABLE*
		other (financial) resources *YES / NO / DON'T KNOW / NOT APPLICABLE*
	if the intervention involves screening/testing, it requires investments in	capacity for a timely analysis of the screening/test data *YES / NO / DON'T KNOW / NOT APPLICABLE*
		capacity for a timely follow-up in case of notable risks or problems? *YES / NO / DON'T KNOW / NOT APPLICABLE*
	if the intervention involves therapy or treatment of prevalent problems, it requires investments in	capacity for completing the therapy/treatment including aftercare *YES / NO / DON'T KNOW / NOT APPLICABLE*

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

APPENDIX 10. DELIVERABLES OF WP5.

D5.1 Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS.

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Contents

1 Introduction 1
2 Background 5
3 Mental health care procedures 7
Rationale 7
Procedures 7
4 Triage 11
Rationale 11
Procedures 11
5 Mental health screening 19
Rationale 19
Procedures 19
6 Psychological first aid 25
Rationale 25
Procedures 28
7 Referral 38
Rationale 38
Procedures 39
8 Children and adolescents 44
Rationale 44
Procedures 45
9 Additional topics 50
Training and expertise 50
Working with interpreters 51
Including refugees and migrants in MH care 54
10 Conclusions and implications for the EUR-HUMAN project 56
Appendix I Mental health screening tools 59
References 76

Textboxes, figures an tables

Box 1 Mental health and psychosocial support (MHPSS) Core Principles 2
Box 2 Societal costs of trauma 6
Box 3 Orienting emotionally overwhelmed survivors 15
Box 4 Cultural appropriate assessment - Syrian MH concepts 18
Box 5 MH screening and Refugee Health Screener 13 (RHS-13) 22
Box 6 Common reactions when terrible things happen 37
Box 7 Principles of successful referral 40

Figure 1 Integrated model of primary health care for refugees and other migrants 10
Figure 2 Triage procedures 12
Figure 3 Screening process 20
Figure 4 Refugee Health Screener 13 (RHS-13) 24
Figure 5 Stepped model of care 38
Figure 6 Worksheet on survivor current needs 42
Figure 7 Worksheet on Psychological First Aid Components provided 43
Figure 8 Visual scale for recognising emotions 47
Figure 9 Psychoeducation leaflet on supporting children 48
Figure 10 Needs for training for different levels of support 50
Figure 11 Psychoeducation leaflet on coping 55
Figure 12 Overall structure of EUR-HUMAN project 56

Table 1 List of most relevant handbooks, manuals, reports and projects for current report 3
Table 2 Physical/behavioural and emotional/cognitive signs of severe distress 13
Table 3 Rapid assessment during triage (assessed by caregiver) 14
Table 4 General guidelines for providing PFA 29
Table 5 Common children's reactions to traumatic events by developmental stages 46
Table 6 PFA activities for children 49
Table 7 Tools for MH screening in the refugee and migrant populations 64

Abbreviations

MH Mental Health

MHPSS Mental Health and Psychosocial Support

PFA Psychological First Aid

PHC Primary Health Care

PTSD Post-Traumatic Stress Disorder

1 Introduction

Objective

European Refugees-Human Movement and Advisory Network (EUR-HUMAN) is an EU founded project aimed at supporting and assisting European member states in dealing with the current refugee and migrant crisis. Specifically, the main objective of the project is to help EU member states effectively address various health needs of refugees and migrants by defining, devising and evaluating comprehensive interventions for the provision of primary health care with a special focus on vulnerable groups. Such interventions are intended to be person centred, culturally sensitive and unbiased in the sense of respecting the wishes and expectations of refugees and migrants and ensuring equal access to the necessary health services. Considering that the project focuses on the period of early arrival as well as longer term settlement, its goal is not only to asses and address refugee's and migrant's initial mental, psychosocial and physical health needs but also to ensure continuous re-evaluation and care during the integration period.

As a part of overall aim of the project, Work Package 5 (WP5) focuses specifically on mental health (MH) and psychosocial needs of refugees and other migrants; a health issue that has often been overlooked.[1] Specifically, WP5 objective was to develop a protocol for early identification of highly traumatized refugees and other migrants, including tools, guidelines and procedures for rapid assessment of MH needs and psychosocial status that can be easily implemented in real settings, and to facilitate early and appropriate interventions and services based on psychological first aid leading to shorter period of recovery from adverse life experiences and exposure to trauma. This is expected to foster successful integration into hosting societies and decrease social isolation and risk for internalised oppression. Such procedures and services should be comprehensive and practically oriented within the framework of integrated and person-centred primary care.

Methodology

This report aimed to build on existing scientific knowledge and expert consensus, while adapting it to current situation. A hierarchical approach was utilised. First, several key guidelines were addressed, focusing on overall approach to mental health and psychological support (MHPSS). Second, over 20 handbooks, manuals and reports focusing on more specific MHPSS topics were collected and assessed. Finally, a comprehensive search of peer-reviewed studies was conducted in order to focus specifically on tools for rapid assessment of MH needs. In the text below, we summarise these steps.

Overall approach to MHPSS in this report is guided by several expert guidelines:

- National Institute for Clinical Excellence (NICE) Guideliness;[2]
- Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings;[3]

- NATO-TENTS Guidance for responding to the psychosocial and mental health needs of people who are affected by disasters or major incidents;[4]
- Canadian Collaboration for Immigrant and Refugee Health (CCIRH) Evidence Based Migrant Health Guideline;[5]
- Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention.[6]

These guidelines influence development of all procedures in this report, ensuring overall approach based on best practices and expert knowledge. We stress core principles of MHPSS approach[3] in Box 1, and discuss how we implemented them to achieve our goals.

Box 1 Mental health and psychosocial support (MHPSS) Core Principles

Ensure human rights and equity

Special concern will be given to individuals under heightened risk of human rights violations, such as children and adolescents. Developed procedures aim to maximise fairness in the availability and accessibility of MHPSS across gender, age and culture.

Participation

Refugees and migrants should be active participants in MHPSS. By having comprehensive information on MHPSS, they should be able to make informed decisions on accessing appropriate health care.

Do no harm

Procedures and tools are carefully developed and selected based on the key principle of doing no harm. Cultural sensitivity and the value of participatory approaches are stressed.

Build on available resources and capacities

Proposed interventions aim to identify and build on available resources and strengths, support coping capacity and strengthen the skills of individuals and families.

Use integrated support systems

Rapid assessment of MH needs and MHPSS are integrated in overall health care. Apart from being more sustainable, integrated services tend to carry fewer stigmas.

Provide a multi-layered support

Support should be organised in several layers. Above and beyond basic services and security, as well as fostering family support (e.g. family tracing and reunification), some number of people will need additional help. Focused, non-specialised support based on PFA should be first offered, followed by with specialised services only for those who need additional support.

Furthermore, handbooks, manuals and reports at the websites of agencies and previous EU projects focusing on MH and/or refugee and other migrant health were assessed. Special topics of interest were procedures and tools for triage and screening, MHPSS and psychological first aid (PFA) and cultural aspects of providing help to refugees and migrants. Although not systematic, this search was comprehensive and resulted in identifying a large number of practically oriented guidance documents (over 20). A short list of most relevant sources for this report can be found in Table 1.

Table 1 List of most relevant handbooks, manuals, reports and projects for current report

Handbooks, manuals and reports	Author(s) (year)	Link
Psychological first aid: Guide for field workers	WHO, War Trauma Foundation and World Vision International (2011)	http://www.who.int/mental_health/publications/guide_field_workers/en/
Psychological first aid Field Operations Guide	Brymer, Jacobs, Layne, Pynoos, Ruzek, Steinberg, Vernberg, Watson; National Child Traumatic Stress Network and National Center for PTSD (2006)	http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf
Walking together: A mental health therapist's guide to working with refugees	Farmer (Ed.); Lutheran Community Services Northwest (2015)	http://www.academia.edu/14444974/Walking_Together_A_Mental_Health_Therapists_Guide_to_Working_with_Refugees
Assessing mental health and psychosocial needs and resources	WHO and UNHCR (2012)	http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/
Culture, context and the Mental Health and Psychosocial Wellbeing of Syrians	Hassan, Kirmayer, Mekki Berrada, Quosh, el Chammay, Deville-Stoetzel, Youssef, Jefee-Bahloul, Barkeel-Oteo, Coutts, Song S, Ventevogel; UNHCR (2015)	http://www.unhcr.org/55f6b90f9.pdf
mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies	WHO and UNHCR (2015)	http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf
Health assessment of refugees and migrants in the EU/EEA: Handbook for Health professionals	European Commission, Directorate-General for Health and Food Safety (2015)	http://ec.europa.eu/dgs/health_food-safety/docs/personal_health_handbook_english.pdf
Psychosocial interventions: A handbook	International Federation Reference Centre for Psychosocial Support (2009)	http://www.ifrc.org/en/what-we-do/health/psychosocial-support/

EU projects	Link
Operationalising Psychosocial Support in Crisis (OPSIC)	http://opsic.eu/
The European Network for Traumatic Stress (TENTS project)	http://tentsproject.eu/
Best Practice in Health Services for Immigrants in Europe (EUGATE)	http://www.eugate.org.uk/

Finally, a systematic search was conducted in order to recommend specific tools for rapid assessment of MH needs. The goal of systematic search was to identify tool(s) that are simple, short and culturally appropriate; hence we focused on tools that were constructed and (or) validated specifically on refugee populations. We conducted the search in one electronic article database (PsycINFO), Google and Google Scholar engines and assessed two previous systematic reviews. For all 21 tools identified, the search was further expanded in order to find additional validation studies. Tools were evaluated based on predefined criteria, and one tool was deemed to suit the current purpose the most. The details of this search can be found in Appendix I.

The structure of the report

The report is structured to reflect WP5 objectives. In the *Background* section, previous studies on MH needs of migrants and refugees are discussed, as well as societal benefits from implementing integrated MH care. In the *Mental health care procedures* section we discuss current context in which MHPSS will be provided and describe stepped model of MH care integrated in overall primary health care. The next two sections, *Triage* and *Screening* describe procedures of rapid assessment of MH needs within the proposed model of stepped care. In *Psychological first aid* section, we describe overall supportive response to refugees and migrants in need of psychological support and give examples of specific and focused steps that can be taken to support them. In *Referral* section we briefly discuss the need for more specialised MH care and propose procedure for successful referral. The next section, *Children and adolescents*, focuses on implementing previously described procedures for these especially vulnerable groups. In section on *Additional topics*, some special issues are discussed, such and training and expertise needed for proposed procedures, working with interpreters, as including refugees and migrants in MHPSS. Finally, in the last section (*Final conclusions and implications for the EUR-HUMAN project*) we discuss this report with respect to other work packages in the project and summarise next steps.

2 Background

By the end of 2014, 59.5 million people were forcibly displaced around the world due to violent conflicts or human rights abuse. Among these, 19.5 million people were refugees, persons who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, are outside the country of their nationality, and are unable to, or owing to such fear, are unwilling to avail themselves of the protection of that country."[7] Although an updated estimation of the number of individuals forcibly displaced or with refugee status was not available at the time of writing this report, the number has likely increased due to of conflicts and instabilities in Syria, Afghanistan, Eritrea, Somalia, and elsewhere. Europe in particular has evidenced a significant increase in the number of refugees and migrants in 2015; more than one million people were registered entering the EU. According to the UNHCR, out of the total number of refugees in the world, around 3.5 million are located in Europe.[8] In addition to traumatic experiences in their country of origin, many refugees face various difficulties during and after resettlement such as health problems, poor accommodation and nutrition, financial problems, separation from family members, language and cultural barriers and discrimination.[9] All this can lead to severe psychological distress and development of mental disorders.

Estimates of MH problems in refugee populations are not always consistent. Tere is evidence that during migration refugees and migrants often experience the "healthy immigrant effect" evident in terms of low levels of depression and anxiety on the way to their destination.[10] However, prevalence of mental illness tends to grow as soon as they settle down in the host country. Studies show high prevalence of psychological disorders (especially PTSD, anxiety and depression) among refugees living in Western countries. For example, the prevalence rates of PTSD range from 4% to 70%, and similar percentages are reported for the prevalence of depression (3% to 88%) and anxiety (2% to 80%).[11–13] Prevalence rates of mental disorders can vary depending on a specific sample studied as well as the precise time and method of assessment. Some studies suggest that the wide range of MH problems in refugees and migrants may be the result of applying Western models of psychiatric illness in cultures with different MH concepts.[12] Despite the fact that most people show resilience in stressful situations, refugees and migrants are at higher risk and special attention should be paid to highly vulnerable groups including people who were exposed to traumatic experiences, women, older people and unaccompanied minors.[14,15] Although alleviating this burden itself is a valued goal for healthcare workers, Box 2 further discusses different societal costs of trauma.

Among the current refugees and migrants there is a number of highly vulnerable individuals and families. Above and beyond adverse experiences in their home countries, they have suffered losses and trauma while traveling towards European countries. Media images of such tragic family losses have shocked the audience across Europe.[16] Some families have lost to death several members but had to continue their transit. The care-providers on the ground, in

the hot-spots, detention and transit centres are struggling to identify such individuals and provide adequate help and support.

Box 2 Societal costs of trauma

Family level

Experiencing traumatic events in war or disasters can lead to intergenerational transmission of dysfunction and violence. In families where parents suffer from MH problems, children have heightened risk of psychopathology and social dysfunction.[17] Some authors propose that this is due to changes in parent-child interactions.[18,19] Furthermore, several studies have shown links between exposure to war and heightened risk for domestic violence.[20] This, in turn, is related to heightened risk of MH problems[21] as well as aggression and violent behavior[22] in children.

Community level

Numerous studies suggest that MH problems, including PTSD, can persist throughout life. This chronic condition of suffering and helplessness can lead to passivation, work impairment, inability to take care of family members and hinder participation in socially productive activities;[20] conditions which make it difficult for migrants and refugees to integrate in community and society as a whole.

Health system

A growing body of research shows relationship between trauma related disorders, especially PTSD, and various health problems, such as decreased immunity, cardiovascular, pulmonary, neurological and gastrointestinal complaints, somatic pain, susceptibility to infectious diseases and even increased risk for cancer.[20] It comes as no surprise that trauma survivors with PTSD are more often on sick leave and are more frequently hospitalised,[20,23] which may lead to greater strain of health system.

3 Mental health care procedures

Rationale

The current status of refugee and migrant crisis in the Western Balkans corridor has introduced a high level of uncertainty in the resettlement and support system. Before mid-February the Western Balkans corridor had two major migrant routes to Europe: the land route from Turkey to Bulgaria and the sea route from Aegean Sea to Greece. However, the corridor has been officially closed for all migrants on 8 March. Furthermore, on 18 March EU and Turkey signed an agreement in order to end the irregular migration from Turkey to the EU and replace it with legal channels for resettlement of persons entitled to international protection.[24] According to this agreement, all new irregular migrants after 20 March, regardless of their nationality or need for international protection, will be returned from Greek islands to Turkey. In addition, for every Syrian being returned to Turkey, another Syrian from Turkey will be resettled to the EU directly. These events have resulted in a number of procedural and humanitarian problems. Greece has moved all previously arrived refugees and migrants from the islands to the mainland and now approximately 48 000 of refugees and migrants, who arrived before 20 March, have limited options for onward travel. Significant numbers of refugees and migrants continue to enter Greece from Turkey and new arrivals (after March 20) are held in detention facilities. A majority of them will probably be returned to Turkey. Although the system for assessing asylum claims in Greece is already understaffed, there has been a large increase in the number of asylum claims and EU relocation programme applications among the stranded refugees and migrants in Greece.[25]

Considering the current situation, it is difficult to predict how the system for relocation will be organised from now on. One possibility is that the majority of refugees and migrants currently stranded in Greece and Turkey will be directly transferred to host countries within the EU through the EU relocation programme. Another possibility is that the number of arrivals in Greece will increase dramatically leading to sporadic, facilitated movement of large number of people through Balkan countries as the border officers in the Former Yugoslav Republic of Macedonia will be unable to prevent the further entry of such large number people. Accordingly, we cannot be sure where and how the procedures for MH screening and PFA will be organised. Therefore, we aimed to develop a comprehensive procedure for rapid assessment of MH conditions and interventions that can be implemented in various settings and scaled up or down based on the needs and available resources. However, we also recommend the context in which certain parts of the process will be most feasible to conduct.

Procedures

Like all other types of health care, MH care starts with identification of people in need. However, MH conditions are typically more difficult to identify. From health care provider perspective, it is difficult to assess such problems since they are usually internally experienced; from patient perspective it is oftentimes difficult to request help for various

reasons, most often fear of stigmatisation.[26] Therefore, identification of MH care needs should be systematic and comprehensive, while in the same time it should also be patient-centred, culture-informed and non-stigmatising.

Following well established principles in provision of MHPSS[3], we propose a stepped model of rapid assessment and care. The purpose of the stepped model of care is to provide MHPSS services based on different levels of individual needs. In the proposed model, assessment of MH needs and provision MHPSS are integrated in overall health care. There are several arguments for this. First, integrating MH care in overall health care reduces the stigma usually attached to MH issues.[3] Second, people are often not aware of strong connection between body and mind symptoms. Refugees and migrants can complain about what seem to be purely physical health conditions which are in fact caused by distress (e.g. chest pain, fatigue, dizziness, headache, edema, back pain, shortness of breath, insomnia, abdominal pain, and numbness as most common).[27] Finally, although there is a substantial rate of psychiatric disorders present in primary care, individuals may not accept a referral to a MH provider at another location, making primary health care appropriate setting for addressing MH problems.[28] The integrated and holistic model of primary health care is shown in Figure 1, while in the text below we briefly describe steps in rapid assessment and delivery of MHPSS care.

Step 1: Triage

MH care for refugees and migrants starts with triage. The purpose of triage is twofold: to recognise urgent, life-threatening conditions and to identify people with immediate health needs. Therefore, the focus in MH triage should be on recognising refugees and migrants whose functioning is so severely impaired that their safety or safety of people around them is endangered. For those migrants and refugees, immediate escort to a specialist should be ensured. If there are no indications of immediate risk to safety during the triage, but the person is highly distressed (e.g. severe anxiety), immediate help should be provided, based on PFA principles of stabilization, establishing safety, calming, connectedness, self-efficacy and hope. For those refugees and migrants, further referral can be made to MH care specialist, if needed.

Triage and elementary PFA should be conducted primarily at hot spots (detention centres) and during transit route. However, these procedures should be available at each contact points with refugees and migrants, since serious MH issues can manifest at different times during resettlement period. In the *Triage* section of this report these procedures are further described. Triage can be conducted by health care personnel, MH professionals, as well as by trained lay persons and volunteers.

Step 2: Screening

The purpose of MH screening is to identify individuals who are experiencing high level of distress and are more likely to develop serious MH problems and MH disorders. The focus of screening is on identifying high risk for MH disorders that are common in the refugee population, such as PTSD, anxiety and depression.[29] For refugees and migrants who

experience high level of symptoms, immediate help based on PFA principles should be provided together with referral to specialised care provider for full assessment and further care. For others, psychoeducation on MH problems and information about accessing services should be provided should their condition deteriorate.

Screening for MH problems should be conducted as a part of any comprehensive health screen. Although the benefits of routine screening are yet to be seen, experts recommend the use of a brief screening instrument due to high levels of distress in refugees and asylum seekers.[2] Because of time constraints, MH screening (as well as comprehensive health screen) will most likely be conducted at temporary or first hosting locations and at permanent locations in the EU. In the *Mental health screening* section we describe the procedures and propose tools that can be used for screening. Care providers conducting screening can have different professional backgrounds (e.g. medical doctors, nurses, psychologists, social workers), however, specific training should be organised.

Step 3: Referral

Based on the model of stepped care, referral to specialised MH services is recommended only in cases where other types of basic interventions and support are not sufficient. In the *Referral* section we describe the procedures that should be used as well as some good practices. Referral should be available at all points of contact with refugees and migrants, during transit, but especially at more permanent locations where the refugees and migrants are resettled.

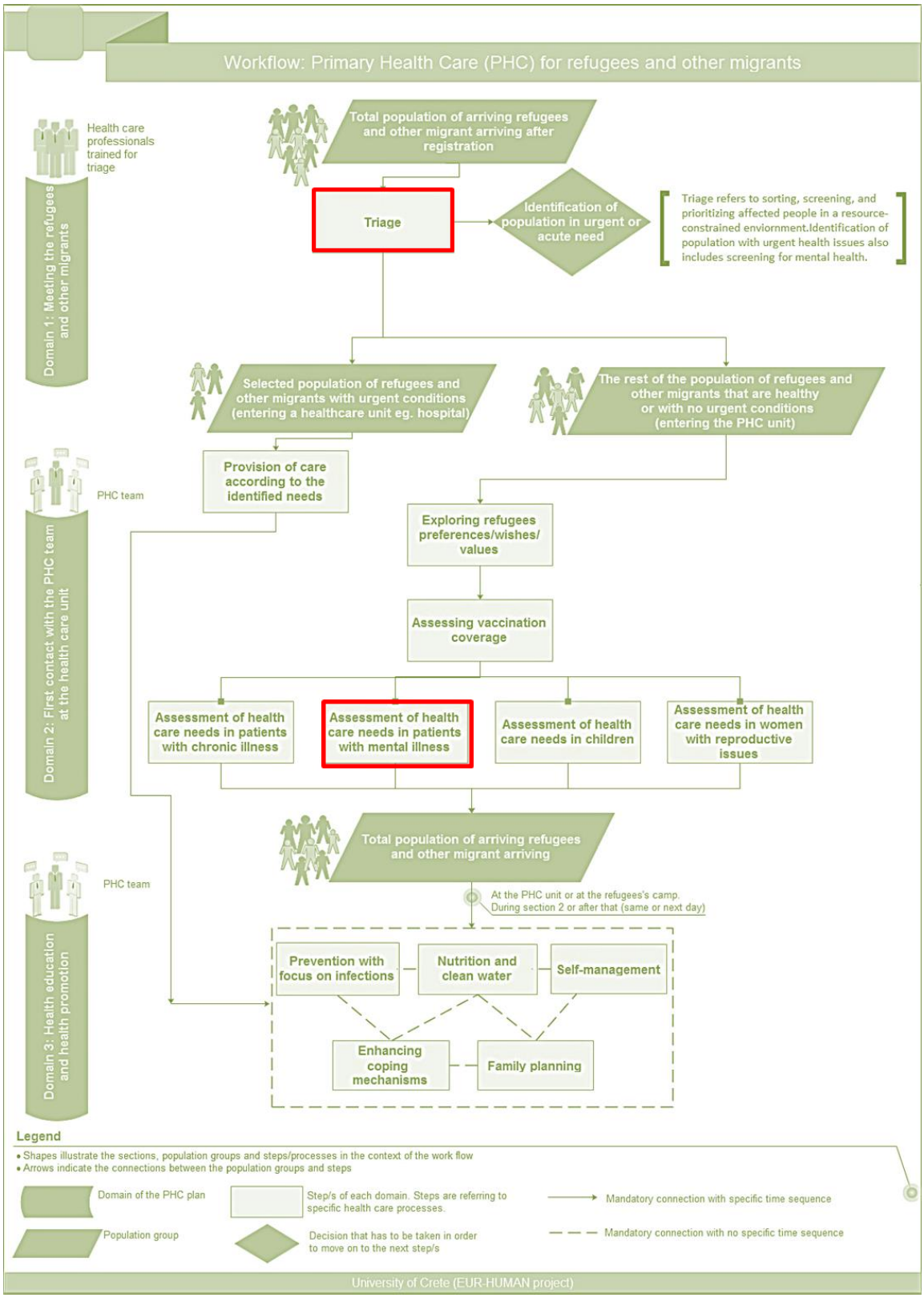

Figure 1 Integrated model of primary health care for refugees and other migrants (red frames indicate points where MH assessment and interventions are integrated in the overall health care)

4 Triage

Rationale

In order to provide immediate MH care to survivors in any emergency setting, the intervention should start with triaging the most psychologically severely affected individuals ("the psychological casualties").[30] By definition, triage includes sorting, screening, and prioritizing affected people in a resource-constrained environment.[31] Triage of serious health issues, including MH, is essential, high-priority response that should be implemented as soon as possible in an emergency. In this early response, triage is not intended for diagnostic purposes but rather to identify those individuals who require immediate attention,[32] primarily for being at risk to themselves or other people.

In recent current refugee crisis thousands of people arrived to Greece on a daily basis. Although the exact "entry point to Europe" is likely to change since the 18 March 2016 agreement,[24] the need to develop procedures to identify individuals who are at immediate risk remains. In terms of MH issues, we define immediate risk as threat to personal safety of the affected people, or threat to safety of people around them. These severe MH problems need immediate specialist attention. However, identifying such individuals is challenging. How can care providers recognise people under such severe distress that their safety is endangered? And what procedures can be used within current situation where thousands of people potentially require help?

Procedures

To our knowledge, there are no prior developed procedures to tackle the issues of MH triage in the context of refugee crisis. Therefore, we aimed to propose procedures that can be easily implemented with limited resources, that rely on a stepped approach and that can reach out to large number of people. The proposed procedure consists of three main steps:

1. Recognition of behavioural signs that indicate severe distress;

2. Rapid assessment and immediate assistance;

3. Referral.

The process is shown schematically in Figure 2, and described in the text below.

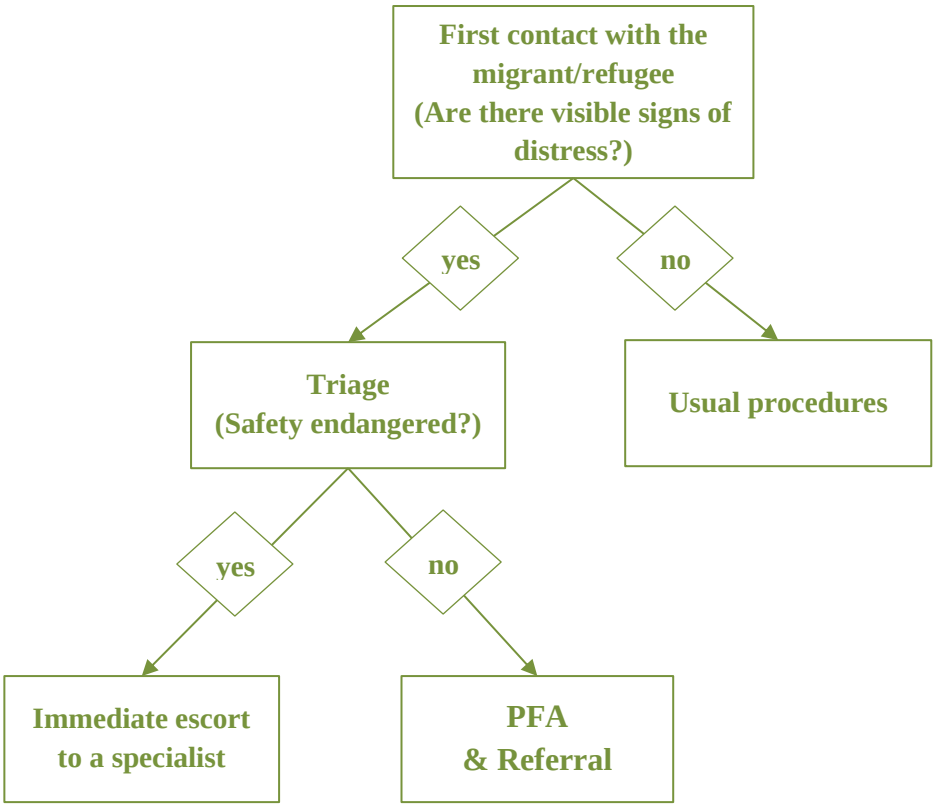

Figure 2 Triage procedures

Step 1: Behavioural signs

Although people react differently to stressful events, there are some physical signs that indicate severe distress in majority of people. In a group of refugees and migrants, care providers should look for signs of being disoriented or overwhelmed[33–37] (Table 2). Care providers should approach directly people showing any of these signs and engage in interaction.

Table 2 Physical/behavioural and emotional/cognitive signs of severe distress

Physical/behavioural	Emotional/cognitive
Looking glassy eyed and vacant, unable to find direction	Exhibiting strong emotional responses, uncontrollable crying
Unresponsive to verbal questions or commands	Feeling incapacitated by worry
Disorientation (engaging in aimless disorganized behaviour, not knowing their own name, where they are, or what is happening)	Unable to care for themselves or their children
Rocking or regressive behaviour	Unable to make simple decisions
Hyperventilation	Feeling anxious or fearful, overwhelmed by sadness, confused
Experiencing uncontrollable physical reactions (shaking, trembling)	Physically/verbally aggressive
Exhibiting frantic searching behaviour	Feeling shocked, numb
Self-destructive or violent behaviour	Guilt, shame (for having survived, for not helping or saving others)

Step 2: Rapid assessment and immediate assistance

Once the care provider identifies a person showing visible signs of distress, it is important to engage in conversation. During the conversation, the care provider has two main tasks: first, to conduct rapid assessment of immediate risk, and second to calm and reassure the person, while offering practical assistance. Guidance on immediate assistance will be presented in detail in *Psychological first aid* section, while rapid assessment will be presented in detail in this section.

Rapid assessment should focus on two most important aspects: overall level of distress and signs that the person functioning is so severely impaired that their safety or safety of people around them is endangered. These signs can be considered as “red flags”; signs that indicate that special attention is probably needed. In addition, it is important to identify available resources, so that immediate practical assistance can focus on strengthening them. These elements of assessment are shown in Table 3, while in the text below, we give practical guidance in conducting this conversation.

Table 3 Rapid assessment during triage (assessed by caregiver)

Distress level	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Personal safety or safety of other people endangered	No Yes
Resources (note up to 3 most important resources)	1. 2. 3.

Starting the conversation. Talking about their MH issues is still uncomfortable for most people. When talking about distress, care providers should first: (1) create a safe, comfortable and confidential setting, (2) establish a basic trustful relationship. Therefore, before asking any further questions, care provider should:

- Introduce himself/herself;
- Ask the person if he/she could be of any help;
- Provide adequate place to talk.

An example of the first contact is shown below:

> *"Hello. My name is XY, and I work for Z organization. Can I help you in any way? It seems to me that you are tired/worried. I can offer you to rest a bit in a more comfortable and quiet space nearby* (point where). *From that place you can still see everything that is going on here, but it might be more comfortable for you."* If the person is under such severe distress so that interaction is impossible, try calming them (Box 3).

It is very important that care providers ensure adequate physical space for conversation. The space should be comfortable and quiet, while also near the central spot of the camp/reception area. Refugees and other migrant should not be exposed to additional stress of worrying about their group leaving without them, e.g. because of train or bus departure, or feeling isolated from others. Families **must not** be separated. A waiting space/room and place for children to play should be established, so that families with children can stay together.

Once the person/family has rested for a few moments, talking about MH condition can start. In the beginning, the conversation should focus on the symptoms the care provider noticed, e.g.:

> *"Earlier it seemed to me you were a bit distant, like many thoughts were passing through your mind. Many people who have gone through difficult situations feel like this. How are you? Can I help you in any way?"*

Box 3 Orienting emotionally overwhelmed survivors[38]

If the person appears extremely agitated, shows a rush of speech, seems to be losing touch with the surroundings, or is experiencing ongoing intense crying, it may be helpful to:

- Ask the individual to listen to you and look at you.
- Find out if he/she knows where he/she is, and what is happening.
- Ask him/her to describe the surroundings, and say where both of you are.

If none of those seems to help to stabilise an agitated individual, a technique called "grounding" may be helpful. You can introduce grounding by saying:

"After a frightening experience, you can sometimes find yourself with emotions or unable to stop thinking about or imagining what happened. You can use a method called "grounding" to feel less overwhelmed. Grounding works by turning your attention from your thoughts back to the outside world. Here's what you do…"

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five non-distressing objects that you can see. For example you could say: "I see floor, I see a shoe, I see a table, I see a chair, I see a person."
- Breathe in and out deeply.
- Next, name five non-distressing sounds you can hear. For example: "I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing things you can feel. For example: "I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel blanket in my hands, I can feel my lips pressed together."
- Breathe in and out slowly and deeply.

You might have children name colours that they see around them. For example, say to the child: "Can you name five colours that you can see from where you are sitting. Can you see something blue? Something yellow? Something green?"

If none of these intervention aids in emotional stabilization, consult with medical or MH professionals, as medications might be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

(Quoted directly, page 51)

Assessing distress level. To estimate the level of distress, care provider should pay close attention to: tone of voice, body language and behaviour that may indicate higher levels of anxiety or depression than expected,[39] for example behavioural/physical and emotional/cognitive signs described in Table 2. Attention should also be given to the refugee's or migrant's ability to communicate thoughts in a coherent fashion (this may require input from an interpreter, if interpretation is needed).

Assessing danger to safety. To assess immediate danger to safety, either to self or others, several indicators need to be taken into account:[37]

- Presence of psychotic symptoms: hallucinations, delusions, paranoid ideas, thought disorder, bizarre/agitated behaviour;
- Presence of affective disturbance: severe symptoms of depression/anxiety, elevated or irritable mood;
- Confused, disorganised behaviour, can't take care of self or children (if applicable);
- Reporting threat of self-harm;
- Reporting threat of harm to others.

Special attention should be given to thoughts and feelings of self-harm, since they are less likely to be observed from behaviour. When talking about suicide, it is recommended to approach the topic gradually, by first asking about other aspects of distress and posing questions that may make it easier for a person to answer honestly, for example:

> *Some people with similar problems have told me that they felt life was not worth living* [40(p 50)].
>
> *Do you sometimes go to sleep wishing that you might not wake up in the morning?*[40(p 50)] *OR Have things ever been so hard or so bad that you felt you wanted to die or did not want to live anymore?*[41(p 73)]

Refugee and migrants may express being "tired of life", "done with life", or wishing that "God would take their life".[26,41] Sometimes these expressions are a way to convey distress, with no real intention of ending their own lives,[26] but if a refugee or migrant says "yes" , more specific questions should follow, for example:

> *Have you ever wanted to end your life or kill yourself?*[41(p 73)]
>
> *Do you think about hurting yourself?*[40(p 50)]
>
> *Have you made any plans to end your life? If so, how are you planning to do it?*[40(p 50)]

It is important to stress that directly asking questions on suicide is extremely important. Oftentimes people can seem stable and future oriented with a pleasant and positive appearance while still endorsing active suicidal ideation. Alternately, people who appear significantly distressed and decompensated can have no suicidal ideation at all.[41] Therefore, care providers should not make their own conclusions regarding a suicide threat without directly asking the refugee or migrant.

Finally, care providers who conduct triage should be culturally sensitive, since expression of distress varies between cultures. Description of some cultural diversities in MH concepts is shown in Box 4.

Resources. Apart from assessing immediate risk, the triage process should include identifying individual's available resources. One of the key principles of early interventions is to increase social support among individuals in distress, as this has been found to reduce the likelihood of chronic posttraumatic psychopathology.[32] It is important to get an insight how the individual perceives his/her own resilience. A simple question as *"What has helped you to survive so far?"* can be helpful. Whatever the answer, it is good to incorporate their response into the intervention. For example, if a person believes that their survival was due to God, then strengthening their connection to prayer or a faith community would be wise. If they believe that they survived for their children, then understanding the current relationship with their children is important.[41]

Step 3: Referral

If immediate threat to personal safety or safety of others is probable, the refugee or migrant should immediately be escorted to a specialist. However, if no such threat is probable, but distress level is high, it is important that the care provider offers PFA, and links the refugee or migrant to additional services. Steps to successful referral will be discussed in the *Referral* section.

Box 4 Cultural appropriate assessment - Syrian MH concepts[26]

Providing acceptable help requires understanding illness models and idioms of distress that are used in a given culture. A good insight in specific MH concepts allows appropriate intervention design to mobilise individual and collective strength and resilience.

Concepts such as "psychological state", "psychological wellbeing" or "mental health" are not commonly understood and often carry negative connotations in the Syrian or Arabic context in general, while suffering is commonly understood as a normal part of life, and therefore, not requiring medical or psychiatric intervention, except in severe cases.

Refugees and migrants with psychological or mental problems often first seek medical services and have physical complaints before addressing psychological, relational or spiritual dimensions of their condition. Most Arabic and Syrian idioms of distress do not separate somatic experience and psychological symptoms, because body and soul are interlinked in explanatory models of illness. People may resort to images, metaphors and proverbs that assume the connection of the psychological and the physical.

Attention should be given to use of everyday expressions and proverbs or metaphors of expressing distress. Some may be misunderstood as "resistance" to direct communication, or even misinterpreted as psychotic symptoms when observed through the prism of Western culture. For instance, some Syrians attribute obsessive rumination to satanic temptations, using the Arabic word "wisswas" (وسْواسْ), meaning both the devil and unpleasant recurrent thoughts. Other examples of such culturally specific expressions of MH issues in Syrian context are shown below:

General distress	Often expressed through physical symptoms, like cramps in the guts, pain in the stomach, head or heart, tightness in chest, numbness of body parts or having the feeling of ants crawling over the skin.
Fear and anxiety	"Falling or crumbling of the heart", "My heart is squeezing".
Helplessness	"The eye sees but the hand is so short or cannot reach", "I feel like I'm paralysed", "Nothing is coming out of my hands".
Sadness	"A black life", "Life has blackened in my eyes", "Blindness got to my heart".
Suicide	Wish they could sleep and not wake up.

5 Mental health screening

Rationale

Given that the focus in refugee and other migrant resettlement is on physical health problems such as injuries and infectious diseases, the detection and the treatment of MH problems is often overlooked. Among the EU countries, medical screening of newly arrived asylum seekers is common, however, MH screening is the least frequent component.[1] The purpose of MH screening is to identify the individuals who are experiencing heightened distress and who are more likely to develop more serious MH issues. Although there are no clinical trials demonstrating the benefits of routine MH screening yet,[5] there are several reasons why such procedures might benefit the refugees and migrants arriving to Europe.

First, majority of refugees and migrants arriving to Europe have suffered directly or indirectly from violence, trauma or loss, not only in their country of origin, but also on the way to their final destinations in the EU. Prevalence studies of mental disorders in refugees after resettlement show that the earlier the acute posttraumatic stress reactions are identified, the better the opportunities for successful intervention and treatment.[42] Furthermore, refugees are often less likely to seek out or be referred to MH services then their counterparts in the general population. For example, in Switzerland the average time between entering the country and admittance to therapy was 7.7 years for refugees who were victims of torture and war.[43] A longitudinal study on refugees resettled in the Netherlands suggests that only 21% of respondents with PTSD contact a MH professional in the first year and only slightly more than half in the first 7 years.[44] The reluctance to seek help for psychological disorders can be a result of language barriers, distrust, fear of stigmatisation, lack of knowledge, time or money, as well as lack of information on available services. In addition, because of the high prevalence of PTSD in refugee population, the National Institute for Clinical Excellence (NICE) recommends the routine use of brief screening to detect PTSD as a part of the initial refugee health assessment.[2] All of the above supports the importance of a systematic procedure for brief assessment of MH needs.

Procedures

Experts in the area agree that MH screening should be conducted as a part of comprehensive health screening.[2,45] Since comprehensive health screening will most likely be conducted in the host country, it is probable that specific context will vary from country to country depending on administrative regulation and laws. Therefore, we aimed to propose procedures that can be implemented within the EU primary health care system. The proposed procedure consists of three main steps:

1. Recognition of behavioural signs that indicate severe distress,
2. Applying the MH screening tool,
3. Referral to a specialist, if needed.

The process is shown schematically in Figure 3, and described in the text below.

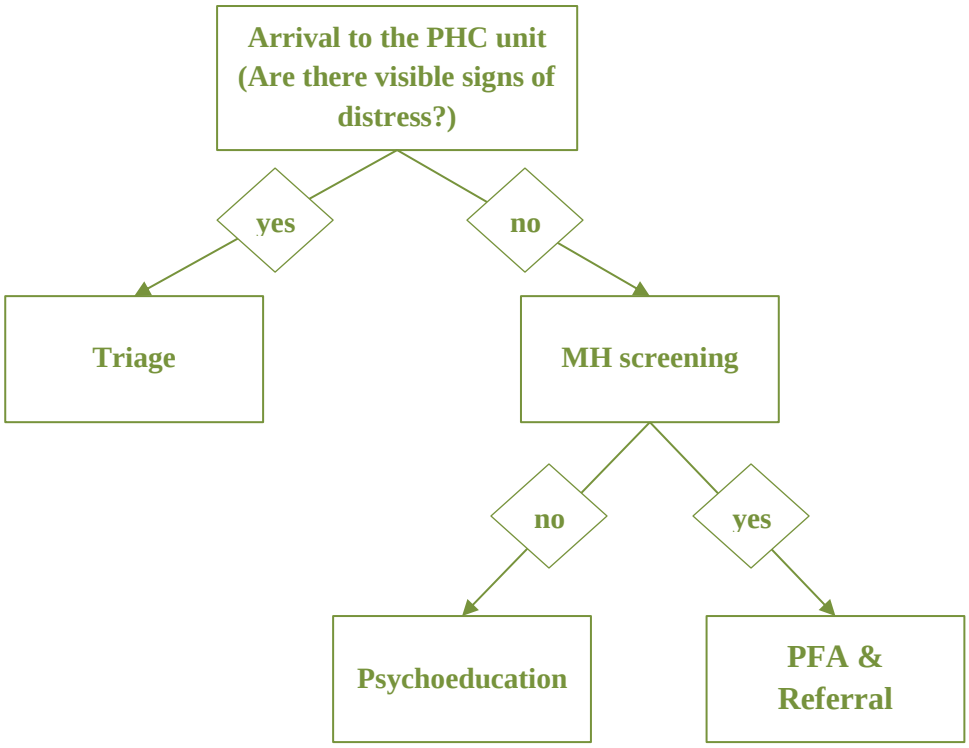

Figure 3 Screening procedures

Step 1: Behavioural signs

Upon the refugee or migrant arrival to the primary health care (PHC) unit, care provider should observe if there are visible signs of severe distress (according to the symptoms described in Table 2. in *Triage* section). If a refugee or migrant shows signs of severe distress, triage and immediate assistance should follow, before starting comprehensive health screening. Otherwise, health care providers can start with overall health screening, including MH.

Step 2: MH screening

When MH screening is conducted as a part of comprehensive health screening, general practice is to conduct the screening at the end of the procedure.[39] Since talking about MH is often uncomfortable, this allows establishing a trustful relationship prior to the MH screening procedure. However, it is important to emphasize that if physical health screening shows that immediate assistance is needed, solving this issues has priority over MH screening.

MH screening is usually conducted by self-administered instruments, where an individual assesses the intensity of certain symptoms. Based on the extensive review of available instruments (Appendix I), we recommend using The Refugee Health Screener 13 (RHS-13) as a screening instrument in primary health care settings for migrants and refugees from age of 14. Additional information on the characteristic of MH screening instruments and RHS-13 can be found in Box 5, while the whole instrument is presented in Figure 4. In the text below we focus on the practical aspects of administering screening instruments in general.

Establishing trust. The issue of trust is extremely important in the context of MH screening, even in if the same primary care provider who conducted physical health screening is conducting the MH screening. Refugees and migrants may be particularly distrustful of services and authorities because of previous experiences in their country of origin. Moreover, they may be unfamiliar with the health care system in the host country, in particular with the way MH care works.[46]

Before administering the screening instrument, the care provider should introduce him/herself and explain what is going to be asked and what the individual can expect in this part of health screening procedure. Making the individual familiar with screening procedure and informing that this part of health screening involves questions about how they are doing both in their body and in their mind is essential. It should be explained that the questions will be about sadness, worries, body aches and pain, and other symptoms that some people get when they have bad experiences, stress at home, or when they travel to a new country. Also, confidentiality of screening should be emphasized. It is important that this is seen as another part of the overall medical check-up. The screening could begin as follows:[41(p 58)]

> *"Hi. My name is XY. Can I get you some tea or water? Again, my name is XY and I work here as a Z. This part of medical check-up will be about things that may be bothering you at the moment. In the EU health care also includes taking care of a wide range of feelings and emotions – from being sad all the time, to not being able to sleep at night, to even feeling like life is not worth living. It is common for many refugees and migrants to have these types of problems because of all the terrible things they have been through. What happens to us in life has an impact on our mind and on our body. The questions we are asking will help us find people who are having a hard time and who might need extra support. Your answers will not be shared with anyone else, without your permission.*

Box 5 MH screening and Refugee Health Screener 13 (RHS-13)

Identifying MH issues in refugees and migrants is a challenging task for a variety of reasons ranging from technical aspects of language barriers and accessibility, to problems such as defining mental illness across cultures.[47] Therefore, few screening instruments have been tested for diagnostic accuracy in refugee and migrant populations.[5] In general, a good screening tool should give consistent results with repeated tests (reliability) and should identify correctly those with and without condition (have good sensitivity and specificity). In addition, routine screening for exposure to traumatic distress should not be conducted, since it could lead to more harm than good in well-functioning individuals.[5] Finally, to be practical to administer, it should include symptoms that predict different common disorders, such as PTSD, anxiety and depression, in multiple refugee groups,[48] and should be short and easy to administer due to limited time for MH screening within the general medical screening.

Based on our review (Appendix I), the RHS-13 scale meets most of the specified criteria and can be recommended as the primary screening tool for refugees on arrival in host country. This instrument was specifically designed for and validated on newly arrived refugees and migrants with items derived from existing and valid instruments used on similar populations. It is translated in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); can be administered in relatively short amount of time; is easily understandable for people of different educational levels and can be administered for persons from age 14. Furthermore, it covers several relevant constructs related to emotional distress which are common in refugee populations.

RHS-13 scale consists of 13 questions assessing 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.

Administering the screener. After the introduction, the care provider should remind the refugee or migrant that he/she will answer the questions by themselves, but that they can ask for help if they cannot read or find the questions confusing. The care provider should explain how to answer the questions (e.g. that one answer from 1 to 5 should be picked, depending on how he/she is feeling) and encourage again to ask for help if needed. It is important that the care provider and interpreter, if interpretation is needed, are highly familiar with the instrument and the purpose of the screening.

Evaluating the results and immediate assistance. Following the administration of the screener, the care provider should calculate the total score. For RHS-13 screening tool, the score of ≥11 indicates positive screen, and immediate assistance based on the PFA principles should follow. In order to help guide the intervention, it is helpful to assess refugee or migrant current resources, as described in the *Triage* section. It is recommended that the feedback and short intervention be provided by the same care provider who conducted the screening. Feedback following positive screen could start as follows:[49(p 22)]

> *"From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees and migrants experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. I would like to ask you what has helped you to survive so far?"*

Step 3: Referral

If a refugee or migrant has been screened positive, after providing PFA intervention appropriate referral should be made. Steps to successful referral will be discussed in the *Referral* section.

Otherwise, if the individual scores below cut-off, care provider should provide information about available services and encourage the person to ask for MH assistance for themselves or their loved ones if ever the need is felt. Even if there are no current indicative signs of distress, numerous resettlement stressors may worsen trauma-related MH symptoms, such as unemployment, unsafe housing, social isolation, discrimination, language and cultural barriers.[50] Screening should end with providing information on common MH issues and available services, orally and in the form of a leaflet for future reference.

ID#

DATE

REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

CHECK ONE: ☐ POSITIVE ☐ NEGATIVE ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

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Figure 4 Refugee Health Screener 13 (RHS-13)

6 Psychological first aid

Rationale

Humanitarian aid organisations and other stakeholders working with refugees and migrants have long recognised the need to provide early interventions in order to avoid deteriorations in psychological wellbeing and MH status. Historically, a number of early psychological interventions have been proposed for working with refugee and migrant clients ranging from trauma-focused interventions to psychosocial approaches.

Trauma focused interventions such as *critical incident stress debriefing* (CISD) or *psychological debriefing* (PD) were developed to reduce initial psychological distress following a traumatic experience and to prevent the development of later psychological disorders by exploring facts, thoughts and reactions to a specific traumatic event.[51] However, these types of interventions proved to be ineffective. For example, recent reviews on single session PD showed that the use of PD after traumatic incidents does not reduce psychological distress or prevent the onset of PTSD, depression and anxiety,[32,51,52] and even suggest that debriefing can have adverse long-term effects.[52] Possible reason why such interventions are not suitable is that they can actually increase psychological distress by re-exposing individuals to traumatic event without sufficient time for therapeutic processing. For some individuals this can aggravate their condition because it interferes with normal recovery processes. In addition, research has shown that not everybody develops acute distress symptoms; some have temporary stress reactions and only a smaller number of individuals develop serious MH problems.[53] In that regard, trauma focused interventions, which put great emphasis on psychological distress, might even induce distress in those who otherwise would not experience it and make people more susceptible to developing psychological symptoms.

In contrast, psychosocial approaches are aimed at addressing the basic needs and reducing distress of people affected with adversity. International Federation Reference Centre for Psychosocial Support of the Red Cross and Red Crescent Societies defines psychosocial support as "a process of facilitating resilience within individuals, families and communities, enabling them to bounce back from the impact of crises and helping them to deal with such events in the future".[54] This approach emphasizes strengths and resources of individuals to recover from the impact of a crisis. Over the years a wide range of interventions were developed to provide psychosocial support among which particularly relevant for this context is psychological first aid.

Psychological First Aid (PFA) is a form of psychosocial support intended for people who have experienced mass violence, natural disasters and other types of distressing events. The term PFA is often used as an umbrella term for a range of different approaches, which resulted in different formal definitions in the literature. For example, National Child Traumatic Stress Network (NCTSN) and National Centre for PTSD (NC-PTSD) define PFA as „an evidence informed, modular approach for assisting people in the immediate aftermath

of disaster and terrorism to reduce initial distress and to foster short and long-term adaptive functioning."[34,38] The NATO guidelines on psychosocial care for people affected by disasters and major incidents usefully describe PFA as: "not a single intervention or treatment but an approach that is designed to respond to people's psychosocial needs after major incidents or disasters which comprises of a number of elements".[55] According to the Inter-Agency Standing Committee (IASC) PFA „…is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support".[3] Despite various formal definitions, the basic elements of PFA are universal and include:[33]

- Providing practical care and support which does not intrude;
- Helping people to address basic needs;
- Listening to people, but not pressuring them to talk;
- Comforting people and helping them to feel calm;
- Helping people connect to information, services and social support;
- Protecting people from further harm.

Main aims of PFA include reducing initial distress, meeting current needs, promoting flexible coping and building people's capacity to recover and adjust. PFA can be provided to anyone who has been exposed to a crisis event and anywhere where it is safe enough to do so (e.g. shelters, camps, transit centres, hospitals). Its implementation is not restricted to MH professionals but can also be delivered by trained lay persons. It should be emphasized that PFA is very different from clinical MH care, emergency psychiatric interventions or psychotherapy because it does not require clinical expertise or discussing the event that caused distress. Furthermore, PFA cannot be assumed to prevent long-term MH consequences of trauma or to reliably assist in identifying individuals at risk for developing MH disorders. Rather, it is an empathic and pragmatic approach to assist people in distress to stabilize and begin their own practical and emotional recovery.[33] Consequently, PFA does not presume that all survivors will develop MH problems but acknowledges that people who are affected by major life adversity may experience a wide range of negative psychological reactions. Some of these reactions may cause enough distress to interfere with adaptive coping for some people and these individuals can be helped by offering support from compassionate and caring providers.[55] Although there is no empirical evidence about the effectiveness of PFA interventions, there is an expert consensus that PFA can help people affected by extreme events to alleviate painful emotions and reduce further harm from initial reactions to a crisis. PFA is the approach recommended by many international expert groups, including National Centers for PTSD, National Institute for Mental Health, World Health Organisation, the Sphere Project, the Inter-Agency Standing Committee on Mental Health and Psychosocial Support, and other lead agencies such as the International Red Cross.

PFA interventions should be consistent with research evidence, applicable in various field settings, adjustable for different age groups and culturally informed. In order to ensure such conditions, an international panel of experts in the fields of mass trauma and disasters has

identified and recommended five empirically supported principles that should inform and guide all PFA intervention practices and programs:[6]

1. Promoting a sense of safety. Traumatic events such as wars, persecution, and natural disasters represent a threat to individual's psychological wellbeing and to subjective sense of safety which can increase the likelihood of developing MH problems.[56] Promoting psychological sense of safety can reduce post-traumatic stress reactions,[57] as well as cognitive distortions such as belief in a dangerous world and exaggeration of future risk.[58,59]

2. Promoting calming. Exposure to traumatic events also leads to an increase in emotionality, anxiety, hyperarousal or numbing responses, which can be normal and adaptive reactions to such events. However, if these responses persist for a longer period of time and remain at a level that disturbs eating, sleep and performance of daily tasks, this can lead to development of anxiety disorders (e.g. panic attacks, dissociation, PTSD), agitation, depression and somatic problems. For this reason, it is important to try to calm down and stabilise people who are overwhelmed and disoriented.

3. Promoting sense of self- and collective efficacy. Self-efficacy is the individual's belief that his/her actions are likely to lead to generally positive outcomes,[60] while collective efficacy represents a sense that one belongs to the group that is likely to experience positive outcomes.[61] After distressing events people can lose their sense of competency to handle new events which could be transferred even to situations that are not related to the original trauma.[62] In the context of mass trauma and violence, the most important aspect of efficacy refers to the subjective sense that one can cope with trauma related events.[63] This includes the perceived ability to regulate emotions and solve problems related to resettlement, restoration of property, job retraining, interpersonal relationships and other tasks after the crisis is over.

4. Promoting connectedness. Research on disasters and terrorist attacks has shown that social connectedness or social support is associated with emotional well-being and recovery following a traumatic event.[15,64,65] Promoting connectedness increases knowledge essential for effective response to a traumatic situation, provides opportunities for social support activities such as emotional understanding and acceptance, sharing of traumatic experiences, mutual instruction about coping, and practical problem solving. Therefore, it is important to identify individuals who lack strong social support or are socially isolated and those whose support system provides undermining messages such as blaming, minimizing problems and needs and unrealistic expectations.[66]

5. Promoting hope. Hope has been defined as a positive, action-oriented expectation that a positive future goal or outcome is possible.[67] However, for most non-Western societies hope has a religious connotation and is not action-oriented.[61] Retaining hope is crucial for people affected by mass trauma because it often provokes reactions of despair, futility, resignation, catastrophizing and a feeling that „all is lost“. Those who are optimistic, positive and confident that life is predictable are likely to have more favourable outcomes after experiencing mass trauma because they can retain a reasonable degree of hope for their future.

Procedures

This PFA procedure was conceived as a general guide for providing psychological care and support for refugees and migrants arriving in Europe. This framework is practically oriented, in line with the five basic intervention principles of PFA and adapted from or in some parts directly taken from existing PFA field manuals (*Psychological First Aid: Field Operations Guide*[34,38] *Psychological First Aid: Guide for Field Workers*[33]). The general framework comprises core PFA actions, which in the ideal case should all be provided to every individual in need of help. However, the choice of specific actions, the amount of time spent on each and the structure of the whole PFA procedure will depend on the specific context in which PFA will be provided (e.g. at the first point of entrance, during transit, in the host country) as well as the particular needs of the individual. In addition, the exact procedure will certainly differ depending on whether it will be provided within the short triage procedure or a more extensive MH screening. The guide is organised around a set of preparatory actions as well as eight core PFA actions.

Step 1: Preparation

PFA providers must be thoroughly prepared before entering the setting in which they will offer help. The preparation includes gathering all relevant information about the nature of the crisis event that forced people to leave their country, cultural specificities of their country of origin, and situation in which they are currently in, including the type of relief and support services that are formally available at their current location.

Cultural beliefs and practices affect the refugee understanding of the event, response to the crisis and the receptivity to PFA. For this reason, it is important to be familiar with the cultural background and social norms of the people being served. PFA providers should therefore learn cultural customs and norms regarding gender roles, family structures, religious practices, spoken languages, rules on emotional expression and other psychological reactions, customary ways of greeting and addressing people and norms for personal space and physical contact. In addition, provider should be aware of their own cultural values and prejudices so they don't interfere with the provision of assistance.

Probably the most important aspect of preparation includes gathering information about the situation in which the refugees and migrants are currently in. Specifically, the PFA providers should know which organisations are involved in help provision, who are the relevant authorities managing the situation and what are the security regulations in the specific country, so that help could be provided in an organised and coordinated way. Furthermore, it is important that they have accurate information about what is going to happen next, what medical and support services are available and where and how can people access these services. In the Table 4 we provide some general guidelines on what behaviours are appropriate and which ones should be avoided when providing PFA. [34,38,68] These basic "dos and don'ts" can help PFA providers to prepare before entering the setting in which they will offer help.

Table 4 General guidelines for providing PFA

Do	Don't do
Be prepared to be either avoided or flooded with contact and requests for assistance.	Avoid assuming everybody who was exposed to a crisis is traumatized or needs to talk.
Speak calmly, slowly, in simple, concrete terms. Be patient, responsive, and sensitive.	Avoid pathologizing the person's conditions, labelling their reactions as „symptoms" or using terms „diagnosis", „pathologies", „disorders".
Listen to people who wish to share their stories and feelings. Focus on hearing what they want you to understand and remember there is no wrong or right way to feel.	Don't force people to share their stories with you, especially very personal details Don't interrupt or rush someone's story.
Acknowledge how they are feeling and any losses or important events they tell you about, such as loss of their home or death of a loved one (e.g. "I'm so sorry. I can imagine this is very sad for you.").	Don't instruct people on what they should be feeling, thinking or doing now or how they should have acted earlier. Don't give simple reassurances (e.g. "everything will be ok" or "at least you survived" or "I know how you feel").
Acknowledge the person's strengths and efforts to help themselves.	Avoid patronizing the survivors and focusing on helplessness, weakness, mistakes, etc.
Provide information that is simple, accurate and appropriate for your audience.	Avoid offering inaccurate information. Always update the information.
Be honest about what you know and don't know. "I don't know, but I will try to find out about that for you.	Don't make promises that may not be kept.
Respect privacy and keep the person's story confidential (if appropriate).	Don't share the person's story with others or tell them someone else's story.
Respect people's right to make their own decisions.	Don't force help on people or judge them for their actions or decisions.
When they express fear or worry, remind people that more help and services are on the way (if accurate).	Don't talk about your own troubles.
Be friendly and compassionate even if people are being difficult.	Avoid expressions of approval and disapproval.
Help people meet basic needs for food and shelter, and obtain emergency medical attention.	Don't criticize existing services or relief activities in front of people in need of these services.
Help people to claim their rights and access available support while preventing discrimination.	Don't exploit your relationship as a helper (e.g. ask the person for any money or favour for helping them).
Make it clear to people that even if they refuse help now they can still access help in the future.	Don't take away the person's strength and sense of being able to care for themselves.
Find out the types and locations of government and nongovernment services and direct people to those services that are available.	Don't criticize existing services or relief activities in front of people in need of these services.
Keep families together. Keep children with parents or other close relatives whenever possible.	Avoid putting people at further risk of harm as a result of your actions.
Treat people with respect and according to their cultural and social norms.	Don't touch the person if you're not sure it is appropriate to do so.
Be aware of and set aside your own biases and prejudices.	Don't exaggerate your skills or act as if you must solve all the person's problems for them.

Step 2: Making first contact

The goal of this core action is to initiate first contact in a non-intrusive, compassionate and helpful manner or to respond to contact initiated by affected persons. The first contact with a refugee or migrant is very important because it creates a foundation for establishing a trusting relationship and increases the likelihood that a person will accept help. Since exposure to traumatic events can make people feel cut off from the world, social contact can provide a sense of connectedness with other people.

The contact can be initiated by making a nonverbal contact first (making eye contact, smiling, sitting or standing using the L stance, having an open posture, leaning forward). Even if the conversation requires an interpreter, provider should always look and talk to the person they are addressing, not the interpreter. PFA providers should then introduce themselves with their first or full name and title, tell for which organisation they are working for, describe their role in the present setting and explain their reason for offering assistance. It is very important to ask for the person's permission to talk to them and to ask how they would like to be called. Adults should be addressed with Mr./Mrs. and last name, unless given a permission to use the first name. After introduction, PFA providers should try to find a quiet, isolated place in order to ensure privacy for the conversation and invite the person to sit. The person should be given full attention and providers should avoid interrupting, rushing the person's story, looking around or being distracted. While communicating, it is also helpful to use a soft, calm tone of voice, positive language, words like „please“ and „thank you“, open and welcoming gestures, interested facial expressions, to let the person know that he/she is listened to (e.g. by nodding head or saying „hmmm..“) and to smile. If the PFA provider is not familiar with the culture of the refugee or migrant, it is best not to approach too closely or touch the person. When engaging in contact with female refugee or migrant, it is also important to pay attention to the gender of PFA provider because in some cultures it is inappropriate for women to discuss some issues with men. In addition, when approaching a family, it may be appropriate to ask who the family “spokesperson” is, and to address that person first. In any case, PFA providers should pay attention to nonverbal cues indicating discomfort.

When initiating first contact, PFA providers need to be prepared for the possibility that some people who have experienced crisis may avoid contact and refuse help. In such situations, help should not be forced and PFA providers should avoid being intrusive or pushy and just let people know where they can be found if necessary. In addition, some people may not need help, but may value a quiet presence from another person and the knowledge that if they need some practical support or just want to talk, someone will be there.

Step 3: Ensuring safety and comfort

This core action includes several strategies to enhance a sense of immediate and ongoing safety, provide physical and emotional comfort and reduce psychological distress. This is important because psychological recovery begins with re-establishing sense of safety and satisfying basic needs, both of which provide comfort while dealing with distress. This includes:

1. Ensuring immediate physical safety. Ensuring physical safety for people who have lived through dangerous, life-threatening experiences is a priority. A sense of safety can be enhanced by making sure that the environment in which they are currently located is safe (e.g. removing sharp objects, unexpected noises), telling them that they are now in a protected and safe environment (if justified), addressing any obvious and urgent needs (e.g. providing food, clothes, blankets, protection from weather), ensuring special protection for people who are likely to be discriminated or persecuted based on their ethnicity, religion or some other characteristic and preventing any violence or conflicts with the help of appropriate authority. If there are indications that someone may hurt themselves or others, PFA providers should seek immediate assistance from a medical or security team.

2. Providing information about available services. Given that crises are often unexpected, shocking and confusing, the sense of safety and comfort can be strengthened by giving people simple and accurate information on what is going to happen next, what is being done to assist them, what are the available services and where can they be accessed. Such information should be presented only if a person appears to be able to comprehend what is being said and if the information is verified. It is also helpful to ask the person if he/she has any further questions or concerns and to answer them in a simple language while avoiding technical jargon.

3. Attending to physical comfort. Physical comfort can be reinforced by making the physical environment more pleasant (e.g. adjusting temperature, lightning, air quality, arrangement of furniture), encouraging people to actively participate in getting the things they need for comfort and helping people to soothe and comfort themselves. For many people, even the mere presence of a calm, supportive person can instil a sense of safety and protection.

4. Promoting social engagement. Besides providing a sense of connectedness with other people, social engagement can also promote a sense of security because proximity to other people is generally soothing and empowering, especially to children. In order to promote safety, PFA providers can help to connect family members or friends and encourage people who are calm and coping adequately to talk with others who are distressed or not coping well. If the person is alone, PFA providers can assist them in establishing contact to people from their own country or with similar experiences.

5. Protection from exposure to additional traumatic events and trauma reminders. Taking into account the amount of stress that refugees and migrants have already experienced, it may be important, depending on individual experiences, to protect them from any stimulus that can increase the sense of danger or remind them of a traumatic event. For example, they can be spared from scenes of other people's suffering in the immediate surroundings, exposure to distressing media news (television, radio, and internet), reporters and other media professionals inquiring about their traumatic experiences.

Step 4: Helping with stabilisation

People who experienced some kind of a crisis or drastic changes in social and living conditions may be emotionally overwhelmed. However, most expressions of strong emotions are expectable and normal reactions to distressing events and they do not require more than a supportive contact. Consequently, most people will not require stabilisation. They can be advised to get adequate rest and diet, to engage in positive distracting activities and to try to maintain a normal daily routine to the extent possible. But for individuals whose reactions interfere with their ability to function or respond to guidance, stabilisation may be needed. A detailed description of visible behavioural and emotional signs that can be used to identify such individuals can be found in Table 2 in *Triage* section.

Once they identify individuals in severe distress, PFA providers can use several simple strategies to stabilize them and help them function on their own. If the person is accompanied by family members of friends, they can be asked to help in comforting and providing emotional support. If the person is alone, he or she can be escorted to a quiet, private place. PFA providers should first give them few minutes alone while remaining close and available if the person requires help. During the intervention, it is important to try to address the person's immediate concern or difficulty, instead of just convincing them to calm down. To orient emotionally overwhelmed individuals, PFA providers should remain calm, help the person focus on specific manageable feelings and solvable problems, orient them to the surroundings, describe emotional reactions to traumatic events and explain simple strategies to cope with them (e.g. breathing deeply, stretching, going for a walk, practising muscle relaxation techniques). In such situations it should be assessed how much information is the person able to take in, and whether he/she is experiencing overly intense emotions and having difficulty to concentrate and understand what is being said. If the person appears extremely agitated, disoriented and seems to be losing touch with the surroundings, it may be helpful to refocus attention by asking the individual to listen and look at the helper, check whether the person knows where she is and what is happening, ask him/her to describe the non-distressing features of the current surroundings or to make contact with the environment or themselves (e.g. feel their feet on the floor, tap their hands on their lap).

In more severe cases of emotional distress a practical grounding technique, described in Box 3 in *Triage* section, can be used. If none of this helps to stabilize the person, the PFA provider should consult with or refer him/her to a MH professional.

Step 5: Gathering information on current needs and concerns

The goal of this core action is to identify immediate needs and concerns of the refugees and migrants and gather additional information on how to meet them. This core action is actually performed throughout all eight core actions of PFA, depending on the context of delivery.

During the conversation, it is useful to focus on concerns about immediate post-resettlement circumstances, separation from or concern about the safety of loved ones, death of a family member or close friend, personal losses in the adversity (home, school, business, neighbourhood, personal property, money), availability of adequate social support (family,

friends, community members) and extreme negative emotions (e.g. guilt, shame). If an individual shows signs of severe distress or adverse reactions that are stronger than those expected in the given situation (e.g. significant impairment in daily functioning), PFA provider should also check for any prior psychological problems or thoughts about causing harm to self and others, especially if the person has not previously gone through the process of triage. Although it is not advisable to pressure people to recount traumatic experiences and related emotions in detail, it can be useful to ask the person if he/she wants to talk about the nature and severity of the events that made him/her leave the country (especially if the person has a history of exposure to trauma). In doing so, it is really important to let the individual lead the discussion and reveal only what he/she feels comfortable with. If they don't want to discuss such experiences, PFA providers should respect that and only let them know that they can talk about it with a professional in the future. In the end, it is useful to ask a general open-ended question to make sure that no important information is missed (e.g. „*Is there anything else we have not talked about that might be important to know?*").

By asking these questions, PFA providers can gain insight into concerns and needs that require the most attention and modify other PFA core actions accordingly. In addition, this can help identify individuals who need immediate referral to a specialist, additional services or a follow-up contact. For example, persons who have thoughts about hurting self or others should be immediately escorted to a health care professional. Those who lack adequate supportive social network or have prior psychological problems can be linked with appropriate services and offered with a follow up meeting. While performing this activity, PFA providers should use their judgment about how to gather this information, how much information to gather, and to what extent to ask questions, while remaining sensitive to the needs of the person. If the survivor has multiple concerns, they should be ordered by priority.

Step 6: Providing practical assistance

Once the immediate needs and concerns have been identified, PFA providers can help refugees and migrants address them. Assisting survivors with current or anticipated problems is a central part of PFA considering that such problems can increase the level of distress and distract them from self-care.

In the prolonged crisis, people are often not aware what needs must be dealt with right away, and what can wait for a while. If the person has several needs or current concerns, they should be ordered by priority and handled one at a time. Basic needs such as providing food, water, clothes, sanitation and medical help or contacting a family member should be immediately addressed. For those needs and issues that cannot be rapidly solved (e.g. locating a missing family member or a friend, asylum claim, application for EU relocation program), PFA providers can discuss what the person has done so far, propose additional possibilities, explain the necessary procedures and help the person in taking concrete actions that address the problem (e.g. contacting family reunification services, helping them to complete the paperwork for asylum claim). In doing so, it is important to inform refugees and migrants what they can realistically expect in terms of potential resources, qualification criteria and application procedures. In addition, PFA providers should encourage people to as much as

they can for themselves in order to reduce the feeling of helplessness, unless the circumstances limit the person's ability to act on their own.

Step 7: Promoting social support

The resettlement process can undermine supportive links between family and community members. This core action focuses on helping people to establish ongoing contacts with primary support persons such as family members and significant others, and to seek out other sources of support. Social support is very important in the recovery process because it provides people with opportunities for a range of activities (sharing information, experiences and concerns, participation in joint activities), ensures practical and material assistance and gives people a feeling that they are needed and appreciated by others.

Most people will want to contact their family members, close friends and neighbours who are not currently with them, whether they remained in the country of origin, are already in the destination country or got separated during the journey. PFA providers can help people reach these individuals by phone, e-mail, through social media or services for tracing missing relatives. People who are completely alone should be encouraged to seek out other available sources of social support, such as other affected persons or relief workers. For example, elderly individuals could be connected with a younger adult or volunteer who can provide social contact and assistance with daily activities or they can be asked to assist families by spending time with their children. Similar-age children could be included in shared activities. Religious people can be connected with individuals from the same faith traditions and offered to pray together or participate in a religious service, if feasible. Some people may be unwilling to seek support because they are embarrassed, don't want to be a burden to others, think that others don’t want to listen or can’t understand them or even because they don't know what they need and where to seek help. Such individuals can be encouraged to think about the type of support that would be most helpful to them and to choose specific ways in which they would like to be involved with other people.

Step 8: Providing information on coping

Refugees and migrants have probably experienced many extremely stressful events in their country of origin or during resettlement. Consequently, they may feel overwhelmed, or distressed, and experience extreme fear and worries, outbursts of strong emotions such as anger and sadness, nightmares and other sleep problems. Many are affected by multiple losses and are grieving for people, places and life left behind. During their journey, some have been separated from family members, robbed, exposed to extremely harsh environmental conditions or have witnessed death of fellow travellers or family members. They may feel fearful or anxious, numb and detached. In addition, a lot of emotional suffering is directly related to current stresses, worries, and uncertainty about the future. Although PFA does not focus on treatment of psychological problems, it provides a good opportunity to strengthen coping behaviours of refugees and migrants. The goal of this core action is to provide information about stress reactions and coping in order to reduce distress and promote adaptive functioning.

Stress reactions caused by crisis events and resettlement process may be alarming for refugees and migrants. Some may be frightened by their own responses and others may view their reactions in negative and distressing ways (e.g. thinking that something is wrong with them, that they are weak or crazy). Some may have positive reactions such as appreciating life, family and friends, or strengthening of spiritual beliefs and social connections. It is therefore important to discuss the reactions they are experiencing, to describe common reactions to stressful events and to clarify that these reactions naturally arise from many stressors they face. This is particularly relevant for individuals who have had significant exposure to trauma or experienced loss of a close person. The detailed description of common reactions to stressful events is provided in Box 6 to orient PFA providers when providing information. When speaking about problematic reactions of refugees and migrants, PFA providers must take care to avoid pathologizing people's responses or use terms like "symptoms" or "disorder" because that might inflict unnecessary stigmatization. It is also crucial to inform them that if their reactions continue to interfere with their ability to function adequately for over a month, they should consider help from a MH professional.

In addition to providing information on stress reactions, it may be helpful to discuss ways of coping with stressful reactions and problems, distinguish between positive and negative coping actions and to encourage the positive ones. This may make people aware of the negative consequences of maladaptive coping actions, help them choose the appropriate strategy to cope and enhance a sense of self-efficacy. Positive coping actions are those that help to reduce anxiety, lessen other distressing reactions and promote adaptation to the situation. They include as talking to another person for support, getting adequate rest and nutrition, exercising, maintaining a daily routine, engaging in positive distracting activities, adapting expectations, setting and achieving goals, using relaxation methods and seeking counselling. On the other hand, negative coping actions such as using alcohol or drugs, passivity, social isolation or withdrawal, anger or aggressiveness, not taking care of themselves, risky behaviour, blaming of self or others can worsen the problem. When there is enough time to discuss coping strategies in more detail, PFA providers can demonstrate simple relaxation exercises, anger management techniques or sleep improvement guidelines if the person is interested.

Step 9: Linking with collaborative services

This core action links refugees and migrants with services needed at the time and informs them about available services that may be needed in the future. Linking individuals with collaborative services increases a sense of hope and safety. This includes immediate services that are available at the place where PFA is provided, as well as referral procedures for future specialised care. Because many refugees and migrants are reluctant to seek help on their own, this PFA component aims to increase the possibility of help seeking by offering early assistance and access to relevant services.

If the refugee or migrant during PFA contact states a need that requires additional help which goes beyond the competence of the provider or expresses needs for some additional service, the PFA provider should do all that is necessary to ensure that the person gets access to the

service (e.g. arrange a meeting with an agency representative who can provide the service, accompany the individual to the agency). For potential issues in the future, refugees and migrants can be provided with a list of resources and available services. If the individual has significant difficulties in daily functioning or prolonged and severe distress, he/she will need a referral to a specialised MH professional. Instructions on how to make a successful referral are described in more detail in the next section.

Box 6 Common reactions when terrible things happen[34,38]

There is a wide variety of positive and negative reactions that survivors can experience. These include:

	Negative responses	Positive responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviours
Physiological	Fatigue, headache, muscle tension, stomach-ache, increased heart rate, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

Common negative reactions that may continue include:

Intrusive reactions

- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again (“flashback”)

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being "on the lookout" for danger, startling easily, or being jumpy
- Irritability or outbursts of anger
- Difficulty falling or staying asleep, problems concentrating or paying attention

Trauma and Loss reminders

- Places, people, sights, sounds, smells, and feelings that remind you of trauma or loss
- Can bring on distressing mental images, thoughts, and emotional/physical reactions

Common examples include: sudden loud noises, destroyed buildings, the smell of fire, sirens of ambulances, locations where they experienced the trauma, seeing people with disabilities, funerals, anniversaries of the trauma, and television/radio news about the trauma

(Quoted directly, page 131)

7 Referral

Rationale

As the number of refugees and migrants increases, governments are struggling to improve current health care services. For example, the Centre for Disease Control and Prevention recent guideliness[39] include MH screening as a part of domestic medical examination for newly arrived refugees and migrants. However, questions emerge regarding the extent to which refugees and migrants are able to access MH services. Following the stepped model of care (Figure 5), for the majority of refugees and migrants ensuring basic needs and security will be sufficient. For a smaller number of individuals help in accessing key community (e.g. support groups, youth clubs, educational activities) and family supports (e.g. family tracing and reunification) will be sufficient to maintain MH and psychosocial well-being. Even smaller number of refugees and migrants will additionally require more focused, non-specialised support guided by PFA providers. Finally, the smallest number of refugees and migrants, who may have significant difficulties in basic daily functioning, will need access to specialised services. This assistance could include referral to specialised services, if they exist (e.g. psychological or psychiatric support) or initiation of longer-term training and supervision of primary health care providers[3] who will become competent to provide such services.

However, this "top layer" of stepped model of care might still encompass a large number of refugees and migrants. Based on previously mentioned research on high prevalence of serious MH problems in these populations, some authors caution that the assumption that majority of affected population will not develop mental illness might be wrong.[30] For example, about 30% of refugees and migrants screened with the Refugee Health Screener score above the scale cut-off, indicating that referral is needed.[69] Therefore, measures should be taken to ensure easy access to MH care for refugees and migrants in need.

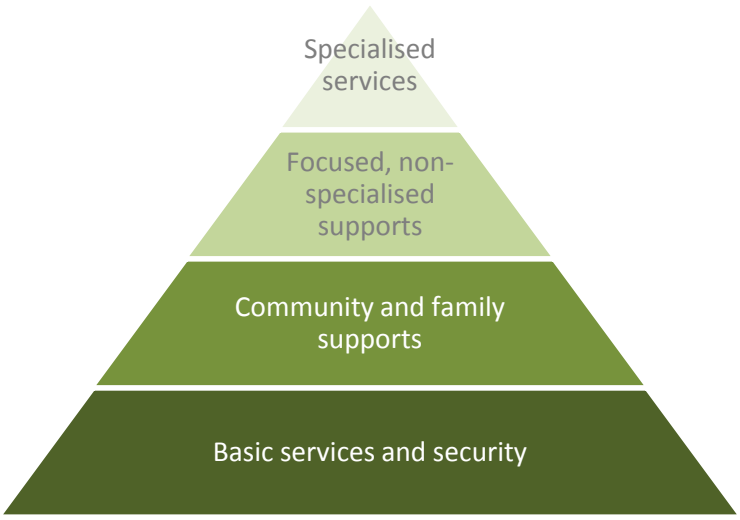


Figure 5 Stepped model of care[3]

Procedures

Even when MHPSS services are available, refugees and migrants may still be unable to access them. One important reason may be lack of financial resources to pay direct or indirect costs, such as treatment itself, transport or medication. There are also other factors that may influence access to MHPSS services, as language barriers, gender and help-seeking behaviour, lack of knowledge, and stigma around psychosocial distress and mental illness.[44,45,70] Therefore, referral should not be considered a routine issue; rather, special care should be given to remove potential barriers, having in mind that it is crucial to help the individual to access adequate care. Guided by the principles of successful referral shown in Box 7, we propose three main steps in referral:

1. Explaining the referral to the refugee or migrant.
2. Ensuring accessibility of services.
3. Continuity of care.

Step 1: Explaining the referral

The importance of referral should be explained in a non-stigmatising manner, focusing on the potential benefits for the refugee or migrant. In addition, procedure should be carefully explained: to who the care provider is referring the migrant or refugee, what information will be provided, and confidentiality should be emphasized. For example, the care provider could say:[49(p 23)]

> *"Sometimes people need help through a difficult time. I would like to connect you to a counsellor. This is a type of healthcare worker who will listen to you and provide help and support. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?"*

Step 2: Ensuring accessibility of services

In order to help refugee or migrant to access the available services, the care provider should proactively address potential barriers. The care provider who is referring the refugee or migrant should be aware of options for MH care services accessible to the individual, and preferably make the appointment herself/himself. In addition, the care provider should help the refugee or migrant tackle practical obstacles in accessing help, such as paying for the treatment, transport, child care options etc. Furthermore, the care provider should be well informed about available services in the local context. Referral paths and collaboration should be established with specialists who are able to offer evidence-based treatments (medication and therapy).

Box 7 Principles of successful referral[45]

Active care coordination

- Direct referral to MH provider (e.g. making appropriate referral on client's behalf, assisting with scheduling of the first appointment).
- Good communication between referring and receiving providers (e.g. discussing referral, case-specific education, sharing case files and assessment results, consultation and ongoing contact after initial referral).
- Good case management (e.g. help in identifying appropriate services, providing information on MH services and how to access them, coordinating discharge planning after psychiatric hospitalization).

Establishing trust and identifying mental health symptoms

- Trust developed through family or ethnic community leaders, health or non-health providers (e.g. referral made by non-MH providers, such as primary care providers, nurses, language learning programs, interpreters).
- Proactive identification of MH symptoms (e.g. accessing MH services through staff not directly involved with MHPSS delivery).
- Access to imbedded MH or referral coordinators (e.g. MH providers embedded in health or non-health settings).

Proactive resolutions of access barriers

- Psychoeducation (e.g. about the process and benefits of accessing MH services, differences between Western and cultural specific MH concepts, roles of different health providers, payment for MH services).
- Interpreters (e.g. interpreter support available for MH appointments and referral).
- Transportation (e.g. providers help arrange transportation for MH appointment like medical taxi drivers).
- Follow up (e.g. reminders about the appointment, contacting the client after the initial appointment to ask how it went, offering additional help such as rescheduling when necessary).

Culturally responsive care

- Knowledge of refugees' culture (e.g. adapting treatment to be culturally relevant, using appropriate language to discuss MH and wellbeing).
- Flexibility to meet in client's home (e.g. because of fear of being stigmatized).
- Multidisciplinary care (e.g. advocacy and assistance to receive additional services and resources, helping with paperwork for medical assistance).

Step 3: Continuity of care

Continuous care should be provided. In practical terms this means that it is important, to the extent possible, to minimize the need of refugees and migrants explaining their situation over and over again and telling their story to each care provider. With the permission of the refugee

or migrant, it would be best if results of assessment and other information gathered during the triage or screening, as well as information on provided support, be shared with the specialised MH care provider. For example, standardised worksheets explaining refugee or migrant needs and PFA components provided can be used (examples shown in Figure 6 and Figure 7). Informing the new provider about the individual is helpful and if possible, making introduction between the individual and helper facilitates the process.[38] It is also recommended that the referring care provider follows-up with the refugee or migrant after the first appointment with a specialised MH care provider.

Provider Worksheets

Survivor Current Needs

Date: _____ Provider: _____

Survivor Name: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
☐ Extreme disorientation	☐ Acute stress reactions	☐ Headaches	☐ Inability to accept/ cope with death of loved one(s)
☐ Excessive drug, alcohol, or prescription drug use	☐ Acute grief reactions	☐ Stomachaches	☐ Distressing dreams or nightmares
☐ Isolation/ withdrawal	☐ Sadness, tearfulness	☐ Sleep difficulties	☐ Intrusive thoughts or images
☐ High risk behavior	☐ Irritability, anger	☐ Difficulty eating	☐ Difficulty concentrating
☐ Regressive behavior	☐ Feeling anxious, fearful	☐ Worsening of health conditions	☐ Difficulty remembering
☐ Separation anxiety	☐ Despair, hopelessness	☐ Fatigue/exhaustion	☐ Difficulty making decisions
☐ Violent behavior	☐ Feelings of guilt or shame	☐ Chronic agitation	☐ Preoccupation with death/destruction
☐ Maladaptive coping	☐ Feeling emotionally numb, disconnected	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____		

2. Check the boxes corresponding to difficulties the survivor is experiencing.

☐ Past or preexisting trauma/psychological problems/substance abuse problems
☐ Injured as a result of the disaster
☐ At risk of losing life during the disaster
☐ Loved one(s) missing or dead
☐ Financial concerns
☐ Displaced from home
☐ Living arrangements
☐ Lost job or school
☐ Assisted with rescue/recovery
☐ Has physical/emotional disability
☐ Medication stabilization
☐ Concerns about child/adolescent
☐ Spiritual concerns
☐ Other: _____

3. Please make note of any other information that might be helpful in making a referral.

_____

_____

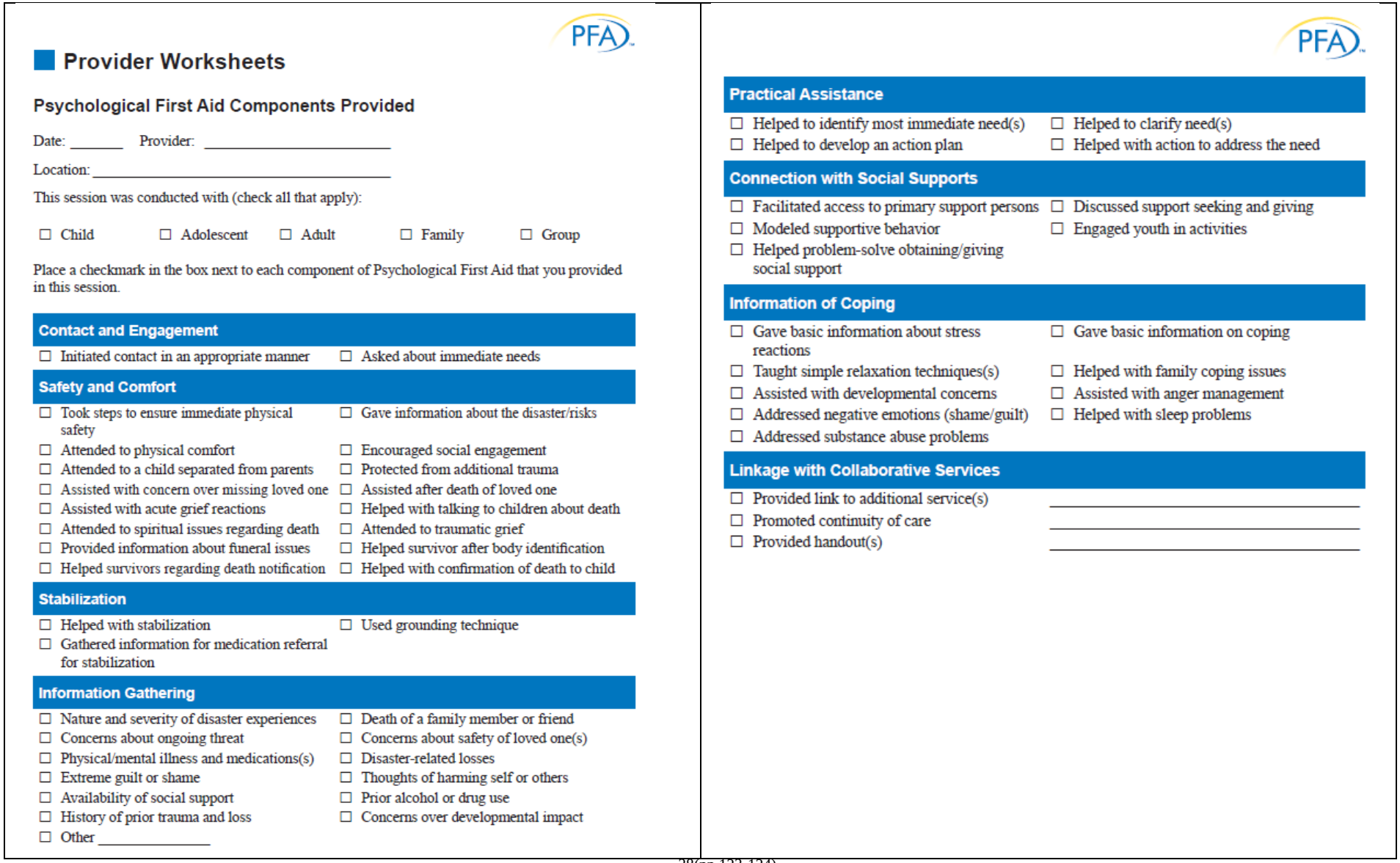
4. Referral

☐ Within project (specify) _____
☐ Other disaster agencies
☐ Professional mental health services
☐ Medical treatment
☐ Substance abuse treatment
☐ Other community services
☐ Clergy
☐ Other: _____

5. Was the referral accepted by the individual?

☐ Yes
☐ No

Figure 6 Worksheet on survivor current needs[38(pp 121-122)]



Provider Worksheets

Psychological First Aid Components Provided

Date: _____ Provider: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement

- ☐ Initiated contact in an appropriate manner
- ☐ Asked about immediate needs

Safety and Comfort

- ☐ Took steps to ensure immediate physical safety
- ☐ Gave information about the disaster/risks
- ☐ Attended to physical comfort
- ☐ Encouraged social engagement
- ☐ Attended to a child separated from parents
- ☐ Protected from additional trauma
- ☐ Assisted with concern over missing loved one
- ☐ Assisted after death of loved one
- ☐ Assisted with acute grief reactions
- ☐ Helped with talking to children about death
- ☐ Attended to spiritual issues regarding death
- ☐ Attended to traumatic grief
- ☐ Provided information about funeral issues
- ☐ Helped survivor after body identification
- ☐ Helped survivors regarding death notification
- ☐ Helped with confirmation of death to child

Stabilization

- ☐ Helped with stabilization
- ☐ Used grounding technique
- ☐ Gathered information for medication referral for stabilization

Information Gathering

- ☐ Nature and severity of disaster experiences
- ☐ Death of a family member or friend
- ☐ Concerns about ongoing threat
- ☐ Concerns about safety of loved one(s)
- ☐ Physical/mental illness and medications(s)
- ☐ Disaster-related losses
- ☐ Extreme guilt or shame
- ☐ Thoughts of harming self or others
- ☐ Availability of social support
- ☐ Prior alcohol or drug use
- ☐ History of prior trauma and loss
- ☐ Concerns over developmental impact
- ☐ Other _____

Practical Assistance

- ☐ Helped to identify most immediate need(s)
- ☐ Helped to clarify need(s)
- ☐ Helped to develop an action plan
- ☐ Helped with action to address the need

Connection with Social Supports

- ☐ Facilitated access to primary support persons
- ☐ Discussed support seeking and giving
- ☐ Modeled supportive behavior
- ☐ Engaged youth in activities
- ☐ Helped problem-solve obtaining/giving social support

Information of Coping

- ☐ Gave basic information about stress reactions
- ☐ Gave basic information on coping
- ☐ Taught simple relaxation techniques(s)
- ☐ Helped with family coping issues
- ☐ Assisted with developmental concerns
- ☐ Assisted with anger management
- ☐ Addressed negative emotions (shame/guilt)
- ☐ Helped with sleep problems
- ☐ Addressed substance abuse problems

Linkage with Collaborative Services

- ☐ Provided link to additional service(s) _____
- ☐ Promoted continuity of care _____
- ☐ Provided handout(s) _____

Figure 7 Worksheet on Psychological First Aid Components provided[38(pp 123-124)]

8 Children and adolescents

Rationale

Children and adolescents represent a vulnerable group in crisis situations due to their cognitive and socio-emotional development level. Beyond experiencing stressful events in their country of origin, they are at risk of being exposed to sickness, injury, violence, exploitation, trafficking and threats to life during their journey. Stressful events in childhood may cause severe short-term and long-term psychological issues,[71–73] so early prevention of these consequences has an important impact on children, their families and society in general.[74] Children's perceptions of traumatic events differ from adult's and depend on the child's age and characteristics of current developmental stage. In comparison with adults, children are less capable of introspecting and verbalizing their own thoughts and feelings, and can have difficulties understanding and explaining certain situations (e.g. that when someone has died, he/she will not come back), what can lead to confusion, sense of insecurity and mistakes in reasoning.[75] Furthermore, children and adolescent MH and well-being are greatly influenced by MH and well-being of their caregivers. On the one hand, the family can serve as a buffer against stress,[76] and family cohesion and adaptability and perception of high parental support predict good MH in refugee and migrant children.[77–81] On the other hand, poor parental MH has been predictive for MH problems in refugee and migrant children in a large number of studies.[82–85] In addition, studies show that parental exposure to trauma can be stronger predictor of children's MH problems then children's own exposure.[86,87] Therefore, providing information and support to parents and other caregivers is one of the most effective ways to support children.[88] However, for some children and adolescents this is not possible, since they have lost members of their family or become separated during transit.

Unaccompanied minor is a "a third-country national or a stateless person under eighteen years of age, who arrives on the territory of the (EU) Member State unaccompanied by an adult responsible for him/her whether by law or by the practice of the Member State concerned, for as long as he or she is not effectively taken into the care of such a person".[89] In most cases the decision to migrate is made by parents or family members, not by the minor himself/herself. From a legal point of view, unaccompanied children and adolescents who seek asylum must be allowed to enter EU territory while those who do not fulfil the conditions for asylum may be returned to their country of origin. Upon entrance into the EU country, unaccompanied minors are immediately referred to child protection officers, and asylum seekers are appointed with a representative.[90] EU states are also required to trace the families of minors with the assistance of international organizations, after an application for international protection is made. In addition to the risks all children and adolescents face during transit, unaccompanied minors face heightened or additional risks because they lack the protection and care of an adult. Research has shown that they often experience higher numbers of adverse events than accompanied children,[91–93] which can have serious consequences on their MH and well-being. For example, a review on MH issues among unaccompanied refugee minors suggests that they have higher levels of PTSD symptoms in comparison to general population and

accompanied refugee minors.[94] Moreover, they also report to have other difficulties, such as sleeping problems, concentration disorders, nightmares, withdrawal, anxiety, somatic symptoms, severe grief reactions and sadness, aggression, diminished interest, hyper-arousal, low self-esteem, severe guilt feelings, fatalistic view of the future, substance abuse, violent behaviour, suicidal acts, psychosis and delinquent behaviour.[92,95–97] Therefore, unaccompanied minors are particularly vulnerable group of children and adolescents and need special attention of care providers.

Procedures

General MH procedures for children and adolescents follow previously described procedures in this report, and consist of triage, screening, PFA and referral. However, these procedures need to be adapted to children's or adolescent's level of understanding and developmental stage, as well as to family context. In general, if children's or adolescent's family is present, we propose helping primary caregiver to support the child or adolescent. If not, the procedures will most likely be utilised by an appointed child protection officer or other representatives. In the text below we briefly outline some specific issues when working with children and adolescents.

Triage

When working with refugees and migrants, care providers should pay special attention to children and adolescents who have serious distress reactions. In Table 5 common reactions to traumatic events by developmental stages are presented. It is important to stress that, if accompanied, further procedures need to include primary caregivers, and is often recommended to strengthen the family system which will in turn serve to protect the children.[66]

Table 5 Common children's reactions to traumatic events by developmental stages[98]

Growth stages (years)	Reactions to traumatic events
Infancy (0-4)	• Clinging more to their parents • Worrying that something bad will happen • Regression to younger behaviour • Changes in sleeping and eating patterns • Increases in crying and irritability • No interest in playing or playing in an aggressive way • Fear of things that did not frighten them before • Hyperactivity and poor concentration • They can be very sensitive to how others react
Early childhood (4-6)	• Clinging behaviour or over independence • Anxiety, fear of things and situations • Regression to younger behaviour • Sleeping and eating problems • Irritability • No interest in playing or playing repetitive games • Inactivity • Confusion or impaired concentration • Sometimes taking an adult role (tries to comfort the parents/siblings) • Stop talking • Physical symptoms like stomach aches
Middle childhood (6-12)	• Swinging level of activity • Confused with what happened • Withdrawal from social contact • Talking about the event in a repetitive manner • Fear • Negative impact on memory, concentration and attention • Sleep and appetite disturbances • Aggression, irritability or restlessness • Somatic complaints with no apparent cause • Concerns about other affected people • Self-blame and guilt
Adolescence (12-18)	• Feeling self-conscious, exposed and different from others • Guilt or shame • Sudden changes in interpersonal relationships • Major shift in views of the world and attitude • Attempt to make major life changes to become an adult. • Increase in risk-taking behaviour • Self-destructive behaviour (e.g. substance abuse) • Avoidant behaviour • Aggression • Intense grief • Feeling hopeless • Concerns about other affected persons • Becoming self-absorbed and feeling self-pity • Defiance of authorities/parents • Relying heavily on peer groups in socialising

Screening

Conducting MH screening is especially challenging with children. While most screening instruments developed for adults can be used with adolescents (for example, previously described RHS-13 screening tool), they are not usually appropriate for younger children. Because of undeveloped or limited verbal communication and less developed introspective and self-assessment skills, during infancy and early childhood parents or caregivers usually report child's symptoms; a procedure not applicable for unaccompanied children. In addition, cultural and language barriers might be more pronounced while working with children. Therefore, formal screening of children's MH needs might not be necessary. Rather, support should be given to all children and adolescents by enhancing parenting abilities and providing information on supporting children after traumatic events.

However, when working with unaccompanied minors, care providers can use different visual stimuli to assess children's distress. For example, a simple visual scale can help children recognise their emotions[99(p 63)] (Figure 8). Since emotions have visual character, this can be more appropriate for children's concrete way of thinking. The intensity of certain emotions or pain may be displayed by colored pencils, for example in different intensity of red color for anger. Care providers can also ask children to draw how they feel, psychologically (i.e. emotions) or physiologically.

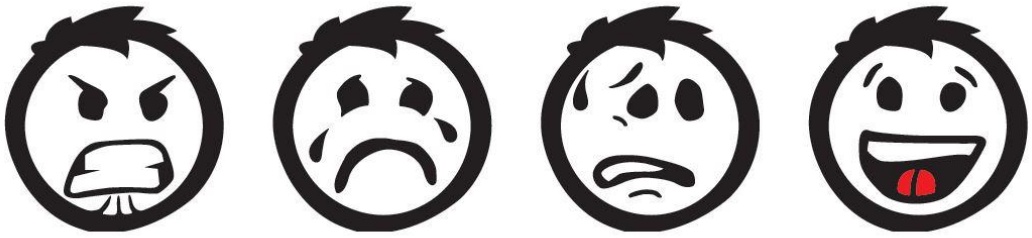
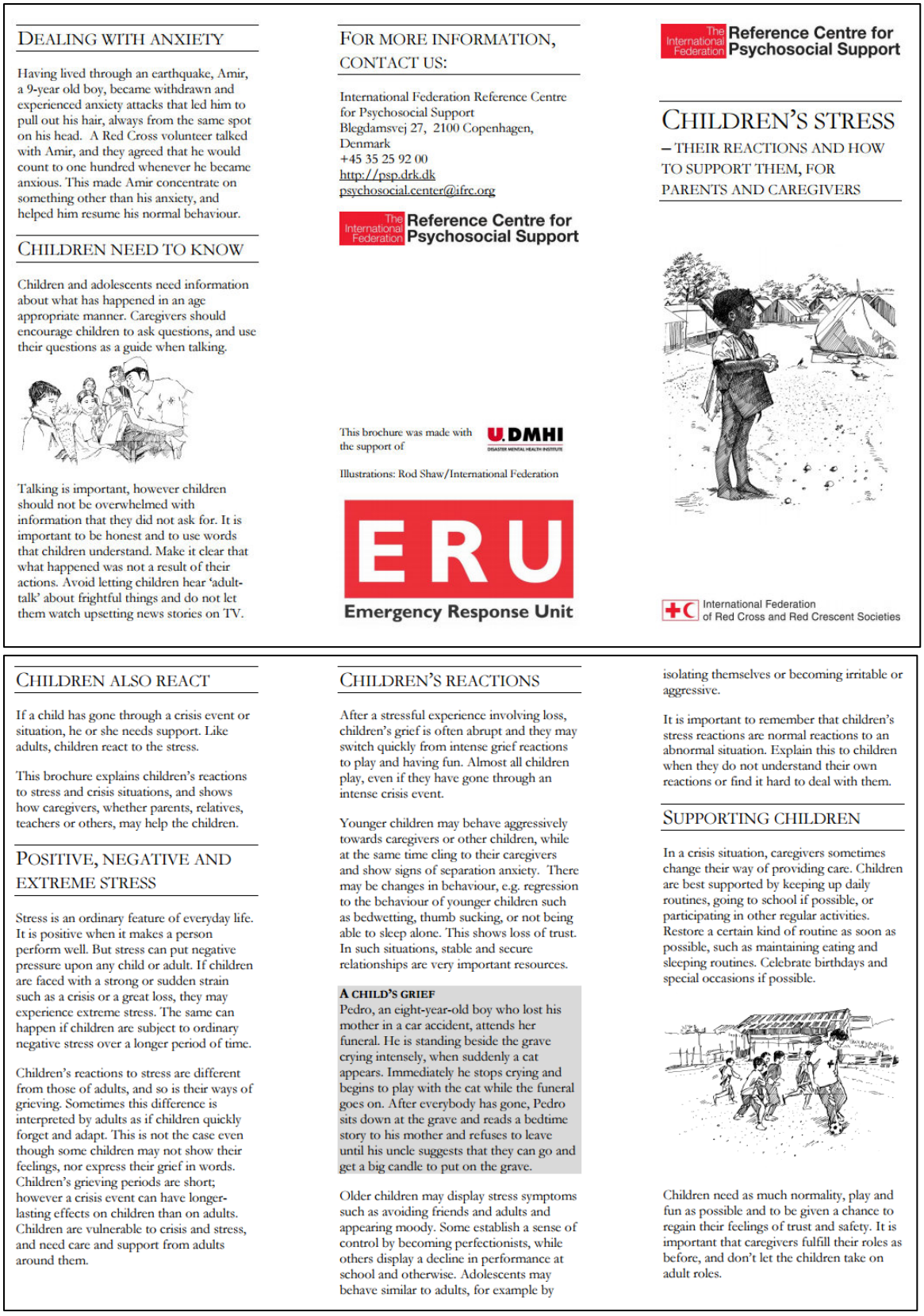


Figure 8 Visual scale for recognising emotions (from left to right: anger, sadness, worry, happiness)

Psychological first aid

Psychological first aid for children follows the same procedure as PFA for adults, while specific core activities need to be age appropriate. Hence, the language used by PFA providers needs to be modified to be understandable to children; activities can be developed for group-level use, and the emphasis in all activities has to be placed on specific developmental concerns and needs of children in different age groups. PFA for children is intended to be delivered primarily through parents and other caregivers, whenever possible, due to their previously mentioned importance in child welfare. Supporting caregivers with already outlined PFA core actions, helps to establish the adult protective shield which is the best possible way to reduce the children's level of distress in crisis situations.[100] In addition, PFA providers can further educate parents on children's reactions to stressful events and ways in which they can help their children stabilize and cope with such events. An example of a

leaflet that can be used for psychoeducation of parents and other caregivers can be seen in Figure 9.



DEALING WITH ANXIETY

Having lived through an earthquake, Amir, a 9-year old boy, became withdrawn and experienced anxiety attacks that led him to pull out his hair, always from the same spot on his head. A Red Cross volunteer talked with Amir, and they agreed that he would count to one hundred whenever he became anxious. This made Amir concentrate on something other than his anxiety, and helped him resume his normal behaviour.

CHILDREN NEED TO KNOW

Children and adolescents need information about what has happened in an age appropriate manner. Caregivers should encourage children to ask questions, and use their questions as a guide when talking.

Talking is important, however children should not be overwhelmed with information that they did not ask for. It is important to be honest and to use words that children understand. Make it clear that what happened was not a result of their actions. Avoid letting children hear 'adult-talk' about frightful things and do not let them watch upsetting news stories on TV.

FOR MORE INFORMATION, CONTACT US:

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ERU
Emergency Response Unit

The International Federation Reference Centre for Psychosocial Support

CHILDREN'S STRESS

– THEIR REACTIONS AND HOW TO SUPPORT THEM, FOR PARENTS AND CAREGIVERS

International Federation of Red Cross and Red Crescent Societies

CHILDREN ALSO REACT

If a child has gone through a crisis event or situation, he or she needs support. Like adults, children react to the stress.

This brochure explains children's reactions to stress and crisis situations, and shows how caregivers, whether parents, relatives, teachers or others, may help the children.

POSITIVE, NEGATIVE AND EXTREME STRESS

Stress is an ordinary feature of everyday life. It is positive when it makes a person perform well. But stress can put negative pressure upon any child or adult. If children are faced with a strong or sudden strain such as a crisis or a great loss, they may experience extreme stress. The same can happen if children are subject to ordinary negative stress over a longer period of time.

Children's reactions to stress are different from those of adults, and so is their ways of grieving. Sometimes this difference is interpreted by adults as if children quickly forget and adapt. This is not the case even though some children may not show their feelings, nor express their grief in words. Children's grieving periods are short; however a crisis event can have longer-lasting effects on children than on adults. Children are vulnerable to crisis and stress, and need care and support from adults around them.

CHILDREN'S REACTIONS

After a stressful experience involving loss, children's grief is often abrupt and they may switch quickly from intense grief reactions to play and having fun. Almost all children play, even if they have gone through an intense crisis event.

Younger children may behave aggressively towards caregivers or other children, while at the same time cling to their caregivers and show signs of separation anxiety. There may be changes in behaviour, e.g. regression to the behaviour of younger children such as bedwetting, thumb sucking, or not being able to sleep alone. This shows loss of trust. In such situations, stable and secure relationships are very important resources.

A CHILD'S GRIEF
Pedro, an eight-year-old boy who lost his mother in a car accident, attends her funeral. He is standing beside the grave crying intensely, when suddenly a cat appears. Immediately he stops crying and begins to play with the cat while the funeral goes on. After everybody has gone, Pedro sits down at the grave and reads a bedtime story to his mother and refuses to leave until his uncle suggests that they can go and get a big candle to put on the grave.

Older children may display stress symptoms such as avoiding friends and adults and appearing moody. Some establish a sense of control by becoming perfectionists, while others display a decline in performance at school and otherwise. Adolescents may behave similar to adults, for example by isolating themselves or becoming irritable or aggressive.

It is important to remember that children's stress reactions are normal reactions to an abnormal situation. Explain this to children when they do not understand their own reactions or find it hard to deal with them.

SUPPORTING CHILDREN

In a crisis situation, caregivers sometimes change their way of providing care. Children are best supported by keeping up daily routines, going to school if possible, or participating in other regular activities. Restore a certain kind of routine as soon as possible, such as maintaining eating and sleeping routines. Celebrate birthdays and special occasions if possible.

Children need as much normality, play and fun as possible and to be given a chance to regain their feelings of trust and safety. It is important that caregivers fulfill their roles as before, and don't let the children take on adult roles.

Figure 9 Psychoeducation leaflet on supporting children (*retrieved form: http://mhpss.net/?get=83%2F1305723318-2._Brochure_on_support_to.pdf*)

When children or adolescents are unaccompanied, or primary caregivers are temporarily unable to adequately take care of them (because of physical injuries or severe distress), PFA can be provided directly to children and adolescents. The key principle of PFA with unaccompanied minors is to reunite them with their caregivers whenever possible. If this is not possible, PFA providers should ensure that the child is never left unattended and should link him/her with appropriate child protection network or agency. In Table 6 we outline several specific activities within each of the eight PFA core actions that can be used with such children until they're linked with family members or appropriate services.

Table 6 PFA activities for children

Contact and Engagement	When making contact with children or adolescents, the PFA provider should get on the child's eye level (sit down, squat), smile, speak slowly, calmly and use developmentally appropriate language (concrete and in short sentences)., ask simple open ended questions while focusing on child's most immediate needs. Example: Hi, I'm ____ and I work with ____. I'm here to try to help you. May I ask your name? Nice to meet you ____. Is there anything you need right now?
Safety and Comfort	It is important to remove the child from any disturbing or stressful situations, (including very upset or suffering adults and exposure to distressing media information) and to create a child friendly-space with available calming, and reassuring activities (colouring books, art projects, building blocks). The child should be connected with adults who are calm and cope well with the situation. Physical comfort can be provided with toys or other age appropriate objects. For children whose family members or close friends have died, PFA providers can help them deal with acute grief reactions by comforting them acknowledging their emotions, engaging them in distracting and relaxing activities, establishing their daily routine and assisting with practical matters.
Stabilization (if needed)	Children who are very distressed, agitated and confused can be stabilized with the same relaxation and grounding techniques as adults with modifications to ensure age-appropriateness. For example, breathing exercises can be explained by blowing bubbles with a bubble wand, using chewing gum or blowing paper balls across the table. Child's attention can be refocused by asking them to name the colours in their surroundings, or imitate sound they hear.
Information Gathering	When working with children, it is important to gather information on name, age, country of origin, family and relatives (where they saw their parents last time, where they might be now, are there any other relatives) as well as their emotional and physical condition. This must done in a careful and thoughtful way because children have a limited understanding of the situation compared to adults and can misinterpretation events.
Practical Assistance	As with adults, PFA providers can help children identify and clarify their most immediate needs and do whatever they can to help them.
Social Support	PFA providers should first help children contact their primary caregivers or other close others who could take care of them. Social support can also be fostered by bringing unaccompanied children together, encouraging group events and facilitating fun activities (playing games, drawing, song singing, telling stories, and organising sport activities). Older children and adolescents can be asked to take care for and lead younger children in various activities.
Information on Coping	When talking about physical and emotional reactions to stress with children, PFA providers can describe different feelings and physical sensations and ask children to pick the ones they are experiencing or even draw an outline of the person to help them explain how they're feeling by themselves. To help children understand positive and negative forms of coping, PFA providers can write them on a paper, have the child pick the ones that he/she is currently using and discuss the ways the child can increase their adaptive coping strategies.
Linkage with Collaborative Services	Unaccompanied children should be linked with child protection officer and family reunification services immediately upon arrival. If deemed necessary, they should be further referred to a paediatrician or MH professional.

9 Additional topics

Training and expertise

Providing MHPSS to people in need requires specific knowledge. However, not all types of interventions require the same level of expertise; as the needs of the affected people increase, so does the need for training the care givers[54] (Figure 10). In the text below we briefly discuss training needs and expertise level for the proposed model of MHPSS care.

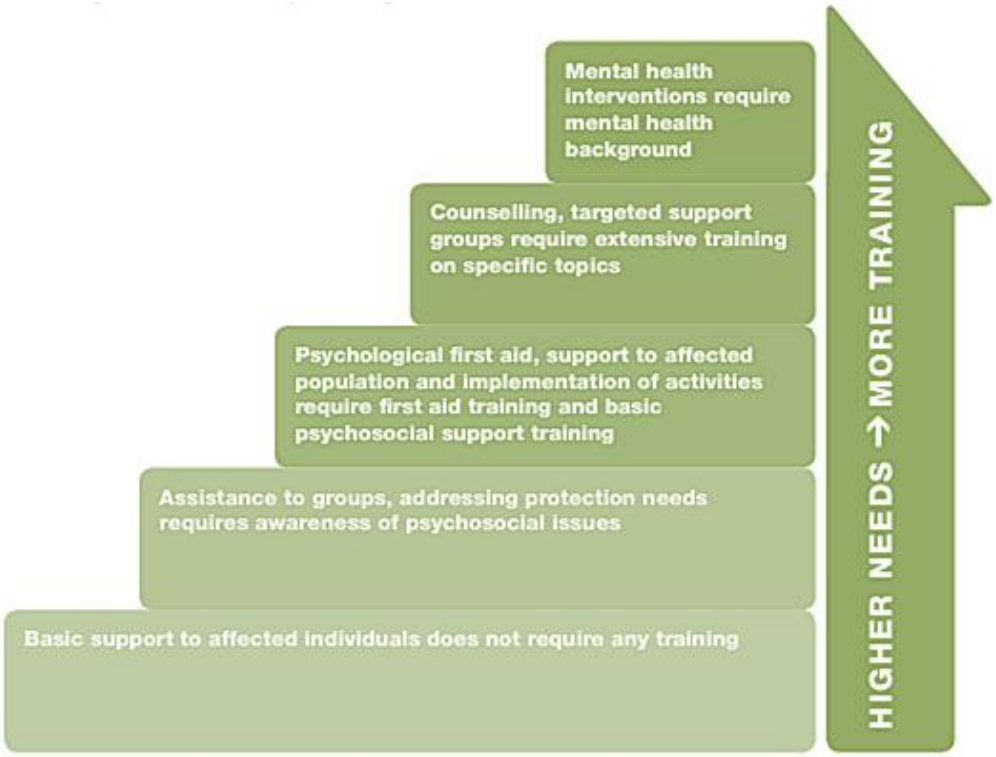

Figure 10 Needs for training for different levels of support[54]

MHPSS should be conducted in a multi-disciplinary setting, and integrated in all types of services offered (e.g. overall health system, shelters, water and sanitation, food and non-food item distribution, cultural immersion, language acquisition, social welfare). Therefore, every provider group working with refugees and migrants should have basic training in MHPSS, which should include the role of MHPSS in overall refugee services, and recognising behavioural signs of distress (Table 2).

Additional training should be provided for those care providers who will conduct triage. These care providers can be MH professionals (such as psychologists, psychotherapists, psychiatrists, psychiatric nurses), but also trained lay persons (emergency services or other psychosocial professions, as well as volunteers). Training should include: establishing confidential and trustful contact, assessing distress, resources and danger to safety (Table 3),

psychological first aid and supportive communication, and cultural framework for working with different groups of refugees.

Since MH screening should most likely be conducted within primary health care units, it is recommended that specific care providers be appointed. These care providers can have different professional backgrounds (medical doctors, nurses, psychologists, social workers etc.), however, specific training should be organised to provide competencies for brief MH assessment and PFA. In addition to training for triage, these care providers should be trained in administering the screening instrument, making referrals and providing first psychological aid within the specific setting. Considering different professional backgrounds, training for professional care providers should take one day, while for other personnel and volunteers two day training programmes should be organized.

Finally, an important training topic for all providers working with migrants and refugees is self-care and burnout prevention. Training should include recognising signs of stress and burnout and self-help techniques. This training can be provided within one or two days, depending on assessment of needs of a specific target group.

Working with interpreters

Since care providers speaking the language of particular refugee or migrant group are scarce, interpreters are essential in provision of MHPSS. Working with interpreters should not only address language barriers, but also understanding the cultural, social and contextual variables of refugee and migrant difficulties and life circumstances that can provide vital information to the care provider and mitigate issues of discrimination or lack of acknowledgement of different cultural constructions and world views. Furthermore, it has been suggested that the use of qualified interpreters in early MH interventions is not only good clinical practice but may be cost effective as the costs of inadequate diagnosis and referral might be higher than hiring qualified interpreters.[101] Therefore, special care should be devoted to ensuring good communication between the care provider, interpreter and refugee or migrant. Some issues should be taken in consideration when having a mediated communication in any form of providing MH care:[41]

Knowing the language of the refugee or migrant. Although this sounds self-evident, many refugees and migrants come from areas that have multiple ethnicities and languages. For example, although Arabic is the official language in Syria several dialects are used, depending on the region. In addition, Kurdish is widely spoken in the Kurdish regions, and Armenian and Syrian Turkmen among Armenian and Turkmen minorities. Therefore, it is important to know the native language, and try to match the interpreter, ideally from the same country and, when necessary, the same dialect that the refugee or migrant speaks.[101]

Using a professional interpreter. It is best to use a professional, qualified interpreter. Using family, friends or community members as interpreters in not recommended, since it can hinder feelings of safety and confidentiality and lower the quality of communication.

Matching interpreter and refugee or migrant gender. Whenever possible, it is good that refugees and migrants can choose the gender of interpreter, but also of the care provider. Both men and women may avoid disclosing their adverse experiences to male care providers because of shame or fear of being judged.[26] This is of special importance when history of sexual assault is probable or if there are culturally specific gender norms of behaviour. This seems to be less critical for men who may be used to women being in a "helper" role than for women who may be forbidden from discussing certain issues in front of a male care provider.[41]

Matching interpreter and refugee or migrant age. An older refugee or migrant may not feel comfortable discussing confidential or personal matters with a much younger interpreter, especially in cultures where age equals authority and respect.

If there are more than one meeting with the refugee or migrant, **having the same interpreter** will make the process easier, facilitate communication and is likely to lead to better outcomes.[101]

Working with interpreters can be divided into three sections: before, during and after meeting.[41] Every part contains some specific topics that should be addressed so that the needs of refugees and migrants can be met.

Before the meeting. A few minutes before the meeting, care provider should meet alone with the interpreter to get an insight in usual customs (e.g. regarding touching people, using appropriate eye contact, or special topics to consider in terms of culturally appropriate approach to specific groups (e.g. elderly, children, women). The interpreter should also be aware if a distressing topic is expected to be discussed (i.e. traumatic experiences) so that he/she could be emotionally prepared. One of the most important topics to discuss before meeting the refugee or migrant is that the interpreter might be confused if the refugee or migrant appears or sounds unusual or the answers may not "make sense". In this case, the interpreter should interpret word for word and not "adjust" the message to make sense. It is essential in a MH assessment for care providers to know if the refugee or migrant is swearing, speaking emotionally, not answering directly etc. Discordant speech may help to diagnose a condition or indicate a reaction to a medication. Below is a sample script that care providers can use for briefing with the interpreter:[41(p 87)]

> *"Hi, my name is XY and I am a PO. I will explain the screening procedure to___, and then gather information about what is bothering him/her. If at any time I am misunderstanding what is happening in the conversation, or I am doing something wrong culturally, I encourage you to let me know. Because I want the refugee/migrant to understand everything in the room, it is important you let the person know that you are stopping to explain something to me. If I don't understand something, I will also stop and ask further questions. All of this will be interpreted for the individual so they do not think we are having a private conversation about him. Do you have any questions?"*

During the meeting. When using interpreter service, the conversation takes more time because everything has to be translated twice. The care provider should begin the meeting by

introducing everyone in the room, discussing confidentiality, and explaining that everything said in the room will be interpreted. By doing this, they set-up the meeting for the greatest success and pro-actively address the most common concern of refugee or migrant, which is privacy within the community. For example, care giver can say:[41(p 88)]

> *"Hi, my name is XY and I am a PO here. Mr. ZZ is a professional interpreter from Agency X. Both Mr. ZZ and I are bound by strict laws of confidentiality, meaning that if we talk about things without your permission, or tell people what was said in this room without your permission, we could get in a lot of trouble. Today Mr. ZZ will interpret what you say and what I say. He is going to interpret everything said in the room so both you and I can have a good understanding of everything that is happening. Please ask any questions you may have at any time."*

When communicating through an interpreter, care provider should look at and talk to the refugee or migrant, not at the interpreter. Providers and interpreters should be positioned side-by-side so that the refugee/migrant only has to look in one direction. Care provider should not say to the interpreter, *"Tell Mr. ____"* or "*Ask Mrs. ____".* Instead, he/she should talk to the refugee or migrant directly which helps develop both rapport and connection with the individual.[41]

To avoid misunderstanding, care provider should pay attention to a few things. It is recommended for care provider to speak in short sentences and pause frequently to give the interpreter time to process the concept and to interpret. He/she should avoid stopping in mid-sentence because the interpreter may not grasp the entire thought. Use of idiomatic speech and acronyms should be avoided. During the conversation the care provider should from time to time stop and ask the interpreter if he/she is speaking clearly enough, or speaking too fast. It should be kept in mind that not every word or concept has a direct equivalent in another language. Therefore, what the interpreter says may not match the length of time the provider spoke.

After the meeting. After the conversation, the care provider should make a brief follow up with the interpreter, asking for a feedback to improve his/her work with interpreters and asking whether there are specific cultural issues that might be relevant for the specific case. If a sensitive topic occurred during the conversation, care provider should ask the interpreter how he/she is doing and offer help if necessary. Many interpreters have shared experiences with refugees and migrants and some topics may trigger memories or difficult emotions. Provider should never ask the interpreter for opinion (e.g. asking the interpreter if the refugee or migrant is telling the truth, or what he/she thinks the real problem is). This is out of the job description of an interpreter and puts him/her in a difficult position, and is also disrespectful to the refugee or migrant. If the interpreter independently begins to give his/her opinion, it needs to be explained how important it is that only care provider analyses the content at face value, and that the only needed information is that one coming directly from the refugee or migrant. For example, the care provider can say:[41(p 89)]

> *"Thank you for your help today. Is there anything that I could have done better to make the interpretation go more smoothly? (Wait for answer) Is there anything I should know about the refugee's/migrant's culture that would help me serve the individual better? (Wait for answer) I know the refugee/migrant talked about _____. I know that was difficult to hear. Are you doing OK? (wait for answer and offer resources if necessary)."*

Including refugees and migrants in MH care

Refugees and migrants should be active participants in provision of MHPSS. To be able to make informed decisions on MH care, refugees and migrants should be given detailed information on MH difficulties and MHPSS in European context. They should be informed how to recognise early signs of MH problems and encouraged to seek help. Hence, it is important to raise awareness of common issues and symptoms experienced among refugees and migrants and provide information on available services. Handouts or flyers containing information about trauma, what to expect and where to get help among arriving groups should be offered at the entry points routinely.[32] Optimally, this educational information should be translated into the refugees' native languages and adjusted to the cultural framework and literacy level. For illiterate individuals, oral information should be provided. Distributed leaflets should be brief and contain essential information about common symptoms and reactions to stressful events, how to cope with them and details where to seek help. The location where to get assistance should be particularly pointed out (e.g. circle on a map of the ground plan of the location). An example of such leaflet is shown in Figure 11.

COPING WITH LOSS AND DEPRESSION

Bhuta lives close to the sea in Khao Lak, Phuket, Thailand. She lost everything, including her hope for the future, in the 2004 tsunami. Now she lives in a two-room barrack with no privacy. Her husband has a new job, but she does not.

She was depressed and felt that her life had no meaning. She had nothing to do, no dreams for the future and no-one to speak to. Then she decided to volunteer for the Red Cross, to interact with others, get sense of normality in her life and bring back a sense of purpose.

FOR MORE INFORMATION, CONTACT US:

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The International Federation Reference Centre for Psychosocial Support

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ERU
Emergency Response Unit

The International Federation Reference Centre for Psychosocial Support

COPING

WITH STRESS AND CRISIS

International Federation of Red Cross and Red Crescent Societies

EXTREME STRESS

Everyone who has lived through a crisis situation will most probably experience extreme stress. Such stress usually causes unpleasant reactions.

This brochure highlights common reactions to extreme stress and gives suggestions on how to cope with them.

FEATURES OF STRESS

Stress is a state of pressure or strain that affects body and mind. It can be caused by any positive or negative change. Stress is an ordinary feature of everyday life and is positive when it makes a person perform optimally e.g. at an exam.

When faced with a strong or sudden emotional and physical strain, such as a crisis situation, most will experience extreme stress. Ordinary negative stress may accumulate over a period of time and become a negative spiral. Extreme stress can seriously affect a persons' health, working ability and private life.

REACTIONS TO STRESS

It is normal to react when experiencing an abnormal situation. This is important to remember when experiencing stress reactions.

Reactions to extreme stress vary. Typical physical reactions include sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.

Typical emotional and behavioural reactions are anxiety, watchfulness and poor concentration, and negative feelings such as guilt, sadness and anger.

Other common reactions include to become disoriented, have intrusive memories and try to avoid being reminded of the crisis situation. Some also react by not feeling anything at all, by having difficulties in making decisions or by isolating themselves from others. Some people increase their intake of alcohol, medicine or drugs to escape the pain they are feeling.

COPING WITH STRESS

Extreme stress reactions will most likely affect your health and daily life, both at work and privately. Coping with and recovering from the effects of a crisis situation can take a long time. Coping is the process of managing difficult circumstances and finding ways of minimizing or tolerating the effects of stress.

It is important to find ways of coping with the stress reactions. It may help to:

Remember that stress reactions are normal reactions to an abnormal situation

Allow yourself to feel sad and grieve

Maintain daily routines and do things that normally give you pleasure

Eat healthy foods, get sleep and exercise if possible

Socialize with other people instead of withdrawing

Seek support and assistance

Accept assistance that is offered

– Exercise if possible.

WHEN TO SEEK PROFESSIONAL HELP

The stress reactions described in this pamphlet may last several weeks. If the reactions persist and make it impossible to function normally over a long period of time, seek help. One option is to contact the local health facility or the Red Cross Red Crescent emergency response unit.

Figure 11 Psychoeducation leaflet on coping *(retrieved from http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf)*

10 Conclusions and implications for the EUR-HUMAN project

The aim of this report as a part of WP5 of EUR-HUMAN project was to develop protocol for rapid assessment of MH and psychosocial needs of refugees and other migrants, including tools, guidelines and procedures and interventions for provision of PFA. The protocol was developed using a hierarchical approach and is based on expert guidelines addressing overall approach to MHPSS, practical handbooks, manuals and reports, and a systematic search for validated tools. The proposed procedure consists of triage (identification of MH conditions requiring immediate specialist attention), screening (identification of individuals who are under increased risk for developing serious MH issues), immediate assistance based on the PFA principles and referral for full MH assessment and care as needed. These procedures are in line with the overall goal of the EUR-HUMAN project: to provide comprehensive person-centred and integrated care for refugees and other migrants.

In the overall structure of the EUR-HUMAN project (Figure 12), WP5 has several important links to other work packages. Therefore, the work conducted in other work packages has implications for WP5, and this report feeds into other work packages. In the text below we highlight these implications and summarise the next steps.

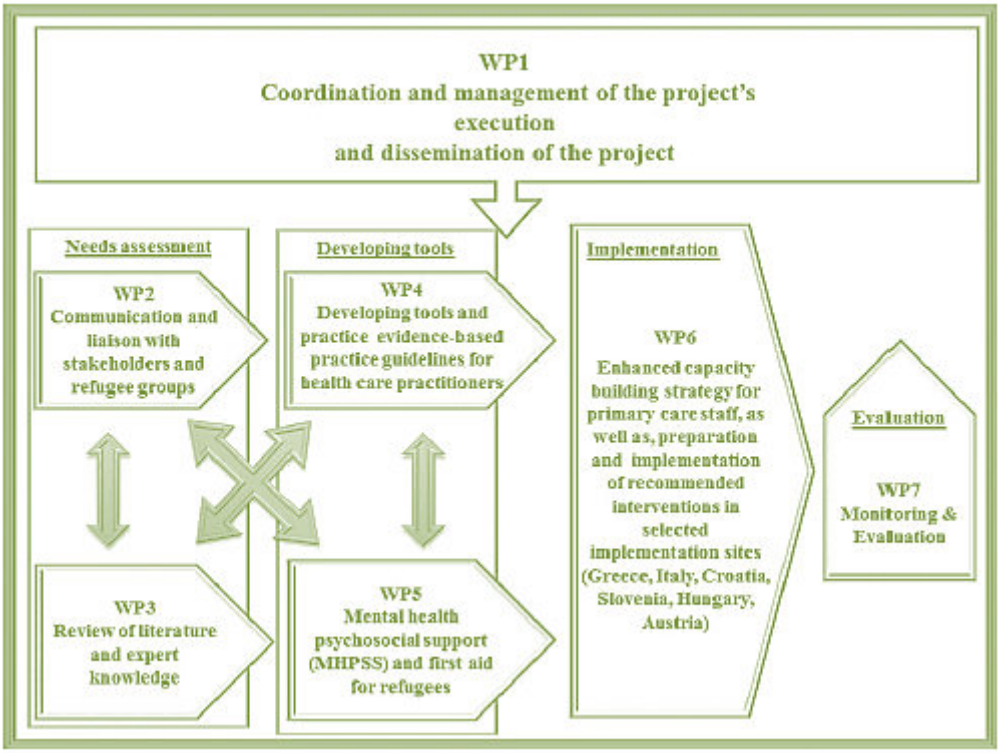

Figure 12 Overall structure of EUR-HUMAN project

WP2 assessed health needs and social problems, as well as experiences, expectations and barriers regarding accessing primary health care and social services of refugees and newly arriving migrants from hotspots via transit centres to longer-stay reception centres. In the

conducted fieldwork, refugees and migrants recognised unmet mental health care needs. Therefore, the procedures described in the present report can help meet these needs. The implications of WP2 fieldwork for procedures developed in WP5 are:

- Interventions for identifying and treating mental health problems should differentiate between hot spots (detention centres), transit centres and longer stay centres;
- MHPSS should start at the first point of entry to Europe and continue during transit and in the long-term stay locations;
- Lay personnel and volunteers should be able to conduct interventions (triage, PFA), especially at the hotspots and transit centres, due to time barriers and restricted resources;
- Since confidentiality issues and language are one of the main barriers in providing MH care, guidance should be provided to the care-givers.

WP3 conducted a systematic review of effective interventions to address health needs of and risks for refugees and other migrants in European countries, focusing on practical implications and implementation challenges. The main findings of WP3 have implications for adapting the protocol for provision of MHPSS to national and regional situations. Based on preliminary findings on the implementation of screening, assessment, and treatment of psychosocial problems, there are several core enablers and barriers for provision of MH care:

- At the professional level, core enabler is training of professionals in cultural sensitive aspects of MH care provision;
- At the refugee and other migrant beneficiary level, core enabler is including the refugees and migrants in organisation of MH care, for example, by making general health promotion programs available;
- At the organisation level, continuity of care should be promoted: MH services should be embedded in national health care organisations, and data on screening, assessment and treatment results should be collected systematically.

The aim of **WP4** is to define the optimal content of healthcare and other services needed to prevent infectious and chronic diseases as well as mental health damage, and to provide good care for those conditions in line with professional standards. These guidelines and tools will be developed and approved by international expert panel, which will be organised in June 2016. From WP5 the following questions arise that are relevant for the protocol for MH rapid assessment and psychosocial care (WP5):

- How can triage, screening and immediate assistance based on the PFA principles be implemented in various settings, from hot spots (detention centres), transit centres and long-stay locations? What resources, in terms of time and personnel are available in these settings in different EU countries?
- How can MH care be implemented in overall health care at the long-stay locations? Who are the care providers who will most likely provide MH care in a local primary health care unit (e.g. medical doctors, nurses, psychologists, social workers, trained volunteers)? Are there relevant national regulations which define what types of professionals can conduct MH screening and care?

- How can the continuity of care be supported, both in the same country and between countries? Are there already some systems for information exchange in place and how do they comply with data security standards and ethical confidentiality issues?

WP6 aims to enhance the capacity building of the primary care workers by assessing the existing situation and developing curriculum and training material for different health needs of refugees and migrants. WP5 will contribute to WP6 by developing the material for identifying mental health needs and providing MHPSS. The training should be adapted for different contexts and specific locations, but should include:

- At hot spots (detention centres) and during transit: triage and elementary PFA for individuals who are recognized as being at exceptionally high level of distress and potentially at risk to harm oneself or others. The hot spots (detention centres) at this time are in Greece and Italy, however triage should be available at all contact points on the transit route and at the locations of more permanent locations;
- At temporary or first hosting locations in EU countries where the contact with PHC is first established: screening for psychosocial and MH conditions, risks and resources, as well as PFA aimed at providing practical assistance;
- At more permanent locations where the refuges are settled: screening for psychosocial and MH conditions, risks and resources and more comprehensive PFA approach, as well as providing referral to specialised services for full MH assessment and care as needed for those refugees and migrants who have screened positive for MH conditions;
- Cross-site issues that were identified as relevant by current findings in WP2, WP3 and WP5: culturally sensitive care, providing continuous care and the issues of professional stress prevention, self- and mutual care of providers and burnout prevention for the care providers.

The next steps in **WP5** include adapting the developed protocol to respective national and regional context in collaboration with local stakeholders (Task 5.3) and developing model of integrated Chain of Psychosocial Refugee Care from Early Hosting and First Care Centres to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee and migrant destinations (Task 5.4).

Appendix I Mental health screening tools

The purpose of this systematic search was to identify tool(s) that are simple, short and culturally appropriate for MH screening of refugees and migrants in the context of current refugee crisis. Therefore, we aimed to identify screening instruments which were constructed and (or) validated specifically on refugee and migrant populations. In short, our aims were to:

- Identify existing instruments for MH screening and their target population;
- Assess the measurement properties of these measures;
- Discuss feasibility and applicability of identified tools.

The search strategy, identified scales and their use are described in more detail below.

Assessment of screening tools

To identify existing tools for MH screening of refugees and migrants, PsycINFO database was searched using the following search strategy:

Step 1. (Migrant OR DE "Immigration" OR DE "Refugees") OR KW (migrant* OR immigrant*OR refugee*) OR AB (migrant* OR immigrant*OR refugee*)

Step 2. (DE "Psychological Screening Inventory" OR DE "Screening" OR DE "Screening Tests" OR DE "Test Construction" OR DE "Test Validity" OR DE "Questionnaires") OR KW (screen* OR instrument OR test* OR identification OR questionnaire)

Step 3. (E "Acute Stress Disorder" OR DE "Post-Traumatic Stress" OR DE "Posttraumatic Stress Disorder" OR DE "Anxiety" OR DE "Major Depression" OR DE "Mental Disorders" DE "Emotional Adjustment" OR DE "Mental Health" OR DE "Distress") OR KW (mental health OR mental illness OR anxiety OR distress OR PTSD or post-traumatic stress OR posttraumatic stress OR depression)

Step 4. S1 AND S2 AND S3

In addition, Internet search was conducted for key words “refugee screening” and “distress in refugees” using Google and Google Scholar engines, and two previous systematic reviews were assessed.[5,102] For all tools identified, the search was then further expanded; tool names were used to search for additional studies that utilised and validated the respective tools on refugee and migrant populations. Authors were contacted for further information on the studies that were not available for download (via E-mail contact or Research Gate requests).

Overall, 21 tools were identified. The description of all the tools can be found in Table 7. The table contains basic information about the tool (name, author, mode of completion, purpose of the measure, number of dimensions and items), description of measurement characteristics (target population, validation sample and measurement properties: reliability, sensitivity and specificity), example of items and the source of data for further research. In some instances,

further development of measures led to reduced or redefined versions of the same scale (for example HSCL-25, HSCL-37). In these instances, results/characteristics are presented separately for each version of the scale.

Some of the 21 identified tools were developed specifically for refugee populations while the others were already existing instruments adapted for use on refugee populations. The scales in general were used on a wide range of refugee populations (Asian, Iraqi, Burmese, Bhutanese, Sudanese, Vietnamese, Bosnian, Albanian, Croatian, Albanian, Somali, Hmong, Namibian, Rwandan), even though most of them individually were administrated on two to three groups of refugees. The number of items on all identified scales ranged from 4 to 49. The mode of completion for most of the measures was self-report with the exception of 4 measures that require administration by MH care professionals. The majority of instruments do not have a predetermined cut-off score which could be used to identify individuals who are likely to develop more serious MH problems. From all of the tools found in our search, below we outline the ones that meet the current needs the most. The first section contains scales that are developed specifically for refugee populations while the second section gives an overview of the scales that are not originally constructed for refugees but were later adapted for this purpose. Other measures, that are not listed below were too long (too many items), have insufficient validation data on refugee samples or need to be administered by clinicians in the form of (in-depth) clinical interviews.

Tools developed for refugee and migrant populations

Harvard Trauma Questionnaire

The Harvard Trauma Questionnaire (HTQ) is a four-part self-report questionnaire.[103] The first and fourth part of the questionnaire are most widely used PTSD measures in refugee and migrant populations.[104] *Part 1* consists of 17 war-related traumatic experiences determined to have affected Southeast Asian refugees. The scale was constructed using expert consensus and clinical experience, and was designed to allow respondents to check as many of 4 responses for each experience that apply to them ("did not happen," "experienced," "witnessed," or "heard about).[105] Part 4 contains a list of 30 trauma symptoms, 16 generated from the DSM-III-R/DSM-IV criteria for PTSD, and 14 which are, culture-specific symptoms related to refugee trauma.[106] Possible responses are "not at all," "a little," "quite a bit," or "extremely."[107] The criterion validity study showed sensitivity of 0.78 and specificity of 0.65 for a cut-off point of 2.5.[103] On a sample of 68 Sudanese refugees the internal consistency reached a high value of α=.87.[108] This questionnaire was frequently used in refugee research focusing on experiences with trauma (e.g. Cambodian refugees in US, Sri Lankan internally displaced refugees, and Burmese refugees in Australia) but it does not address anxiety, depression or other mental issues common in refugees.

The Vietnamese Depression Scale (VDS)

Vietnamese Depression Scale was developed using a well described consensus approach from extensive clinical experience.[109] The measure consists of 15 items and each item is assessed on a scale from 0 ("sometimes") to 3 ("often"). Culturally appropriate terms were added to the

existing Western symptoms of depression so the scale measures three types of symptoms: physical symptoms associated with depression in Western countries, Western psychological symptoms of depression, and symptoms unrelated to Western concepts of depression.[102] The cut off score of 13 out of a possible 34 points is recommended, but no data about sensitivity and specificity are available. Internal consistency in a sample of 180 Vietnamese refugees living in USA for approximately 9 years is α=.88 (subscales range .80-.92).[70] The advantage of this scale is that it includes culturally sensitive symptoms of depression but they are primarily adapted for Vietnamese refugees and may not be appropriate for other refugee populations.

The Posttraumatic Symptom Scale (PTSS-10-70)

The Posttraumatic Symptom Scale (PTSS-10-70) is a modified version of the self-report instrument PTSS-10.[110] The scale was used to assess the level of posttraumatic stress disorder (PTSD) symptoms among refugees from Bosnia (N=206) compared to a group of Swedish patients in health care centres (N=387). The PTSS-10 showed high internal reliability (Cronbach's alpha = .92).[110] This short measure of PTSD symptoms has good psychometric characteristics but it would be appropriate in the current context only if used in combination with measures of other mental disorders.

The Refugee Health Screener-15

The Refugee Health Screener-15 (RHS-15) was designed to be a short, neutral language measure of common mental disorders in refugees (15 questions) that does not directly address issues of violence, torture, or trauma.[69] The screener has three sections. The first part consists of 13 questions of symptoms 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 (variably full jars of sand). The second part consists of one item assessing coping on a scale from 0 to 4 (Generally over your life, do you feel that you are: „Able to handle (cope with) anything that comes your way - 0 to "Unable to cope with anything"- 4). The last section is a graphic distress thermometer (0 - no distress - things are good, to 10 - extreme distress - I feel as bad as I ever have). The RHS-15 was empirically developed to be a valid, efficient and effective screener for common mental disorders in refugees. Symptoms that are included in the validated version of RHS-15 were derived from twenty-seven New Mexico Refugee Symptom Checklist-121 items (NMRSCL-121), the Hopkins Symptom Checklist-25, and the Posttraumatic Stress Symptom Scale Self-Report because they were found to be most predictive of anxiety, depression, and PTSD across the target samples of Iraqi, Nepali, Bhutanese, and Burmese refugees.[69] The internal consistency of the scale on a sample of 190 refugees from Bhutan, Burma and Iraq is excellent α=.95. The recommended cut-off score for the first 14 items is ≥ 12, which yields sensitivity of 0.94, 0.95, 0.81 and specificity of 0.86, 0.89, 0.87 for anxiety, depression and PTSD respectively. The recommended cut-off score for the distress thermometer is ≥5. It has already been translated into eleven languages, including Arabic, and Farsi.[69] The RHS-15 has been integrated into standard physical health screenings for newly arrived refugees at Public Health Seattle & King County and in a number of other places across the U.S.[48] The RHS-15 is open access tool and may be obtained through Lutheran Community Services Northwest (LCSNW).

In further research, the same authors tested a shorter version of the same instrument; RHS-13. This version is without the coping item and the distress thermometer. Authors report that the coping item is the most time consuming and difficult for many refugees to understand. It has been tested on 179 refugees from Bhutan, Burma and Iraq. This short form showed excellent internal consistency (α=.96) with sensitivity ranging from 0,82-0,96 and specificity ranging 0,86-0,91 with a cut-off point of ≥11.[29] The 13-item scale may be more efficient in daily use and effective for case identification.

Tools adapted for refugee and migrant populations

The Hopkins Symptom Checklist-25

The Hopkins Symptom Checklist-25 (HSCL-25), is a widely used and validated screening tool for measuring symptoms of depression and anxiety, originally designed to measure changes in 15 anxiety and 10 depression symptoms in psychotherapy.[111] The participants rate every item on a 4-point severity scale (from 1='not at all' to 4='extremely'). An average-item score >1.75 indicates "clinically significant distress," and is used as a diagnostic proxy in general U.S. studies and in several refugee studies as well (Sri Lankan internally displaced refugees, Burmese refugees in Australia, Bhutanese and Iraqi refugees in the US, Cambodian refugee women, Tibetan refugees).[112] Although this measure is widely even on refugee samples, it has no information about sensitivity and specificity and it should be administrated only by health care professionals.

The Impact of Event Scale

The Impact of Event Scale (IES) has been used in a handful of refugee studies.[102] The 22-item scale (IES-R) has been validated on a small sample of treatment seeking patients with refugee background, while the 15-item measure has been validated on a large refugee sample of Croatian and Bosnian Children (N=1,787). The scale assesses seven intrusion and eight avoidance items on 3-point descriptive scales measuring intrusive thoughts, body sensations and avoidance behaviours after trauma. It has been proven valid and reliable, and its development is well described.[113] The internal consistency for the two subscales are satisfactory (α=.82 and .74 for the two subscales).[102] However, this is another unidimensional measure more suitable for use in combination with other indicators of mental distress in this setting.

Summary

Most refugee and migrant studies have been conducted after the resettlement and included refugee samples that were already in a primary health care system. The specific circumstances (e.g. available time) and characteristics of those samples are probably different from the refugees and migrants that are currently arriving to Europe. There is evidence that the predominantly used instruments on refugee and migrant samples are Harvard Trauma Questionnaire (with questions about trauma), Hopkins Symptom Check list (symptoms of anxiety and depression), Vietnamese Depression Scale (depression symptoms only) and IES

(symptoms of PTSD). Most of these instruments contain a substantial number of items, measure one or two constructs and directly ask about trauma-related experiences.

It is important to keep in mind that MH screening of refugees and migrants (a highly vulnerable population by definition) is conducted in a very specific situation and many requirements need to be met to avoid harm and potential problems. Professionals who deal with such sensitive issues are aware of this but empirical evidence to guide conducting the screening in such settings are still lacking.

Through this systematic search several caveats and gaps were identified:

- Most of the assessments tools available are not comprehensive, but rather assess specific experiences and/or symptoms and disorders. There are not many instruments that measure several common MH problems of refugees and migrants;
- Majority of data available is derived from research conducted after the resettlement;
- A large number of prevalence studies have been conducted on clinical populations, refugees and migrants who were already enrolled in a MH or general health programme, which introduces a selection bias;
- Finally, it should be noted that for some refugees and migrants post-migration living difficulties might be equal or even stronger factor of emotional distress than migration related difficulties. Poverty and unemployment, for example, are factors that may be a source of distress either immediately or months after arrival in the new country.

Recommendations

The goal was to find a simple, short and culturally appropriate screening measure to assess emotional distress in refugees and migrants during their resettlement. Ideally, the scale would assess PTSD, anxiety and depression as the most common MH issues in the refugee and migrant populations, it would be validated on refugee and migrant samples and would be brief in administration. Furthermore, it should not evoke trauma experiences because there is not enough time during the screening to deal with it appropriately. According to information available in the literature we conclude that the RHS-13 measure meets most of these criteria. Therefore, RHS-13 instrument can be recommended as the primary screening tool for refugees and migrants upon arrival in destination country. This instrument was specifically designed for and validated on newly arrived refugee samples with items derived from existing and valid instruments used on similar populations. It is available in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); it can be administered in relatively short of time and is easily understandable for people of different educational levels. Furthermore, it measures several relevant MH constructs related to emotional distress typical for refugee and migrant populations. RHS-13 can be used as a 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 simply points out the need for full MH assessment and follow-up.

Table 7 Tools for MH screening in the refugee and migrant populations

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
The Refugee Health-Screener-15 (RHS-15)	Hollifield et al. (2010)	PTSD, anxiety and depression	Self-report	13 symptom items, 1 coping item + distress thermometer Total : 15 items Time of administration: 4-12 min.	Developed in a community public health setting for detection of emotional distress in refugee groups	Bhutan, Burma, Iraq (N=190) Refugee women (Iraqi, Burmese, Somali) (N=26)	α=.95 Sens: 0.81-0.95[69] Spec: 0.86-0.89[69] Cut-off: ≥ 12 on 14 items or distress thermometer score ≥5	Feeling helpless (from 0 – not at all to 4 – extremely)	[48,69,48,114]
The Refugee Health-Screener-13 (RHS-13)	Hollifield et al. (2010)	PTSD, anxiety and depression	Self-report	13 symptom items		Bhutan, Burma, Iraq (N=179)	α=.96 Sens: 0.82-0.96 Spec: 0.86-0.91 Cut-off ≥11	Feeling helpless (from 0 – not at all to 4 – extremely)	[29]
Harvard Trauma Questionnaire (HTQ)	Mollica et al. (1992)	War related trauma and PTSD	Self-report	Part I: 17 items on traumatic life events Part IV:16 items generated from the DSM-III-R criteria for PTSD and 14 symptoms related to refugee trauma Total: 47 items	Adult refugees and Bosnian and Croatian war veterans	Sudanese refugees (N=68) Sri Lankan refugees (N=1448)[115] Cambodian refugees in U.S. (N=490)[116]	α=.87[108] Cut-off = 2.5 Sens: 0.78 Spec: 0.65	Part I: Lack of food or water (experienced, witnessed, heard about, did not happen) Part IV: Feeling on guard (from 1 - not at all, to 4 - extremely)	[102, 104,107, 108, 105,111, 115, 116, 117, 118, 119]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Vietnamese Depression Scale (VDS)	Kinzie et al. (1982/87)	Depression	Self-report	Depressed affect (8) Somatic symptoms associated with depression (7) Culture specific symptoms (3) Total: 18 items	Developed for use with Vietnamese refugees in the US	Vietnamese refugees living in USA approx. 9 years (N=180)	α=.88 subscales =.80-.92[70] Cut-off >13	Feel that the future is hopeless (from 0 – sometimes to 3 - often)	102, 70
Hopkins Symptom Checklist (HSCL-25)	Derogatis et. al (1974)	Depression, anxiety	Health care professionals	Anxiety symptoms (10) Depression symptoms (15) Total: 25 items Separate scores for anxiety, depression and total	Originally for use in primary care and non-clinical settings. Validated on US general population and Indochinese refugees.	Sri Lankan internally displaced refugees (N=1448)[115] Old and new patients with a refugee background (N=61)	Cut-off >1.75 for each of 2 components[112]	Suddenly scared for no reason (Not at all to Extremely)	102, 112, 111 115, 117, 119, 120, 118, 121, 122, 123
Hopkins Symptom Checklist (HSCL-37)	Derogatis et. al (1974)	Depression, anxiety, internalizing and externalizing trauma related reactions	Health care professionals	10 anxiety 15 depression 12 externalizing behaviour (trauma-related) Total: 37 items	General population in a family practice or a family planning service	Sudanese refugees (N= 68) Adolescent refugees from 48 countries in Netherlands and Belgium (N= 3890)	Subscales: [108] anxiety = .83 depression = .89 somatisation = .82 α=.90 (.84-.95)[124]	Bullies, steals things (1-not/never to 4-always)	108, 124

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Impact of event scale (IES)	Horowitz et al. (1979)	PTS symptoms	Self-report	2 scales: 7 intrusion 9 avoidance measuring intrusive thoughts and body sensations after trauma Total: 15 items	Study of bereaved individuals and exploring psychological impact of trauma	Croatian and Bosnian children (N=1787)	α=.82 and .74[102] If the score on either subscale is >19, medium for scores of 8.5 to 19, and low-level for scores of 1 to 8.5.[125]	I thought about it when I didn't mean to (from 0 – not at all to 4 – often)	102,125
IES-R (Norwegian version)	Eid et al. (2009)	PTS symptoms	Self-report	3 scales: 8 items Intrusion scale 8 Avoidance scale 6 hyperarousal items Total: 22 items		Old and new patients with a refugee background (N=61)	α =.99[126] Cut-off ≥33[126]	I found myself acting and feeling like I was back at that time (from 0 - not at all to 4- extremely)	112, 126
Health Opinion Survey (HOS)	MacMillan (1957)	General mental health	Self-report	16 items	Adults in rural communities	SE Asian refugees Vietnamese refugees	Have not been tested for validity in refugees	Do you have loss of appetite? (often to never)	102,127

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Posttraumatic Symptom scale (PTSS-10-70)	Holen, Sund, and Weisaeth (1983)	PTS symptoms	Self-report	10 items	Clinical follow-up of psychotherapy treatment for refugees	Bosnian refugees (N=206) Swedish adults (N=387)	Among refugees α=.92 In compared group α=.90	Indicate the extent to which you had experienced each of the following: sleeping problems, nightmares about the trauma (from 1 – no problems to 7 – very severe problems)	[102,110]
Beck Depression Inventory (BDI)	Beck et al. (1961)	Depression	Self-report	21 symptoms of depression Time of administration: 5-10 min.	Derived from clinical observations on attitudes and symptoms displayed by depressed psychiatric patients	Vietnamese refugees Somali refugees living in Helsinki, older adults (N=128) Albanian refugees in UK (N=842) Hmong refugees N=97[128]	α=.89[129] <9/10 = no depression 10-18 = mild to moderate depression 19-29 = moderate to severe depression 30-36 = severe depression[15] among refugees α=.93 Sens: 0.94 Spec: 0.78[104]	Sadness (0 – I don't feel sad to 3 – I am so sad or unhappy that I can't stand it)	[15, 102,129]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Norbeck Social Support Questionnaire (NSSQ)	Norbeck et al. (1984)	Dimensions of support	Self-report	3 dimensions of support: Social network size Emotional support Esteem support	Measurement of social support in general population	Namibian refugees (N=88)[130]	α=.83[102] No further reliability testing among refugees	How much does this person make you feel liked or loved?	[102,131]
Primary Care Posttraumatic disorder (PC-PTSD)	Prins et al. (2003)	PTSD	Self-report	4 items	PTSD-screen in Veterans using VA health care		Cut-off=2/3[129] Sens: 0.78 Spec: 0.87 Unknown cultural validity	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? (yes/no)	[5, 129]
Short screening scale for DSM-IV posttraumatic stress disorder	Breslau et al.(1999)	PTSD	Interview	7 symptom screening scale for PTSD Time of administration 5 min.	Representative US sample in Detroit (N=2,181)	Participants from general medical and women's health clinics at a VA Healthcare System (N=134)	Cut-off= 4/5[18] Cut-off: 4-most sensitive option) Sens: 0.85 Spec: 0.84 Unknown cultural validity	Did you begin to feel more isolated or distant from other people? (yes/no)	[5, 132]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Self-Report Questionnaire (SRQ-5)	WHO (1994)	common mental disorders primarily in primary health care settings in developing countries	Self-report	Total: 5 items	Created for Congolese women (short version of SRQ-SIB)[14]	Displaced women living in refugee camps in Rwanda (N=810)	Not yet implemented. further research needed[14]	Do you sleep badly? Do you often have headaches? Do you find it difficult to enjoy daily activities? Are you able to play a useful part in life? Is your daily life suffering? (yes/no)	14, 38,133
Mini International Neuropsychiatric Interview (MINI)	Sheehan (1990)	PTSD, depression	Clinical instrument	Time of administration 15-30 min.	Psychiatric evaluation and outcome tracking in clinical psychopharmacology trials and epidemiological studies	Adapted for different immigration groups Old and new patients with a refugee background (N=61)		Since X, do you feel tired or without energy? (yes/no)	112, 134

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
The Posttraumatic Symptom Scale (PSS-SR)	Foa et al. (1993)	PTSD	Self-report	3 subscales: re-experiencing, avoidance, and arousal, as well as a total score Total: 17 items	PTSD symptom severity and caseness in trauma affected population	Kurdish (N=48) and Vietnamese (N=32) refugees in the U.S.	α =0.95 cut-off: 13	Have you had upsetting thoughts or images about the trauma that came into your head when you didn't want them? (0-not at all or only one time to 3 -5 or more times a week / almost always)	[135]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Post-traumatic Stress Diagnostic Scale (PDS)	Foa, (1997)	PTSD	Self-report	49 items (10–15 min)	Patients identified as victims of a traumatic event or to assess symptoms when already PTSD	Arab Muslim immigrant women (N=453)	α= 0.93. Diagnosis only when DSM IV criteria A to F are met cut offs for symptom severity rating : 0 no rating, 1–10 mild, 11–20 moderate, 21–35 moderate to severe and .36 severe.	Having upsetting thoughts or images about the traumatic event that came into your head when you did not want them to. (0-not at all or only one time to 3 -5 or more times a week / almost always)	[136, 137]
General Health Questionnaire (GHQ- 28)	Goldberg and Hillier (1979)	General mental health	Self-report	4 subscales: Somatic symptoms (7) Anxiety and insomnia (6) Social dysfunction (6) Severe depression (6) Time: 5 minutes	Individuals likely to have or to be at risk of developing psychiatric disorders	Albanian refugees in UK (N=842) Albanian refugees, refugees in Kosovo (N=1358)	General cut-off point: >7 traumatised people: > 12-13 No cut-off scores published for refugee populations[138]	Have you recently found at times you couldn't do anything because your nerves were too bad ? (Not at all, to Much more than usual)	[117, 138, 139]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
General Health Questionnaire (GHQ-12)	Goldberg et al. (1997)	General mental health	Self-report	2 factors: 'psychological distress' and 'social dysfunction' Total: 12 items	Short version of GHQ-28	Somalian refugees living in Helsinki, older adults (N=128)	α=.95 Cut-off point of 3/4, with scores above 3 suggesting high probability	Lost much sleep (less than usual, to much more than usual)	[15, 138, 140]
25-item psychiatric symptom checklist	Dawn Noggle (1999)	Depression, anxiety and PTSD (DSM-IV based)	Self-report	25 (all the symptoms required for a diagnosis of depression, most items required for a diagnosis of PTSD, and two symptoms of panic attacks)	Refugees aged >18 years (not designed for children)	Refugees from 24 countries in the Denver health screening (N=1,058; 128 screened positive)	Reliability and validity have not been established No cut-off point because of cultural factors influencing symptom endorsement	Intrusive memories of the bad things that happened in your country or refugee camp (yes/no)	[141]

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D5.2 Model of Integrated Care.

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Contents

Executive Summary 1
1 Introduction 3
Objective 3
Summary of previous work in EUR-HUMAN project 3
2 Background 5
3 Model of Continuity of Psychosocial Refugee Care 7
Identifying highly distressed refugees and migrants 7
Psychological First Aid 13
Informational continuity of care 16
Conclusions and next steps 23
Appendix I Refugee health screener 13 24
References 25

Abbreviations

MH Mental Health

MHPSS Mental Health and Psychosocial Support

PFA Psychological First Aid

PHC Primary Health Care

PTSD Post-Traumatic Stress Disorder

Executive Summary

Objective. The purpose of this report is to describe a Model of Continuity of Psychosocial Refugee Care (MCPRC), which will tackle the challenge how to identify highly psychologically distressed refugees and migrants, provide Psychological First Aid (PFA), refer the refugee or migrant to specialised health services, if needed, and transfer the necessary information to other care providers, either within the same country or cross-border.

Background. Refugees and other migrants per definition have been exposed to adverse life threatening experience. Despite this, there is evidence that they are reluctant to seek help for psychological problems until they really become unbearable or make them dysfunctional. Therefore, there is a need to develop a model which will foster person-centred, integrated and multifaceted support for these groups of people. The Model is based on three key assumptions: (1) If highly distressed refugees and other migrants are identified early and receive initial care, they will be more likely to seek assistance for mental health (MH) problems later on; if needed (2) Refugees and migrants under elevated risk for developing MH conditions should receive appropriate, person-centred care over time, based on PFA principles; (3) Continuity of care should be fostered.

Model of Continuity of Psychosocial Refugee Care. The Model consists of three key components: identifying highly distressed refugees and migrants, providing brief and focused PFA interventions and fostering informational continuity of care. Identifying highly distressed refugees and migrants includes triage and screening for MH-problems. The purpose of triage is to recognise refugees and migrants who are dysfunctional and/or at immediate risk of harm to themselves or other, so they can be immediately referred to a specialist. Since MH issues can emerge at any point during refugee transit or the asylum seeking process, triage should be conducted at any point of meeting the refugee or migrant. MH screening aims to identify individuals who are experiencing heightened distress and who are more likely to develop more serious MH conditions, and is recommended to be conducted as a part of overall health check-up. Tools for conducting both triage and screening are presented as a part of the Model. Psychological first aid should be provided to all refugees and migrants, as it focuses on addressing basic needs, comforting and connecting people to information, services and support. A brief summary guide on possible PFA interventions during short, medium term and long term stay is presented. Finally, information on MH conditions of refugees or migrants, and information on the received interventions should be available to other care-givers, either in the same country of between countries. Two existing systems for information sharing are presented and a recording system for mental health of refugees and migrants is proposed.

Conclusions and next steps. The proposed Model of Continuity of Psychosocial Refugee Care should tackle the challenges of providing person-centred, integrated and multifaceted support for refugees and other migrants. It includes a protocol for identifying highly psychologically distressed refugees and migrants, a guide to PFA interventions and a

recording system for information sharing. The next steps in WP5 include piloting the proposed procedure, in close cooperation with IOM Croatia.

1 Introduction

Objective

The EUropean Refugees-HUman Movement and Advisory Network project (EUR-HUMAN) aims to enhance the capacity of European member states in addressing refugees' and other migrants' health needs, safeguarding refugees and migrants from risks and minimising cross-border health risks; both in the early arrival period and longer-term settlement. As a part of overall aim of the project, Work Package 5 (WP5) focuses specifically on mental health (MH) and psychosocial wellbeing of refugees and other migrants. The purpose of this report is to describe a Model of Continuity of Psychosocial Refugee Care (MCPRC). The Model will tackle the challenge how to identify highly distressed refugees and migrants, provide Psychological First Aid (PFA), refer the refugee or migrant to more specialised services, if needed, and transfer the necessary information to other care providers, either within the same country or cross-border. Best practices and existing guidelines for providing mental health and psychosocial support (MHPSS) to people who endured or witnessed possible shocking events (e.g. traumatized by destruction, organized violence or loss) will guide development of the model,[1–5] as well as previous work conducted as a part of EUR-HUMAN project.

Summary of previous work in EUR-HUMAN project

The previous work in EUR-HUMAN project highlighted several issues that need to be accounted in the development of Model of Continuity of Psychosocial Refugee Care.

WP2 assessed health needs and social problems, as well as experiences, expectations and barriers regarding accessing primary health care and social services of refugees and newly arriving migrants from hotspots via transit centres to longer-stay reception centres. Key finding from the perspective of WP5 is the recognition of unmet MH needs by the refugees and migrants themselves. These needs include distress related to shocking events before or during journey, depression, suicide risks, insomnia, fatigue, anxiety and uncertainty. Thus, the MCPRC needs to take into account early and accurate identification of refugees and migrants who are facing MH problems. In addition, lack of continuity of care was mentioned as a barrier to addressing health needs in general. This included lack of information on previous treatment, difficulty to obtain medication for chronic diseases during the journey and lack of knowledge among the health care workers on the care available in the next country. Although the specific circumstances have changed since the closure of "Balkans route", refugees and other migrants remain a highly mobile population, and the challenges to provide continuous care persist.

WP3 conducted systematic review of literature databases, online survey and expert interviews to identify success factors and obstacles in the implementation of health care tools and interventions for refugees and other migrants. The collected material points at recurring success factors and implementation obstacles, linked to characteristics of health care

interventions and measures, professionals, patient/refugee population, professional-patient interaction, incentives and resources, local capacity for organizational change, and social, political and legal factors. Key finding from the perspective of WP5 and this report was the identification of continuity of care as a cross-cutting obstacle in providing health care to refugees and other migrants.

WP4 conducted 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. Overall, nine areas were discussed, including mental health and continuity of care. The most important findings for this report support the central role of continuity of information about care, continuity in delivery of health care to migrants and other refugees, and the need for integration of MH care in primary health care.

WP5 (Deliverable 5.1) developed protocol for rapid assessment of MH and psychosocial needs of refugees and other migrants, including tools, guidelines and procedures and interventions for provision of PFA. The protocol was developed using a hierarchical approach and is based on expert guidelines addressing overall approach to MHPSS, practical handbooks, manuals and reports, and a systematic search for validated tools. The proposed procedure consists of triage (identification of MH conditions requiring immediate specialist attention), screening (identification of individuals who are under increased risk for developing serious MH conditions), immediate assistance based on the PFA principles and referral for full MH assessment and care as needed. Short, practical tools guiding these processes are included as a part of the comprehensive Model.

To sum it up, key findings from EUR-HUMAN project for development of Model of Continuity of Psychosocial Refugee Care point that:

- refugees are in need for compassionate psychosocial support related to distress following adverse or shocking events (WP2);
- there is a lack of information on previous treatment, hindering delivery of care (WP2);
- in general, (lack of) continuity of care is cross-cutting obstacle in delivery of care to refugees and migrants (WP3);
- informational continuity of care as well as integration of MH in primary care represent key challenges for delivery of care to refugees and migrants (WP4).

2 Background

Refugees and other migrants can be exposed to adverse life threatening experiences due to for example war and persecution, which made them decide to flee across international boarder in search of safety.[6,7] Data show that prevalence of mental health disorders leading to difficulties in family and work functioning, as well as problems of social integration in hosting societies is very high: up to 40% may have posttraumatic stress disorder (PTSD).[8] This is about 10 times higher than in the non-affected populations. [9,10] But this also shows that most refugees show remarkable resilience as they cope reasonably well in the aftermath of losses, traumatization and uprooting. [11] However, refugees are much more reluctant to seek help for mental health problems, than for physical health issues. Only when mental health problems become unbearable or have dysfunctional consequences, people are likely to reach out for support. There are estimates that it takes about 7 years of mental suffering for refugees hosted in Netherlands and Switzerland to reach out to care providers to seek assistance.[12,13] This increases the toll for the individual and family, as well as social and health costs for the host society. Therefore, there is a need to develop a model that would support early identification of highly distressed refugees and other migrants, provision of PFA, referral procedures, and continuity of care. Based on previous work in the EUR-HUMAN project, the Model is based on the following key assumptions.

Key assumption one: Refugees and migrants who are highly distressed and possibly dysfunctional should be identified early on and receive appropriate MH and psychosocial care. Moreover, it is assumed that if they find such interventions reassuring and helpful, they will be more likely to seek assistance for mental health problems at the point of their final destination and during resettlement, if needed. They will be motivated to do so if their positive experiences with health care and psychosocial personnel along the transit route, in hot spots or first reception centres helps to destigmatize suffering as a consequence of trauma and losses. Moreover, if the short and focused psychosocial support interventions help them deal better with adverse experiences, potentially traumatic events and losses, their coping capacity and resilience will be enhanced and the path to recovery will start early. Early identifying of highly distressed and possibly disrupted functioning refugees and migrants should be a two-step process which includes (1) triage and (2) screening.

Key assumption two: Those individuals with elevated risk for developing mental health conditions should receive appropriate, person-centred and compassionate care or support over time. This beginning of care should be based on principles of Psychological First Aid (PFA), approach which focuses on addressing basic needs while facilitating resilience within individuals, families and communities. The PFA approach is based on five basic principles:[5] promoting a sense of safety, promoting calming, promoting self- and collective efficacy, promoting connectedness and promoting hope. PFA can be provided to anyone who has been exposed to an adverse experience or crisis event, and anywhere where it is safe enough to do so (e.g. shelters, camps, transit centres, hot spots, reception centres, PHC, hospitals). Its implementation is not restricted to MH professionals but can also be delivered by PH teams,

allied health personnel, trained lay persons and volunteers. Therefore, PFA can be especially useful in situations where there is a large number of people in need of assistance and scarcity of MH and PH professionals.

Key assumption three: Continuity of care is important. Based on a multidisciplinary review of continuity of care,[14] there are three elements of continuity: informational, management and relational continuity (Box 1). Informational continuity links care from one provider to another and from one healthcare event to another. Both information on the condition and on patient's preferences, values and context are important to ensure services that are responsive to needs. Management continuity is achieved when services from several providers are delivered in a complementary and timely manner. This can be facilitated by shared management plans or care protocols, as well as flexibility in adapting care to changes. Relational continuity, emphasised especially in primary and mental health care, is often interlinked with informational continuity, as knowledge about the patient is accumulated in the memory of the provider. Even when there is no expectation of establishing an ongoing relationship, a consistent core of staff can provide a sense of predictability and coherence from the patient perspective. In the current situation informational continuity seems the most urgent element to ensure continuity of care. WP2 field work, reflecting the needs of refugees and other migrants, found that the lack of information is one of the most pressing barriers. In addition, at the Expert Consensus Meeting (WP4) in Athens (June 8th – 9th 2016), it was agreed that informational continuity is a minimum that should be established. Therefore, in this report we will focus on this aspect of continuity of psychosocial care for refugees and other migrants.

Box 1 Types of continuity of care[14]

Informational continuity. The use of information on past events and personal circumstances to make current care appropriate for each individual.

Management continuity. A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.

Relational continuity. An ongoing therapeutic relationship between a patient and one or more providers.

(Quoted directly, page 1220)

In the next section of the report, all three key assumptions of Model of Continuity of Psychosocial Refugee Care are described: identifying highly distressed refugees and migrants, providing brief and focused Psychological First Aid interventions and fostering informational continuity of care.

3 Model of Continuity of Psychosocial Refugee Care

Identifying highly distressed refugees and migrants

Identifying highly distressed and potentially dysfunctional refugees and migrants includes two separate but interlinked steps: triage and screening. The purpose of triage is to recognise refugees and migrants who are dysfunctional and/or at immediate risk, defined as a threat to personal safety of the possible affected person, or a threat to the safety of people around them. MH triage consists of recognising behavioural signs that indicate severe distress, conducting a rapid assessment of immediate risk and providing psychoeducation and referral if needed. Since MH issues can emerge at any point during refugee transit or the asylum seeking process, it is important that various groups of care providers/personnel working with refugees are familiar with the triage process.

The purpose of MH screening is to identify individuals who are experiencing heightened distress and who are more likely to develop more serious MH conditions. Screening should be based on using a reliable and valid measure of distress in refugee and migrant populations. Based on the review of MH screening tools (D5.1), the use of the Refugee Health Screener 13 (RHS-13) is recommended (Appendix I).[13] This instrument was specifically designed and validated on newly arrived refugees and migrants with items derived from existing and valid instruments used with similar populations. It is translated in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); can be administered in short amount of time; is easily understood by people of various educational levels and can be administered to individuals from the age of 14. Furthermore, it assesses symptoms of Post-traumatic stress disorder (PTSD), anxiety and Depression Disorder, which are the most common MH conditions in refugee populations. It serves as a quick screener of probable risk of having or developing PTSD, anxiety or depression (cut-off score ≥ 11). It is important to emphasize that a positive screening on the RHS-13 does not mean that the person needs clinical MH treatment since it is not a diagnostic tool, but indicates the need for full assessment, referral and possible follow-up.

MH screening should be conducted as part of a comprehensive health check-up, at the first point of contact by primary care providers with refugees and other migrants. MH screening can be conducted by trained PC personnel, allied health professionals and volunteers with PHC background. If MH screening indicates a chance of developing more serious MH conditions ("positive screening"), care providers should make appropriate referral. Both triage and screening should be followed up by immediate brief interventions, based on PFA approach, such as psychoeducation.[16]

Tools to guide caregivers in the triage and screening processes are shown below and are briefly described in Table 1. These tools were developed for adult refugees and migrants. They can also be used with children and adolescents, if adapted to the appropriate level of understanding and developmental stage, as well as family context (*see Deliverable 5.1*).

However, many authors agree that providing information and support to parents and other caregivers is one of the most effective ways to support children.[15]

Table 1 Description of MH Triage and Screening Tools

	MH Triage	MH Screening
When	Any contact with the individual	Temporary or long term centres; as a part of comprehensive health check-up
Provider	Trained paraprofessionals and volunteers, professionals	Trained paraprofessionals and volunteers, professionals
Target group	14+	14+
Time to complete	20-30 min	15-20 min
Preconditions	(1) Creating a safe, comfortable and confidential setting; (2) Establishing basic trustful relationship (more information in D5.1, pp 14-15).	(1) Establishing trust (more information in D5.1, p 21); (2) Possibility to offer immediate assistance, if needed; (3) Possibility to offer referral, if needed.

MH Triage tool

1. Are there visible signs of distress?

Look for:

Physical/behavioural signs

- Looking glassy eyed and vacant, unable to find direction
- Unresponsive to verbal questions or commands
- Disorientation (engaging in aimless disorganized behaviour, not knowing their own name, where they are, or what is happening)
- Rocking or regressive behaviour
- Hyperventilation
- Experiencing uncontrollable physical reactions (shaking, trembling)
- Exhibiting frantic searching behaviour
- Self-destructive or violent behaviour

Emotional/cognitive signs

- Exhibiting strong emotional responses, uncontrollable crying
- Feeling incapacitated by worry
- Unable to care for themselves or their children
- Unable to make simple decisions
- Feeling anxious or fearful, overwhelmed by sadness, confused
- Physically/verbally aggressive
- Feeling shocked, numb
- Guilt, shame (for having survived, for not helping or saving others)

If NO

Usual procedures

If YES

2. Are there visible signs of danger to safety?

If YES

Immediate referral
(See referral script)

While engaging the person, look for:

- Presence of psychotic symptoms: hallucinations, delusions, paranoid ideas, thought disorder, bizarre/agitated behaviour
- Presence of affective disturbance: severe symptoms of depression/anxiety, elevated or irritable mood
- Confused, disorganised behaviour, can't take care of self or children (if applicable)
- Reporting threat of self-harm
- Reporting threat of harm to others

If NO

3. Are there thoughts or plans for self-harm/suicide?

If YES

Immediate referral
(See Immediate referral)

Ask:

1. Some people with similar problems have told me that they felt life was not worth living. Do you sometimes go to sleep wishing that you might not wake up in the morning? (if YES, ask 2.)
2. Have you ever wanted to end your life or kill yourself? Have you made any plans to end your life? If so, how are you planning to do it?

If NO

Psychoeducation
(See Psychoeducation)

Immediate referral[1]

Inform

- ✓ Explain to the person that you are worried about him/her harming himself/herself and that you have a professional duty to act in the interest of preventing that.

Take precautions

- ✓ Remove means of self-harm.
- ✓ Create a secure environment while waiting – if possible, offer a separate, quiet room.
- ✓ Do not leave the person alone – assign a staff or family member to ensure safety.

Refer

- ✓ Immediately consult a mental health specialist and ensure escort to that specialist. If it is not possible to ensure immediate escort to specialist, ensure a safe environment and make an appointment as soon as possible.

Psychoeducation[2]

Normalise

- ✓ A lot of people experience sadness, worries, bad memories and feel stress when they go through terrible life events

Explain

- ✓ Experiencing stressful life events affects body and mind.
- ✓ Typical physical reactions ("body symptoms") are sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.
- ✓ Typical emotional and behavioural reactions ("mind symptoms") are anxiety, watchfulness and poor concentration, and negative feelings such as guilt, sadness and anger.
- ✓ Some people become disoriented, have intrusive memories and avoid being reminded of the thing that happened. Others may isolate themselves or increase intake of alcohol, medicine or drugs.

Encourage

- ✓ It is important to find ways of dealing with reactions to stressful life events.
- ✓ It may help to:
  Remember that these reactions are expected after terrible experiences.
  Allow yourself to feel sad and grieve.
  Maintain daily routines and do things that normally give you pleasure.
  Eat healthy foods, get sleep and exercise if possible.
  Socialize with other people instead of withdrawing.
  Seek support and assistance.
  Accept assistance that is offered.

Offer support

- ✓ If you start/continue feeling like this, and it persists over several weeks, seek help (*give contact where the person can do that!)*.

[1] Based on http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
[2] Based on http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf

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- Self-destructive or violent behaviour

Emotional/cognitive signs

- Exhibiting strong emotional responses, uncontrollable crying
- Feeling incapacitated by worry
- Unable to care for themselves or their children
- Unable to make simple decisions
- Feeling anxious or fearful, overwhelmed by sadness, confused
- Physically/verbally aggressive
- Feeling shocked, numb
- Guilt, shame (for having survived, for not helping or saving others)

If YES

Go to step 2 in MH Triage procedure

If NO

2. Does the physical health screening indicate immediate assistance is needed?

If YES

Attend physical health needs first

When MH screening is conducted as a part of comprehensive physical health screening, conduct the MH screening at the end of the procedure. If physical health screening shows that immediate assistance is needed, solving this issue has priority over MH screening.

If NO/N.A.

3. Does MH screening indicate positive screen?

If YES

Referral offer
(See Referral script)

Utilise reliable, valid screening tool, tested for diagnostic accuracy in refugee and migrant populations (*See Refugee health screener-13 in Appendix I*). Screening should assess current functionality or symptomatology. Routine screening for exposure to traumatic events is not recommended.

If NO

Psychoeducation
(See Psychoeducation)

Referral script[3]

✓ Offer referral. You can use the following script[4]:

"From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. In *(state country)*, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time. I would like to connect you to a counsellor. This is a type of healthcare worker who will listen to you and provide help and support. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?"

✓ Make an appointment for the refugee.
✓ Proactively address potential barriers: ask the refugee if there are any obstacles that need to be addressed (e.g. money, transport, child care).
✓ Follow-up with the refugee after appointment.

Psychoeducation[5]

Normalise

✓ A lot of people experience sadness, worries, bad memories and feel stress when they go through terrible life events.

Explain

✓ Experiencing stressful life events affects body and mind.
✓ Typical physical reactions ("body symptoms") are sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.
✓ Typical emotional and behavioural reactions ("mind symptoms") are anxiety, watchfulness and poor concentration, and negative feelings such as guilt, sadness and anger.
✓ Some people become disoriented, have intrusive memories and avoid being reminded of the thing that happened. Others may isolate themselves or increase intake of alcohol, medicine or drugs.

Encourage

✓ It is important to find ways of dealing with reactions to stressful life events.
✓ It may help to:
Remember that these reactions are expected after terrible experiences.
Allow yourself to feel sad and grieve.
Maintain daily routines and do things that normally give you pleasure.
Eat healthy foods, get sleep and exercise if possible.
Socialize with other people instead of withdrawing.
Seek support and assistance.
Accept assistance that is offered.

Offer support

✓ If you continue or start feeling like this, and it persists over several weeks, seek help (*give contact where the person can do that!)*

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[3] Based on http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
[4] Taken from http://www.lcsnw.org/pathways/pdf/RefugeeHealthScreener.pdf
[5] Based on http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf

Psychological First Aid

Psychological First Aid (PFA) is a form of psychosocial support intended for people who have experienced mass violence, forced displacement and other types of highly distressing events. The term PFA is often used as an umbrella term for a range of different approaches, which resulted in different formal definitions in the literature. Despite various definitions, the basic elements of PFA are universal and include:[17]

- Providing practical care and support which is non-intrusive;
- Helping people to address basic needs;
- Listening to people, but not pressuring them to talk;
- Comforting people and helping them to feel calm;
- Helping people connect to information, services and social support;
- Protecting people from further harm and offering compassionate care and support.

Although there is no empirical evidence about the effectiveness of PFA interventions, there is an expert consensus that PFA can help people affected by extreme events to alleviate painful emotions and reduce further harm from initial reactions to a crisis. PFA is the approach recommended by many international organisations and expert groups, including National Center for PTSD, National Institute for Mental Health, World Health Organisation, the Sphere Project, the Inter-Agency Standing Committee on Mental Health and Psychosocial Support, and other lead agencies such as the International Red Cross.[2,18–20]

As a part of the Model of Continuity of Refugee Psychosocial Care, the PFA procedure is conceived as guidance for providing psychological care and support for refugees and migrants arriving in Europe. The general framework comprises core PFA actions, which in the ideal case should all be provided to every individual in need of help. However, the choice of specific actions, the amount of time spent on each and the structure of the whole PFA procedure will depend on the specific context in which it will be provided (e.g. at the first point of entrance, during transit, in the host country) as well as the particular needs of the individual. A detailed description of the PFA process is described in D5.1, while in Table 2 a summary of practical guidance on interventions that can be implemented in the short term, medium term and long-term stay is provided

Table 2 Summary of core Psychological First Aid actions

PFA CORE ACTIONS	Short term stay (up to 3 days)	Medium term stay (up to two weeks)	Longer term stay
Prepare	✓ Familiarise yourself with the cultural background of refugee of migrant groups you're most often in contact with ✓ At all times, be aware and up to date about: *The current situation regarding refugee movement, legal provisions and entitlements* *Types of relief and support services available at the current location*		
Make first contact	✓ Initiate first contact in a non-intrusive, compassionate and helpful manner *Make nonverbal contact first (eye contact, smile, open posture, lean forward)* *If using interpreter always look and talk to the refugee or migrant* *Introduce yourself and explain your role* *Avoid touching, since it may not be culturally appropriate*		
Ensure safety and comfort	✓ Improve immediate psychological safety: *Remove sharp objects/sources of noise* *Tell that this is a safe environment* *Address urgent needs (food, clothes, protection from weather)* *Attend to vulnerable groups (elderly, families with children, pregnant women, disabled)* *Provide information on what is going to happen next*	✓ Attend to physical comfort *Make environment more pleasant (adjust temperature, lighting, air quality, arrangement of furniture)* ✓ Provide information about available services ✓ Promote social connections *Help make contact with family and friends, connect with people who are coping well* ✓ Protect form additional exposure *Protect for scenes of people suffering, minimise exposure to distressing media (esp. for children), do not routinely enquire about traumatic experiences*	
Help with stabilisation	✓ Stabilise people in severe distress *Orient the person to the surroundings, use breathing relaxation techniques or grounding if necessary*	✓ Support people who are emotionally overwhelmed: *Ensure adequate space for rest* *Ensure adequate diet* *Engage in positive distracting activities* *Help maintain routine*	

PFA CORE ACTIONS	Short term stay (up to 3 days)	Medium term stay (up to two weeks)	Longer term stay
Gather information on current needs and concerns	✓ Focus on most pressing needs and concerns: *Need for medical assistance* *Look for signs of extreme distress (see Triage)* *Separation or concern for loved ones*	✓ Identify needs and concerns in the immediate future: *Inquire on the needs and concerns* *Address availability of social support* *Look for signs of extreme distress (see Triage)*	✓ Identify needs and concerns in the immediate future: *Focus on immediate post-resettlement circumstances* *Address availability of social support* *Screen for distress as a part of comprehensive health check*
Provide practical assistance	✓ Ensure meeting of basic needs (*food, water, clothes, sanitation, protection from weather*) ✓ Offer medical assistance, if needed	✓ Help establish contact with separated family members ✓ Ensure supportive session with a member of psychosocial support team ✓ Give detailed information on next steps and procedure, if possible ✓ Give information on coping (psychoeducation)	✓ Connect with family members ✓ Give detailed information on the asylum seeking process, entitlements and obligations ✓ Give information on coping (psychoeducation) ✓ Refer to specialised care providers, if needed
Promote social support	✓ Help establishing contact with family members, close friends and neighbours (*via phone, e-mail, social media*) ✓ If travelling alone, connect with a similar group of people (*e.g. of the same origin, gender*)	✓ Help establish contact with family members, close friends and neighbours (*via phone, e-mail, social media*) ✓ Encourage to seek support	✓ Connect with family members ✓ Engage in social activities (*creative workshops, camp/reception centre improvement groups, sports activities)*
Provide information on coping	✓ Provide information on stress and coping, verbally or via leaflets *(see pg. 9. Psychoeducation)*		
Link with collaborative services	✓ Refer to general practitioner, if needed	✓ Refer to general practitioner and members of psychosocial team, if needed	✓ Refer to general practitioner, members of psychosocial team or social services, if needed ✓ Refer to specialised health and MH services, if needed and possible ✓ Connect with free legal services

Informational continuity of care

At the Expert Consensus Meeting (Athens, June 8th – 9th 2016), a small group discussion was held regarding the issue of continuity of care (Deliverable D4.1 & D4.2). All participants emphasized the importance of ensuring, at minimum, information transfer on the health needs and provided interventions. There was a strong support for use of online electronic systems, since this would be a safer and faster way of data transfer, but if not possible, a password protected memory stick (USB) could be given to the refugee to carry with them during the migration/resettlement. Language barriers among EU member states were identified as an important issue, and two possible solutions were discussed: using English language, or using universal (international) codes for diseases/medication and vaccination. Two systems for fostering informational continuity of care emerged: the recently developed IOM personal health record[22] and The International Classification of Primary Care (ICPC-2).[23] The next two paragraphs briefly present both systems, stressing the parts of the systems that refer to mental health care.

IOM personal health record (PHR) aims to assess health status of refugees and migrants, regardless of their point of entry in EU countries and/or length of stay at the time of health assessment. It combines personal history, physical examination, basic laboratory tests and assessment of mental health status and aims to evaluate health needs regarding acute/chronic conditions, communicable or non-communicable diseases, immunisation status, injuries or mental health problems.[22] This procedure is expected to be followed up by immediate treatment, if needed, and follow-up. In the process of health assessment, examining physician/nurse/healthcare assistant takes patient's medical history including their known vaccination record. In case of indication of a need for immediate follow-up or further investigation, the patient will be referred to an appropriate health facility. IOM is currently developing an electronic personal health record and platform.

In the PHR, there are 4 questions concerning mental health:

- In medical history section, questions on previous/current mental illness/problems and on history of torture or violence (Y/N questions);
- In exam finding section, mental status should be assessed (including mood, intelligence, perception, thought processes, behaviour during examination) (Normal/Abnormal/Not assessed). Two assessment instruments are included in PHR: Mini-mental state examination - MMSE (only assessing cognitive impairment) and Assessment of activities of daily living – ADLs (assessing basic self-care functioning, e.g. ability to feed, dress and wash oneself);
- In summary findings section, significant mental health condition can be specified.

ICPC-2 was published for the first time in 1987 by World Organisation of Family Doctors (WONCA), and is designed to help primary health care providers to classify three elements of the health care encounter: reasons for encounter, diagnoses or problems, and process of care.[23] ICPS is linked to existing classifications such as ICD-10 (International Classification of Diseases) and is included in the WHO-FIC (WHO Family of International Classifications).

The system consists of symptoms codes, diagnoses and process codes referring to tests or actions undertaken per encounter. Since code thesaurus is universal, it bridges the language barrier: GP's in different countries can see the patient information in their own language.

In ICPC-2, there are 29 codes for psychological symptoms, and 17 codes for psychiatric diagnoses. In addition, there is a process code regarding intervention in the area of psychosocial assistance: therapeutic counselling/listening. Among the 29 symptoms, there are 5 that can refer to expressions of distress usually found in the refugee populations: feeling anxious/nervous/tense, acute stress reaction, feeling depressed, feeling/behaving irritable/angry and sleep disturbance. Furthermore, there are additional 29 codes for different social problems, some of which are very relevant for refugee and migrant population, for example poverty, housing problem, unemployment, legal problem or health care system problem.

Although psychological symptoms are better represented in ICPC-2, both systems lack what we believe are important pieces of information concerning MH status of refugees and migrants. Neither of these systems proposes a way to assess the intensity of distress which would indicate that action is needed. Proposing a standardised and valid procedure to screen people in distress is especially important in refugee populations, since identifying MH issues in refugees and migrants is a challenging task for a variety of reasons, ranging from cultural aspects of language barriers and accessibility, to problems such as defining and understanding mental illness across cultures.[24] In addition, these systems do not propose a way to record psychosocial interventions provided to the refugee or migrant. Therefore, we propose a recording format which would be based on a validated screener for psychological distress (RHS-13, Appendix I) and on a checklist of interventions that are recommended under the PFA approach. This recording system can be integrated in PHR and ICPC-2 systems, and can be used in a paper or electronic version.

The recording system for mental health of refugees and migrants which is proposed here includes results of MH screening, in terms of "positive" (above-the-cut off) screen on RHS-13 scale.[21] Individual symptoms could be described in a comment (PHR format), or entered as a symptom code (ICPC-2 format). In addition, the system would include a list of interventions, where care providers can mark and comment on interventions they have provided (PHR format) or enter the interventions as a process code (ICPC-2 format). This recording system would serve two purposes: first, to describe psychological state of the refugee or migrant based on the most relevant symptoms, and to provide information on the relevant areas of interventions that have been provided or deemed important. In the text bellow, the two recoding formats for MH issues that can ensure the continuity of refugee psychosocial care are illustrated: PHR format on pages 16-18 and ICPC format on pages 19-20.

Psychosocial Health Record I (PHR format)

Section 1 PROVIDER INFORMATION

Family name

Last name

Profession

Contact information City, Country

Email

Phone

Section 2 CLIENT INFORMATION

Family name

Last name

Date of birth

Country of origin

Language

Gender ☐ Male ☐ Female

Section 3 CURRENT NEEDS

Screening above cut-off on RHS-13 ☐ Negative ☐ Positive

If positive, please briefly comment on the most prominent difficulties (screener questions with the highest score):

Referral to MH specialist for full assessment and care provided ☐ Yes ☐ No

Are you aware of other difficulties the client is experiencing?

☐ Thoughts of harming self or others *Add comment*

☐ Alcohol or drug abuse *Add comment*

☐ Concerns about ongoing threat *Add comment*

☐ Physical/mental illness and medication(s) *Add comment*

☐ Extreme guilt or shame *Add comment*

☐ Concerns about safety of loved one(s) *Add comment*

☐ Availability of social support *Add comment*

Section 4 PSYCHOLOGICAL FIRST AID COMPONENTS PROVIDED

Safety and Comfort

☐ Attended to physical safety and comfort *Add comment*

☐ Attended to a child separated from parents *Add comment*

☐ Assisted with concern over missing loved one *Add comment*

☐ Assisted with grief reactions *Add comment*

☐ Assisted after death of loved one *Add comment*

☐ Gave information about the current situation *Add comment*

Stabilisation

☐ Helped with stabilisation *Add comment*

Practical assistance

☐ Helped to identify most immediate need(s) *Add comment*

☐ Helped to address immediate need(s) *Add comment*

Connection with Social Supports

☐ Facilitated access to social support *Add comment*

☐ Helped to engage in activities *Add comment*

Information on Coping and Psychoeducation

☐ Gave information about stress and coping *Add comment*

☐ Taught simple relaxation technique(s) *Add comment*

☐ Addressed negative emotions/anger management *Add comment*

☐ Addressed substance abuse problems *Add comment*

☐ Helped with sleep problems *Add comment*

Linkage with Collaborative Services

☐ Provided link to additional services *Add comment*

Section 5 OTHER

Do you have any other comments?

Psychosocial Health Record I (ICPC-2 format)

Psychological symptoms

PXX Severe distress (*coded if patient scores above cut-off on RHS-13*)

- PXX.X Muscle, bone, joint pains *(coded if intensity is at least "1")*
- PXX.X Feeling down, sad or blue most of the time *(coded if intensity is at least "1")*
- PXX.X Too much thinking or too many thoughts *(coded if intensity is at least "1")*
- PXX.X Feeling helpless *(coded if intensity is at least "1")*
- PXX.X Suddenly scared for no reason *(coded if intensity is at least "1")*
- PXX.X Faintness, dizziness, or weakness *(coded if intensity is at least "1")*
- PXX.X Nervousness or shakiness inside *(coded if intensity is at least "1")*
- PXX.X Feeling restless, can't sit still *(coded if intensity is at least "1")*
- PXX.X Crying easily *(coded if intensity is at least "1")*
- PXX.X Had the experience of reliving the trauma; acting or feeling as if it were happening again? *(coded if intensity is at least "1")*
- PXX.X Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma? *(coded if intensity is at least "1")*
- PXX.X Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings) *(coded if intensity is at least "1")*
- PXX.X Been jumpier, more easily startles (for example, when someone walks up behind you) *(coded if intensity is at least "1")*

PXX Thoughts of harming self or others

PXX Alcohol or drug abuse

PXX Extreme guilt or shame

Social problems

ZXX Concerns about safety of loved one(s)

ZXX Availability of social support

Process codes

XX Attended to physical safety and comfort

XX Attended to a child separated from parents

XX Assisted with concern over missing loved one

XX Assisted with grief reactions

XX Assisted after death of loved one

XX Gave information about the current situation

XX Helped with stabilisation

XX Helped to identify most immediate need(s)

XX Helped to address immediate need(s)

XX Facilitated access to social support

XX Helped to engage in activities

XX Gave information about stress and coping

XX Taught simple relaxation technique(s)

XX Addressed negative emotions/anger management

XX Addressed substance abuse problems

XX Helped with sleep problems

XX Provided link to additional services

Conclusions and next steps

The Model of Continuity of Psychosocial Refugee Care includes identifying refugees and migrants in need of psychosocial help and offering brief, focused PFA support. This support should be compassionate, person-centred and based on needs and wishes of refugees and migrants. Information about assessment of the mental and psychosocial status and the following PFA interventions provided to an individual refugee or migrant should be stored, with full and informed consent of each individual, and in a way so that only care-providers authorized by the patient can access it at all points of contact and at the final refugee destination. This can be done as a paper health record booklet or stored on a transferrable media (e.g. USB stick) or in a secure data base, with passwords known only to the patient. For this process, it is of paramount importance to obtain bioethical approval from the relevant institutions. Information transfer such as this would enable the care-provider to quickly understand the history and status of the refugee patient who reached out avoiding repetition of asking questions about the symptoms, see what PFA interventions were provided, and to provide a next "dose" of interventions that are consistent with the previous ones. Upon doing this, the care-provider should enter simple information about the interventions, so that there are cumulative, continuous records on one client/patient. Refugees and migrants should be encouraged to access the designated mental health psychosocial support care-providers and be informed how to do this at the next point of contact.

The next steps in WP5 include piloting of the screening procedure, including using RHS-13 scale in the Reception Centre Porin in Zagreb, for which ethical approval was obtained from the relevant body of the University of Zagreb on 5 July, 2016. The screening procedure will be piloted with approximately 120 asylum seekers. The results of those who score above the cut-off on the screening tool will be shared with the psychosocial support team in the Reception Centre and with the GP who is responsible for providing health care in the Centre, with the consent of the individual. In this way the feasibility of conducting mental health screening and of the information sharing protocol previously described will be tested.

In addition, cooperation has been established with IOM Croatia, who will be conducting physical health screening and collecting data for PHR in the next months. Therefore, experiences from WP5 piloting of the screening procedure will be shared with IOM PHR, but not the individual data. Upon this piloting, we will provide recommendations on integration of mental health screening in overall health screening for refugees and migrants with the hope that more relevant set of information on asylum seeker mental health needs will be included in the PHR.

Appendix I Refugee health screener 13[6]

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

CHECK ONE: ☐ POSITIVE ☐ NEGATIVE ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

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[6] can be obtained at: http://www.lcsnw.org/pathways/

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WP5 Piloting of face to face MH training.

In addition to the Grand Agreement (Annex 1) a special curriculum was developed in the framework of WP5 and it is entitled: “Piloting of the face-to-face training course Mental Health of Refugees and Other Migrants”.

As the need for capacity building in the area of mental health is a common finding in all EUR-HUMAN project work packages, a special curriculum for a face-to-face training focusing on these topics was developed based on WP5 deliverable D5.1 - Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS.

Piloting the two-day face-to-face training mental health of refugees and other migrants with 30 primary health providers and other care providers demonstrated high level of effectiveness and feasibility of the program. The piloted program was assessed as highly acceptable and recommendable to other care providers. The face-to-face mode of training proved efficient and culturally appropriated in relating the new knowledge to daily experiences of the training beneficiaries. They assessed that this training is likely to increase different aspects of their competencies for providing care to the seekers of international protection. The resources needed for delivery of this training program when using the prepared guide book for trainers and the slide presentations are not very demanding, which may contribute to wide dissemination of this training program and the consequential capacity building.

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Contents

Executive summary 1

Mental health of refugees and migrants: Piloting the face to face training for care providers .. 2

- Introduction 2
- Background 3
  - Developing the curriculum 3
  - Resources 4
- Piloting 4
  - Participants recruitment 4
  - Participants 5
  - Implementation 6
- Evaluation 7
- Adaptation of the program after piloting 9
- Conclusions and Recommendations 10
- Appendix I. Participants 11
- Appendix II. Programme 13

Executive summary

Introduction. As the need for capacity building in the area of mental health is a common finding in all EUR-HUMAN project work packages, a special curriculum for a face-to-face training focusing on these topics was developed.

Background. The two-day, face to face training programme is based on WP5 deliverable D5.1 - *Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS.* Training programme has multiple sessions that cover topics concerning mental health, psychosocial needs and MHPSS activities aimed at supporting and helping refugees and migrants in the context of the European migration crisis. Extensive training materials were developed. They include two power-point presentations, a detailed step-to-step guide in English and Croatian, and several handouts for participants. The curriculum is applicable for other European countries, after adaptation to local context, which should include at minimum adapting the statistical data, legal framework and role-play scenarios.

Piloting. 32 professionals of different background (general practitioners, psychologists, social workers, interpreters) from institutions and organisations providing services in reception centres for seekers of international protection Croatia, attended the two-day training that took place on 4th and 5thof November 2016 in Zagreb.

Evaluation. Evaluation questionnaire included 15 self-rating questions and several open-ended questions. 27 participants filled out the evaluation form. The most appreciated training topics were PFA for children and adults, including does and dont's exercise, and new "tools" that were presented, including triage and screening procedures. Participants were also satisfied with the opportunity to share their experience with other professionals, which is one of the main advantages of face-to-face trainings comparing to other training modalities.

Recommendations. The piloted program was assessed as highly acceptable and recommendable to other care providers. Primary health and other care providers assessed that this training is likely to increase different aspects of their competencies for providing care to the seekers of international protection.

Mental health of refugees and migrants: Piloting the face to face training for care providers

Introduction

European Refugees-Human Movement and Advisory Network (EUR-HUMAN) is an EU founded project aimed at supporting and assisting European member states in dealing with the current refugee and migrant crisis. The main objective of the project is to help EU member states to effectively address various health needs of refugees and migrants by defining, devising and evaluating comprehensive interventions for the provision of primary health care with a special focus on vulnerable groups. This report describes piloting of the face-to-face training for primary health and other care providers on the topic of mental health and psychosocial support (MHPSS) for refugees and other migrants.

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 principles) would suffice, but for some people there is also a need for more specialised psychological aid. In Austrian long-term refugee centres, for example, it was recognised that there is a great need for mental health care, 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 seekers Porin in Zagreb, Croatia (**WP5**), where 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 out 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 on 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 care. 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 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 appropriate. The process of developing this curriculum, as well as the piloting the course delivery, is presented in this report.

Background

Developing the curriculum

Training curriculum was developed based on WP5 deliverable D5.1 - *Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS.* D5.1 summarised the knowledge on MH triage, screening and psychological first aid interventions based on key expert guidelines, handbooks and scientific papers. Key principles guiding the proposed protocols were human rights and equity, active participation, 'do no harm', building on available resources and capacities, using integrated support systems and providing multi-layered support. Following these principles is in line with the overall person-centred, integrated and compassionate models of health care approach of the EUR-HUMAN project.

This training aims to meet the needs of a broad group of primary health care providers who work with refugees and migrants, ranging from professional health and allied personnel (medical doctors, nurses, psychologists, social workers) to paraprofessional and volunteer staff (health care volunteers, community workers, volunteers among the migrant population, cultural mediators and interpreters). The two-day, face-to-face training programme consists of 8 training sessions and an introduction (Day 1) and evaluation (Day 2) 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 on day two.

The first session defines the basic terminology and presents an overview of refugee and migrant experiences, including traumatic exposure and their consequences, difficulties during resettlement and most common mental health issues and psychosocial needs. The second session introduces the participants to the Psychological First Aid (PFA) approach for providing mental health and psychosocial support and practical assistance to refugees and migrants. Core PFA actions are explained and two exercise sessions help the participants to rehearse different aspects of PFA approach based on scenarios that are likely to occur in their daily work. Session three describes the procedure of mental health triage for quick identification of individuals in severe distress who require immediate attention. At the end of the first day, participants discuss their experiences and clarify any questions they might have regarding the contents of the training.

Day two starts with a quick recap of the previous day and an introduction to the day's activities. Session four describes procedures for screening of mental health conditions and referral to specialised mental health care as needed. Participants are also introduced to a short

and validated tool for mental health screening (RHS-13). Session five provides an overview of culture specific topics relevant for the refugee and migrant populations, while session six highlights important considerations when working with interpreters. In session seven participants learn about mental health needs and interventions for refugee and migrant children and adolescents. The eighth and final session of the training explains the legal framework relevant for international protection applicants and describes the conditions and rights of refugees and migrants seeking international protection.

Two power-point presentations (for Day 1 & 2) and a detailed step-to-step guide in English and Croatian were developed and 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. Preparation of these materials took approximately 3 person months.

Resources

Delivering this training required about one person-week strictly dedicated to organisational issues. Before the training, these included registration of the training course with the responsible professional chambers (e.g. Chamber of Physicians, Nurses, Psychologists, Social Workers), preparing online registration forms, inviting participants, communicating with the participants, booking the venue and preparing materials for the participants. After the training, the workload included registering the participants for credits with the respective professional chambers and analysing evaluation data . Another two full days were needed for support during the training and delivering the training itself.

Trainers should have a good track record of previously held similar trainings and advanced teaching skills. They should have profound knowledge, if not extensive hands-on experience in working with migrants. They should be very well acquainted with local conditions regarding asylum process and services available to refugees and other migrants. This is especially important in order to adapt the curriculum to local needs and capacities. Local adaptation should include at minimum adapting the statistical data, legal framework and role-play scenarios. Translation of the presentation (121 slide) and guidebook (78 pages) into the local language also requires time.

Piloting

Participants recruitment

Since there is currently little new staff starting to work with refugees and other migrants, it was decided to recruit the participants who are currently working in the two only asylum-seekers reception centres in Croatia, located in Zagreb and Kutina. This, however, allowed us to receive valuable feedback and realistic evaluation from the participants who have direct working experience with these groups. We specifically asked the participants to evaluate from

their experience whether this training would have been useful to them if they were just starting to work with refugees and migrants.

The invitations were sent to all relevant institutions and organisations providing services for refugees and migrants, both governmental and non-governmental (see next section on participants). Invitation was also sent to organizations involved in other projects funded by CHAFEA under the same call, including IOM, Médecins du Monde and Croatian Institute for Public Health.

Participants

In total, 32 participants attended the training (Appendix I.). Participants came from the following organizations: International Organisation for Migration (IOM), Médecins du Monde, Croatian Institute of Public Health, Croatian Red Cross, Medical Health Centre Zagreb, Jesuit Refugee Service (JRS), Society for Psychological Assistance, Centre for Peace Studies, Rehabilitation Centre for Stress and Trauma, National Protection and Rescue Directorate, Andrija Štampar Institute of Public Health, Department of Social Services Zagreb, and Primary School "Fran Galović" Zagreb (children from the reception centre Porin are enrolled in their school programme). *Table 1* shows the participant structure according to their current role in working with refugees and other migrants.

Table 1. Training participants according to their role in working with refugees and other migrants

Role	N
Psychologist	8
Interpreter	5
General medical practitioner	5
Social worker	4
Occupational therapist	2
Volunteer	2
Epidemiologist	2
Visiting nurse	1
Project assistant	1
Programme administrator	1
Lawyer	1

The evaluation form was completed by 27 participants. They were mostly female (65%), and average age was 33 years. They had, 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 previously at least one training about working with migrants (54% of them attended 3 or more courses), while 88% participants attended at least one course about mental health and psychosocial support of migrants (46% joined 3 or more trainings).

Implementation

The training took place on 4th and 5thof November 2016 in Zagreb. Detailed time schedule is provided in the Appendix II. Training was delivered by prof. Dean Ajduković, Helena Bakić., Ines Rezo, and NikolinaStanković. 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. candidate at the Department of Psychology, University of Zagreb, with extensive experience and education in psychological counselling, psychotraumatology and resilience factors in recovery process. Ines Rezo is also a Ph.D. candidate at the Department of Psychology, University of Zagreb, with extensive experience in counselling and psychosocial support of children and families in distress. Nikolina Stanković, univ. back. 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 of the Mental Health of Refugees and Other Migrants Training Course

Participants exercise breathing and relaxation techniques for children

Evaluation

The evaluation questionnaire included 15 self-rating items and several open-ended questions. Overall, participants were very satisfied with the training and would recommend it to their colleagues. They were very confident in their ability to provide different aspects of MH care to adult refugees and migrants, including triage, screening procedures and PFA. These rating were little lower for working with children, which may indicate that participants understood that working with children requires more specialised knowledge and skills, and points to the need for further training specifically on this topic. They assessed that they have acquired new knowledge in intercultural competences and working with interpreters to a moderate degree, which probable reflects participants' experience in working in the context of refugee crisis. This is also reflected in the fact that topics in this training were not overly new to them, which was expected, but it still provided them with new knowledge, insights and skills to a large degree. Summary of responses to all self-rating items is presented in Table 2.

Table 2. Summary of responses to self-rating questions

	Question	N	M	Min	Max	NA*
1.	Will you be able to provide psychological first aid to adult refugees and other migrants	24	4.3	1	5	2
2.	Will you be able to identify an adult showing signs of severe psychological distress	25	4.6	2		1
3.	Will you be able to apply the Refugee Health Screener (RHS-13)	25	4.2	1	5	1

	Question	N	M	Min	Max	NA*
4.	Will you be able to provide psychological first aid to children	23	3.8	1	5	3
5.	Will you be able to identify a child showing signs of severe psychological distress	25	4.2	2	5	1
6.	Will you be able to plan and implement psychoeducational activities with children	23	3.7	1	5	3
7.	Did you acquire new knowledge on cultural issues which can help you in working with refugees and other migrants	25	3.5	1	5	1
8.	Did you acquire new knowledge needed for successful collaboration with interpreters	25	3.0	1	5	1
9.	Considering the overall content of the training, did it provide you with new knowledge and skills that will be useful in your work with refugees and other migrants	24	4.0	2	5	1
10.	To what extent were the topics in this training new to you	26	2.8	1	5	0
11.	To what extend will this training help you to improve activities at your current work place	25	3.8	2	5	0
12.	How were the trainers prepared and qualified to lead the training	25	4.4	3	5	0
13.	Did the training meet your initial expectations	26	4.2	2	5	0
14.	Would you recommend this training to your colleagues	26	4.5	2	5	0
15.	How satisfied are you with the training as a whole	26	4.4	2	5	0

*NA: not applicable. N is number of responsed, M is arithmetic mean, Min and Max are lowest and highest assessments by individual participants.

Responses to the open ended questions (*Table 3)* revealed that the most appreciated training topics were PFA for children and adults, including does and dont's exercise, and new tools that were presented, including triage and screening procedures. Participants were also satisfied with the opportunity to share their experience with other professionals, which is one of the main advantages of face-to-face trainings comparing to other training modalities.

There were only a few answers to the question on unnecessary or too extensive topics. Some participants mentioned that jargon should be better adapted to participants; an issue that always presents a challenge when working with a multidisciplinary group. Two participants mentioned that PFA role-playing exercise should be replaced with a discussion, which was also observed by trainers during the exercise. Recommendations for future trainings included adding more practical exercises and more time for discussion. Participants also expressed the need for further training on some specific topics, for example, working with the interpreters, unaccompanied minors, women and topics on professional self-care and burnout. Finally, when asked about the barriers to implement new skills at workplace, lack of staff was mentioned (e.g. interpreters and specialised care providers), legal obstacles (e.g. limited access to specialised non-acute care) and lack of time in general, as well as some organisational barriers, such as lack of coordination and overall organisational climate.

Table 3. Summary of answers to open-ended questions

Category	N
Most liked aspects/topics of the training	
PFA for children	11
PFA –including does and dont's	6
Tools (triage, screening)	6
New experiences, sharing experiences	5
Very good trainers	4
New knowledge	2
The best MH training I attended so far	1
Topic about interpreters	1
Too extensive or unnecessary topics	
Jargon better adapted to participants of the training	4
Everything was perfect	3
None	3
Avoid role playing, instead add a discussion	2
More exercises with interdisciplinary cases	1
Suggestions and recommendations for future trainings	
Adding more exercises	4
A training for interpreters only	3
Adopting the terms and content to characteristics of the participants	3
Add topic about professional self-care and burn-out	2
More attention to topic about interpreters	2
More time to network with other participants	2
Talking more about real situations to learn from others experience and mistakes	2
Topic about unaccompanied minors	2
More tools	1
Reducing the number of lectures	1
Topics about working with women	1
Barriers of applying skills at work place	
Language barrier/lack of interpreters	5
Legal framework and administrative barriers	5
Lack of time	4
Not working with migrants at the moment	2
Demotivated migrants	2
Interpreters have many roles and this is a big barrier	1
Lack of personal (psychiatrists, paediatricians)	2
Poor organisation	1
Not enough collaboration at the institution I am working at	1

Adaptation of the program after piloting

Based on the observations of the trainers and suggestions provided by participants, only small modifications were made to the original training program. The role-play activity is changed into an activity of studying the case scenarios in small groups and formulating suggestions

how to resolve the problem having in mind the principles of PFA. Small changes in the time schedule include extending the lunch break on both days to 60 minutes, The topic on legal framework was shorted from 30 to 15 minutes.

Conclusions and Recommendations

Piloting the two-day face-to-face training Mental Health of Refugees and Other Migrants with 30 primary health providers and other care providers demonstrated high level of effectiveness and feasibility of the program.. The piloted program was assessed as highly acceptable and recommendable to other care providers. The face-to-face mode of training proved efficient and culturally appropriated in relating the new knowledge to daily experiences of the training beneficiaries. They assessed that this training is likely to increase different aspects of their competencies for providing care to the seekers of international protection. The resources needed for delivery of this training program when using the prepared guide book for trainers and the slide presentations are not very demanding, which may contribute to wide dissemination of this training program and the consequential capacity building.

Co-funded by the Health Programme of the European Union

EUR-HUMAN

Filozofski fakultet Sveučilišta u Zagrebu

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Appendix II. Programme

Day 1

Time (duration)	Topic	Contents
9:00-9:30 (30')	Introduction of the day	1. Welcome and introduction of participants 2. Programme overview, participant expectations
9:30-10:30 (60')	Refugee and migrant experiences	1. Definition of terms 2. Consequences of being a refugee/migrant a. Stages of migration b. Common mental health disorders and symptoms c. Societal costs of migration d. Psychosocial needs of refugees and migrants
10:30-10:45 (15')	Coffee break	
10:45-12:15 (90')	Psychological First Aid (Part I)	1. Introducing Psychological Frist Aid (PFA) 2. Group activity: "PFA do's and don'ts" 3. PFA core actions: a. Preparation b. Making first contact c. Ensuring safety and comfort
12:15-13:15 (60')	Lunch break	
13:15-15:00 (105')	Psychological First Aid (Part II)	1. PFA core actions: a. Stabilisation b. Assessing current needs and concerns c. Providing practical assistance d. Promoting social support e. Providing information on coping f. Linking with collaborative services 2. Group activity: PFA role play
15:00-15:15 (15')	Coffee break	
15:15-15:45 (30')	Triage for mental health urgency	1. Definition of triage 2. Triage steps 3. Behavioural signs 4. Rapid assessment and immediate assistance
15:45-16:00 (15')	Wrap-up	

Day 2

Time (duration)	Topic	Contents
9:00-9:15 (15')	Introduction	1. Brief reflection of day 1 2. Introduction to the day's programme
9:15-10:00 (45')	Screening and Referral	1. Mental health screening a. Introduction to mental health screening b. Screening steps c. Refugee Health Screener (RHS-13) d. Screening vs. Triage 2. Referral a. Introduction to referral b. Referral steps c. Principles of successful referral
10:00-10:30 (30')	Culture specific topics of providing MHPSS	1. Cultural competence 2. Cultural considerations
10:30-10:45 (15')	Coffee break	
10:45-11:15 (30')	Working with interpreters	1. Guidelines for choosing an interpreter 2. Working with interpreters pre, during and after the meeting
11:15-12:15 (60')	Refugee children and adolescents (Part I)	1. Mental health of refugee children a. Differences between children and adults b. Traumatic experiences of children c. Mental health problems of children
12:15-13:15 (60')	Lunch	
13:15-14:15 (60')	Refugee children and adolescents (Part II)	1. Psychological first aid for children: a. Preparation for delivering PFA to children b. PFA do's and don'ts for children c. PFA core activities for children 2. Communicating with parents 3. Activities for refugee children
14:15-14:30 (15')	Rights and obligations of refugees and migrants in Croatia	1. International protection procedure 2. Rights of international protection seekers in Croatia 3. Accommodation facilities for refugees and migrants
14:30-15:30 (60')	Discussion, wrap-up and evaluation	

APPENDIX 11. DELIVERABLES OF WP6.

D6.1 Report about the results of the assessment of the local situation and resources available.

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Work package 6, Task 6.1

Deliverable 6.1

Report about the results of the assessment of the local situation and resources available

Final Version 2016/07/04

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"The content of the EUR-HUMAN report for deliverable 6.1 represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commissions 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"

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Executive summary

The EUR-HUMAN project, aims to identify, design, assess and implement measures and interventions to improve primary health care delivery for refugees and other migrants. Deliverable 6.1 reports on the results of the assessment of the local situation and resources available in terms of refugee facilities, primary health care for refugees, initial health assessment, interpreters and cultural mediators, challenges and barriers for primary health care providers and health care skills amongst refugees.

Each intervention site country (Greece, Italy, Croatia, Slovenia, Hungary, and Austria) compiled a structured national report on the local country specific challenges and resource situation. In order to ensure that all relevant aspects for the assessment and identification of existing capacities were covered, three methods were proposed to be combined: 1) a narrative literature review, 2) (semi-) structured interviews with local primary health care providers or stakeholders involved in refugee care provision or organisation, and 3) participant observation. All six intervention partners applied all three suggested methods and gathered data independently between April 1st and 30th and submitted their national reports to MUW until May 15th 2016.

Specific challenges were identified on different levels, one of the biggest challenges was found to permeate the systemic level. The extremely dynamic nature and complexity of the refugee crisis and the continuous changes that were undertaken with regards to it, pose a huge challenge to the intervention countries in terms of health care provision for refugees and other migrants. After the high influx of refugees via the Balkan route the situation changed quite substantially after the EU-Turkey deal came. This shift had different implications for intervention site countries and poses challenges for countries to respond to it. Findings also showed that challenges emerged due to varying capacities of facilities for refugees, frequently centres and camps were e.g. converted, re-named, opened and closed during the high influx of refugees 2015.

On an organizational level the greatest challenge in all intervention countries appeared to be the lack of staff and resources. Particularly the lack of multidisciplinary teams, including GPs, pediatricians, nurses, psychologists, social workers, cultural mediators, pediatricians and midwifes was found extremely problematic and challenging in terms of adequate health care provision. The term cultural mediator specifically refers to interpreters who are not only translating but also function as cultural mediators. Furthermore we found that clear pathways for (primary) health care for refugees are missing in many intervention site countries. For instance, there is no standardized initial health assessment in place in the intervention countries and documentation and monitoring structures are often unsuitable or missing. The lack of specific guidelines for vulnerable refugees, such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence, was also identified as challenging for health care provision. Another crucial organizational challenge that was specified was related to the coordination of different organizations, which provided (primary) health care services. Especially in settings e.g. Greece, where a clear division of competences and responsibilities is difficult to establish and many different organizations are engaged, the situation of challenged the health care provision for refugees.

On the level of primary health care providers, challenges and barriers existed particularly with respect to lack of information and knowledge on specific refugee care provision, risk factors, country specific illnesses, mental health support and recognizing and treating post-traumatic stress disorders. Linked to that findings showed that cultural barriers also posed a challenge to provision of care e.g. different

understandings of illness, treatment, privacy and taboos lead to ethical dilemmas and finally also hampered the work of health providers on the ground. Knowledge on country specific idioms of distress, as well as different illness concepts was noted as insufficient. At the same time legal questions on work permission, insurance and ethical aspects were issues important in the context of refugee care. Another aspect was the lack of a standardized format for medical documentation, or the difficult access to medical data records of refugees or asylum seekers, that was mentioned as a barrier in terms of providing health care and especially continuity of care. For GPs who provided long-term care for asylum seekers, the lack of remuneration for additional efforts as well as the lack of translation services available was also identified as challenging and problematic.

Lastly, the summary report found that there was hardly any information on health care skills of refugees. In most intervention site countries data on (primary) health care professionals who are refugees was difficult to obtain or did not exist at all, because it has never been collected. Findings showed that in some cases voluntary assistance and help of refugees who were health care workers was reported, however, they mostly acted as interpreters. In Austria, documentation on refugee health workers is increasingly established though an informal network of Arab speaking health professionals, and negotiations take place to engage people earlier into the workforce, potentially before their official validation of foreign studies and degrees is finished. Based on the findings, it is recommended that this unused potential should be formally recognized and built upon.

This deliverable 6.1 can be considered as assistance for the intervention countries of the EUR-HUMAN project. In brief, to be able to tackle the multifaceted challenges regarding primary health care for refugees and other migrants, integrated, person-centered, multi-professional interventions are needed which are adaptable to the special needs as well as cultural and ethical challenges of the local sites.

List of content

List of Contributors 2
Executive summary 3
Introduction, aims and objectives 6
WP 6, task 6.1: 6
Specific objective of WP 6, task 6.1 6
Deliverable 6.1 7
Timeline 7
Methods 8
Design 8
Data generation and analysis 10
Ethical approval 12
Results 12
Overall number of refugees and other migrants 12
Refugee facilities 14
Primary health care in general 25
Primary health care provision for refugees 27
Initial health assessment 42
Interpreters and cultural mediators 46
Challenges and barriers for primary health care providers 48
Refugees who worked in (primary) medical care and have applied for asylum 54
Discussion of main findings and implications for further Work Packages 56
Systemic level 56
Organizational level 56
Provider level 57
Potential remains unused 57
References 59
List of abbreviations 68
List of tables 68
List of figures 69
Annex 70
A1. Final template for national report for deliverable 6.1 70
A2. Country Report Greece 77
A3. Country Report Italy 105

A4. Country Report Croatia 114
A5. Country Report Slovenia 129
A6. Country Report Hungary 154
A7. Country Report Austria 167

Introduction, aims and objectives

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

The 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.

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

WP 6, task 6.1:

Identification and assessment of existing capacity of local organisations regarding primary care for refugees and other migrants and of refugees and other migrants who have themselves worked in primary care.

Specific objective of WP 6, task 6.1

Specific objective for task 6.1: to identify and assess the capacity, local situation, and needs of staff in Community-oriented Primary Care centres as well as other existing primary care settings (in six countries) regarding primary health care for refugees in order to improve the primary health care delivery for newly arrived refugees and other migrants with a focus on vulnerable groups.

In order to reach the specific objective each intervention site country (Greece, Italy, Croatia, Slovenia, Hungary, and Austria) provided input regarding their national as well as implementation site situation by writing a structured national report. The summary report described the situation as it was in April and May 2016, however, in some countries as e.g. in Greece the situation is not the same at the current date (29th June 2016). Thus, the provided information in the summary report relates to the situation as it was in April and May 2016, unless specified otherwise when updated data could be included during finalisation of the summary report. All national reports provided input to this deliverable 6.1.

Deliverable 6.1

Report about the results of the assessment of local resources available.

Timeline

Timeline	Tasks	**Responsible EUR-HUMAN partner**
1. April – 30. April	Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and other migrants and of refugees and other migrants who have themselves worked in medical care through: • Literature review (obligatory) • Semi-structured interviews • Participatory observation (for details please see methods section below)	**UoC, UoD, UL, FFZG, MUW, AUSL11**
1. May – 15. May	Writing and sending the national reports (=complete the blank sections of this template) to MUW	**UoC, UoD, UL, FFZG, MUW, AUSL11**
16. May – 05. June	Preliminary summary report of deliverable 6.1 for WP4 (expert meeting) to RUMC and UoC	**MUW**
10. June - 30. June	Synthesis and finalization of the summary report **(Deliverable 6.1)**	**MUW**

Methods

Design

The identification and assessment of the existing situation and the local primary health care resources available in six EU countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) was conducted by answering to the following questions:

- Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?
    - If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)
- Main countries where refugees and other migrants come from in your country?
- What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
- How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
- How is Primary Health Care provided in your country in general?
- Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?
- Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
- How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
- Primary health care staff situation (numbers, capacity, payment, safety, …)?
- Biggest challenges and barriers for primary health care providers?
- Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum? In what way are these resources documented and used already?

In order to be able to answer these questions three different methods were proposed to be combined: 1) narrative literature review/search of grey and scientific literature and reports, 2) (semi-) structured interviews with local primary health care providers treating refugees and other migrants and stakeholders involved in the organisation of primary health care for refugees and 3) participant observations in refugee camps and centres. According to the timeline, the intervention countries applied these methods between April 1st to April 30th 2016 and wrote and sent their national reports to MUW until May 15th 2016.

As defined in the final template for the national report for deliverable 6.1 (see A1. Final template for national report for deliverable 6.1) the narrative literature review was the minimum methodological criterion which had to be conducted for the national report. However, it was recommended to combine all of the following methods for the national report.

- **Narrative literature review/search of local grey[1] and scientific literature and reports** (existing documents on the local/national primary care capacity situation which include our questions raised above). Narrative means to describe and discuss the state of the existing literature of a specific topic or theme from a theoretical and contextual point of view. A narrative review consists of critical analysis of the grey and scientific literature published.[2] It does not describe the methodological approach that would permit reproduction of data nor does it answer to specific quantitative research questions. Nevertheless, a narrative review provides readers with up-to-date knowledge about a specific topic or theme. Examples for grey literature are reports by NGOs, governments, national, regional and international organisations, websites, publications in non-reviewed, non-indexed journals and quality newspaper articles.

- **(Semi-) structured interviews** with local primary health care providers treating refugees and other migrants and stakeholders involved in the organization of primary health care for refugees (~ 6-10 persons). The interviews could be face-to-face, as telephone-interviews, or skype interviews. It was voluntary to audiotape and transcribe the interviews for analysing the content, taking memory notes was also an option. It was also possible to send the question per email to certain persons and receive answers via email. The analysis should have been conducted with the aim to be able to answer the questions raised (the detailed interview guideline can be found in A1. Final template for national report for deliverable 6.1).

- **Participatory observations in refugee camps and centres**: Participatory observation is a technique of field research, commonly used in anthropology or sociology, by which one or more investigators (participant observers) study the life of a group by sharing in its activities and observing and documenting the incidences occurring, the behaviour of individuals and the group, as well as the interactions between individuals. In the context of primary health care, for instance, this allows the researcher to better understand the challenges and issues in clinical practice by observing the interactions between patients and health care workers.

[1]Luxembourg Convention on Grey Literature. Perspectives on the Design and Transfer of Scientific and Technical Information. Third Conference on Grey Literature. [http://www.greynet.org/]. Dobbins M, Robeson P: A Methodology for Searching the Grey Literature for Effectiveness Evidence Syntheses related to Public Health. The Public Health Agency of Canada; 2006.

[2] Cook DJ et al. Ann Intern Med 1997;126:376-380

Data generation and analysis

The six EU countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) generated data independently and submitted their national reports to MUW until May 15th 2016. All three suggested methods were applied by the respective intervention site partners. In order to ensure that all relevant aspects for the assessment and identification of existing capacities were covered, MUW provided a template on how to write the national report including an (adaptable) interview guideline (see: A1. Final template for national report for deliverable 6.1). The template was based on required information and developed with input of all EUR-HUMAN partners.

Table 1: Applied methods per country

Country	Literature search	Interviews	No.	Participant observation	No.	Explanatory note
Greece	✓	✓	8	✓	1	Greece: observations at hotspot of Moria
Italy	✓	✓	6	✓	1	Italy: observations at facility for asylum seekers and refugees with severe pathologies
Croatia	✓	✓	9	✓	2	Croatia: two observations at Porin Reception Centre
Slovenia	✓	✓	22	✓	2	Slovenia: observations at transit centre and an accommodation centre
Hungary	✓	✓	8	✓	*	Hungary: observations from WP2
Austria	✓	✓	8	✓	3	Austria: observations at three different long-term refugee camps

In addition, the six EUR-HUMAN intervention partners also included results from earlier studies, protocols from presentations and meetings, and results from already finished WPs in order to complete the questions raised in their national reports.

The (semi-) structured stakeholder interviews were conducted with the following representatives as listed in Table 2.

Table 2: List of conducted (semi-) structured interviews

Country	No.	Stakeholder/ Representative
Greece 8 Interviews	1	The Greek part of Médiciens Sans Frontières/Doctors Without Borders (MSF)
	2	The Greek part of Médiciens du Monde (MDM)
	3	The Greek Red Cross
	4	Praksis NGO
	5	Metadrasi NGO
	6	International Organization of Migration (IOM)
	7	United Nations High Commissioner for Refugees (UNHCR)
	8	The National Health Operations Centre (EKEPY) of the Hellenic Ministry of Health
Italy 6 Interviews	6	Six Health workers were interviewed of the Tuscan Local Health Unity (ASLTC) who deal with migrants and refugees in different ways and contexts; persons with different qualifications: GPs, obstetricians, paediatricians, public health doctors

Croatia 9 Interviews	1	Croatian Red Cross employee working in Kutina/Porin - psychologist
	2	Croatian Red Cross employee working in Kutina/Porin - social worker
	3	Croatian Red Cross employee working in Kutina/Porin - occupational therapist
	4	Volunteer coordinator - Centre for Peace Studies
	5	Volunteer - Centre for Peace Studies
	6	Psychologist - Society for Psychological Assistance
	7	Psychologist - Society for Psychological Assistance
	8	GP
	9	GP
Slovenia 22 Interviews	12	Interviews with health workers at Schengen border
	1	Volunteer at reception centre Vrhnika
	2	Nurse from Brežice
	3	Doctor from emergency medical aid
	4	Head GP of medical care in Vrhnika
	5	Coordinator for health care of migrants from Ministry of Health (Rigonci & Dobova)
	6	Medical technician from Brežice
	7	Head GP of health care of migrants in Brežice
	8	Nurse from Brežice
	9	Medical technician from Brežice
	10	GP from Logatec Health Centre
Hungary 8 Interviews	8	Eight local primary health care providers were interviewed, who treat refugees and other migrants in community shelters or in refugee camps
Austria 8 Interviews	1	GP, who also worked in transit centres
	2	GP, who also worked in transit centres
	3	GP, who also worked in transit centres
	4	Stakeholder, Asylkoordination
	5	Dentist from Syria, who also worked in transit centres
	6	Stakeholder, Austrian Red Cross federal representative for emergency rescue
	7	Refugee camp manager
	8	Refugee camp manager

All intervention site partners analysed their gathered data themselves and filled out the template. Several researchers were involved who co-authored the respective country reports and independently analysed at least part of the data.

MUW then completed the thematic analysis of all country reports, assembled it for the summary report and provides main findings and implications in this Deliverable 6.1.

Due to the different citation format and the huge amount of references in the respective national reports, the citations and references are not listed each individually in this summary report but all references per country are listed below in the section: “References” and can be checked in detail in the respective national reports.

Ethical approval

No specific ethical approval was necessary for the expert interviews; however several countries applied for ethical approval for the methods used in WP6 task 6.1 together with the methods used in WP2 of the EUR-HUMAN project. In Table 3 the countries and ethical approval numbers are listed.

Table 3: Overview of ethical approvals

Country	Approval	Ethic committee	Date/ File number
Greece	Approval	2nd health region of Piaeus and Aegean. Approval from the governor of 2nd health region	Protocol number: 7496, date 22-02-2016
Italy	No approval necessary	-	-
Croatia	No approval necessary	-	-
Slovenia	Approval	National Ethic Committee	24-03-2016
Hungary	No approval necessary	-	-
Austria	Approval	Ethics committee of the Medical University of Vienna	Austria: EK-No: 2181/2015

Results

Overall number of refugees and other migrants

As described in Deliverable 2.1, the flow of migrants and especially refugees entering Europe considerably increased in 2015. The majority of refugees arrive at the Greek islands or Italian shores (hotspots), until March 2016 they continued to travel from there through Croatia, Slovenia, Hungary to Austria or other countries of final destination in Northern Europe. This route was referred to as the "Western Balkan route" (Fact sheet: The Refugee/ Migration Crisis and Greece, April 2016).

European countries were challenged with different scenarios during 2015 until March 2016, while counties with sea borders (Greece and Italy) face a huge challenge of first point of entry hotspots; other countries remained primarily transit countries for refugees and migrants or became firstly host countries for asylum seekers. Croatia for example, reported that although it remained a transit country, the number of people applying to for asylum increased after the introduction of more restrictive measures for the control of refugees and migrant influx in mid-February (Croatian national report 6.1). After the EU-Turkey agreement came into effect and the west borders of Greece (Greece-FYROM borders) were closed, many refugees and immigrants got "stacked" in Greece. Due to this agreement, approximately 48,000 refugees and migrants who arrived before 20th March, which is the date on which the agreement came into effect, continued to be stranded in Greece with reduced options for onward travel (Greek national report 6.1).

Table 4: Number of refugees entering the country and number of asylum applications

	Refugees entering the country 2015	entering until March 2016	Asylum applications 2015	Asylum applications until March 2016
Greece	862.138	151.656	13.197	2641 (Jan+Feb)
Italy	153.842	23.179*	83.970	22.596
Croatia	558.242	100.487	152	379
Slovenia	360.213	98.068	385	340**
Hungary	~ above 500.000		177.130	7.185
Austria	730.000	114.124	88.151	14.328
* until April 13th 2016				
** incl. persons accommodated in deportation centres				

As Table 4 explicitly shows, all six EUR-HUMAN intervention site countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) recorded high numbers of refugees entering the country between 2015 until March 2016. While the various specific challenges in terms of primary health care for refugees and other migrants may vary in the different countries, the principal selection of the six intervention countries is once more underscored by the given numbers. It should be mentioned that the refugees entering Croatia, Slovenia, Hungary and Austria are largely coming from Greece and Italy.

The numbers in Table 4 were directly taken from the respective national reports sent to MUW, which rely on different sources, and final numbers on transit refugees as well as on asylum applications may differ according to these sources. Thus, Table 4 has an overview purpose as numbers cannot be compared one-to-one and should be treated with caution.

During 2015, **Greece** received 85% of refugees and migrants who wished to reach Europe and became the first entry point for 862.138 refugees and migrants for this explicit reason. Most of these people crossed the border via the "Balkan transit route" until the EU-Turkey agreement was reached and EU-borders were closed. The Greek national report estimates that the number of asylum seekers in Greece will raise due to the deal, as refugees can apply for asylum at Greek authorities, in order to avoid deportation to Turkey (Greek national report 6.1).

Italy is the second most important first entry point to Europe with established hotspots counting 153.842 refugees and migrants to have entered in 2015. Many of those persons continued traveling, however 83.970 persons applied for asylum in Italy until the end of 2015. According to the latest data from the Italian Ministry of Interior there are a total of 111.081 refugees and asylum seekers in Italy as of April 29th 2016 (Italian national report 6.1).

With the closing of the "Balkan transit route" the situation also changed substantially in the transit countries as well as in host countries. Before the EU-Turkey deal the majority of refugees who entered Slovenia or Croatia for example, did not apply for asylum but transited further. In Slovenia there exists the possibility that a person who does not apply for asylum can apply for a 6-month permit of retention in Slovenia, they are entitled to accommodation and basic care in accommodation centre (Slovenian national report 6.1). As with the closure of borders, the Croatian national report indicated that all new refugees and migrants who come to Croatia are mainly readmission cases, from other EU countries. The Dublin regulation and the challenges that rise from it are furthermore mentioned. The possibility of large numbers of asylum seekers to be continuously transferred back to Croatia from other EU countries is assumed to be hardly manageable under the system in its current state (Croatian national

report 6.1). Hungary, for example, erected a fence on the Serbian-Hungarian border and stopped the movement of refugees and migrants through the country. The Hungarian national report describes that people who crossed the border legally were transported to open refugee facilities, but most persons did not stay at Hungarian camps. In order to close predictable alternative routes, Hungary plans to also erect a fence between Hungary and Rumania (Hungarian national report 6.1). It is noted that the Austrian authorities started controlling the border between Hungary and Austria and did not allow the crossing of persons without official documents (Hungarian national report 6.1).

In terms of number of asylum applications in each country, it is relevant to note that the provided numbers do not reflect how many asylum seekers actually reside in a specific intervention site country. It was reported that e.g. in Hungary the number of asylum applications are much higher compared to the number of persons who are actually residing in the country (Hungarian national report 6.1). The dynamic situation poses specific challenges for the intervention site countries as well as for other countries of destination, where persons will not be admitted to an asylum procedure but have to potentially reside without any recognized status or option for international protection.

Refugee facilities

There exist different refugee facilities in the six intervention site countries, in line with Deliverable 2.1 this summary report classifies:

1) **HOTSPOTS,** or **HOTSPOT CENTRES** in Greece and Italy, and **TRANSIT CENTRES** in other countries – both places intended for short periods of stay
2) **INTERMEDIATE** short-stay centres for registration and/or application
3) **LONG-TERM** refugee centres, where persons reside who applied for asylum and are in the asylum process

Lastly, we also added deportation centres for persons who are not admitted to an asylum application in the country that they applied for asylum (Dublin III) or for persons who received a negative asylum decision.

4) **DEPORTATION CENTRES**, where persons reside who are not entitled to remain in the country.

It is relevant to note that this classification serves mainly to gain an overview of the different refugee facilities in the respective intervention site countries. However, in certain settings this classification falls short to precisely classify a facility under the scheme as centres were re-classified or converted during the high influx of refugees in 2015 and until March 2016 (e.g. from intermediate to long-term centres).

Table 5: Different refugee facilities per country

		HOTSPOT CENTRES (Greece, Italy), TRANSIT CENTRES	INTERMEDIATE (registration/ application)	LONG-TERM (during asylum procedure)	DEPORTATION
Greece (last data: 29.6.2016)		5 hotspots/reception centres: Eastern Aegean islands of Samos, Lesvos (Moria), Chios, Kos, Leors (now these became pre-departure-detention centres)	46 hosting centres: whereof 13 in Athens hosting around 14.870 persons, 5 in central Greece hosting 2172 persons, 1 in south Greece hosting 248 persons, 27centres in north Greece hosting 24.768 persons; the 4 unofficial camps were [all closed], additionally to the state centres there are 4745 persons hosted in UNHCR facilities, around 150 are out hosting centres		see hotspots section
	Capacity	(see Figure 1)	(see Figure 1)	Capacity of accommodation centres: 33.910 (30.000 new accommodation places will be created shortly)	see hotspots section
	Time period	all new arrivals are held while their case is assessed, Syrian refugees often leave immediately, others stay between 3 days and 1 week (WP2)	in reception centres for over 6 months, not intended	immigrants/refugees are hosted in relocation camps until a decision for asylum or for relocation in an EU country comes out	see hotspots section
Italy		6 hotspots in Lampedusa, Porto Empedocle, Pozzallo, Trapani, Augusta, Taranto	14 CARA, CPSA, CDA, Regional Hubs and 1657 temporary reception centres (CAS) established 2014 to face emergencies when there is no places at CARA, CPSA, CDA, Regional Hubs or in the SPRAR	SPRAR Project facilities (Protection System for Asylum Seekers and Refugees) (e.g. Villa Pepi and Villa Immacolata WP2)	5 CIE (Centres for identification and expulsion) in Rome, Turin, Bari, Caltanissetta, Trapani
	Capacity	Capacity: 2.100	Capacity CARA, CPSA,CDA: 9.504 Capacity CAS: 37.028	Total amount of asylum seekers in SPRAR: 20.596	N/A
	Time period	72 hours	time necessary to apply for international protection	until asylum decision is made (in theory)	N/A
Croatia		around 8 transit/temporary reception centres: in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo, Sisak, Opatovac, Slavonski Brod [all closed]	Reception Centre for Asylum Seekers Kutina and Porin (Zagreb)		Detention centre for Irregular Migrants Ježevo
	Capacity	Capacity Opatovac: 4000 Capacity Slavonski Brod: 5000	Capacity Kutina: 100 Capacity Porin: 600		Capacity: 100
	Time period	36 to 48 hours	N/A (all refugees who applied for asylum in Croatia were accommodated there; refugees who did not apply for asylum but were considered vulnerable groups were also accommodated in a closed section of Porin)		total maximum of 18 months

Slovenia		Transit Zone: Šentilj accommodation centre/reception centres Transit centre: Dobova Temporary accommodation centre Vrhnika [closed]		Accommodation places: 2 in Ljublijana 1 in Logatec Youth Crisis Centre: 10	Centre for Foreigners Postojna
	Capacity	Capacity Šentilj: 4152 Capacity Dobova: 4000		overall capacity: N/A (current occupancy) Ljubljana AH LI: 203 (187) Kotnikova (part of AH LI): 90 (65) Logatec (part of AH LI): 220 (29) Private houses or flats: N/A (11)	Postojna: 50 (occupancy: 38)
	Time period	only a few hours		until asylum decision is made	N/A
Hungary		Transit Zones: Röszke, Tompa, Letenye, Beremend	Permanent reception centres: Bicske, Vámosszabadi, Debrencen [closed] Temporary reception centre: Nagyfa, Körmend, Szentgotthárd Community Shelter: Balassagyarmat For unaccompanied children: Fót, and Hódmezővásárhely		Closed-off reception centres: Békéscsaba, Nyírbátor, Kiskunhalas; Győr
	Capacity	N/A	Capacity Bicske: 439 Capacity Vámosszabadi: 216 Debrencen: [closed] Capacity Nagyfa: 300 Capacity Körmend: 300-500 Capacity Szentgotthárd: N/A Capacity Balassagyarmat: 111 Capacity Fót: N/A Capacity Hódmezővásárhely: N/A	There are no numbers of how many asylum seekers are currently located in Hungarian refugee centres	N/A
	Time period	some hours, maximum days	Permanent reception centres & temporary reception centre: stay for the time of asylum process, can leave before Community Shelter: maximum stay of 2 months For unaccompanied children: N/A		maximum stay is 12 months
Austria		Transit centre: there existed over 80 emergency shelters along the transit routes [all closed]	Initial reception centres: Traiskirchen, Thalham Five federal refugee centres Seven distribution centres	Refugee camps	One specific detention centre Vordernberg for asylum seekers
	Capacity	capacity depended on the emergency shelter, detailed number is not available	Initial reception centres: Capacity Traiskirchen: 1500 Capacity Thalham: 150 Distribution centres: Capacity Bad Kreuzen: 180 Capacity distribution centre Vienna: 150 Capacity Traiskrichen East: 180 Capacity Gaisberg: 160	~ 85.000 (but reports show that the capacity is not sufficient)	specific detention centre Vordernberg: 200-220

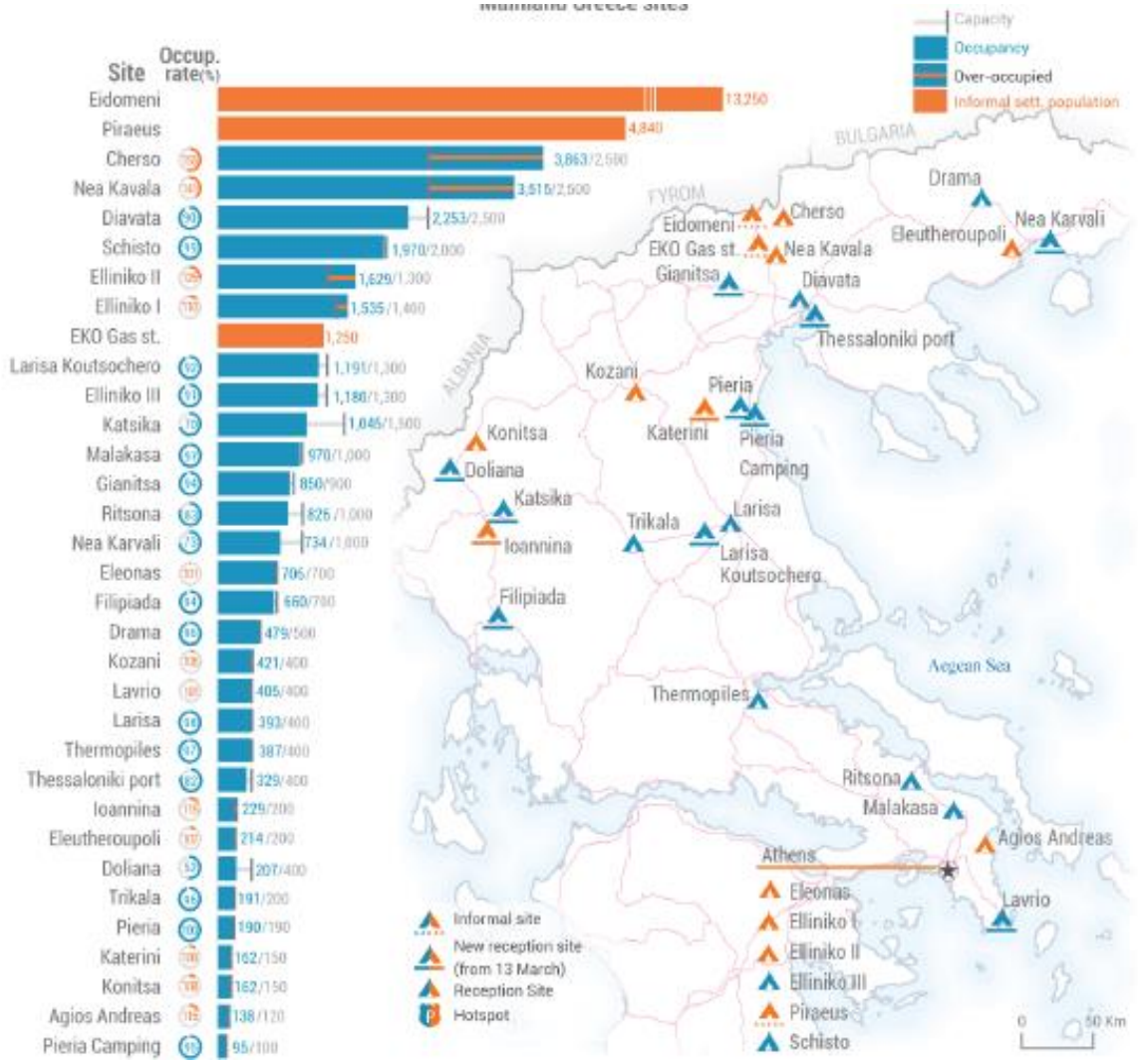
			Capacity Innsbruck: 200 Capacity Fehring: 150 Capacity Ossiach: 200		
	Time period	several hours, one day for up to three days	distribution centres: 48 hours but often refugees also remain there longer; persons who are assumed not be eligible for an asylum application in Austria are brought to the initial reception centre	Asylum seekers stay in the refugee camps until the asylum procedure is finished	Stay is as long as it takes for the person to get deported

Persons, who arrive in **Greece** after the EU-Turkey agreement, which came into effect on March 18th 2016, are accommodated in the 5 hotspots on the Greek islands. The lack of personnel in asylum procedures is the most significant obstacle for the procedure to be finished within the agreed 6-months' time frame (Greek National Report 6.1).

In terms of refugee facilities there exist at the moment 5 hotspots (in fact the 5th is the island of Kos due to island residents' reactions is unofficially out of order) Figure 5 shows the situation of relocation camps/hosting centres as of May 2016 (see: Figure 1), even newer data is provided below. In Lesvos island also, except the hotspot of Moria, which is the first created in Greece, there exists the hosting centre of Kara Tepe mainly for Syrian families. Refugees and immigrants can apply for asylum during their arrival at the hotspot, when they get recorded or at any time when they reach the mainland. They can also apply for asylum (after EU-Turkey agreement) even at the moment when they are on a boat being deported to Turkey.

By the shutting down of the main "Balkan migration route" to Western Europe, more than 42.000 refugees/migrants remain temporarily stranded across Greece, with an increasing trend. Latest data from Greece showed, that as of 29th June 2016, around 14.870 persons are hosted in 13 centres in Athens, 2172 persons are hosted in 5 centres in central Greece, 248 persons were hosted in one centre in south Greece, and 24.768 persons were hosted in 27 centres in north Greece. The unofficial camps were closed already. In addition to the formal state centres, there are different facilities from UNHCR hosting 4745 persons and around 1500 hosted in out hosting centres. At the Greek mainland, the majority of these centres have reached or have gone over their full capacity. Additionally, dilatory asylum procedures keep people stranded in reception centres for over six months, and as a conclusion of that, they will increasingly require integration assistance, education, and longer-term health interventions. In addition to reception facilities, over 30 accommodation centres are in operation throughout Greece as of April 2016, with a total capacity of 33.910 places, while 30.000 new accommodation places will be created shortly. In terms of long-term facilities it is relevant to note that until the EU-Turkey deal, Greece was a country not considered as final destination for refugees and migrants, so there are few long-term facilities or a mechanism to integrate these populations (Greek national report 6.1).

Figure 1: Cities capacity vs. occupancy in Greek hotspots and reception centres (UNHCR 2016)



In **Italy** a refugee plan is in place organized on three main levels, first a hotspot system provides for first reception services, first aid, identification and photo signalling. Persons are supposed to stay at hotspots between 48 and 71 hours, the 6 hotspots in the south are listed above in Table 5. The second level of reception is represented by government centres – CARA (Reception Centre for Asylum Seekers), CPSA (First Aid and Reception Centre), CDA (Reception Centre) – and Regional Hubs that are covering widespread the Italian territory. After their arrival in the South of Italy, migrants and asylum seekers are distributed throughout the Italian territory according to the capacity of the different structures in the Regions. In the government centres, migrants can apply for international protection and wait for the conclusion of procedures by the Commission or the competent territorial section.

There exist also temporary reception centres (CAS), established in 2014, according to Ministry of the Interior Circular no. 104, on January 8th 2014. According to their definition, they should be temporary reception centres, established to face emergencies and exceptional situations when there are no places available in the second level and in the SPRAR project (third level see below). De facto, they are used for ordinary reception and, according to the data available the majority of asylum seekers arriving

to Italy are placed in this type of centres. Situations of overcrowding in the second level of reception have been denounced by several NGOs.

The third level of reception is represented by the SPRAR project (Protection System for Asylum Seekers and Refugees). The SPRAR project is managed by the Ministry of Interior and by Italian local authorities (ANCI), including third sector organizations and network. The SPRAR project deals with refugees and asylum seekers waiting for the granting of international protection and aims at providing for 'integrated hospitality'. Refugees and asylum seekers receive not only board and lodging, but also social support activities, aimed at an effective integration in the territory and access to local services, including health and social assistance. The SPRAR project provides also for Italian language courses, training to facilitate employment and measures taken to have access to housing, enrolment of children in school and legal support. Theoretically, the person should stay at the second level centre for the time necessary to apply for asylum or protection. Then, the person should participate to the SPRAR project. Actually, due to the lack of places in the SPRAR, persons keep staying in the second level even after the application. Thus, in theory, every asylum seeker should run through the three levels. They should stay in the hotspots no longer than 72 hours. Equally, they should stay in the second level of reception only for the time necessary to apply for international protection. After the application, they should be involved in the SPRAR project, in order to start a pathway of integration. The Italian national report indicates that the actually situation is very different, as asylum seekers stay in the second level reception centres for months. Thus, although temporary reception centres (CAS) were settled to be extraordinary, they are actually used for ordinary reception. Available places in the SPRAR project are scarce and the waiting lists are long, this results in persons waiting for available places while they remain staying in the second level of reception.

CIE (Centres for identification and expulsion) are detention centres for irregular migrants in Italy (persons without legal documents to entry Italy, persons who haven't applied for international protection or who received a negative asylum decision), waiting to be expelled (Italian national report 6.1).

For **Croatia** the massive influx of refugees and migrants travelling across the "Balkan migrant route" was reported to have begun on September 16th 2015. Refugees crossing the Croatian border were transferred by buses and trains organised by the Croatian Ministry of Interior to several temporary reception centres in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo and Sisak. In these temporary and provisional facilities the persons were registered and Croatian Red Cross staff provided humanitarian assistance. After registration, the persons were transported by bus and train directly to Slovenian or Hungarian border. As the influx of refugees and migrants continued to grow, the Croatian Government opened a large reception centre in the village of Opatovaci in eastern Croatia on September 21st. All centres established during the first few days have been completely vacated as migrants left for Hungary and Slovenia and all people entering the border since September 21st were transferred to the Reception Centre Opatovac. In order to provide adequate conditions for a large number of refugees and migrants during winter months, the Government opened a Winter Reception and Transit Centre in Slavonski Brod on November 3rd. During September and December 2015 several reception centres were opened, closed and re-opened again, for a detailed description see: Croatian national report 6.1.

After the Balkan migrant route was officially closed on March 30th, Croatian authorities closed the Winter Reception Transit Centre Slavonski Brod on April 15th and the remaining 320 refugees and

migrants were transferred to existing long-term accommodation facilities for foreigners in Croatia. At that time these persons were presented with an official ban from leaving the centre and could only apply for asylum in Croatia or leave the European Economic Area voluntarily. Individuals who applied for asylum in Croatia were moved either to Reception Centre for Asylum Seekers Kutina (mostly vulnerable groups of asylum seekers) or to the Reception Centre for Asylum Seekers Porin in Zagreb (single men and other categories of asylum seekers). The "permanent" Reception Centre for Asylum Seekers Kutina provides long term accommodation for vulnerable groups of asylum seekers such as unaccompanied minors, families, pregnant women, persons with disabilities and persons suffering from mental disorders. This is an open type of facility so that the residents can go outside whenever they want but they have to be back by 10pm. If they want to leave the centre for a longer period of time they have to get permission from the administrator of the facility. At the moment of writing this report there were 54 individuals at Kutina, mostly particularly vulnerable individuals. The second Reception Centre for Asylum Seekers is Porin, initially intended to accommodate single male asylum seekers, in a leased part of the former railways hotel Porin located in Zagreb's neighbourhood of Dugave. Porin also functions as registration centre where asylum seekers provide their fingerprints, submit their asylum applications and receive their seeker's identity card. Just like in Kutina, the residents of the centre are free to go outside and are entitled to similar conditions. They also receive primary health care on the location. The centre currently accommodates 221 persons in total, including 169 asylum seekers and 42 family members who did not apply for asylum and are located in the separate part of the centre.

Individuals who did not apply for asylum in Croatia, were mostly directly moved to Detention Centre for Irregular Migrants Ježevo, except for those pertaining to vulnerable groups such as families who were transferred to a separate part of the Reception Centre Porin. The Croatian national report notes that, many persons who applied for asylum in Croatia after the EU-Turkey deal did not remain on Croatian territory but left the country within a short period of time. As of the closure of the borders, all new refugees and migrants that come to Croatia mainly due to readmission from other EU countries are situated in one of the long-term accommodation facilities (Croatian national report 6.1).

In **Slovenia** reception centres are places were the immigrants enter (or leave) Slovenia, they are registered and afterwards sent with trains or busses to the border, or they are sent to accommodation places. Accommodation places are facilities where immigrants stay a longer period (some hours to days) before the leave the country, or they apply for asylum. Šentilj, denominates an accommodation centre and an emergency makeshift railway platform, set up for the arriving migrants to get off the train in the immediate vicinity of the overburdened Šentilj accommodation centre. The accommodation centre in Šentilj, the point of exit from Slovenia with the heaviest refugee traffic, had up to 7000 people passing through it each day. According Slovenian national report, all the people accommodated in Šentilj were well taken care of. Some 160 to 200 people were caring for the transit refugees at the centre each day, not counting members of the police. The refugee reception procedure is conducted by the police with the support of the Armed Forces and at least one Arabic, Kurdish and Iraqi interpreter was assisting at all times. The tents were heated and had wooden floors. In addition to a total of 2,000 beds, refugees could also make use of shower facilities. A regular routine had been established at the transit centre, where refugees were provided with all the necessary care, and once the tents were vacated, they were thoroughly cleaned. Food was also provided. It was reported that during the day, regular medical teams, each comprising a physician and two nurses, assisted by volunteers, whose ranks include paediatricians and infectious disease specialists were working at the

centre. Together, they were able to examine around 100 to 150 people in eight hours. Since most patients could be treated on site, transportation to hospitals was reported to be not required and the overall situation was described as manageable.

At Dobova transit centre all refugees and other migrants first underwent a security check directly at the Dobova railway station and also received medical assistance. Then, they boarded the Slovenian train and were transferred to accommodations centres, where they underwent the registration procedure, with a view to simplifying and speeding up the registration of migrants, some technical improvements have been introduced, such as e-application, which enables fast entry of personal data into the police records. The procedure also included the taking of fingerprints and photographs. The number of registration points was reported to have been increased. The camp of Dobova was the major and only camp at the border to Croatia. It was close to the train station where the trains from Croatia arrived and the refugees were transferred to the authority of the Slovenian government. Recently, the camp was enlarged with new tents for food distribution and sanitation, and the floor was concreted to avoid mud and flood. On November 19th 2015 about 2000 refugees were expected to transit through the Dobova transit centre. When the refugees arrived at Dobova station, they were separated in two groups in order for the police to proceed with the registration. The first one was going to the accommodation camp Livarna in Dobova, while the other group remained at the train station. Registration included identity controls and issuing of "permission to remain" on the Slovenian territory. After registration, refugees were transferred to other accommodation camps in Slovenia (mainly Šentilj, or they were taken by train through Jesenice to Austria). The general situation in the camp was reported as good, there was also food distribution and the Red Cross set up a restoring-families-link wifi hotspot signal, for detailed description see: Slovenian national report 6.1. An overall lack of interpreters and doctors was reported for Dobova, at certain times there was just one doctor and one interpreter for Arabic available per shift. As a result of that the medical tent was saturated with requests. It was observed that many refugees did not have time to see a doctor before leaving the camp again. Furthermore interpreters were not able to assist the medical staff with interpreting as they were constantly needed at the registration.

Refugees who apply for international protection or asylum in Slovenia are generally transported to receiving asylum homes, where there are health controls, and the entire procedure for obtaining asylum is carried out. Slovenia has 3 asylum homes/centres (2 in Ljubljana, 1 in Logatec) and one national Centre for foreigners in Postojna. A total of 342 refugees and other migrants were accommodated in these centres as of April 28th 2016 and not all of them applied for asylum in Slovenia. There were 10 young people accommodated at a Youth Crisis Centre.

In autumn 2015 refugees and other migrants were staying in accommodation centres operated in the municipalities of Ankaran, Celje, Gornja Radgona, Lenart, Lendava, Logatec, Ljubljana, Maribor, Šentilj and Vrhnika (Slovenian national report 6.1).

In **Hungary** the transit zones were the legal open points of entry into the country, there refugees were registered, and could apply for asylum. In the Hungarian report it was described that, refugees only stayed in transit zones only for a short period (hours, max. days), containers were made available there, before they continued their way to one of the centres or to other counties of destination. Registered transit zone in Hungary were at: Röszke, Tompa, Letenye, Beremend. According to the latest official data and terminology, there are now 3 main types of reception facilities: Open reception centres, closed asylum reception centres and Community shelters. In open reception centres persons can leave

the centre whenever they want, in closed reception centres they cannot as they are mainly for detained asylum-seekers and for the majority who are people waiting for their deportation and community shelters (semi-open camps), in which a maximum stay of 2 months is possible. Open reception centres operate in Hungary (with a maximum capacity) and are located in Bicske (439) and in Vámosszabadi (216). Nagyfa (300) is the newest reception centre, which opened on January 12th 2015, initially meant as a temporary facility but since September 2015 being used as a regular reception centre. The centre consist of heated containers. Nagyfa is located inside the territory of a penitentiary institution and it is far away from the nearest settlement. Refugees who are accommodated in open camps have to register, and they can apply for asylum. While it is an open camp, they can leave the camp and some of them really leave before the end of the asylum process. Closed asylum reception centres operate in Békéscsaba, Nyírbátor and Kiskunhalas and they can be left only upon permission. The biggest reception centre in Debrecen was closed in October 2015 and one new open centre was opened in Körmend. There were approximately 200 people in Körmend in May 2016, however, it has a capacity of approximately 300-500 people. The Community Shelter in Balassagyarmat (111), co-operates with different societies, NGOs, charity, international, partner, local governmental and law enforcement organizations. Asylum seekers can leave the camp during the day but must return before 10pm. Among others cooperating organisations in the community shelter are the Hungarian Red Cross and the Menedék NGO (Association for help of migrants, in the field legal assistance with the Hungarian Helsinki Committee). The community shelter works for asylum seekers, persons tolerated to stay, persons in immigration procedure and foreigners who have exceeded 12 months in immigration detention, and now also receive beneficiaries of international protection. Generally, asylum seekers can also request to stay in private accommodation at their own cost, however in that case, they are then not entitled to most of the material reception conditions.

These centres are managed by the BÁH, the reception centres operate financially under the direction of the Director-General as an independent department and perform their professional tasks under the supervision of the Refugee Affairs Directorate of the BÁH. Thus, only one central body is responsible for the financial operation and the professional duties of the reception centres. Nevertheless, NGOs who work in the field of asylum cooperate with the refugee authority in providing supplementary services for asylum applicants. The BÁH coordinates the activities carried out in the reception centres. Refugees and migrants applying for asylum at the border zones are kept inside the transit zones, unless they are exempted from the border procedure, whereby they are transferred either to the asylum detention centre or are directed to go to the open reception centres. Where the detention grounds do not apply, they are given a train or bus ticket and are taken to the closest station so as to travel to the designated reception centre. Those asking for asylum at the airport can stay in a small facility (maximum capacity of 8 persons) within the airport transit area up to 8 days (Hungarian national report 6.1).

In **Austria** a differentiation is made between facilities intended for refugees who seek asylum in Austria (federal refugee centres, initial reception centres, distribution centres, refugee camps) and temporary facilities for transit refugees (emergency shelters, transit centres). Additionally there are also detention centres, for persons who receive a negative asylum decision and are obliged to return to their country of origin. From a procedural point of view the asylum procedure is a multi-stage process, at the beginning at the initial registration (at an initial reception centre or a distribution centre or at a BFA site) the person gets a procedure card (*Verfahrenskarte*, a green coloured card). After the person

is admitted to the asylum procedure he/she gets a white card, an asylum application card, which is a residence permit for the length of the asylum proceeding.

In terms of refugee facilities, as of May 2016, there exist five federal refugee centres in Austria (*Bundesbetreuungsstellen*), whereof two are located in Lower Austria Traiskirchen (Bundesbetreuungsstelle Ost) and Reichenau an der Rax (Bundesbetreuungsstelle Süd), and two in Upper Austria Thalham in Str. Georgen in Attergau (Bundesbetreuungsstelle West) and Bad Kreuzen (Bundesbetreuungsstelle Nord), and in Vienna Alsergrund (Bundesbetreuungsstelle Mitte). Two of these federal refugee centres also function as initial reception centres (*Erstaufnahmeeinrichungen*), and additionally, there is an initial reception centre at the international airport Vienna Schwechat, which is directly run by the Federal office for Immigration and asylum (.BFA), an authority directly reporting to the MoI and the final authority conducting first instance asylum procedures. Until summer 2015 the initial reception centres were responsible for the registration procedures for refugees who want to seek asylum in Austria. Refugees stayed there for the time that was required for checking if a person is admitted to asylum procedures in Austria (Dublin III). An asylum application can also be submitted at any police department or police officer and the first inquiry takes place. In the admissibility procedure an examination takes place to find out whether a person is admitted to the asylum process in Austria (Dublin III).

In summer 2015, with the increasing number of refugees coming to or transiting through Austria, seven so called distribution centres were established in several Austrian federal states, in order to disburden the two overcrowded initial reception centres Traiskirchen East and Thalham West. Not all of these distribution centres were newly established, some existed already as federal refugee centres and were converted into distribution centres. The distribution centres are set up by the federal government at the following locations: Bad Kreuzen (Upper Austria), Vienna Alsergrund/Nussdorferstraße (in charge of Burgenland and Vienna), Traiskirchen East (Lower Austria), Gaisberg (Salzburg), Innsbruck (in charge of Tyrol and Vorarlberg), Fehring (Styria), and Ossiach (Carinthia). Through the adoption of a new law Fremdenrechtsänderungsgesetz 2015 (BGBI. I Nr. 70/2015) asylum seekers do not need to be initially registered in one of the two initial reception centres, but can directly be brought to any of the distribution centre, where the first registration, first inquiry and the initial health assessment takes place. After the admissibility procedure, which should in principle only take 2 days, but can in fact take up to several weeks, the refugee either enters the basic welfare support scheme and is brought to a permanent refugee camp, or, if it is decided that Austria is not competent to examine the application of asylum, the person is transported to the initial reception centre Traiskirchen or Thalham, and is brought back to the country where he/she was first registered (Dublin III). The MoI reports that currently (May 2016) asylum seekers are only transferred to one of the initial reception centres if it is expected that another EU country is responsible for the asylum proceedings (Dublin III) or if the person is identified or presumed to be an unaccompanied minor.

In addition to general federal refugee centres there are also UMR federal refugee centres (specific focus on unaccompanied minor refugees), these are also supervised by the MoI.

Asylum seekers (except they are identified as or assumed to be unaccompanied minors), who are admitted to the asylum procedure in Austria, ought to be directly transferred from a facility by the federal government (distribution centre) to one of around 700 different refugee facilities in one of the nine provinces. These refugee camps can be organized or private accommodations, and persons are entitled to financial and social support based on the Basic Welfare Support Agreement 2004. As of

January 2015 there were about 85.000 asylum seekers in the basic welfare support scheme housed in various different forms of refugee camps. The report emphasised, that the capital city Vienna accepted a much higher quota of asylum seekers in refugee camps than the other provinces, and as of April 5th 2016 a total of 21.100 were located in Vienna. But by now every province has created refugee camps for asylum seekers and primary health care providers in all these provinces became provider for refugees (Austrian national report 6.1). For a detailed description of refugee facilities for unaccompanied minor refugees as well as refugee facilities set up as transit centres and emergency shelters please see: Austrian national report 6.1.

Primary health care in general

Before examining how primary health care is provided for refugees, primary health care systems in the six different countries are described in brief.

In **Greece**, primary health care is delivered through a combination of publically funded state health services, by general practitioners (GPs), who work at the private sector, and specialists. The choice of the provider is free but there are some charges. People can arrange an appointment at PEDY (Institution of Primary Health Care Provision in Greece) but there are long waiting times, which is considered as a main problem. The public service is delivered through Regional Health Care Centres, Health Care Centres in rural and remote areas (which are accessible 24 hours a day, 7 days a week) and public hospitals. Private GPs and specialists provide their services on a fee-for-service basis. Since the beginning of the financial crisis, Greece has been trying to improve national health care services with a focus on strengthening PHC services but the results remain poor. The creation of a National Organization for Healthcare Provision (EOPYY), the development of the electronic prescribing system and the creation of a Primary Healthcare Network in an effort to meet the needs of the population and ensure the efficient use of public resources were some of the Greek government efforts in order to improve primary health care services in the country.

In **Italy**, primary health care is provided by the State according to principles of universalism, equality and equity. The National Health Service (Servizio Sanitario Nazionale) is organized at a local level, where Local Health Services and Hospitals provide for health assistance. In the last 20 years, Italian Regions have gained significant autonomy in the field of health assistance and Primary Health Care is now one of the Regions' main tasks. Italian Regions have to formulate policies, draw operational tools in order to implement and supervise policies, set priorities and develop strategies. In Italy, primary health care providers are GPs. Primary Health Care centres exist all across the country and every person has a reference GP. Local Health Units (ASL) are part of the National Health Service and consist of hospitals, social districts and prevention departments. Depending on the territory, every ASL could consist of hospitals, health districts, continuity care assistance, family planning centres, mental health services, paediatricians, specialist exams, pathological dependencies.

In **Croatia** the health care system is organized by the Ministry of Health, it is based on the principle of social health insurance by which citizens are required to participate in the expenses for basic health care services with an exception for certain categories of insured persons. The main financing body is the Croatian Health Insurance Fund, which provides universal health coverage to the whole population,

defines basic health services and prices covered under the mandatory, as well as voluntary health insurance. Basic health insurance is mandatory for everyone in Croatia, including temporary residents. The primary care physicians are usually patients' first point of contact and each insured citizen has to register with a general practice doctor, a paediatrician, a gynaecologist and a dentist of their choice. If necessary, primary health care physicians refer the patient for further treatment to secondary or tertiary specialist health care facilities. Secondary health care includes specialist-consultative healthcare, hospital health care in general and specialized hospitals and health resorts. Tertiary health care refers to most complex forms of health care in specialised clinical centres and national health institutes. Mental health services are mainly provided within institutions such as general and university clinical hospitals as well as specialist psychiatric hospitals. Local county governments own most of the public primary and secondary health care facilities while the state owns and controls tertiary health care facilities.

Health care in **Slovenia** is funded by a mix of public and private spending. The public sector is the primary source of health care funding. On average across EU countries, three-quarters of all health care spending was publicly funded in 2012. Slovenia's health system is funded by compulsory health insurance for everyone meeting statutory requirements, by state revenues, voluntary health insurance, and out-of-pocket spending. The delivery of PC is organized in health care centres and health stations and independent contractors, so called concessionaires. Health care personnel involved in PC include family practitioners (FPs)/ general practitioners (GPs), primary gynaecologists, and paediatricians, specialists in occupational medicine, and nurses with diploma in model practices. There are pomologists in some health centres. FPs in Slovenia act as "gatekeepers," controlling access to secondary services. Patients must choose their own personal FPs, who is responsible for providing PC for their patients, including emergency care 24 hours a day provided by physicians working in rotation outside regular office hours. This requirement has had a great impact on both the quality and cost of health care. Most first-patient contacts are made by FPs, and continued good access is of the utmost importance. There are 7,153 physicians registered with the Medical Chamber of Slovenia. At the primary level, there are 1,057 FPs working at health centres and around 343 FPs in the form of independent contractors. The Health Insurance Institute of Slovenia (HIIS) concluded contracts with 1,784 providers: 224 public institutions and 1,560 concession-holders in 2011. The number of contractors fell by six in 2011 compared with 2010.

Primary care in **Hungary** is financially regulated by the government and services are provided by a one doctor (GP) one nurse system. Based on single handed private practices there are about 6800 primary care physicians working in Hungary, whereof around half are providers for the adult population, around a quarter are providers for children, and one quarter of providers care for mixed populations (from new-borns to elderly). There are no group practices in the countries, and the financing is mostly based on capitations with other elements and small incentives. Thus, GPs mostly working as private enterprisers contracted with local municipalities for services and with the National Health Insurance Fund (NHIF) for financing.

The **Austrian** health care system provides universal coverage for a wide range of benefits, there is a free choice of providers, unrestricted access to all care levels such as general practitioners, specialist physicians and hospitals. The health care system is by constitution a federal responsibility and

overseen by the Federal Ministry of Health assisted by a range of national institutions. The implementation of health insurance has been delegated to social security institutions brought together in a national Federation of Austrian Social Security Institution (HVSV). In 2011 almost the entire population (99,9%) had health insurance coverage, membership of a specific scheme is determined by place of residence and/or occupation and social insurance contributions are determined at federal level by parliament; there are also private health insurance funds made use of by a small part of the population. A clear distinction of the three level of professional health care into primary, secondary and tertiary health care in Austria is lacking. From a patient point of view it is remarkable that the free choice of provider incorporates that besides only a few exceptions (e.g. radiology or labour medicine) a person can seek out to extra- as well as intramural working specialists directly and without medical referral at the primary care level. Thus, in Austria primary health care physicians are not always patients' first point of contact. In a nutshell the Austrian system is marked by coexisting decentralization, relatively weak regulation and little budget control with limited "gatekeeping".

Primary health care provision for refugees

In this chapter overall primary health care provision for refugees in the respective countries is addressed. However the main focus is given to primary health care provision in special refugee centres since the national reports also focus on the provision of primary health care in special centres (e.g. the Greek national report focuses on PHC provision in Moria, the Austrian national report focuses on PHC provision in long-term facilities).

Several authorities are involved in refugee (health) care in **Greece**, including ministries, regional and municipal authorities, port authorities, Greek coast guard and police, primary health care services (PEDY), hospitals, tertiary health services, the Greek army, national and international non-government organizations (NGO's), NATO and Frontex. At the Greek hotspots primary health care is provided mainly by national and international NGOs, such as Praxis, Médecins Sans Frontières/Doctors Without Borders (MSF), Médecins du Monde (MDM), the Greek Red Cross, KEELPNO, who provide humanitarian support in the field. The UNHCR is responsible for coordinating all NGO activities and the EKEPY is the coordination authority on all provided health care services to refugees in Greece. Refugees in need of medical assistance are mainly escorted to Médecins Sans Frontières / Doctors without Borders (MSF), Médecins du Monde (MDM), Women and Health Alliance International (WAHA), Greek Red Cross and PRAKSIS facilities at the hotspots and refugees camp. They can escort them to the hospital (emergency department which provides also primary health care services). In general, refugees and immigrants are not referred to PEDY due to its lack of facilities and personnel. KEELPNO (Hellenic centre for control and prevention of diseases), provides health services too, usually through mobile units.

MDM provides health care services (including mental health care services) to all refugees and immigrants who arrive in Greece and are in need, as they informed us during an interview we had conducted with their coordinator, in Moria's (Lesvos) hotspot. The health care professionals of MDM consist of a multidisciplinary team of general practitioner (GP), cardiologist, orthopedist, otolaryngologist, nurse, psychologist and social worker. An exact number of health care personnel could not be obtained from the interviewed stakeholder as it highly depended on the migrant influx.

In general the personnel of MDM at the hotspot of Moria included six or seven physicians, two nurses and two interpreters (Arabic and Farsi). MDM also launched a program entitled "strengthening of first reception mobile units in areas with huge refugees/immigrant influx", providing psychological support to refugees and immigrants reaching Lesvos shores. It is reported that MDM provided services to 168.955 refugees/immigrants/asylum seekers in 2015, and the number of visits to MDM services in Lesvos reached 34.254 visits.

MSF provides medical care, shelter, water, sanitation and hygiene promotion services (watsan), and distributing relief items to refugees and migrants arriving in the Dodecanese Islands as well as in Lesbos, Samos and Agathonisi, in Athens and at the Eidomeni's border crossing to FYROM. They provide medical care, in mobile clinics, at the island of Kos and other nearby islands. Since June 2015, in Lesvos they have provided health care services, in mobile clinics, distribute hygiene kits and improve water and sanitation facilities in the camps at Kara Tepe and Moria. In Eidomeni medical care is provided through mobile clinics to people, who are trying to cross the borders to reach FYROM. In collaboration with other NGOs, they set up a short stay camp and installed water and sanitation facilities along the border. In Athens, MSF provides medical care, psychosocial support and legal assistance to refugees, who have been tortured. MSF teams in Greece, are providing first aid, medical and psychological support, shelter, water, sanitation and essential relief items at reception centres and transit camps. MSF teams provide also medical health care services to refugees and migrants in Moria camp and at the port of Mytilini. It is reported that MSF psychologists have assisted 149 people through individual sessions and have conducted 133 group sessions with 589 participants in Lesvos island. Also the Greek Red Cross is active in Lesvos, they provide health services, first aid, nursing services and psychological support. Additionally they engage in informative actions and education programs for volunteers. In Moria as of 26th June 2016, there are 3 clinics that provide PHC. MDM provides services from 10:00-23:00 with doctors, nurses, psychologists, social workers and translators (Farsi and Arabic). One center works from 10:00-16:00. The Dutch organization BRF provides services with a doctor from 23:00-9:00. At Karatepe centre the NGO Human Appeal provides services 24/7 with a doctor, a nurse and a translator. MDM and MsF provide also services 8 hours per day.

It is recognizable that various organizations are providing primary health care at the Greek hotspots, for a very detailed record of health care provision at different sites please see: Greek national report 6.1.

Table 6: Primary health care staff situation in different centres in Greece

Centre	Staff	Problems
Moria hotspot	MDM provides services from 10:00-23:00 with doctors, nurses, psychologists, social workers and translators (Farsi and Arabic). One center works from 10:00-16:00. The Dutch organization Boat Refugee Foundation (BRF) provides services with a doctor from 23:00-9:00.	There is sewerage network but the sewage tank overflow.

Karatepe	NGO Human Appeal provide services 24/7 with a doctor, a nurse and a translator. MDM and MsF provide also services 8 hours per day.	
Samos (+hotspot)	Organizations: -Greek army is responsible for coordinating all NGOs activities and provides on call services during weekend and late at night. -Medin provides its healthcare services for 8 hours (9:00-17:00) from Monday to Friday. The healthcare professionals of Medin are consisted of a team:2 physicians, 2 nurses, 1 psycologist and 1 sociologist. -KEELPNO and Hellenic Red Cross (HRC) provide nursing/physician coverage for 8 hour per day (9:00-17:00) from Wednesday to Sunday. - Medicaments are provided by several NGO's -There is 1 bus available by police authority for regular occurrences (such as pregnancy, accompanied minors, etc.). For emergency issues there is 1 EKAB ambulance available. The healthcare services offices are located 3 containers (1 HRC, 1 Medin, 1 KEELPNO).	
Chios(+hotspot)	-Greek Army provides nursing/physician coverage for 8 hour per day (7:00-15:00). -HRC in collaboration with Spanish Red Cross provide nursing/physician coverage (1 physician and 3 nurses) for 7 hours (10:00-17:00) per day (except Friday). -Praksis provides nursing/physician coverage (1 physician and 1 nurse) for 8 hours per day. -WAHA International provides nursing/physician coverage for 5 hours per day (17:00-22:00) and for emergency issues during the night provides on call services. -Praksis, Greek Army and HRC provide medicaments. -There is 1 ambulance available by NGO for regular occurrences. For emergency issues there is 1 EKAB ambulance available.	There are complaints about the food supplies, which are under the coordination of UNHCR.

	-MDM provides its services to unofficial camps of Souda and DHPETHE for 8 hours per day (9:00-15:00) and WAHA International provides nursing/physician coverage for 5 hours per day (17:00-22:00) and for emergency issues during the night provides on call services.	
Schisto	-Greek Army provides nursing/physician (2 physicians and 3 nurses) coverage (1 clinic for adults and 1 for children) for 5 hours per day (8:00-13:00) and Greek Air Force provides nursing/physician (1 physician and 1 nurse) coverage for 3 hours per day (17:00-20:00). -MDM provides a mobile unit only Tuesday and Friday (1 pediatrician). -There is 1 available ambulance by Greek Air Force for emergency conditions.	There is great issue with septik tank. It is recommended a connection with the central sewer.
Elaionas	-KEELPNO and WAHA International provide nursing/physician coverage. -MSF provides its services (2 emerge containers with a dentist office) for 7 hours per day (13:00-20:00) in collaboration with 2 cultural mediators (Arabic-Farsi).	
Elliniko	-KEELPNO and several NGO's provide nursing/physician coverage under the coordination of EKEPY and KEELPNO. -The medicaments are provided by several NGO's.	-Lack of security guards during the night. -Lack of personal hygiene facilities for refugees and for the personnel too.
Baseball field	-MDM provide nursing/physician coverage in collaboration with 2 cultural mediators (Arabic and Farsi) for 4 hours per day (10:00-14:00). -WAHA international provides nursing/physician coverage in collaboration with mission team Aigaleo for 7hours per day (16:00-23:00).	
Hockey field	-KEELPNO provides nursing/physician coverage for 4 hours per day (9:00-13:00). -MDM provides nursing/physician coverage (1 physician and 2 nurses) in collaboration with 2 cultural mediators (Arabic and Farsi) for 7 hours per day (10:00-14:00 and 16:00-19:00) -Solidarity dentist of Elliniko provides its services 2 times per week.	

Arrival area	-FAIR PLANET, Metropolitan Social Solidarity clinic of Elliniko provide physician coverage for 4 hours per day (10:00-14:00) -MDM provides nursing/physician coverage in collaboration with cultural mediators for 4 hours per day (16:00-20:00). -Metropolitan Social Solidarity Pharmacy and Pharmacists du Monde (PDM), provide medicaments. -Social Solidarity clinic and pharmacy of Athens provides nursing/physician coverage (such as otolaryngologist, dentist, hematoogist, nurse, etc.) for morning and afternoon shift in collaboration with the NGO's, which mentioned above. -KIFA offered an ultrasound and a precision scale.	-PDM needs an extra place in order to establish a proper pharmacy (cabinets, fridge, etc.), which will be accessible to other refugee camps (such as Baseball and Hockey field). -Piraeus Dental Association is requested to establish a dental unit (with the support of volunteers) at the same area (due to the maintain needs).
Ag.Andreas	-Greek Army provides 24-hour nursing/physician coverage (3 physicians and 3 nurses) in collaboration with Greek Navy.	
Malakasa	-MDM provides nursing/physician coverage (gynecologist, pediatrician and midwife) in collaboration with cultural mediators for 4 hours per day (10:00-16:00). -MSF provide psychosocial services for 6 hours per day (12:00-18:00). -There are available 1 EKAB ambulance (for emergency issues) and 1 bus for regular occurrences.	
Lavrio (Agrotiki bank camp)	-Greek Navy provides physician coverage 24 hours per day. -There is 1 bus available for regular occurrences offered by Municipality of Lavrio.	
Lavrio (asylum seekers camp)	-National authority (since 1999, next to PHC unit of Lavrio) provides nursing/physician coverage (physician and administrative personnel for 4 hours per day and nurse for 24 hours per day) five days per week.	
Piraeus Port	-2nd Regional Health Directorate, EKAB, AEMY, GRC, KEELPNO, Athens Medical Association, Piraeus Dental Association, The smile of the child, other NGO'S and	

	individual volunteers provide nursing/physician coverage. -Medical materials are provided by MDM and MSF. -All provided healthcare services are under the coordination of EKEPY and AEMY. -KEELPNO and GRC provide mobile units and a vehicle for internal transport among the gates for 6 hours per day (17:00-23:00).	
Skaramanga	-Greek Army provides nursing/physician coverage (1 Physiatrist, 1 nurse for 24 hours per day and 1 endocrinologist for morning shift). -Mobile unit provides nursing/physician coverage (1 physician/paediatrician, 2 nurses and 1 cultural mediators) for 5 hours per day (9:00-14:00). -KEELPNO provides physician coverage (1 paediatrician) for 5 hours per day (9:00-14:00). -Soon 2 containers will be transformed to a dental clinic and a pharmacy.	There is a great need for mosquitocide
Merchant Marine Academy	Greek Army provides nursing/physician and pharmaceutical coverage (1 physician and 1 nurse) for 8 hours per day (7:00-15:00).	
Ristona	Greek Army, Greek Air Force in collaboration with GRC, French and Spanish Red Cross provide a mobile unit (1 GP and nurse) for 5 and half hours per day (10:00-14:30 and 16:00-19:00). -There are available 1 EKAB ambulance (for emergency issues) and 1 bus for regular occurrences.	-Lack of containers -Lack of fire precaution
Fthiotida-Thermopyles	-Lamia Medical Association provides voluntary physician coverage. -There are available 1 EKAB ambulance (for emergency issues) and 1 vehicle for regular occurrences offered by Prefecture of Central Greece.	
Larisa-Koutsochero	-GRC provides nursing/physician coverage sporadically (not proper conditions) -5th Regional Health Directorate provides 1 mobile unit (not proper conditions).	-Lack of containers -Lack of protection against snakes.

	-MDM provides a mobile unit (1 physician, 1 nurse and 2 cultural mediators).	
Oinofyta-Boeotia	-Greek Army provides accommodation in an old factory. -ADVENTIST provides nursing/physician and pharmaceutical coverage 24 hours per day. -There is drinking water available.	There is a great need for mosquitocide.
Volos	-Greek Army provides accommodation (in old car factor) and nursing/physician and pharmaceutical coverage (1 army physician, 3 paediatricians for 3 times per week, 1 dentist, 1 cardiologist and 1 volunteer physician from the hospital).	
Andravida	-Greek Army provides a GP (every Tuesday). -PHC unit provides a GP (every Thursday). -Amaliada Medical Association provides physician coverage (1 paediatrician 2 times per week and midwife/gynaecologist every Friday).	
Diavata	-Greek Army, EKEPY, GRC, WAHA International, MDM, Praksis, Protecta, social clinic, PHC unit Diavata, Salonica pharmaceutical Association provide and nursing/physician and pharmaceutical coverage.	-Lack of ambulance. -Lack of cultural mediators during the night shift.
Thessaloniki (port)	-EKEPY, Thessaloniki Port Authority, MDM, WAHA International, GRC,Medical Associations, Social clinic and individual volunteers provide nursing/physician and pharmaceutical coverage under the coordination of EKEPY.	
Lagadikia (Army camp UNHCR)	-MDM provides nursing/physician coverage (1 paediatrician 3 times per week, 1 gynaecologist once a week, 2 nurses and cultural mediators) for 8 hours per day (8:00-16:00) under the coordination of UNHCR and Greek Army.	There is a great need for mosquitocide.
Oraiokastro (Thessaloniki)	-MDM provides nursing/physician coverage 5 days per week (morning and evening shift).	There is great issue with septik tank. It is recommended a connection with the central sewer.
Sindos (Karamnlis building-Thessaloniki)	-Sam Global Response provides nursing/physician coverage for 8 hours per day.	Lack of drinking water.

Sindos (Frakapor-Thessaloniki)	-Sam Global Response provides nursing/physician coverage for 8 hours per day (9:00-15:00).	Lack of drinking water.
Kalochori (Iliadi-Thessaloniki)	-Sam Global Response provides nursing/physician coverage for 8 hours per day (9:00-15:00).	There is a great need for mosquitocide.
Kordelio	-GRC in collaboration with Finish and German Red Cross provides nursing/physician coverage for 10 hours per day (9:00-17:00).	
Vagiochori (Thessaloniki)	-Greek Army provides nursing/physician coverage (in 2 tents)	
Derveni (Alexil-Thessaloniki)	-WAHA International provides nursing/physician coverage for 8 hours per day.	
Sinatex (Kavalari-Thessaloniki)	-Humedica provides nursing/physician coverage for 8 hours per day.	
Herso (Kilkis)	-Greek Army and International Red Cross (IRC) provide nursing/physician coverage for 24 hours per day (18:00-8:00 Greek Army and 8:00-18:00 IRC) -Kilkis Medical Association provides nursing/physician coverage (1 paediatrician and 1 nurse every afternoon- volunteers). -Kilkis Pharmaceutical Association provides medicaments.	Lack of containers
Polycastro	-Greek Army and IRC provide nursing/physician coverage (in 3 tents) for 24 hours per day (8:00-17:00 IRC and 17:00-8:00 Greek Army) -There is 1 bus available for regular occurrences.	
Drama	-Municipality of Drama, Medical District, Drama Medical Association and GRC provide nursing/physician coverage in 4 different clinic (1 for males, 1 for females, 1 for children and there is a pharmacy) (1 paediatrician and 1 pathologist for 3 hours per day during the morning, 1 dermatologist on some mornings during the week, 1 gynaecologist once a week). -There is 1 ultrasound available. -Drama Pharmaceutical Association provides medicaments.	
Chalkero (Kavala)	-Greek Army provides accommodation.	

	-MDM provides nursing/physician coverage (2 physicians and 2 nurses) for 6 hours per day (10:00-13:00 and 17:00-20:00) from Monday to Friday. - Medical district of Kavalas provides 1 mobile unit and 2 pharmacists.	
Konitsa	-PHC unit of Konitsa provides nursing/physician coverage (personnel of 8 people). - There is 1 ambulance available.	
Pieria (Hercules field)	- Katerini Medical Association provides physician coverage (physician and paediatrician -volunteers) for 3 times per week. -Katerini Pharmaceutical Association and Prefecture of Central Macedonia provide medicaments. - There is 1 vehicle available for regular occurrences.	
Pieria (Nireas camping)	-PHC unit and hospital provide nursing/physician coverage. -The regular occurrences are handled by volunteers. -This camp will be shut down soon.	
Petra (Olympos)	-ADRA provides nursing/physician coverage (1 physician and 2 nurses) for 16 hours per day and 1 vehicle for regular occurrences.	There is a great issue with scabies.
Filipiada (Preveza)	- Greek Army, 6th Medical District, PHC units (Kalentini, Preveza, Thesprotiko, Filipiada), Social clinic of Preveza and Arta Medical Association provide nursing/physician coverage. - There is 1 EKAB ambulance available.	
Doliana	-Greek Army provides nursing/physician coverage (2 army physicians 24 hours per day, 1 GP, 1 nurse and 1 midwife once a week). -There is 1 EKAB ambulance available.	
Tsepelovo (Ioannina)	-Greek Army provides physician coverage (1 physician) for some hours every Monday and Wednesday.	
Katsika (Ioannina)	-Greek army, GRC, PHC unit (Voutsara) and hospital provide nursing/physician coverage (2 army physicians for 24 hours per day, GPs from PHC unit and Hospital, paediatrician from hospital, gynaecologists and midwife from hospital).	There is great issue with septik tank. It is recommended a connection with the central sewer.

	- Medicaments are provided by hospitals and social pharmacy.	
Giannitsa	-Greek army and volunteers from Pella Medical Association provide physician coverage (1 army physician and volunteers). -WAHA International provides nursing coverage (1 nurse and 1 cultural mediator) for 8 and half hours per day (9:30-18:00). - Medicaments are provided by Pella Pharmaceutical association.	Lack of protection against snakes.
Veria (Army camp Armatolou Kokkinou Imathias)	-Greek army and volunteers from Veria Medical Association provide physician coverage (1 army physician for 3-4 hours during the morning shift and 1 dentist, 1 pathologist, 1female gynaecologist and 1 ophthalmologist- volunteers). -Medicaments are provided by Veria Pharmaceutical Association.	
Aleksandia (Imathias)	-Greek Army provides physician coverage (1 army physiatrist and 1 surgeon) for morning shift. -Saint Elisabeth University of Slovakia provides nursing/physician coverage. -Medicaments are provided by Veria Pharmaceutical Association.	There is a great need for mosquitocide.
Kordogianni field (Vasilika)	-Greek army and Social clinic of Thermi provide limited nursing/physician coverage.	

In **Italy** NGOs and third sector organizations also have a key role in providing primary health care for refugees and migrants. A first health screening is provided to every refugee or migrant arriving to Italy at the hotspots in the first hours after arrival. Italian hotspots are strictly regulated, staff is highly trained and it is reported that it is highly difficult to get a permission to enter. After arrival at the hotspots refugees and asylum seekers are allocated among the Italian regions to reception centres, in which there is no primary health care staff supplied. Thus, there is no special health assistance for

refugees and asylum seekers and primary health care is officially supplied by the Local Health Services at that point.

Italian legislation allows access to healthcare for all, differentially regulated among the different legal statuses. Migrants from non-EU countries and without legal documents can access Italian healthcare through the STP code (Temporarily Present Foreigner), which guarantees access to healthcare for the period preceding the asylum request or the obtaining of documents and papers. STP code guarantees first aid and emergencies, and every health service considered essential for people health and wellbeing. STP code is valid for 6 months and it is renewable. After international protection is granted or the documents are obtained, persons are registered in the National Health Service (SSN), and they are assigned to a general practitioner (GP). It is reported that de facto, NGOs and third sector organizations play a crucial role in the collaboration with Local Health Units for the provision of health assistance to asylum seekers hosted in centres. Since primary health care is provided at a local level, the involvement of NGOs and local organizations is extremely variable depending on the territory. The Italian intervention site partners emphasized in their national report that interviewed health and social workers from the Tuscan Local Health Units expressed the necessity to improve their skills dealing with migrants. Based on that finding the possibility to organize the Italian training in the Region of Tuscany, especially in the ASLTC (Central Tuscany Local Health Unit) is assessed.

Primary health care in the **Croatian** temporary reception centres, that were operating at some point during the refugee and migrant crisis but are now closed, was provided by several international and civil society organizations and NGOs. The Croatian Ministry of Interior appointed the Headquarters for Crisis Coordination to coordinate all activities related to the arrival of refugees and migrants in Croatia and Croatian Red Cross (CRC) to coordinate all other organisations involved in providing care for refugees and migrants in temporary reception centres and border crossings. Amongst other organisations the State Commodity Reserves, the UNHCR and the United Nations Children's Fund (UNICEF), the Caritas Croatia, the Zagreb Islamic Community Mesihat, Magna NGO and the IOM were operating in different fields of refugee care. Furthermore the Jesuit refugee Service and local NGOs such as the Centre for Peace Studies, and the Society for Psychological Assistance provided support at these sites, which are mostly closed now. The Winter Reception Centre Slavonski Brod a well organised system for providing humanitarian response and health care for refugees and migrants in transit was established. It included 20 organisations and around 320 volunteers and staff members. National health system employees (physicians, nurses and medical technicians) organised by the Croatian Ministry of Health provided immediate medical services with the support of CRC and Magna. In the case of a more serious medical problem medical staff transported the patients to a nearby hospital in Slavonski Brod with a dedicated ambulance vehicle. Interpreters from various organisations assisted medical personnel during medical interventions in the centre and local hospitals. UNICEF, Save the Children International and Magna were responsible for providing specialised care for children and babies in child friendly spaces and mother-baby areas. UNHCR had a permanent presence in the centre in order to identify people with specific needs or at risk and to refer them to other organisations and services if needed and also provided the majority of non-food necessities. CRC and other NGOs (ADRA Croatia, Volunteer Centre Osijek, Volunteer Centre Slavonski Brod, Intereuropean Human Aid Association, JRS, Caritas Croatia, Union of Baptist Churches in Croatia, Samaritan's Purse, CPS, SPA) provided food, water, blankets, raincoats, hygienic kits, specific children supplies and psychosocial support. Considering that the transit centres in Croatia are now closed and that some of the staff now works in one of the two Reception Centres for Asylum Seekers in Kutina and Zagreb, in the remaining part of the report we will focus on these, currently active centres.

Primary health care in both currently active reception centres for asylum seekers is provided by a nurse who is a full-time employee of the Ministry of Interior, a general physician (GP) from the local medical health centre (also has a contract with the Ministry of the Interior) and several NGO workers in the helping professions. Nurses in the centres are usually present for eight hours a day, but at the moment they are both on a maternity leave and they have not yet been replaced. The medical nurses are in charge of basic medical care including monitoring and administering medication, measuring temperature and blood pressure. The GP in Reception Centre Kutina comes when the centre employees call him (usually 2-3 times a week), having a contract with a local pharmacy a prescription is officially stamped by the centre and JRS or CRC workers can pick up the necessary medication at the pharmacy free of charge, as the costs are covered by the Croatian Health Insurance Fund. The GP at the Reception Centre Porin provides medical examinations 2 times a week for 4 hours and is also on call for emergency cases. Within the GP office at the Porin centre typical medicines (also funded by the Croatian Health Insurance Fund) are available and the GP is also responsible that necessary medication is in-stock. When needed, the GPs refer patients with chronic diseases, acute mental disorders and pregnant women to specialist treatment in community health clinics or hospitals. JRC or CRC personnel accompanied by an interpreter (if available) transport them to the hospital and, when possible, cover the costs of specialized medical examinations and treatments, which are not provided by the national insurance. Although no paediatricians or other children's health specialists are present in the centre, the GPs refer children to appropriate specialist in the community health clinic or hospital. If a medical intervention is needed outside the doctor's working hours and the nurse alone is not able to help, asylum seekers are transported to the nearby hospital and provided with emergency medical help. SPA also sees the asylum seekers in need of psychological therapy and counselling in their offices in the centre of the city for free. CRC employees and volunteers as well as psychologists from SPA provide psychosocial support and counselling. Given that asylum seekers are not entitled to dental care, but only tooth extraction, two dentists with private practices in Zagreb provide free dental services to asylum seekers from Porin and Kutina. There is also a general practitioner who works in a county health centre but, as she is not allowed to receive asylum seekers there, they usually meet outside of working hours and a gynaecologist who provides free services mostly to non-pregnant women in her private practice. Unfortunately, primary medical providers who, unlike health personnel working in the reception centres, do not have a contract with the Ministry of Interior are not allowed by the law to provide services to refugees and migrants. However, volunteers in reception centres usually find a way to contact and organise appointments with several external health care providers who volunteer to give free medical examinations and treatments of asylum seekers.

In addition to the nurse and the GP, one social worker and one occupational therapist from CRC are also working full time in every reception centre and the CRC psychologist comes on a weekly basis. Finally, SPA teams visit the centres every week to provide counselling and psychosocial support mostly consists of psychologists and interpreters who are specially trained to interpret psychological counselling. According to the GPs working in these centres, the level of medical care currently provided is sufficient considering the number and the severity of health problems of asylum seekers. Besides the medical staff, CRC and JRS have contracts with the Ministry of Interior in both centres which allow them to employ full-time staff working on distribution of necessities and medicines, interpretation, transportation of people to medical examinations and treatments outside of the centre, organisation of medical records and the provision of psychosocial support. In addition, staff and volunteers from the CPS and SPA, although they're not full-time employees, often provide psychological assistance and

organise various activities with asylum seekers (workshops, language courses, recreational activities, etc.).

In **Slovenia** medical care is provided by medical teams in reception and accommodation centres, which has been organised in cooperation with the health centres from individual regions. The coordination on the ground is in the hands of the respective health centre closest to the reception centres; if necessary, other health centres in the vicinity are set in motion. Representatives of the Slovenian and Hungarian Caritas, volunteer health professionals and Doctors Without Borders are also engaged in providing medical care to the migrants on the ground. The head of a reception centre informs the nearest health centre about the arrival of the migrants. If it is not possible to assemble a medical team of professionals on regular duty or volunteer doctors, such a team is sent to the reception centre by the head of the emergency medical service. All persons who are assessed to urgently need medical help are examined. If there is a suspicion of any contagious disease among the migrants, the Slovenian Epidemiological Service of the National Public Health Institute is activated. Migrants from the reception centres who are in need of emergency treatment in a healthcare institution are accompanied there by the medical staff. The health care workers attend to the reception centres always when a new contingent of refugees was arriving and stayed there around 2 to 8 hours. In terms of health care providers on the ground, it is reported that personnel was present according the number of migrants at the accommodation centres. When it was very busy health care providers were available 24 hours a day in Šentilj and Dobova, in Gornja Radgona and Lendava around 4 hours per day and later only on call if they were needed. In Logatec and Vrhnika health care providers are only available on call. If the staff was on-call duty they managed the work additionally to their usual workload, but at the facilities where there existed attendance times/the hours were fixed staff worked every day at the fixed hours and were extra paid for their work in the receptions or accommodations canters. In terms of adequacy of health services the report included contrary views of interviewed persons, *"the camp as a whole functioned perfectly"* (HW6) versus *"in the camp health care was not adequately provided"* (HW2). In Deliverable 2.1 it was also reported that the local health care workers cooperated with the Slovenian Red Cross, Caritas Slovenia, Civil Protection Services, Administration for Civil Protection and Disaster Relief, and foreign organizations and offices (Deliverable 2.1).

Table 7: Primary health care staff situation in selected centres

Centre	Staff	Hours of health care providers presence
Dobova [transit, closed]	GP and nurse, paramedics, Red Cross workers, interpreters	24 hours
Vrhnika [transit, closed]	GP, nurse, paediatrician, psychologist, interpreters	24 hours and on-call combination
Ljubljana [AH LI]	GP, nurse, emergency medicine, psychologist, interpreters	24 hours and on-call combination
Šentilj [transit, closed]	GP and nurse, paramedics, Mobile Czech Republic Military Hospital, Red Cross workers, interpreters	24 hours

Gornja Radgona [accommodation centre, closed]	GP and nurse, paramedics, paediatrician, Red Cross workers, interpreters	4 hours every day
Lendava [accommodation centre, closed]	GP and nurse, paramedics, Red Cross workers, interpreters	2-4 hours at the arrival time of refugees and every day on-call if there were people at the centre
Postojna [Centre for Foreigners]	GP and nurse, paramedics, interpreters	24 hours and on-call combination
Logatec [part of AH LI]	GP and nurse, paramedics, social workers, interpreters	24 hours and on-call combination

In **Hungary** health services at the official camps are provided by doctors employed or contracted with the BÁH, the Office of Immigration and Nationality. Nurses and medical assistants work in these camps as well, and in some NGOs provide specialists such as paediatricians, gynaecologists and psychiatrists. According to the results of the Hungarian report continuous access to medical care was provided in all refugee facilities. In the permanent reception centre Bicske and Vámosszabadi a nurse was present for 10 hours a day, responsible for triaging the cases and informing the GPs or paediatricians, who also perform surgeries according to the needs at approximately 4 to 8 hours per day (sometimes shifts were longer). It is reported that in the centres access to urgent-emergency medical care 24/7 was available every day through the nearby location in the next village or city, if this was required.

The report highlights the high turnover of inhabitants of the refugee camps, which follow an "open-policy" and point to the health care provision challenges in this context. It is described that persons who wanted to move to Western EU countries left Hungary while the remaining camp inhabitants applied for asylum or temporary permit for staying in Hungary. In terms of transit zones a quick general health assessment was conducted at the transit zones and as soon they are in the centre they receive the same medical care as the Hungarian population (Hungarian national report 6.1).

As soon as a person applies for asylum in **Austria** and is admitted to the asylum procedure, the person is insured in the common health insurance system and is entitled to receive health care equally to Austrian citizens. At the initial reception centres and distribution centres, which are the intermediate facilities where refugees/asylum seekers are transferred to initially, operated by the Ministry of Interior, an initial health assessment is mandatory within 72 hours and primary health care is provided. The ORS service GmbH is commissioned by the MoI to conduct the initial medical assessment and is also responsible for the provision of primary health care in these facilities. The ORS Service GmbH officially provides primary health care in these federal facilities, but based on contractual provisions regarding confidentiality the company is not obligated to reveal the specific contractual content. In terms of UMFs, the federal reception facility east in Traiskirchen provides a 24 hours a day supervisor to whom she/he can refer with any questions or problems for each UMR, and a special practice to be applied to UMFs below the age of 14[3], as they are taken care of additionally by selected women who

[3] For unaccompanied minor refugees who are underage, thus under 14 years old, there are special provisions in the Basic Welfare Support Scheme 2004.

function as so-called remuneration mothers. The 24-hours care, psychological care and day-structuring measures, etc. were also reported in a response to the parliamentary question PA 7312/J dated January 26th 2016, where the MoI identifies all federal refugee centres (both UMF federal refugee centres and normal federal refugee centres) to be operated by ORS Service GmbH. Based on a care-giving contract and a "comprehensive care concept" for unaccompanied minor refugees the ORS Service GmbH is responsible for provision (1), however, details of what is included in the "comprehensive care concept" are again unclear and not accessible to the public. With regards to the situation in Traiskirchen and especially in the case of UMFs the ORS Service GmbH is caught in crossfire of criticism, for a detailed analysis also with regard to primary health care staff in federal facilities please see: Austrian national report 6.1.

After the asylum seeker is admitted to the procedure, he/she is transferred to a long-term facility of operated by the provinces, herein referred to as refugee camp. In these refugee camps there are no provisions on additional health care and primary health care is provided within the conventional health care provision system. In some larger refugee camps additional medical service is available on-call or regularly, but largely asylum seekers have access to the conventional system. Depending on the respective Austrian province asylum seekers might receive e-cards (which is the personal electronic smart card with which one can access the health care system, indicating name and social security number) or e-card alternatives with which physicians and GPs can be visited.

With regards to transit centres (which do not exist anymore, as of 2016/06/21), health care was first and foremost provided by NGOs (Austrian Red Cross, Medical Aid for Refugees, Samariterbund, and other NGOs with the medical personnel capacity), there were also a huge amount of primary health care professionals working as volunteers involved in assisting the NGO personnel, later they were formally integrated in the NGO structure. For a more detailed report on primary health care provision in transit centres and emergency shelters please see: Austrian national report 6.1.

Initial health assessment

The initial health assessment is conducted differently in the respective implementation site countries; Table 7 was created for providing an overview.

Table 8: Initial health assessment per country

	Initial health assessment	Protocol	obligatory	voluntary	Documentation	Level of execution
Greece	no: currently there is no health assessment especially for asylum seekers in place in Moria	according to Greek legislation, all Greek authorities can request a health examination (within the official asylum procedure) from the asylum seeker in order to keep proceed with their asylum application (according to Ministry of citizens protection, 2010 basic information for asylum seekers in Greece	when authorities thing an initial health examination is necessary it contains e.g. vaccination for communicable disease control (not specified which vaccinations), tuberculosis or x-ray		no information available	according to NGO representatives assessment, there is no health assessment for refugees who apply for asylum at the present
Italy	yes: a first health screening is provided in the hotspots	no information, only that health workers express necessity of specific guidelines for asylum seekers and refugees in case of vulnerable migrants	no information available		no information available	no information available
Croatia	yes: when admitted to asylum process no: when transit	no special protocol for initial health screening	initial check-up: clinical interview, taking blood pressure and pulse, mouth and throat inspection, examinations of lung and heart functions using a stethoscope		asylum seekers carry medical records (in Croatian) with them	estimated level is good, all in Kutina, Porin and Slavonski Brod have had initial health screening
Slovenia	no: there is no initial health assessment for persons who applied for asylum	no information available	no information available		no information available	no information available
Hungary	yes: a first quick general health assessment at transit zones, and another health assessment in the centres	there are special operational plans, regulated by the National Public Health and Medical Officer Services	the health assessment in the centre includes blood test, skin-inspection, chest x-ray, screening for infectious diseases, physical examination, other investigations if necessary		documentation is paper and computer based	no information available
Austria	yes: when admitted to asylum process* no: when transit	guideline by Ministry of Health, pursuant to Article 6(1)(4) of the Basic Welfare Support Agreement - Article 15a B-VG	x-ray of the lung/ TC screening	vaccination recommendations (MEA-MUM-RUB(-VAR), DIP-TET-IPV, MEN)**	no information available	estimated level is very low, many asylum seekers were never assessed, currently in the process of conducting all remaining initial health assessment

*when a person initially entered the country as refugee and not through a visa

**according to three-letter code vaccine nomenclature in line with EU legislative framework

For **Greece**: the health providers at Moria's hotspot reported that currently there is no health assessment, especially for asylum seekers. This was due to the fact that until the EU-Turkey deal, Greece was also, a transit country where refugees arrive and leave after a couple of days. In general, according to the Greek legislation, all Greek authorities can request from the asylum seekers, to conduct health examinations (within the official asylum procedure) in order to keep proceed with their asylum application. When authorities think that an initial health examination is necessary (e.g. such as vaccination for communicable disease control, mainly Tuberculosis or x-ray) this is conducted according to the Ministry of Citizens Protection, 2010 basic information for asylum seekers in Greece. MDM has established a referral system with the hospital in Lesvos and Chios, whilst MSF operates a small clinic in the abandoned Captain Elias hotel in Kos and are scaling up to manage mobile clinics in Kara Tepe in Lesvos.

According to the MDM doctors, usually pregnant women are directly recommended to visit the hospital. Their usual practice is to recommend people in need to hospitals and secondary health care services. However, the head of the emergency department of Lesvos hospital mentioned that most of these recommended cases could be easily managed and delegated at the hotspot or at PEDY.

According to both MDM and MSF interviews, there is no health assessment for those refugees who apply for asylum at the present. The MDM official informed us that their health personnel has recognized the needs of the current situation and have made efforts to use the known and most common methods and guidelines in PHC for triage. The MSF field worker informed us that only a rudimentary triage procedure is being conducted in the sites of Piraeus, Elliniko and Victoria square.

The MDM NGO has an official agreement with KEPY and Lesvos hospital, in order to refer refugees and immigrants there. At Piraeus port, KEPY is firstly informed, in case a refugee/migrant should be transferred to the hospital, in order to have the authorization of the referral and afterwards the person in need could be escorted and transferred to the hospital.

A first health screening is provided in the hotspots in **Italy**, mainly to identify infectious diseases and to assess children's age (wrist x-ray). The procedure of wrist x-ray in order to assess children age has been extremely criticized by NGOs present in the hotspots. The screening is carried out by health workers from the Local Health Unit.

Once migrants and asylum seekers are provided with the STP code, they can access to health assistance trough 'normal' channel: first aid, hospitals and Local Health Units. In this context, there are no special procedures dedicated to asylum seekers and refugees.

Health workers we interviewed did manifest the necessity of specific guidelines for asylum seekers and refugees in case of vulnerable migrants (pregnant women, unaccompanied children, migrants subjected to torture and violence). According to this, special procedures and guidelines could be useful in order to assess mental health.

In the **Croatian** national report it is stated, that according to the general practitioner from Reception centre Kutina, all asylum seekers have gone through an initial health screening during their stay in Winter Reception Centre Slavonski Brod and they carry their medical records (in Croatian) with them. Because of this, the doctor in Kutina doesn't carry out a thorough medical examination of asylum seekers once they arrive at the centre, but only inquires whether they have some kind of a medical problem or take any medication. The general practitioner from Reception Centre Porin claims that all

refugees and migrants in Porin, not only asylum seekers, are offered to take an initial check-up. Although there is no special protocol for initial health screening of asylum seekers, these check-ups usually include a clinical interview about the health status and possible complaints, taking blood pressure and pulse, mouth and throat inspection and examinations of lung and hearth functions using a stethoscope. He also mentioned that the asylum seekers have had initial health assessment while staying in Slavonski Brod. However, there is neither an initial assessment nor a screening for mental health issues. Also, no recommendations for triage are formalized specifically for asylum seekers.

In the **Slovenian** national report one quote is given:

> *"There is no initial health assessment for persons who applied for asylum" (Interview ATS from Slovenian national report 6.1)*

In **Hungary** there is firstly a quick general health assessment in the transit zones, then another health assessment in the centres, for all migrants/refugees/asylum seekers. The health assessment includes more tests in the centres (blood test, X-ray, screening for infectious diseases, other investigations if necessary). The documentation is paper and computer based.

> *"They receive the same medical care, as the Hungarian population; there are also special operational plans, regulated by the National Public Health and Medical Officer Service. The care starts when they get off the bus-there is general health assessment, test for infectious diseases e.g., screening for parasites, x-ray, general health check-dehydration, malnutrition of if there is a need for hospital admission." (Interview from Hungarian national report 6.1)*

Described in the Local Report Hungary for WP2 a medical screening is performed before the official admission into a camp, it contains skin-inspection, chest x-ray, physical examination and others depending from the findings (WP2 Local Report Hungary).

Persons who seek asylum in **Austria** and are admitted to the asylum process and who entered Austria as refugees[4] an initial health assessment is obligatory. It is a standardized assessment procedure which is supposed to take within 72 hours after the registration process, in German it is called: *Medizinische Untersuchung bei der Erstaufnahme* translated as initial health assessment (3). According to the guidelines provided by the MoH an operational plan is followed and includes a self-anamnesis, an x-ray of the lung (obligatory) and a (voluntary) vaccination (MEA-MUM-RUB(-VAR), DIP-TET-IPV, MEN). As the federal facilities in Austria are operated by ORS Service GmbH, they are responsible for the initial health examination as well as the provision of primary health care in these facilities, commissioned by the MoI and the MoH. Interviewed stakeholder reported that as of March 2016 there is a huge backlog with the initial health assessment, as the ORS Service GmbH is several months behind. It was also reported that only a few persons were actually vaccinated and only the x-ray was extensively conducted. From mid-March 2016 onwards the Austrian Red Cross was assigned to additionally conduct initial health assessments, asylum seekers who were already accommodated in permanent refugee camps were then subsequently assessed. In terms of documentation of the assessment we found that no coherent documentation was available, especially primary health care providers are facing a challenge when they later treat asylum seekers. Generally it was reported that

[4] For persons who entered Austria through a Visa (e.g. student visa, working visa, etc.) and only after entering Austria applied for asylum there is no initial health assessment required.

initial health assessment was given priority in initial reception centres and a triage system in order to detect acute disease was not in place.

Interpreters and cultural mediators

Based on the empirical data from WP2 a lack of interpreters was observed in Moria hotspot in **Greece**. Furthermore a lack of interpreters and especially interpreters who speak Farsi was reported at the hotspot. In principle each organisation or NGO has their own interpreter(s) for Arabic and Farsi. However, there appeared a lack of coordination among the organizations (NGOs) and their interpreters. The Greek researchers were informed by the authorities (EKEPY) that the biggest issue was with interpreters from Afghanistan (Farsi) who were available in a very limited number. The hospital of Lesvos since February 2016 had four interpreters working in shifts, mostly in the emergency department. MSF, MDM and PRAKSIS representatives informed us that their organizations have interpreters but the number and the capacity and the lack of medical terms and knowledge (especially Farsi language) embedded them from achieving the level of medical services they intent to provide to the refugees and migrants. All of stakeholders stated that there is a lack of interpreters in the different hosting/detention places.

> *"There are a lot, but do not have the capacity to do the job. Around 150 interpreters are capable to do this […]" (MDM official)*

As of April 2016, persons from refugees/migrant communities (mainly in Piraeus and Eidomeni centres) are used as interpreters, whether or not they possess the appropriate knowledge or capacity. These "interpreters" work as volunteers (mainly refugees/migrant from Syria and sometimes from Afghanistan) and are used due to the absence of official interpreters in these places.

In **Italy** interpreters and cultural mediators are provided in the hotspots and first reception centres depending on the capacity of the place. The provision of interpreters and cultural mediators is managed at a local level, by local institutions and organizations. Regarding the presence of interpreters and cultural mediators in the Local Health Units, hospitals and first aid services, this is extremely variable depending on the territory.

On average, the interviewed health workers were satisfied by the effectiveness of the interpretation service. For example, the Careggi Hospital (one of the main hospitals in Florence) has 4 languages present in the service: Chinese, Arab, Romanian and Albanian. Interpreters and cultural mediators are not available 24 hours a day but only in limited time slots, mainly in the morning. There is also a service of telephone mediation, called Help Voice. Health workers mainly facing with urgencies (e.g., first aid, women giving birth, urgent necessity of informed consent) judged the service of cultural mediation insufficient.

In **Croatia** there are enough interpreters from different organisations available in the two reception centres Kutina and Zagreb. Especially during medical examinations an interpreter is always present, unless an asylum seeker speaks English well and can communicate on their own. According to the CRC social worker whom we interviewed, around 30 interpreters are available in Reception Centre Porin alone. Croatian Ministry of Interior provides official interpreters for various languages free of charge but only during the asylum application procedure or other legal issues. However, CRC and JRS both have unofficial interpreters in their teams who regularly visit the centres Porin and Kutina, although

these are mostly people who are fluent in the required languages but not trained for interpretation. CRC has 6 interpreters (3 for Arabic, 1 for Urdu, Pashto and Farsi) and JRS employs 5 native speakers of Arabic and Farsi who have been granted asylum in Croatia few years ago (before the European migrant crisis started) and are now helping in interpretation and communication with the medical staff. SPA provides 8 interpreters for various languages who are specially trained for interpretation during psychological counselling.

The **Slovenian** national report details the initial problem of the lack of interpreters, it is stated that by and by interpreters were present in more places. However, these were not always in the appropriate number they were needed and often refugees with good English skills stepped, as the following quotes confirm:

> *"[…] the young or minor were able to speak English much better than the older, including for example persons of 25 plus. So minors they also helped with the interpretation. The main problem was the communication" (Interview Logatec)*
>
> *"In a case if a refugee does not speak English or speak very badly, and you are in situation that currently you do not have an interpreter available. It's really challenging because you do not know what and how to help him. (Interview Dobova)*
>
> *"In the refugee camps the availability of interpreters and mediators was very scarce at the very beginning. With time, when things were more organized it was better. UNHCR, the Organization for Refugees United Nations High Commissioner for Refugees provided interpreters. They provide a lot of interpreters. In principle, they were primarily planned to help in police operations and people seeking asylum, to inform them. But they were also constantly available for health care. When there were large numbers of refugees - refugees themselves helped us if they were able to speak English. At the beginning there was definitely a shortage of interpreters." (Interview Dobova)*

In **Hungary** the centre/camps staff is usually supported by interpreters who are available in all centres and camps for certain times when it is required. Generally interpreters are not available all the times, one health care worker explains:

> *"There are native language interpreters, we (the doctors and nurses) also speak basic Farsi, Arabic, etc. or English if they speak English." (Interview from Hungarian National Report 6.1)*

In **Austria** a person who applies for asylum has a right to an asylum proceeding in a language understandable to him/her and interpreted by an official interpreter under oath during the asylum process, where inquiries on personal circumstances, travel to Austria, and reasons for flight, are made by the Federal Office for Immigration and Asylum. In detail, first the fingerprints and interview is made at the police, an interpreter should be present, then at the Federal Office for Immigration and Asylum an admission procedure is undertaken, inquiries on travel route, etc., an interpreter is present, after admission is granted the asylum procedure takes place, the interview on the reason for fleeing the home country, and again an interpreter is present.

In the different other settings described above, outside of the interrogation for the asylum process, interpreters or cultural mediators were solely available on a voluntary and sometimes sporadic basis and the organisation in charge organised these services as voluntary work (for more details see below

section: challenges for primary health care providers). The self-anamnesis document which is to be filled out by the asylum seeker at the initial health assessment was reported to be available in various languages, certainly in Arabic, Farsi and English.

In emergency shelters/ transit centres a lot of volunteers, who had themselves migratory background worked as interpreters and helped out with their bilingual skills.

> *"Arabic from Tunisia is something completely different than Arabic from Iraq or from Syria and if sometimes then even little dialects came it was certainly a huge challenge [for the people who volunteered as interpreters]. I would say for acute symptoms it is not even necessary because we had really good pictograms" (Interview 2, GP)*

In cooperation with the Red Cross, the Caritas and the Medical Aid for Refugees initiative pictograms were developed and used[5]. Generally the GPs and other health care providers can use video or telephone interpretation systems. Salzburg is the first province who offers from March 2016 onwards telephone interpretation systems for resident doctors/GPs the province co-finances this with the Medial Association Salzburg. This 6 months pilot project is exceptional in Austria as in all the other provinces the expenses have to be covered by the GPs themselves. There is neither a refunding for purchase of the device nor for the actual interpretation service in all other provinces in Austria. The application of video interpretation systems are still in their infancy in the Austrian health care system, also in hospitals video interpretation tends to be the exception rather than the rule. In the federal government detention centre Vordernberg in Styria video interpretation is available since October 2014, on the website it reads:

> *"[…] the introduction of video interpretation in the ambulance of the AHZ Vordernberg was a very good decision. The medical care of our clients is very important to us in our facility and through the quick availability and the linguistic diversity the provision of care is ensured" (http://www.videodolmetschen.com/portfolio/anhaltezentrum-vordernberg-steiermark-oesterreich).*

The conclusions are that there were overall not enough interpreters available in the different refugee facilities in the intervention countries during the high influx of refugees in 2015 and up to the present point. As a result we saw that lay persons with language skills were engaged as interpreters or for interpretation.

Challenges and barriers for primary health care providers

There were specific challenges and barriers for primary health care providers identified in the six intervention site countries.

The **Greek** national report identifies the lack of providing medical services and psychosocial support for refugees and migrants as one of the biggest challenges, as services are mostly provided by national and international NGOs. It is reported that in 9 out of the 24 refugee camps at the Greek mainland health care facilities were non-existent and/or not available within less than 5 km distance, e.g. in

[5] see: http://buerobauer.com/projekte/first-aid-kit/

Elliniko I, II and III, in Ristona, in Nea Kavala, in Cheerso, in Giannitsa, in Eleftheroupoli and in Drama. Another important issue mentioned is that the Ministry of Health does not provide psychosocial programs in any of the hosting centres. Furthermore only 17 out of the 24 refugee camps have asylum services and only 5 out of the 24 camps provide food distribution. Additional difficulties were identified by the interviewed stakeholders specifically but not exclusively for the hotspot Moria and subsumed in the following Table 8.

Table 9: Challenges and barriers for primary health care providers identified in the Greek national report 6.1

Key issue	Explanation, specification
Lack of leadership	All the national and international authorities who are located in the hotspot of Moria have different responsibilities and each one believes that he is responsible for the hotspot
Lack of commitment	The coordination organization UNHCR does not have permanent personnel on the spot and this fact makes the implementation for the agreed decisions made by the weekly assembly of NGOs difficult
Lack of PEDY involvement	Primary Health Care (PHC) in Greece is not present to support the attempts of the authorities which are located in this hotspot
Lack of political stability and information	The majority of refugees have a great desire to move on from Greece to their final destination (to finish their trip and to find a safe place to live), so they don't pay attention to the provided health care services in the hotspot of Moria
Lack of personnel at KEPY first reception and inadequate facility	KEPY has an interdisciplinary team to take care of children, but as the head of KEPY explained the facility resembles more to a prison, it is inappropriate for children who suffered a lot in their countries and during the trip. Secondly the facility lacks a pediatrician
Lack of psychosocial programs in the detention and hosting centres	The medical services and psychosocial support services are not provided by the MoH for refugees and migrants
Safety of health care providers	The safety is threatened because it is difficult to explain to refugees that they have to respect queues because someone else has priority because of a more serious problem
Absence of institutional framework	The absence of an institutional framework at hotspots and hosting centres poses a huge challenge
Lack of qualified personnel	A crucial problem is the difficulty in recruiting a well-trained multidisciplinary team to address the humanitarian crisis, because a significant number of physicians and nurses have emigrated from Greece do different central and north European countries in order to find jobs
Lack of space	The lack of space in mobile units is identified as a challenge
Lack of medical stock	Especially on the islands there are limited amounts of medicines available
Lack of cultural mediators	Due to the absence of qualified interpreters there are linguistic barriers
Referrals to hospitals	Referrals to and returns from hospitals are problematic due to the usual lack of transport possiblities via hospital ambulances

Cronic disease management	Furthermore the difficulties in chronic disease management are mentioned
Lack of integrated care	The lack of integrated care was identified by interviewed representatives

The **Italian** national report portrays the challenges and barriers for health care providers as follows.

Table 10: Challenges and barriers for primary health care providers identified in the Italian national report 6.1

Key issues	Explanation, specification
Language barriers	According to the interviewed health workers, the biggest challenge was the language barrier and the lack of sufficient cultural mediation
Use of first aid	It is reported that the bad use of first aid services is problematic
Lack of guidelines	The lack of specific guidelines for vulnerable refugees and migrants (such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence) was mentioned, as well as the lack of specific guidelines for mental health
Management of severe pathologies	The management of severe pathologies is an additional challenge that health care providers face

In the **Croatian** national report both interviewed GPs working in the reception centres Kutina and Porin respectively assess the available health care in the centres as sufficient. In terms of challenges and barriers several key issues were identified, as listed in the figure below.

Table 11: Challenges and barriers for primary health care providers identified in the Croatian national report 6.1

Key issues	Explanation, specification
Lack of personnel	As the greatest difficulty was the absence of the two medical nurses in the reception centres identified, both were on maternity leave and have not been replaced
Medical data record	The medical data on the asylum seeker is not entered into an official, national data base. The CRC keeps some kind of medical record but for GPs it is difficult to access. Thereby the work of GPs is made more complicated as it is difficult to access health records of refugees; thereby also the establishment of continuity of care is prevented
(Mis-) Understanding of GP role	Asylum seekers often expect GPs to help them understand their legal situation, future perspectives, and opportunities, while doctors have no knowledge on that
Lack of mental health care services	Highly distressed, apathetic or tense individuals in the centres require help that is outside of a GP's or a nurse's working domain; additional mental health services are needed but they are not covered by the national health insurance
Restricted access to reception centres	There are external health care providers who would like to provide health care for asylum seekers in centres free of charge, however, access to the reception centre is restricted by law

The **Slovenian** national report identified four problem areas: 1) communication (language barriers), 2) refugees' social deprivation and traumatic occurrences, 3) negative attitudes among health workers and refugees, and 4) cultural differences.

Table 12: Challenges and barriers for primary health care providers identified in the Slovenian national report 6.1

Key issues	Explanation, specification
Language barriers	Communication problems were identified as the biggest and most common challenge, also previous data showed that it is the biggest obstacle for comprehensive health service provision for refugees; Making a diagnosis is identified as difficult and challenging; Health workers are therefore in permanent stress due to incomplete communication with the patient and possible wrong diagnosis or misidentification treatment;
Lack of interpreters	Therewith related was the absence of formal interpreters mentioned, it was reported that the present interpreters were mostly volunteers and the medical team had no interpreter, some interviewees explained they rely on google translate
Refugees social deprivation and traumatic occurences	Due to the refugees experiences in their countries of origin (surviving war zones and war situations) they acted suspicious and introverted towards health workers; the need for psychological (moral) support, understanding and a sense of security and acceptance was identified
Negative attitutes	With the previous issue related, was the fact that negative attitudes existed among health workers and refugees. E.g. refugees rejected hospitalization because they did not want to be separated from their peers, or refused detailed medical examination because of fear.
Cultural differences	The report links the negative attitudes to cultural differences and different cultural heritage of people; different understandings of illness, treatment, privacy and family ties; through different importance and meanings of those issues ethical dilemmas emerged and finally also hampered the work of health workers on the ground

The **Hungarian** report stresses that the overall primary care capacity situation in Hungary is insufficient to manage a higher amount of patients, with different origin, having quite different cultural backgrounds, and a high linguistic diversity. Barriers and specific challenges are concretely outlined in Table 12.

Table 13: Challenges and barriers for primary health care providers identified in the Hungarian national report 6.1

Key issues	Explanation, specification

Lack of resources	The capacity of Hungarian primary care is reported to be insufficient to manage a higher amount of patients with different origin, different cultural backgrounds and high linguistic diversity; but also the lack of financial resources and lack of organisation was highlighted as challenging for provision of health care
Language barrier	High linguistic communication barriers were identified as huge challenges for health care providers and they would need more support for developing communcation skills with people having differen languages
Lack of knowledge	Primary health care providers would need more support and information about never seen morbidities
Cultural barriers	The report suggest that most of the refugees never received any treatment from primary care in their country, and some do not cooperate and do not understand why these investigations are needed

The **Austrian** national report identifies three different levels on which specific challenges and barriers for primary health care providers exist, [1] first at the level of emergency shelters/transit centres, [2] secondly at the triage level and first assessment at entry point level, and [3] third at the first contract level with the primary health care system, which is the level of long-term primary health care.

Table 14: Challenges and barriers for primary health care providers identified in the Austrian national report 6.1

Key issues	**Explanations, specifications**
Logistical challenges	It was noted that the provision and availability of all kinds of drugs, material and medical equippment in emergency shelters was challenging
Challenge of provision of adequate care	The very short time frame was identified as a barrier for providing adequate care, disease monitoring and treatment was difficult if persons were only accommodated shortly [1]; in cases when impatient care was needed but persons wanted to continue their travel hospitalisation could not be enforced [1], also the cooperation with border authorities were sometimes hindering provision of adequate care [1]
Documentation of disease cases	The lack of a standardized format to document patients was noted [1], also GPs identified the lack of passing-on documentation as challenging and hindering [3]
Inadequate accommodation/ sanitation	Inadequate accommodation/ sanitation was identified as a barrier for health care providers, e.g. danger of overmedication when lack of water/tea [1]
Lack of psychological support	Difficulty to provide psychological support in short-time settings [1], the lack of a psychiatric-neurological service as well as psychological crisis internvention which is available 24 hours was identified for the second level [2], and underfunded mental health support in long-term care, e.g. limited therapy places and even further limited therapy places with interpretation services [3]

Unclear legal working status of health workers	The legal working status of health care providers in emergency settings was noted, questions of insurance were raised [1], additionally the question of refusal of patients by GPs was noted without interpretation [3]
Overload of personnel	Work overload and the necessity of burn-out prevention for health care workers was pointed to as the work in emergency settings since all work was done additionally to the day-to-day work [1], at the second level reports also show an under-staffed situation and high workloads were noted [2]
Lack of specialist	Women- and children's specialists were absent at the second level as well as dental acute-care was absent [2]
Lack of triage	Repors show that initial health assessment was prioritized over provision of primary health care to vulnerable persons, such as pregnant women, children, old or disabled persons and no triage system in order to detect acute diseases, which have to be treated as a matter of priority was in place at the second level [2]
Hesitant health seeking behaviour	Refugees are hesitant to seek health care at the second level, not only because of the long waiting hours, but because of fear of consequences e.g. that it has a negative effect on their asylum procedure [2]
Difficulty of referral	Difficult to transfer asylum seekers to specialists, or hospitals, in many cases the refrerrals are informally organised [2]
Access to apparatuses	The cooperation with hospitals was sometimes difficult and also the access to necessary medical devices or laboratories was sometimes difficult, e.g. roentgen, blood count, etc. [2]
Lack of remuneration	As the biggest challenge for primary health care providers at the thrid level was the difficulty in remuneration identified [3]
Language barrier	There is no free interpretation services available for primary health care providers and especially in terms of first anamnesis and explanation of diagnosis and treatment the physician face a huge communcation barrier [3]
Culture related communication differences	It is reported that it is very challenging for the GP e.g. to interpret traumatising experiences of patients as well as cultural differences in non-verbal communication [3]
Lack of information	For GPs it is often unclear and undocumented what medical assessment occurred before the first contact with the conventional primary health care system, e.g. vaccination, or a general patient record also hospitalization [3]
Lack of information material for refugees	Interviewed persons pointed to the lack of infos for refugees on health services within the Austrian health care system, also in terms of vaccination, etc. [3]
Lack of information material for health care workers	GPs and other health care workers note that it would decrease barriers if they had easy access to information on country of origin, flight conditions, nutrition habits, taboos, etc. from refugees or asylum seekers [3]
Lack of knowledge	GPs or other health care providers at the third level might lack the knowledge on post-traumatic stress disorders, psycho-trauma and similar conditions [3]
Financial barriers	Refugees who are in the asylum process might not be able to procure costs which are not covered by the insurance, e.g. transportation costs, costs for ultasound [3]

Refugees who worked in (primary) medical care and have applied for asylum

In the majority of the national reports from the intervention country we found hardly any evidence about refugees who worked in (primary) health care and have now applied for asylum or were already granted asylum or subsidiary protection.

In **Greece**, no evidence to address this issue was found in literature also in existing national reports from NGOs operating in Greece no information on this topic was available. According to the Greek Ministry of Migration, 3.362 persons (of various specialties) will be hired in order to address this issue. Regarding the interviews, MDM and MSF stakeholders, PRAKSIS and Metadrasi reported that there are some refugees/migrants who informed them, that they were health personnel in their origin country and who wanted to assist them. However, all the volunteers, apart from two, could not provide any evidence to support this claim, which embed the refugees from joining the already existing medical teams of NGOs.

> "*There must be around 20 persons mainly from Syria at Piraeus port with a background in health services, but we are not sure […]" (MDM official)*

Both MDM official and MSF field worker, agreed that that does not exist any record procedure about profession in the country of origin.

According to the interviewed stakeholders in **Croatia**, no primary medical care staff has been identified among the asylum seekers in the reception centres. What was reported that a Syrian dentist assisted in the Reception Centre Porin, he consults the GP in the centre when the patients suffer from acute dental conditions.

No data was available for **Italy** on that issue. Yet, all interviewed health workers emphasized that migrants with health care experience could present an important resource, while also difficulties to in involve them were also raised.

No data was available for **Slovenia** on that issue. Several quotes suggest that stakeholders referred to persons who helped out as interpreters and had a medical background.

No data was available for **Hungary** on that issue. One stakeholder explained that some of the refugees worked as health care workers before but they could not be involved in the care of refugees.

In **Austria** 112 persons were registered to have worked in a medical profession and were granted asylum or subsidiary protection as of March 2016, whereof 83 live in Vienna. For persons who are still in the asylum process there was an informal network of Arab speaking health care professions established by a Syrian dentist who works in Vienna for 15 years. The network includes persons from Syria, Iraq, Egypt and Libya, the communication is in Arabic and the main purpose is the increased information exchange and event organisation. The group includes 180 contacts, registered with number, email address, time of arrival in Austria, level of German and date which they plan to take the Nostrification (the validation of foreign studies and degrees).

Up to the present date, the health care professionals had the possibility to work as non-medical assistants in refugee camps, however, without treating patients they often fulfilled merely acted as interpreters. Furthermore a few of these professionals could do an unpaid traineeship (*Hospitanz*) at hospitals and from the next asylum novella onwards it should be provided that they can also engage in occupations as they are possible within clinical traineeships (*Famulaturen*). Many asylum seekers

who worked as (primary) health care workers suffer especially from the long waiting period where they are not allowed to work and are afraid to be out of training once they are allowed to work again.

Discussion of main findings and implications for further Work Packages

Based on the findings it becomes clear that the situation in the respective intervention site countries is highly complex and very dynamic. Main findings and specific challenges were observed on different levels and implications will be discussed in the following.

Systemic level

One of the biggest challenge is assumed to be to respond to the challenges that emerge on a systemic level. The extremely dynamic nature of the refugee crisis and the continuous changes that are undertaken with regards to it, pose a huge challenge to the intervention countries in terms of health care provision for refugees and other migrants. As reported in the findings, after the high influx of refugees via the Balkan route the situation changed quite substantially, after the route was closed and one or more alternative routes were taken. The shift of "illegal" routes, however, had different implications for the different intervention site countries. Political decisions are inter-related in this context, and with the closing of borders by some countries combined with the coming into force of the EU-Turkey deal dramatic systemic challenges arose. During the peak of the refugee crisis, it was also found that frequently centres and camps were converted, re-named, opened and closed. Furthermore the capacity of facilities varied according to (new) legislative guidelines but also depended on classification of a facility. The overall question is, which systemic orientation the institutions, states and organizations establish the respond to the challenges that arise from the refugee crisis.

Organizational level

On the organizational level it appeared that the greatest challenge in all intervention countries, where data were collected, was the lack of staff and resources. Particularly the lack of multidisciplinary teams in the (primary) health care of refugees was noted, but also particularly the lack of certain specialists such as pediatricians and mental health professionals. Multidisciplinary teams ideally consist of general practitioners, nurses, psychologists, social workers, cultural mediators, pediatricians and midwifes. They are considered optimal for providing comprehensive person-centred and integrated care for all ages and alignments, and have the capacity to take into account the trans-cultural setting and needs, wishes and expectations of refugees. The term cultural mediators in this context specifically refers to interpreters who are not only translating but also function as cultural mediators and are e.g. trained in asylum specific and health specific translation (see: e.g. UNHCR Trainings program).

Secondly, we found that clear pathways for (primary) health care for refugees are missing in many intervention site countries. Findings showed that treatment pathways, as well as structures in health care for refugees were to some extent lacking and often unclear responsibilities challenged the health care provision for refugees. For instance, it was reported that there is no standardized initial health assessment in intervention countries and documentation and monitoring structures are often missing. Furthermore the lack of specific guidelines for vulnerable refugees, such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence, was identified as challenging for health care provision.

Thirdly, a crucial problem and challenge on the organizational level was the coordination of different organizations that provided (primary) health care services. In Greece e.g. this was a particular big issue, despite the improvement of the situation in June 2016 compared to previous months, the considerable coordination effort that is needed considering this enormous challenge was recognized.

Provider level

On the level of primary health care provider we found several challenges and barriers for health care provision for refugees, as listed in the chapter on Challenges and barriers for primary health care providers, we could resume that the following challenges and barriers exist at the provider level.

First of all, results showed that a lack of information and knowledge regarding flight specific diseases and risk factors and regarding country of origin specific illnesses, by providers. The lack of mental health support for refugees who may suffer from post-traumatic stress disorders, or other mental health problems were identified by primary health care providers. Linked to that some providers explained that the cultural barriers posed a challenge to provision of care, e.g. different understandings of illness, treatment, privacy and taboos lead to ethical dilemmas and finally also hampered the work of health providers on the ground. Knowledge on country specific idioms of distress, as well as different illness concepts was noted as insufficient. At the same time we found that legal questions on work permission, insurance and ethical aspects were issues important in this context. Another aspect was the lack of standardized format for documentation, or the difficult access to medical data records of refugees or asylum seekers, that was mentioned as a barrier in terms of providing health care and especially continuity of care. For GPs in particular the lack of remuneration was a huge challenge as well as the lack of translation services available.

Potential remains unused

In terms of refugees and other migrants who have themselves worked in (primary) health care and have now applied for asylum we found that these resources are hardly documented and the considerable potential remains unused. Data on refugees or asylum seekers who worked as primary health care providers was in most of the intervention site countries difficult to obtain or did not exist at all because the data was never collected. In most countries no data was available on that issue, in some cases voluntary assistance and help was reported, however, refugees mostly acted as interpreters. In Austria, where documentation on refugee health workers is increasingly established though an informal network of Arab speaking health professionals, negotiations take place to engage individuals earlier in the workforce, before their official validation of foreign studies and degrees is finished. Based on the findings, it is recommended that this unused potential should be formally recognized and used.

The summary report identified specific challenges on different levels that were emphasized in the national reports, and were highly relevant in the respective local national contexts. This deliverable 6.1 can be considered as assistance for intervention countries. In brief, to be able to tackle the multifaceted challenges regarding primary health care for refugees and other migrants, integrated, person-centred, multi-professional interventions are needed which are adaptable to the special needs as well as cultural and ethical challenges of the local sites.

With regards to the continuity of the project this deliverable 6.1 indicates the situation in the respective intervention countries in terms of refugee care, primary health care system, human resource situation of primary health care providers, challenges and barriers of primary health care proiders and limitations. Thereby it serves as a basis to understand the local conditions and settings in order to carry out tasks 6.8 – 6.13, and be able to ultimately aim to implement interventions to improve primary health care deliverable for refugees and other migrants. The EUR-HUMAN objective thereby is to provide good and affordable comprehensive person-centred and integrated care for all ages and all alignments, taking into account the local situations and conditions.

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List of abbreviations

Table 7: List of abbreviations

AH LJ	Slovenia: Asylum home Ljubljana
ASL	Italy: Local Health Units
BÁH	Hungary: The Office of Immigration and Nationality/ Bevándorlási és Állampolgársági Hivatal
BFA	Austria: Federal Office for Immigrations and Asylum/ Bundesamt für Fremdenwesen und Asyl
CARA	Italy: Reception Centre for Asylum Seeker
CAS	Italy: Extraordinary and temporary reception centres
CDA	Italy: Reception Centre
CIE	Italy: Centres for Identification and Expulsion
CPSA	Italy: First Aid and Reception Centre
CRC	Croatian Red Cross
EKEPY	Greece: The National Health Operations Centre
EOPYY	Greece: National Organization for Healthcare Provision
FP	Family practitioner
GP	General practitioner
HIIS	Slovenia: Health Insurance Institute of Slovenia
HVSV	Austria: National Federation of Austrian Social Security Institution
IOM	International Organisation of Migration
JRS	Croatia: Jesuit Refugee Service
MDM	Greece: Médecins du Monde
MoH	Ministry of Health
MoI	Ministry of Interior
MSF	Médecins Sans Frontières
NGO	Non-governmental organisation
NHIF	Hungary: National Health Insurance Fund

List of tables

Table 1: Applied methods per country 10
Table 2: List of conducted (semi-) structured interviews 10
Table 3: Overview of ethical approvals 12
Table 4: Number of refugees entering the country and number of asylum applications 12
Table 5: Different refugee facilities per country 15
Table 6: Primary health care staff situation in selected centres 39
Table 7: Initial health assessment per country 42
Table 8: Challenges and barriers for primary health care providers identified in the Greek national report 6.1 49
Table 9: Challenges and barriers for primary health care providers identified in the Italian national report 6.1 50

Table 10: Challenges and barriers for primary health care providers identified in the Croatian national report 6.1 50
Table 11: Challenges and barriers for primary health care providers identified in the Slovenian national report 6.1 51
Table 12: Challenges and barriers for primary health care providers identified in the Hungarian national report 6.1 51
Table 13: Challenges and barriers for primary health care providers identified in the Austrian national report 6.1 52
Table 15: List of abbreviations 68

List of figures

Figure 1: Cities capacity vs. occupancy in Greek hotspots and reception centres (UNHCR 2016) 18

Annex

A1. Final template for national report for deliverable 6.1

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 07/04/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1
Name of authors

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."

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Introduction

The national reports will provide input to Deliverable 6.1: Summary report about the local resources available (deliverable 6.1 month 6 – preliminary results in month 5). Deliverable 6.1 is part of the WP 6 with the aim to enhance the capacity building of the primary care workforce through the assessment of the existing situation and the development of an online curriculum for local primary care professionals and refugees who are primary care professionals. For the summary report MUW is responsible with the support and input of the intervention site countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria).

Task 6.1

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and other migrants and of refugees and other migrants who have themselves worked in medical care.

Specific objective for task 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.
What we need to know from each intervention country to be able to complete the task, deliverable, and aim:

The situation should be described like it is at the moment (e.g. March/April 2016).

- Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?
    - If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)
- Main countries where refugees and other migrants come from in your country?
- What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
- How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
- How is Primary Health Care provided in your country in general?
- Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?
- Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
- How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
- Primary health care staff situation (numbers, capacity, payment, safety, …)?
- Biggest challenges and barriers for primary health care providers?
- Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum? In what way are these resources documented and used already?

Timeline

1. April – 30. April	Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and other migrants and of refugees and other migrants who have themselves worked in medical care through:	**All intervention countries (UoC, UoD, UL, FFZG, MUW, AUSL11)**

	• Literature review (obligatory) • Semi-structured interviews • Participatory observation (for details please see methods section below)	
1. May – 15. May	Writing and sending the national reports (=complete the blank section of this template) to MUW	**All intervention countries (UoC, UoD, UL, FFZG, MUW, AUSL11)**
16. May – 05. June	Preliminary summary report of deliverable 6.1 for WP4 (expert meeting) to RUMC and UoC	**MUW**
10. June - 30. June	Synthesis and finalization of the summary report **(Deliverable 6.1)**	**MUW**

Methods

The literature search is the minimum criterion in the context of limited resources. However, it would be optimal to combine all of the following methods for the national report. At the end of this section is space for you to describe the methods selected and conducted:

- **Narrative literature review/search of local grey[6] and scientific literature and reports** (existing documents on the local/national primary care capacity situation which include our questions raised above). Narrative means to describe and discuss the state of the existing literature of a specific topic or theme from a theoretical and contextual point of view. A narrative review consists of critical analysis of the grey and scientific literature published.[7] It does not describe the methodological approach that would permit reproduction of data nor does it answer to specific quantitative research questions. Nevertheless, a narrative review provides readers with up-to-date knowledge about a specific topic or theme. Examples for grey literature are reports by NGOs, governments, national, regional and international organisations, websites, publications in non-reviewed, non-indexed journals and quality newspaper articles.

- **(Semi-)structured interviews** with local primary health care providers treating refugees and other migrants and stakeholders involved in the organization of primary health care for refugees (~ 6-10 persons).
  Possible interview guideline (depending on the position of the provider/stakeholder interviewed), please adapt the questions accordingly:
  - Thank you for your participation in this interview. We would like to talk to you specifically about health care for refugees. Could you first, please, give us an overview of what you are doing and on the relevant concerns in your field of work?
  - What kind of refugee centre do you work in/ does your organisation administrate (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum)?
    - If applicable: How many refugees visited your organization/PHC unit per day/per month? (If possible gender and age information)

[6]Luxembourg Convention on Grey Literature. Perspectives on the Design and Transfer of Scientific and Technical Information. Third Conference on Grey Literature. [http://www.greynet.org/]. Dobbins M, Robeson P: A Methodology for Searching the Grey Literature for Effectiveness Evidence Syntheses related to Public Health. The Public Health Agency of Canada; 2006.

[7] Cook DJ et al. Ann Intern Med 1997;126:376-380

- Who – if anyone – is providing primary health care in these different centres/camps/shelters (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)?
- Which are the main countries where refugees and other migrants come from?
- Are there any differences in the health needs of refugees from different countries of origin? How are these health needs documented/solved/dealt with?
- How is the primary health care staff in the different centres composed of (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)? Which responsibilities? Are there special operational plans for them?
- How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
- What is the situation of the primary health care staff in the centres/camps/shelters?
- If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?
- Is there a sort of initial health assessment for persons who applied for asylum? Do objective criteria or recommendations for triage and referral exist?
- What are the biggest challenges and barriers for primary health care providers?
- Do you have an idea of the number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your centres? In what way are these resources documented and used already?

The interviews can be face-to-face, as telephone-interviews, or skype interviews. It is voluntary if you audiotape and transcribe the interviews for analysing the content or if you take memory notes. It is also possible to send the question per email to certain persons and receive answers via email. The analysis should be conducted with the aim to be able to answer the questions raised.

- **Participatory observations in refugee camps and centres** (like for example the report from Dean from the Croatian transit centre): Participatory observation is a technique of field research, commonly used in anthropology or sociology, by which one or more investigators (participant observers) study the life of a group by sharing in its activities and observing and documenting the incidences occurring, the behavior of individuals and the group, as well as the interactions between individuals. In the context of primary health care, for instance, this allows the researcher to better understand the challenges and issues in clinical practice by observing the interactions between patients and health care workers.

Please, describe the method(s) used in your country for this report in detail:

Use as much space as necessary…

Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Main countries where refugees and other migrants come from?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
How is Primary Health Care provided in your country in general?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible**

(2) Web based report/article: Title, Link **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Primary health care staff situation (numbers, capacity, payment, safety, …)? **If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?**
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Biggest challenges and barriers for primary health care providers?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

Use as much space as necessary

Thank you very much!

Best regards,

The Viennese EUR-HUMAN team!

A2. Country Report Greece

EUR-HUMAN

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

National Report (Greece) – Version 18/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

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Co-funded by the Health Programme of the European Union

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Funding

"This EUR-HUMAN national report for deliverable 6.1 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020)."

Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?

- ***If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)***

Greece is the country that receives 95% of refugees and migrants, who wish to reach Europe[1] and during 2015, it was the country that became the first entry point of 862,138 refugees and migrants for this explicit reason.[2,3] During the first three months of 2016 (1/1/2016 - 1/4/2016) 151,656 people[4,5] had crossed the Mediterranean Sea and arrived in Greece, mainly via the ports of Mytilene (Lesvos), Samos, Chios, Kos and Leros. The average daily arrivals during March (2016) in Greece were 856 people and during February 1,931 people respectively (see appendix table 1 and 2). Until the 6th of April 2016 the average arrivals in Greece were 229 persons per day. On 8 March 2016- the date where the former Yugoslav Republic of Macedonia (FYROM) closed the border from Greece- leaving over 46,000 refugees and migrants stranded in mainland of Greece (until 11 April). [6]

During 2015 the number of arrivals reached its peak in October 2015 when in Greece arrived 211.663 persons. In general, during 2015 it is estimated that around 2.362 refugees and immigrants arrived in Greece per day. In Lesvos during 2015 arrived 500.018 in total (1370 per day). 59% of total refugees and immigrants arrivals are estimated to have reached Lesvos in 2015. The estimated departures per day to the mainland were 1753. During 2016 (January-March 2016) in Lesvos arrived 86.432 immigrants and refugees (59% of total). As about Chios, the island during 2015 was reached by 123.279 persons (14% compared to total) and the estimated departures to mainland were 1375 per day.

The most of these people crossed the border via the called "*Balkan transit route*" and reached central European countries. After the EU-Turkey agreement come into effect and the western borders of Greece (Greece-FYROM borders) closed, many refugees and immigrants get "stacked" in

the country. Due to this agreement, approximately 48,000 refugees and migrants who arrived before 20 March (date that come into effect the deal) and continue to be stranded in Greece with reduced options for onward travel.

The situation in Greece indeed demonstrated that large numbers of potential applicants for asylum arriving in an irregular manner by sea can lead to severe difficulties in the registration foreseen by the new legislation.[7] In Greece during 2015, 13.197 asylum application were applied when in 2014 were 9432 (an increase of 40%). From them, only 625 were approved. The most of asylum applicants in 2015 were from Syria (3.495), Afghanistan (1708), Pakistan (1617) and Albania (1003). During January and February 2016, 1171 and 1470 asylum applications were done.[8,9] After the EU-Turkey agreement[10], Greek authorities recorded an estimated 2.870 people who expressed interest in applying for asylum. The authorities confirmed that these people will not be sent back until their claim is assessed, a procedure that is bound to last at least two weeks. Within the next months, is estimated that the number of asylum seekers in Greece will raise due to the EU-Turkey deal. Refugees and immigrants could apply to the Greek authorities to seek asylum, in order avoid to be deported to Turkey. That was also the main reason EU commission, EASO and FRONTEX agreed to deploy officers to help with asylum procedures.[3,11]

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Main countries where refugees and other migrants come from?

The main countries of origin of refugees and migrants, who arrived in Greece, are the following: Syria, Afghanistan and Iraq (see appendix table 1). In 2015, 56% of the total arrivals in Greece were from Syria, 24% from Afghanistan, 10% from Iraq, 3% from Pakistan, 1% from Somalia and 6% from other countries. From the total number of arrivals, 55% were male, 17% female and 28% children. Until the 16th of March almost half of refugees (50.5%) came from Syria, 25.3% came from Afghanistan and 14.7% from Iraq. However, 3% and 4% reach Greece shores from Iran and Pakistan, respectively. The remaining refugees (approximately 2.5%) arrived from Morocco, Bangladesh, Egypt and other countries of North Africa.[1,2]

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What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

Currently, in Greece exists 5 hotspot (in fact the 5th in the island of Kos due to island residents' reactions is unofficially out of order) and 24 relocation camps/hosting centres plus four unofficial camps (see figure 1); In Lesvos island also, except the hotspot of Moria, which is the first created in Greece exists the hosting centre of Kara Tepe mainly for Syrian families.[1-3] Refugees and immigrants can apply for asylum during their arrival at the hotspot (when they get recorded or at any time when they reach the mainland). They can also apply for asylum (after EU-Turkey deal) even at the moment when they are in the boat deported to Turkey.[4]

References:

1. European Commission. Managing the refugee crisis. Greece: state of play report. Available at: http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/background-information/docs/greece_state_of_play_report_en.pdf *(15/4/2016)*
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4. Discussion with IOM representative during the meeting with stakeholders in Lesvos (Mytilene).

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

Following the full closure of borders between Greece and FYROM (until then to the Greece-FYROM border only some refugees were allowed to pass), known as "*Balkan transit route*" on the 8th of March, the EU-Turkey agreement came into effect at midnight on the 20th of March. Any new arrivals to Greece after this date, regardless of nationality and need for international protection, are subject to possible deportation back to Turkey after a fast-tracked asylum process. With Turkey reclassified as a "*third safe country*" migrants and refugees can still claim asylum in Greece, but applications could likely be declared as "inadmissible". As a result of this event, Greek hotspots had overnight become pre-departure - detention facilities where all new arrivals are held while their case is assessed.

In Greece exists also 24 official relocation camps, of which the most of them are abandoned military camps (see appendix table 2); Except the official hotspots and hosting centres/hosting camps/ relocation camps there are at least four "*unofficial*" hosting centers /unofficial camps in Greece; The first was in Piraeus port, the second at National Road to FYROM borders, the third at Eidomeni close

to the Greece-FYROM borders and the fourth at Victoria square in Athens. As a conclusion, by the shutting down of the main *"Balkan migration route"* to Western Europe, up to 52.352 migrants remain temporarily (5.984 on the islands, 2.542 in Central Greece, 14.506 in Attica, 28.980 in Northern Greece and 340 in Southern Greece) stranded across Greece, with an increasing trend.[1] Refugees and migrants are hosted in a total of 33 relocation centers and "informal" sites on the mainland and 5 hotspots which now became detention centers on the islands. Reception centres are the 5 hotspots which became detention centres after the EU-Turkey deal. Relocation camps are centres in the mainland in which immigrants/refuges are hosted. They are hosted in these centres until a decision for asylum or for relocation in an EU county comes out. In the mainland, the majority of these centers have reached or have gone over their full capacity. Additionally, dilatory asylum procedures keep people stranded in reception centers for over six months, and as a conclusion of that, they will increasingly require integration assistance, education, and longer-term health interventions.[2]

Capacity

In addition to reception facilities, over 30 accommodation centers are in operation throughout Greece in April, with a total capacity of 33.910 places, while 30.000 new accommodation places will be created shortly. In this context, Greek authorities are making efforts to relocate all refugees/migrants from unofficial camps to organized accommodation facilities that guarantee decent living conditions.[1] As about long-term facilities, until EU-Turkey deal Greece was a country which was not the final destination of refugees and migrants, so does not have long-term facilities or a mechanism to integrate these populations. Persons that arrives in Greece after the EU-Turkey deal are accommodated in the 5 hotspos in the Greek islands. They have to wait in these facilities about their asylum decision. It was agreed that the decision should come out in less than six month. As about the refugees/migrants in the mainland they are accommodated in the hosting centres. Officially in less than six month a decision should be taken. The lack of personnel in asylum procedures is the most significant obstacle the procedure to be finished so quickly.

Humanitarian organisations have major concerns about the human right protection of thousands of refugees and migrants who are now in overcrowded detention facilities on the Greek islands and may soon be returned to Turkey. The system for assessing asylum applications in the Greek islands and mainland seems to be understaffed and inadequate. The two major characteristics of refugees and migrants that are likely to have the greatest impact on the level of protection that refugees and

migrants receive from European states and their access to services, irrespective of their specific needs and vulnerabilities are arrival date and nationality.[3-6]

References:

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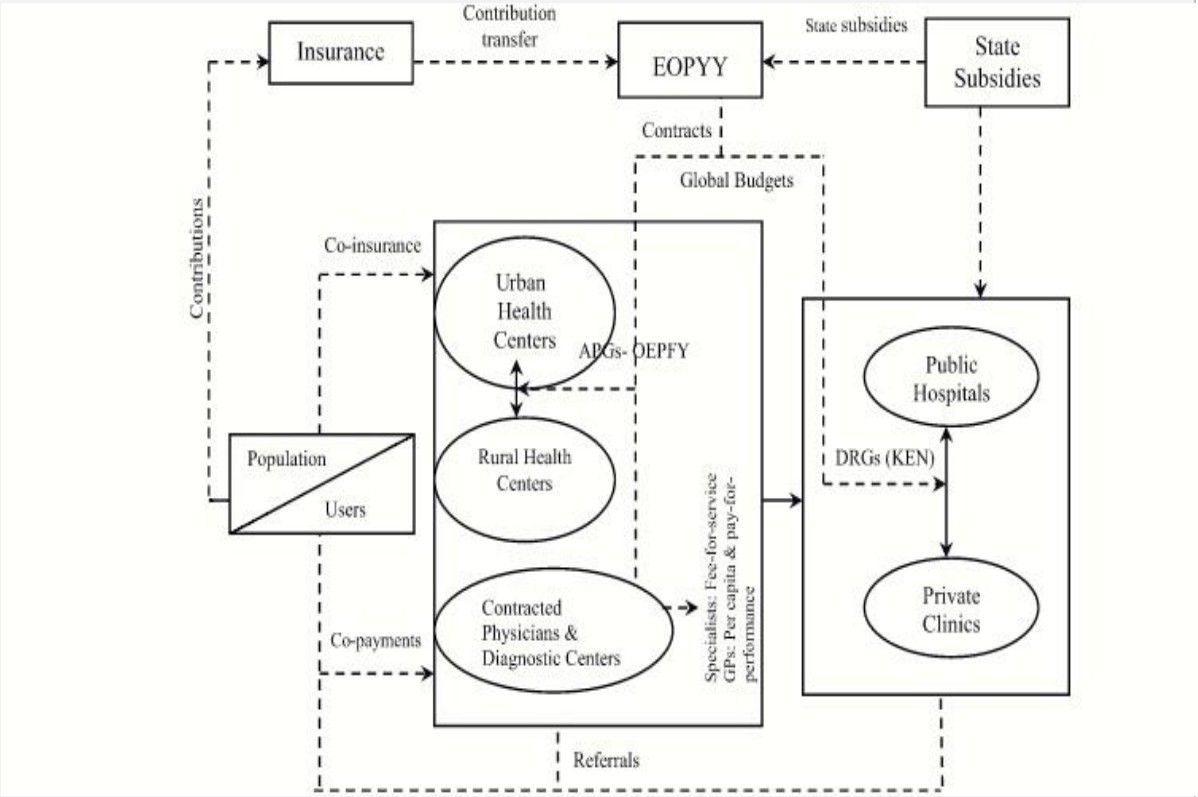
4. Discussion with Police representative during the meeting with stakeholders in Lesvos (Mytilene).
5. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).
6. Discussion with EKEPY head during the meeting with stakeholders in Lesvos (Mytilene).

How is Primary Health Care provided in your country in general?

In Greece, PHC is delivered through a combination of publically funded state health services, by general practitioners (GPs), who work at the private sector and specialists. The choice of the provider is free but there are some charges. On the other side people can arrange an appointment at PEDY (Institution of Primary Health Care Provision in Greece) but the existence of long waiting times is the main problem.[1,2] The public service is delivered through Regional Health Care Centers, Health Care Centers in rural and remote areas (which are accessible 24 hours a day, 7 days a week) and public hospitals. Private GPs and specialists provide their services on a fee-for-service basis.[1] Since the beginning of financial crisis, Greece has been trying to improve national health care services with a focus on strengthening PHC services but still the results are poor.[3] The creation of National Organization for Healthcare Provision (EOPYY), the development of the electronic prescribing system and the creation of a Primary Healthcare Network in an effort to meet the needs of the population and ensure the efficient use of public resources were some of the Greek government efforts in order to improve primary health care services.[3,4]

The following figure presents the structure of the Greek National Healthcare System.

Figure 1.Flows of proposed Health Provision and Financing in Greece.



Source: Polyzos et al.[2]

References:

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2. Polyzos et al. : The introduction of Greek Central Health Fund: Has the reform met its goal in the sector of Primary Health Care or is there a new model needed? BMC Health Services Research 2014 14 :583.
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Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

In addressing refugee/migrant issue several authorities were involved, including ministries, regional and municipal authorities, port authorities, Greek coast guard and police, primary health care services (PEDY), hospitals, tertiary health services, Greek army, national and international non-government organizations (NGO's), NATO and Frontex.[1]

In general, primary health care services are provided mainly by several national and international NGOs which provide humanitarian support in the field such as: Praxis, Médecins Sans Frontières/Doctors Without Borders (MSF), Médecins du Monde (MDM), the Greek Red Cross, KEELPNO. The UNHCR is responsible for coordinating all NGOs activities. The EKEPY is the coordinator authority on all provided health care services to refugees. Refugees with need of medical assistance are mainly escorted to Médecins Sans Frontières / Doctors without Borders (MSF), Médecins du Monde (MDM), Women and Health Alliance International (WAHA), Greek Red Cross and PRAKSIS facilities at the hotspots and refugees camps, especially in Piraeus port, Elaionas and Elliniko. They can escort them to the hospital (emergency department which provides also primary health care services). In general, refugees and immigrants are not referred to PEDY due to its lack of facilities and personnel.[2] KEELPNO (Hellenic center for control and prevention of diseases), provides health services too with mobile units usually.[2]

MDM provides health care services (including mental) to all refugees and immigrants that arrived in Greece and are in need as they informed us during an interview we had conducted with their coordinator, in Moria's (Lesvos) hotspot. The health care professionals of MDM consist of a multidisciplinary team of general practitioner (GP), cardiologist, orthopedist, otolaryngologist, nurse, psychologist and social worker. They could not provide us with an e exact number of their personnel as they informed us that depends on the migrant influx. In general at the hotspot of Moria

the personnel of MDM included six or seven physicians, two nurses and two interpreters (Arabic and Farsi).[2]

MDM launched the program entitled "strengthen of first receptions mobile units in area with huge refugees/immigrants influx". This program provides primary health care services and psychosocial support to refugees and immigrants reaching Lesvos shores. At Kara Tepe center in Lesvos, they provide primary health care services and pharmaceutical services. At hotspot of Chios island, MDM have also, established a unit providing primary health care services at the island's hotspot. They provide primary health care services, pharmaceutical services and psychosocial support at the different refugees and migrant hosting centers in Attica (Elaionas, Elliniko, Faliro and Galatsi). Finally, they also provide the same services at Eidomeni. During 2015, MDM provided services to 168.955 refugees/immigrants/asylum seekers. The number of visits to MDM services in Lesvos reached 34.254, 6.610 visits in Chios, 11.710 visits in Eidomeni, 2.551 visits in Attica and 95 visits in Tilos.[3]

MSF provides medical care, shelter, water, sanitation and hygiene promotion services (watsan), and distributing relief items to refugees and migrants arriving in the **Dodecanese Islands** as well as in **Lesbos, Samos and Agathonisi,** in **Athens** and at the **Eidomeni's border crossing** to FYROM. They provide medical care, in mobile clinics, at the island of Kos and other nearby islands. Since June 2015, in Lesvos they have provided health care services, in mobile clinics, distribute hygiene kits and improve water and sanitation facilities in the camps at Kara Tepe and Moria. I**n Eidomeni** medical care **is** provided through mobile clinics to people, who are trying to cross the borders to reach FYROM. In collaboration with other NGOs, they set up a short stay camp and installed water and sanitation facilities along the border. **In Athens**, MSF provides medical care, psychosocial support and legal assistance to refugees, who have been tortured.[4] MSF teams in Greece, are providing first aid, medical and psychological support, shelter, water, sanitation and essential relief items at reception centres and transit camps.

In Kos island, MSF runs a medical clinic which includes access to a psychologist. In Leros, MSF is providing shelter and hygiene facilities to host the people brought to the island for registration from the neighbouring military island of Farmakonissi, conducting medical activities and distributing NFI's and water. The MSF team has been conducting vulnerability screenings in order to identify the most vulnerable groups like pregnant women, minors, but also people without access to health services,

providing medical consultations and mental health support. Since the beginning of January 2016, MSF medical teams have conducted a total of 919 medical consultations in Kos island and 1.971 medical consultations in Leros. MSF psychologists have, in the same time, conducted 48 mental health counselling sessions and 265 group sessions with 1,370 participants. MSF teams provide medical health care to refugees and migrants in Moria camp and at the port of Mytilini. There have been treating several pathologies related to the winter conditions, such as respiratory tract infections as well as injuries associated with the journey. Since the beginning of January, MSF medical teams have conducted 8372 medical consultations. MSF psychologists have assisted 149 people through individual sessions and have conducted 133 groups sessions with 589 participants in Lesvos island. MSF is running a medical clinic that carried out over 4.000 medical consultations the first two weeks of March. The main pathologies treated are respiratory tract infections and gastroenteritis, all linked to the hygienic and shelter conditions and the cold weather. Since January 2016, MSF medical teams have treated an increasing number of patients for injuries consistent with violent behaviour from FYROM police and army. Between the 1rst and the 12th of March 2016, MSF medical teams conducted 3.865 medical consultations between Eidomeni Transit Camp and the called «Gas Station camp». The main morbidities are respiratory tract infections (associated with inadequate shelter - 54%) and gastrointestinal pathologies (associated with inadequate access to hygiene facilities - 12%). Since beginning of January 2016 and until the date of report, MSF psychologists have conducted 149 individuals sessions and 174 group sessions with a total of 2.016 participants. An MSF team provided first aid to refugees once they arrived in Samos. In Vathy (Samos) MSF is performing medical and mental health activities and during weekends, they also run a mobile clinic next to the screening center in the north of Vathy town. Medical services also, have been provided to Agathonisi and Korinthos. At Eleonas Hospitality Centre in Athens, MSF is still providing outpatient medical consultations. The medical team is consistied of one medical doctor, one nurse, one Arabic translator and one Farsi translator. They are present every day including weekends.[5]

According a MSF worker in Athens in port of Peiraeus port (mainly to Gate E1 where around 4500 refugees/migrants were hosted) their organization provided 24/7 health services. Their team is included by a doctor, a nurse and a cultural mediator (one arabic and one farsi). During the last period (since March 2016) there have been efforts to also include a psychologist to the team.[6]

PRAKSIS NGO provide medical services in Piraeus, Elaionas and Elliniko. Prior to this allocation of health services, PRAKSIS provided health services to the following islands: Samos, Leros and Kos. Since October 2015, in collaboration with the International Medical Corps, Praksis, PRAKSIS has launched the programm of Medical Mobile Units. Since October 2015, in collaboration with with World Jewish Relief provided of the refugees/migrants in Northern Greece. The NGO Praksis provides its services in Piraeus for 8 hours per day to an average of 60 refugees per day, while in islands was 6 hours per day to an average of 40 refugees per day, respectively. Every mobile unit of Praksis is consisted of a multidisciplinary team; a General Practitioner (GP), a nurse, a social scientist, a cultural mediator and a driver. At Eleonas detention center in Athens, Praksis provides daily (16:00-20:00 local time) psychosocial support.[7]

The representative of NGO PRAKSIS informed us about the following collaborations with other NGOs and local/national authorities in order to provide PHC to these specific areas:[7]

Samos: MSF, PRAKSIS, WAHA, Greek Red Cross

Kos: MSF, PRAKSIS

Leros: MSF, PRAKSIS

Piraeus: MSF, PRAKSIS, Greek Red Cross, MDM, KEELPNO, Athens Medical Association, 2nd Healthcare Region of Piraeus and Aegean islands.

KEPY (the First Reception System) that was originally designed by the Greek authorities, involved a team of professionals (a legal advisor, doctor, nurse, psychologist, social worker) to welcome all refugees in purpose-built, high standard reception facilities prior to any contact with the police authorities.[8]

Metadrasi NGO provides the following services: interpretation, protection to unaccompanied minors and humanitarian aid in every hotspot and refugee camp all over the Greece. Since 31/12/2015 and up until today (April 2016), Metadrasi has been provided its services, to 110 unaccompanied minors (accommodation, psychological support, escorting to healthcare services).[9]

Greek Red Cross provides services to refugees/immigrants, as well. With emergency response units in Samos, Chios and Eidomeni through the Emergency Appeal Programme of International Organizations of Red Cross and Crescent Greek Red Cross provides health services. They provide health services at Cherso, Nea Kavala, Piraeus port, Skaramanga, Lesvos, Relocation center at

Diavata and at detention centers in Chios and Samos. Red Cross provides first aid services, nursing services and psychosocial support. Informative actions are made too (creation and leaflets distributions, health treatment to control diseases and epidemics). Education programs for volunteers and humanitarian aid are also provided. In a weekly basis, 2.397 refugees/migrants are served by the ten Red Cross health units, while 3.325 refugees/migrants received psychosocial support services. In addition, 1.565 refugees/immigrants received hygiene promotion interventions.[10]

Both the representatives of PRAKSIS and Metadrasi mentioned that one of the crucial health issues of the refugees, is the injuries and the hardships of the journey.[7,9]

There has been a significant variation in the demographics data of the Piraeus camp population over the last six months (second half of 2015).[6,8] At the end of 2014 the majority of new arrivals were 18 – 35 year olds. During the second half of 2015, MDM recorded the new arrivals of refugees/migrants including a larger number of neonates and elderly people. According to these records, chronic diseases seem to have an increase within the refugees/migrants population, including mainly hypertension, diabetes mellitus and renal failure. MDM has reported that 5 - 7% of the affected population have disabilities (through conflict-related wounds).[8] Red Cross officials informed us that they had launched on (November 2015) an electronic record system (Open Data Kit) to record and manage refugees/immigrants health needs.[10]

According to the interview with an MDM official, they collaborate with KEPY, PRAKSIS, METADRASI and other organizations that provide health services at the different detention and hosting centers.[11]

EKEPY has records of PHC professionals and refugee healthcare services, but unfortunately they are not available for sharing at this point.[12]

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1. Ministry of Economy, Growth and Tourism. Impacts of refugees' influx in Aegean islands. September 2015 (in Greek)
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3. MDM. Annual action report. Available at: http://mdmgreece.gr/app/uploads/2016/03/Annual-Report-A_SmallSize.pdf (15/4/2016) in Greek
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9. Interview with Metadrasi representative (central offices Athens).
10. Communication with Greek Red Cross authorities.
11. Discussion with MDM official by phone.
12. Representative of EKEPY (central offices MoH Athens)

Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?

The health care professionals of MDM in Moria's hotspot are consisted of a team of a nurse, a general practitioner (GP), a cardiologist, an orthopedist, an otolaryngologist, a psychologist and a social worker. Health care providers usually come from different parts of Greece to take turns in providing support and services. In general, at the hotspot of Moria's they had 6-7 doctors, 2 nurses and 2 interpreters (Arabic and Farsi).[1]

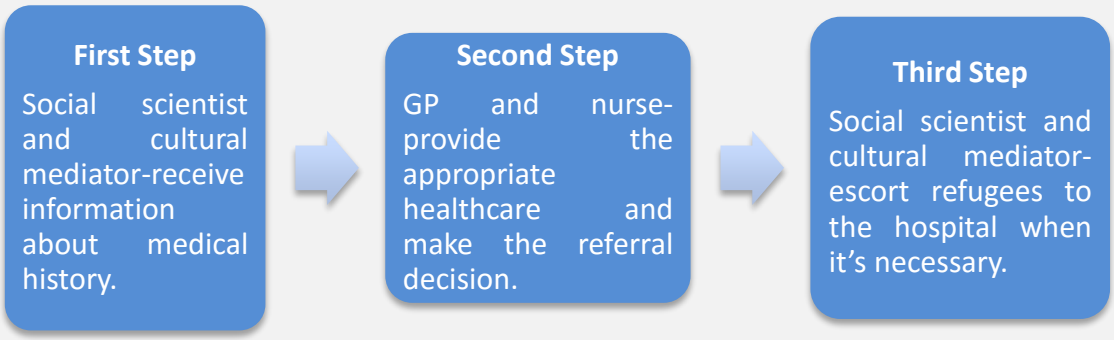
There is limited primary health care coverage across migrant and refugee sites. Migrants and refugees do not get a health screening as standard on arrival at formal and informal camps. MDM manage clinics in the Detention Centres of Moria (Lesvos) and Mersinidi (Chios).[2]

There are mobile clinics of MSF, at the island of Kos, Leros, Samos, Eleonas and Eidomeni (see above). The medical teams are consistied of one medical doctor, one nurse, one Arabic translator and one Farsi translator.[3]

Regarding PRAKSIS, the multidisciplinary team of the mobile unit is not made up of volunteers and it consists of the following personnel: two GPs, two nurses, one social worker, one psychologist, one administrative staff, one information officer, one driver and one cultural mediator. So, the overall number of the professionals would be between 20-24 persons.[4]

The figure 2 below, presents the healthcare process that PHC professionals, who provide services to refugees through PRAKSIS.[4]

Figure 2. Process of PHC professionals (PRAKSIS)



Source: Representative of PRAKSIS (central offices Athens)

During the interview with the MSF field worker, we were informed that their team at Piraeus port is consisted by a doctor, a nurse and two interpreters. Psychologists are usually volunteeres.[5] In the interview with the MDM stakeholder, it was stated that their mobile teams are consisted mainly by doctors, nurses, social workers (included here psychologistes), interpreteres and administrative staff.[6]

According interviews with MDM and MSF personnel, the MDM teams in the mainland are consisted of a doctor, a nurse, a psychosocial worker, a mediator and administrative staff. Regarding the MSF, their team is composed of a doctor, a nurse and a mediator. Currently, they are trying to include a psychologist too.[5,6]

Regarding the Greek Red Cross, their team is consisted of GPs, pathologists, pediatricians, nurses, social workers and volunteers.[7]

References:

1. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).
2. Save the Children. Multi-sector needs assessment of migrants and refugees in Greece. Available at: http://www.savethechildren.de/fileadmin/Berichte_Reports/Greece_Assessment_Report_Save_the_Children.pdf (16/4/2016)
3. MSF. EU migration crisis update –March 2016. Available at: http://www.msf.org/article/eu-migration-crisis-update-march-2016 (12/4/2016)
4. Interview with Praksis representative(central offices Athens)
5. Discussion with MSF field worker by phone.
6. Discussion with MDM official by phone.
7. Communication with Greek Red Cross authorities.

Primary health care staff situation (numbers, capacity, payment, safety, …)?
If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

The interviewed stakeholders (Praksis, Metadrasi and EKEPY) informed us that PHC services to refugees are provided by national, international NGO's, medical associations and national healthcare system.[1-3] Apart from Praksis organization that informed us that the number of PHC professionals were around 24, all the other organizations could not provide us an exact personnel number.

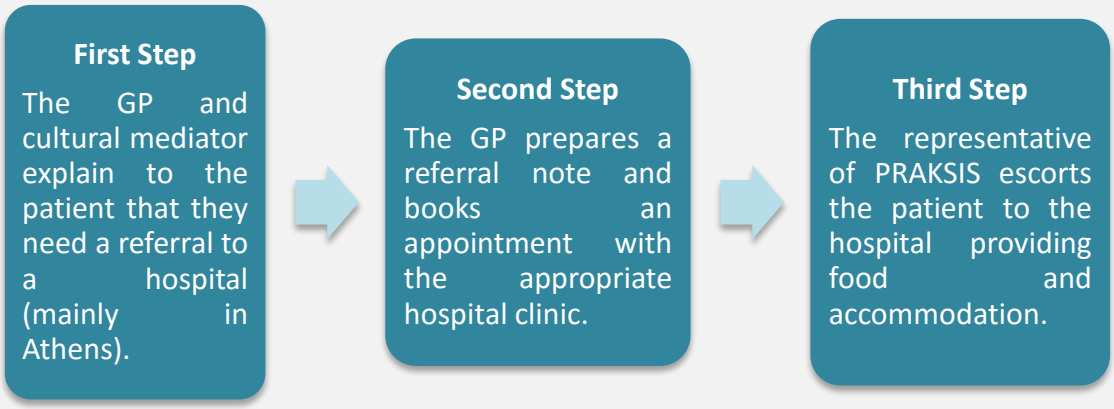
References:

1. Interview with Praksis representative (central offices Athens).
2. Interview with Metadrasi representative (central offices Athens).
3. Representative of EKEPY (central offices MoH Athens).

Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
As we have discussed with the health providers at Moria's hotspot, currently there is no health assessment, especially for asylum seekers. This was due to the fact that until the EU-Turkey deal, Greece was also, a transit country where refugees arrive and leave after a couple of days. In general, according to the Greek legislation, all Greek authorities can request from the asylum seekers, to conduct health examinations (within the official asylum procedure) in order to keep proceed with their asylum application.[1] When the authorities think that this is necessary (e.g. such as vaccination for communicable disease control (mainly Tuberculosis) or x-ray, according to the Ministry of citizens protection. 2010 Basic Information for asylum seekers in Greece. (Available at: http://www.minocp.gov.gr/images/stories//2011/BASIC_INFO_FINAL_22072011_LR.pdf) Refugees and migrants in the most of the hosting and detention centres (17 almost) can apply for asylum in Greece (see table 4).[2] MDM has established a referral system with the hospital in Lesvos and Chios, whilst MSF operates a small clinic in the abandoned Captain Elias hotel in Kos and are scaling up to manage mobile clinics in Kara Tepe in Lesvos.[3] According to the MDM doctors, usually pregnant women are directly recommended to visit the hospital. Their usual practice, is to recommend people in need to hospitals and secondary health care services. However, the head of the emergency department of Lesvos hospital informed us that most of these recommended cases could be easily managed and delegated at the hotspot or at PEDY.[4,5] According to both MDM and MSF interviews, there is no health assessment for those refugees who apply for asylum at the present. The MDM official informed us that their health personnel has recognized the needs of the current situation and have made efforts to use the known and most common methods and guidelines in PHC for triage. The MSF field worker informed us that only a rudimentary triage procedure is being conducted in the sites of Piraeus, Elliniko and Victoria square.[6,7] The MDM NGO has an official agreement with KEPY and Lesvos hospital, in order to refer refugees and immigrants there. At Piraeus port, KEPY is firstly informed, in case a refugee/migrant should be transferred to the hospital, in order to have the authorization of the referral and afterwards the person in need could be escorted and transferred to the hospital. [6,7]

The following figure describes the referral process of PHC professionals of PRAKSIS. [8]

Figure 3. The referral process of PRAKSIS.



Source: Representative of PRAKSIS (central offices Athens)

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2. UNHCR. Site profiles – Greece. Available at: http://rrse-smi.maps.arcgis.com/apps/MapJournal/index.html?appid=dc0cf99f05f44858b886c824f3a5633d#map
3. Save the Children. Multi-sector needs assessment of migrants and refugees in Greece. Available at: http://www.savethechildren.de/fileadmin/Berichte_Reports/Greece_Assessment_Report_Save_the_Children.pdf (16/4/2016)
4. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).
5. Discussion with stakeholders in Lesvos (Mytilene).
6. Discussion with MSF field worker by phone.

7. Discussion with MDM official by phone.
8. Interview with Praksis representative (central offices Athens).

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?

In general, based on the empirical data during the data collection within the framework of WP2 in Morias's hotspot, exists an absence of interpreters. There was also, a lack of interpreters at the hotspot, and especially with interpreters speaking Farsi. Each organization (NGO) has their own interpreter(s) (that spoke mainly Arabic and Farsi). However is seems to be a lack of coordination among the organizations (NGOs) and their interpreters. We were informed by the authorities (EKEPY) that the biggest issue was with interpreters from Afghanistan (Farsi) who were in a very limited number. The hospital of Lesvos since February 2016 had four interpreters working in shifts, mostly in the emergency department.[1] MSF, MDM and PRAKSIS representatives informed us that their organizations have interpreters but the number and the capacity and the lack of medical terms and knowledge (especially Farsi language) embedded them from achieving the level of medical services they intent to provide to the refugees and migrants. [2-4] All of stakeholders stated that there is a lack of interpreters in the different hosting/detention places. [2-4]

"*There are a lot, but do not have the capacity to do the job. Around 150 interpreters are capable to do this…*" (MDM official).

At present (April 2016) are used persons from refugees/migrant communities (mainly in Piraeus and Eidomeni centres) but without the appropriate knowledge and capacity. These "interpreters" are volunteers (mainly refugees/migrant from Syria and sometimes from Afghanistan) and are used due to the absence of interpreters in these places.[2,3]

References:

1. Discussion with stakeholders in Lesvos (Mytilene).
2. Discussion with MSF field worker by phone.
3. Discussion with MDM official by phone.
4. Interview with PRAKSIS representative (central offices Athens)

Biggest challenges and barriers for primary health care providers?

As far as the medical services and psychosocial support for refugees and migrants, it seems to be a lack of providing these services, since these are mostly provided by national and international NGO's (see appendix table 2). Also in 9 (of 24) refugees camps health care facilities are nonexistent or available within less than 5 Km (see appendix table 3). For instance, at Elliniko, Ritsona, Nea Kavala

and other hosting centres in the mainland health facilities are nonexistent, not available or more than 5km away from the centre. Another important issue is that Ministry of Health does not provide psychosocial programs in any of the hosting centres. According to table 4 (see appendix table 4), 17 out of 24 refugee camps have asylum services, while only 5 of them provide food distributions. Also, the representatives of stakeholders mentioned the following difficulties:

-There is more than one national authority responsible at the refugees' camps and hotspots, so these areas do not have a director.

-The coordination of UNHCR has a lot of problems, because the personnel of this organization is not permanent and there is no commitment about the implementation of the approved decisions by the majority of NGOs (MDM, MSF, Red Cross, IOM, etc.).

-The national authorities provided services until 23:00 every day and certain hours during the weekend.

-There are no referrals to the Greek National Primary Health Care Network (PEDY), most of the refugees/migrants refer to national hospitals.

-The majority of the refugees/migrants aims to continue their journey and are seeking out health care services only when they have to face a serious health issue (injuries/diseases of their children or a health problem which makes them unable to continue).

-MSF field worker mentioned that the most important issues for health care providers were safety, maintain the balance between different cultural groups, the difficulties in explaining them to respect the queues and that someone else probably has a more serious problem than them. MDM official reported all the above issues and also mentioned that except the hotspots, there is an absence of an "institutional" framework at hotspots and hosting cetres.[3,4]

-The representative of PRAKSIS mentioned that a crucial problem they faced, is the recruitment of a well-trained multidisciplinary team to address this humanitarian crisis, because a significant number of physicians and nurses had also emigrated from Greece in different Center and North European countries in order to find a job.[5]

-Lack of space in mobile units.[5]

-Limited amounts of medicines especially in islands.[5]

-Difficulties in chronic disease management.[5]

-No integrated care. [6]

-Lack of cultural mediators. [6]

Regarding the Red Cross, they mentioned that a significant problem at present (April 2016, especially at Piraeus and Eidomeni hosting centres) is the safety of health personnel. Another important problem is the management of chronic diseases because these persons usually are not educated for their health problem (health literacy). In addition, the Red Cross stakeholders mentioned that the referrals of refugees to hospitals and their return are a crucial problem due to the usual lack of transportation via hospital ambulances. Finally, they informed us about linguistic barriers also, due to the absence of qualified interpreters.[7]

References:

1. Greek Reporter. Greece Completes Refugee Hotspots Amid Citizen Reactions. Available at: http://greece.greekreporter.com/2016/02/17/greece-completes-refugee-hotspots-amid-citizen-reactions/#sthash.Jo409nZi.dpuf (17/2/2016)
2. UNHCR. Site profiles – Greece. Available at: http://rrse-smi.maps.arcgis.com/apps/MapJournal/index.html?appid=dc0cf99f05f44858b886c824f3a5633d#map
3. Discussion with MSF field worker by phone.
4. Discussion with MDM official by phone.
5. Interview with PRAKSIS representative (central offices Athens).
6. Representative of EKEPY (central offices MoH Athens).
7. Communication with Greek Red Cross authorities.

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

During this search, we found no evidence in the literature to address this issue. The existing national reports and from NGOs oparating in Greece was searched but there were no information. According to Greek Ministry of Migration, 3.362 persons (of various specialties) will be hired in order to address this issue.[1] Regarding the interviews, MDM and MSF stakeholders, PRAKSIS and Metadrasi reported that there are some refuggees/migrants who informing them, that they were health personnel in their origin country and that wanted to assist them. However, all the volunteers, apart from two,

could not provide any evidence to support this claim, which embed the refugees from joining the already existing medical teams of NGOs.

"*There must be around 20 persons mainly from Syria at Piraeus port with a background in health services, but we are not sure…*" (MDM official).

Both MDM official and MSF field worker, agreed that that does not exist any record procedure about profession in the country of origin.[1,2,3,4]

References:

1. Ethnos. 3,362 contracts for Refugee Hosting Centres. Available at: http://www.ethnos.gr/ergasia/arthro/3_362_symbaseis_gia_to_kentro_filoksenias_prosfygon-64343621/ (17/2/2016)
2. Discussion with MSF field worker by phone.
3. Discussion with MDM official by phone.
4. Interview with PRAKSIS representative (central offices Athens)
5. Interview with Metadrasi representative (central offices Athens)

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

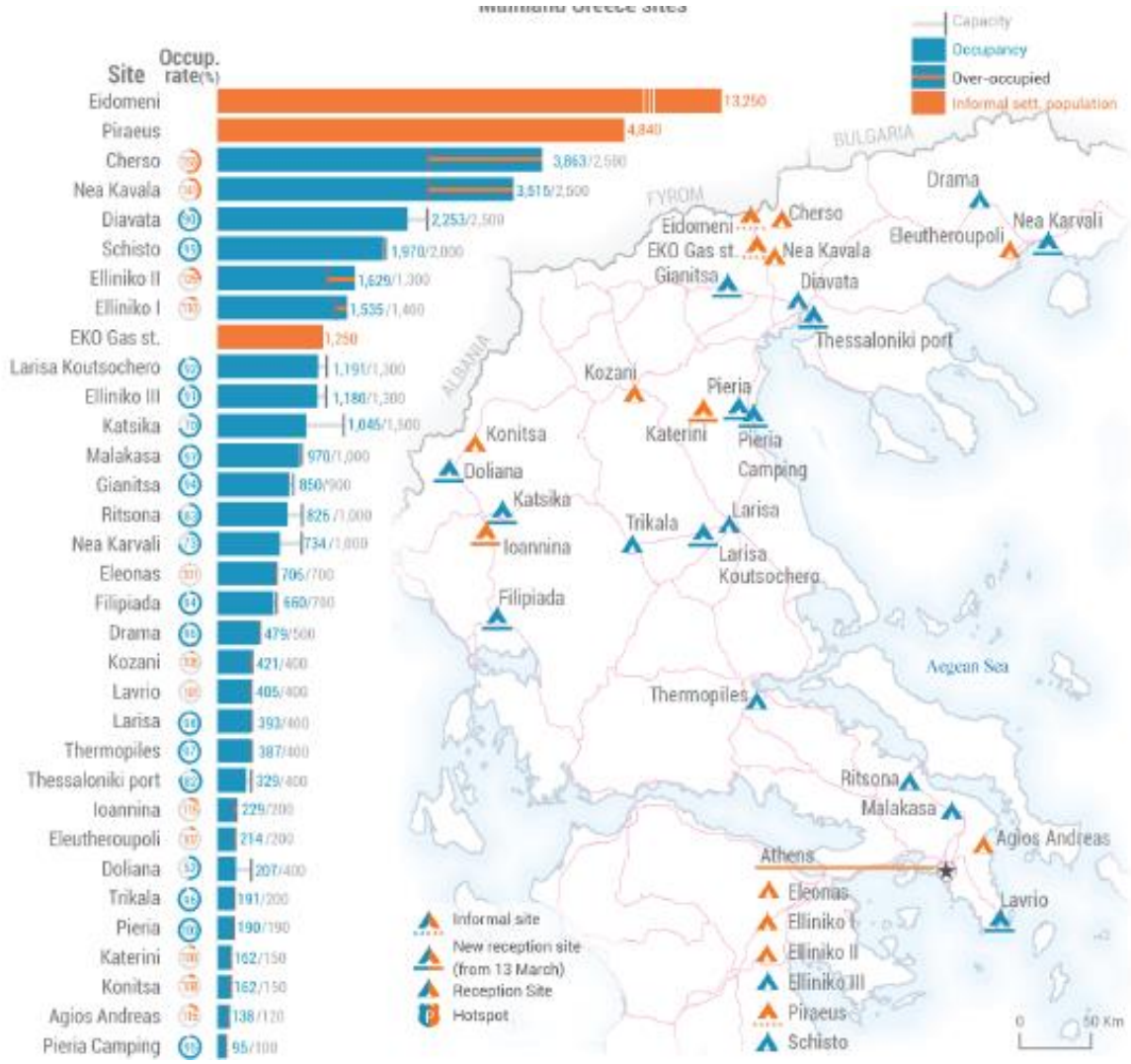
Use as much space as necessary

Table 2. Key issues

Key issue	Explanation	Possible solutions and additional issues
Lack of leadership	All the National and International authorities who are located in the hotspot of Moria have different responsibilities and each one believes that is responsible for the hotspot.	It will be useful for the Greek policy makers to decide which national authority must rule the hotspot. This issue is fundamental for the implementation of our project.
Lack of commitment	The coordinator organization (UNHCR) doesn't have permanent personnel and this fact makes the implementation of the agreed decisions made by the weekly assembly of NGO's difficult.	It is important for UNHCR to provide a stable environment and to encourage and support the role of the NGO's in the hotspot of Moria. Since the NGO's are our stakeholders we need their collaboration and of course the coordination by UNHCR, which will affect our project.

Lack of PEDY involvement	Primary Health Care (PHC) in Greece is not present to support the attempts of the authorities which are located in this hotspot.	The Greek policy makers should realize that the immigration crisis is a crucial issue with multidisciplinary approach. The role of PHC should be leading in health care services of these vulnerable population. So, our project gives us the opportunity to highlight the involvement of PHC in immigration crisis.
Lack of political stability and information	The majority of refugees have a great desire to move from Greece and to arrive in their final destination (to finish their trip and to find a safe place to live), so they don't pay attention to the provided health care services in the hotspot of Moria.	Since the political field about the immigration crisis is still open, this situation has a great impact in our project.
Lack of personnel at first reception (KEPY). KEPY first reception is primarily responsible for unaccompanied minors	KEPY has an interdisciplinary team to take care the children, but "the facilities here is like prison, which is something inappropriate for children who suffer a lot in their countries and during the trip" told us the head of KEPY. Secondly, I do not have a pediatrician her.	Improving the facilities of KEPY, hiring a pediatrician.
Lack of psychosocial program in the detention and hosting centers.	The medical services and psychosocial support for refugees and migrants are no provided services from MoH	More services provided by MoH

Figure 1. Cites capacity vs occupancy in Greek hotspots and reception centres



UNHCR 2016

Appendix

Table1. Data about refugees arrivals in Greece

Data about refugees and immigrants in Greece	Numbers/percentages
Total arrivals in Greece (2015)	862,138
Total arrivals in Greece (1/1/2016-1/4/2016)	151,659 (67,415 on January, 57,066 on February and 26,623 on March)
Average daily arrivals during February 2016	1,931
Average daily arrivals during March 2016	859
Average daily arrivals during April 2016 (until April the 6th)	229
Total asylum applications during January	1,171
Total asylum applications during February	1,470
Top 3 nationalities of arrivals in Greece during January (2016)	45% Syria, 28% Afghanistan, 18% Iraq
Top 3 nationalities of arrivals in Greece during February (2016)	52% Syria, 25% Afghanistan, 16% Iraq
Total arrivals on Lesvos island (1/1/2016-5/3/2016)	76,856
% arrivals on Lesvos compared to total (2015)	60%
% arrivals on Lesvos compared to total (2016)	59%
Average daily arrivals on Lesvos during February 2016	1,058
Average daily arrivals on Lesvos during March 2016	718
Estimated residual population staying on the island	3,550
Top 3 nationalities of arrivals on Lesvos during January (2016)	44% Syria, 27% Afghanistan, 19% Iraq
Top 3 nationalities of arrivals on Lesvos during February (2016)	38% Syria, 25% Afghanistan, 26% Iraq
Total number of hotspots in Greece	5 (Eastern Aegean islands of Samos, Lesvos, Chios, Kos and Leros)
Total number of relocation camps	24

Source: UNHCR[1]

Table 2. Arrivals and departures in 2015

Island	Total number of arrivals in 2015	Estimated departures to mainland	Number of arrivals until April 2016	Estimated departures to mainland	% of total arrivals
Lesvos	500.018	1753	152.476	7	59
Chios	123.279	1375	31.494	0	14
Samos	104.366	403	9.491	0	7

Source: UNHCR[1]

Table 3. Health facilities in Greek mainland refugee camps

Area	Distance to nearest health facility: Available or less than 5km away	Ministry of Health (MoH) Psychosocial programs available	Other Psychosocial programs available	24x7 referral service in place
Elliniko I (Hochey Stadium)	No	No	Yes	Yes
Elliniko II (West/Olympic Arrivals)	No	No	No	Yes
Elliniko III (Baseball Stadium)	No	No	No	Yes
Eleonas	Yes	No	Yes	Yes
Schisto	Yes	No	No	Yes
Ristona	No	No	Unknown	Unknown
Larisa-Koutsochero	Yes	No	No	Yes
Trikala (Frourio)	Yes	No	Yes	Yes
Magnisia (Aerinou)	Yes	No	No	Yes
Fthiotida(Thermopiles)	Yes	No	No	Yes
Doliana	Yes	No	No	Yes
Diavata	Yes	No	Yes	Yes
Nea Kavala	No	No	Yes	Yes
Cherso	No	No	Yes	Yes
Kozani(Leykovrisi Stadium)	Yes	No	Yes	Yes
Filipiada	Yes	No	No	Yes
Katsika Ioanninon	Yes	No	Yes	Yes
Giannitsa	No	No	No	Yes
Veria (Armatolou Kokkinou)	Yes	No	No	Unknown
Konitsa	Yes	No	Yes	Yes
Nea Karvali	Yes	No	No	Yes
Eleftheroupoli	No	No	No	No
Drama	No	No	No	No
Andravida	Yes	No	No	Yes

Source: UNHCR[2]

Table 4. Asylum Procedures and food distributions in Greek mainland refugee camps.

Area	Asylum Procedures	Food distributions
Elliniko I (Hockey Stadium)	Yes	Yes
Elliniko II (West/Olympic Arrivals)	Yes	Yes
Elliniko III (Baseball Stadium)	Yes	No
Eleonas	Yes	Yes
Schisto	Yes	Yes
Ristona	Yes	Yes
Larisa-Koutsochero	Yes	No
Fthiotida(Thermopiles)	No	No

Doliana	Yes	No
Diavata	Yes	No
Nea Kavala	Yes	No
Cherso	Yes	No
Kozani(Leykovrisi Stadium)	No	No
Filipiada	No	No
Katsika Ioanninon	No	No
Giannitsa	Yes	No
Veria (Armatolou Kokkinou)	Yes	No
Konitsa	No	No
Nea Karvali	Yes	No
Eleftheroupoli	Yes	No
Drama	Yes	No
Andravida	No	No
Eidomeni	Yes	Yes
Victoria Square	No	No

Source: UNHCR[2]

Thank you very much!

Best regards,

The UoC team

A3. Country Report Italy

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 13/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Authors: Maria José Caldes, Nicole Mascia, Giulia Borgioli, Laura Delli Paoli

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This EUR-HUMAN national report for deliverable 6.1 is part of the project '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme 2014-2020).

Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
In Italy, in 2015, arrived 153.842 migrants. This is the monthly distribution of the migrants arrivals: January 3.528; February 4.354; March 2.283; April 16.063; May 21.235; June 22.891; July 23.186; August 22.609; September 15.922; October 8.916; November 3.218; December 9.637. In 2016 (up to April 13th), arrived 23.170 migrants. This is the monthly distribution of the arrivals: January 5.273; February 3.827. Number of arrivals distributed per week is not available. As for the number of asylum applications, these are the data available. Total amount of applications in 2015: 83.970. Total amount of applications in 2016: 22.596. Distribution month by month: January 7.505; February 7.693; March 7.398 References: (1) UNHCR, Sea arrivals to Italy, http://unhcr.it/risorse/statistiche/sea-arrivals-to-italy (2) Italian Ministry of the Interior, http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/trend-arrivi-dei-migranti-sulle-coste-italiane ; http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/i-numeri-dellasilo (3) IOM, http://doe.iom.int/docs/WEEKLY%20Flows%20Compilation%20No%2013%207%20April%202016.pdf ; http://migration.iom.int/europe
Main countries where refugees and other migrants come from?
Main countries of origin of people who arrived in Italy in 2015 (from January 1st to December 31st): Eritrea 39.162; Nigeria 22.237; Somalia 12.433; Sudan 8.932; Gambia 8.454; Syria 7.448; Senegal

5.981; Mali 5.826; Bangladesh 5.040; Morocco 4.647; Ghana 4.431; Ivory Coast 3.772; Ethiopia 2.631; Guinea 2.629; Egypt 2.610; Pakistan 1.982; Occupied Palestinian Territories 1.673; Iraq 996; Tunisia 880; Cameroon 662; Libya 563; Burkina Faso 470; Guinea Bissau 456; Benin 396; Togo 360; Algeria 343; Sierra Leone 250; Comoros 192; Chad 174; Congo 154; Niger 154; Liberia 137; Iran 119; Afghanistan 117; Other (26 countries) 393; Unidentified 7.138. TOTAL: 153.842

Main countries of origin for 2016 (from January 1st to February 29th): Nigeria 17,2%; Gambia 12,8%; Guinea 9,6%; Senegal 9,3%; Morocco 9,2%, Mali 7,5%; Ivory Coast 6,3%; Somali 5,2%; Sudan 2,4%; Eritrea 2,3%; Ethiopia 2,1%; Algeria 1,9%; Cameroon 1,8%; Ghana 1,6%; Other 6,2%; Unidentified 4,6%[8].

References:

(1) UNHCR, http://data.unhcr.org/mediterranean/country.php?id=105

(2) La Repubblica, Flussi migratori: 12 mesi di sbarchi in Italia, January 7th 2016, http://www.repubblica.it/solidarieta/immigrazione/2016/01/07/news/flussi_migratori_12_mesi_di_sbarchi_in_europa-130787694

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

The Italian refugee plan is organized in three main levels.
The hotspots system provides for first reception service, first aid, identification and photo signalling. First aid in the hotspots is provided by health workers of the Local Health Units and by health workers from other organizations and NGOs (e.g., Italian Red Cross, MSF) People should stay in the hotspots between 48 and 72 hours. In Italy, there are 6 hotspots in the South (5 in Sicily and 1 in Apulia): Lampedusa, Porto Empedocle, Pozzallo, Trapani, Augusta e Taranto.
The second level of reception is represented by government centres – CARA (Reception Centre for Asylum Seekers), CPSA (First Aid and Reception Centre), CDA (Reception Centre) – and Regional Hubs that are covering widespread the Italian territory. After their arrival in the South of Italy, migrants and asylum seekers are distributed throughout the Italian territory according to the capacity of the different structures in the Regions. In the government centres, migrants can apply for international protection and wait for the conclusion of procedures by the Commission or the competent territorial section. Theoretically, the person should stay at the second level centre for the time necessary to apply for asylum or protection. Then, the person should participate to the SPRAR project. Actually, due to the lack of places in the SPRAR, persons keep staying in the second level even after the application.
The third level of reception is represented by the SPRAR project (Protection System for Asylum Seekers and Refugees). The SPRAR project is managed by the Ministry of Interior and by Italian local authorities (ANCI), including third sector organizations and network. The SPRAR project deals with refugees and asylum seekers waiting for the granting of international protection and aims at providing for 'integrated hospitality'. Refugees and asylum seekers receive not only board and

[8] Since the data is recent, it was not possible to find the total amount of migrants from each country but only a percentage.

lodging, but also social support activities, aimed at an effective integration in the territory and access to local services, including health and social assistance. The SPRAR project provides also for Italian language courses, training to facilitate employment and measures taken to have access to housing, enrolment of children in school and legal support. In theory, every asylum seeker should run through the three levels. They should stay in the hotspots no longer than 72 hours. Equally, they should stay in the second level of reception only for the time necessary to apply for international protection. After the application, they should be involved in the SPRAR project, in order to start a pathway of integration.
Actually, the situation is very different. Asylum seekers stay in the second level reception centres for months: temporary reception centres (CAS) settled to be extraordinary are actually used for ordinary reception.
Available places in the SPRAR project are not enough. There are waiting lists and the persons waiting for available places keep staying in the second level of reception.

According to the latest data from the Ministry of Interior (last update April 29th 2016), refugees and asylum seekers in Italy are 111.081.

Data available on reception centres date back to February 2015.
Number of government centres for primary reception (CARA/CPSA/CDA): 14
Number of CAS (extraordinary and temporary reception centres): 1657
CAS (temporary reception centres) have been established in 2014, according to Ministry of the Interior Circular no. 104, January 8th 2014. According to their definition, they should be temporary reception centres, established to face emergencies and exceptional situations when there are no places available in the second level and in the SPRAR project. De facto, they are used for ordinary reception and, according to the data available, the majority of asylum seekers arriving to Italy are placed in this type of centres.

Are there detention centres for persons who are not admitted to the asylum process (Dublin III) or persons who receive a negative asylum decision?

CIE (Centers for identification and expulsion) are detention centres for irregular migrants (persons without legal documents to entry Italy, persons who haven't applied for international protection or who received a negative asylum decision), waiting to be expelled. At the moment, there are 5 detection centres in Italy: Rome, Turin, Bari, Caltanissetta and Trapani.

References:

(1) Italian Ministry of the Interior, http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/presenze-dei-migranti-nelle-strutture-accoglienza-italia ; http://www.interno.gov.it/sites/default/files/dati_statistici_marzo_2015.pdf ; http://www2.immigrazione.regione.toscana.it/?q=norma&css=1&urn=urn:nir:ministero.interno:accordo:2014-07-09

(2) SPRAR, http://www.sprar.it/index.php?option=com_k2&view=itemlist&layout=category&task=category&id=19&Itemid=667

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

Total capacity of the 6 Italian hotspots: 2.100
Total amount of migrants in CAS (temporary reception centres): 37.028
Total amount of migrants in CARA/CDA/CPSA: 9.504
Total amount of refugees and asylum seekers in the SPRAR project: 20.596

Exact data are not available. As already mentioned, reception centres settled to be extraordinary are used in the ordinary reception. Many situations of overcrowding in the second level of reception have been denounced by the NGOs. Available places in the SPRAR project are not enough.

References:

(1) Italian Ministry of the Interior, http://www.interno.gov.it/sites/default/files/dati_statistici_marzo_2015.pdf ; http://www.meltingpot.org/IMG/pdf/roadmap-2015.pdf ; http://www.meltingpot.org/IMG/pdf/2015_ministero_interno_14106_6-_10_accoglienza.pdf

How is Primary Health Care provided in your country in general?

In Italy, Primary Health Care is provided by the State according to principles of universalism, equality and equity. Article 32 of the Italian Constitution states that "the Italian Republic protects right to health as a fundamental individual right and an interest of the community, and safeguards free access to health assistance for needy people". The National Health Service (Servizio Sanitario Nazionale) is organized at a local level, where Local Health Services and Hospitals provide for health assistance. In the last 20 years, Italian Regions have gained significant autonomy in the field of health assistance and Primary Health Care is now one of the Regions' main tasks. Italian Regions have to formulate policies, draw operational tools in order to implement and supervise policies, set priorities and develop strategies. In Italy, Primary Health Care providers are GPs. There are Primary Health Care centres and every person has a reference GP. Local Health Units (ASL) are part of the National Health Service and consist of hospitals, social district and prevention department. Depending on the territory, every ASL could consist of hospitals, health districts, continuity care

assistance, family planning centres, mental health services, pediatricians, specialist exams, pathological dependencies.
Italian legislation allows access to healthcare for all, differentially regulated among the different legal statuses. Migrants from non-EU countries and without legal documents can access Italian healthcare through the STP code (Temporarily Present Foreigner), which guarantees access to healthcare for the period preceding the asylum request or the obtaining of documents and papers. STP code guarantees first aid and emergencies, and every health service considered essential for people health and wellbeing. STP code is valid for 6 months and it is renewable. After the international protection is granted or the documents are obtained, they are registered in the National Health Service (SSN), and they are assigned to a general practitioner (GP).

References:

(1) Italian Ministry of Health, http://www.salute.gov.it/portale/salute/p1_4.jsp?lingua=italiano&area=Il_Ssn ; http://www.salute.gov.it/portale/salute/p1_5.jsp?lingua=italiano&id=187&area=Servizi_al_cittadino_e_al_paziente

(2) Region of Tuscany, http://www2.immigrazione.regione.toscana.it/sites/default/files/circolare%20RT%2015%20gennaio%202016.pdf ; http://www.immigrazione.regione.toscana.it/lenya/paesi/live/contenuti/percorsoguidatoaiprocedimenti/attribuzionetesserinostp.html?sigla=FI&p=Firenze#accesso

Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

No Primary Health Care staff is supplied in the reception centres for migrants, refugees and asylum seekers. A first health screening is provided in the hotspots, at the arrival. The first health screening is provided to every migrant arriving to Italy in the hotspots, in the first hours after their arrival.
Officially, Primary Health Care is supplied by the Local Health Services, since migrants are provided with the STP code and, after the granting of international protection, they are assigned to a General Practitioner. *De facto*, NGOs and third sector organizations have a key role in the collaboration with Local Health Units for the provision of health assistance to people hosted in the centres. Since Primary Health Care is provided at a local level, the involvement of NGOs and local organizations is extremely variable depending on the territory.

References:

1) Medici Senza Frontiere, http://www.medicisenzafrontiere.it/notizie/news/rapporto-pozzallo-condizioni-inaccettabili-servono-risposte-urgenti-e-strutturate ; http://archivio.medicisenzafrontiere.it/pdf/Rapporto_CPI_CPSA_Pozzallo_final.pdf

2) MEDU, http://www.mediciperidirittiumani.org/pdf/MEDU_Rapporto_CAS_26_aprile_FINALE.pdf ; http://www.mediciperidirittiumani.org/rapporto-cara-mineo-modello-accoglienza-incompatibile-dignita-persona
Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
No Primary Health Care staff is provided in the centres for migrants, refugees and asylum seekers.
Primary health care staff situation (numbers, capacity, payment, safety, …)? **If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?**
As already said, no Primary Health Care staff is provided. Primary Health Care is supplied by the Local Health Units, trough the STP code. After the first screening in the hotspots, migrants, asylum seekers and refugees can access to health assistance trough Local Health Units, first aid and hospitals.
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
A first health screening is provided in the hotspots, mainly to identify infectious diseases and to assess children's age (wrist x-ray). The procedure of wrist x-ray in order to assess children age has been extremely criticized by NGOs present in the hotspots. The screening is carried on by health workers from the Local Health Unit. Once migrants and asylum seekers are provided with the STP code, they can access to health assistance trough 'normal' channel: first aid, hospitals and Local Health Units. In this context, there are no special procedures dedicated to asylum seekers and refugees. Health workers we interviewed, did manifest the necessity of specific guidelines for asylum seekers and refugees in case of vulnerable migrants (pregnant women, unaccompanied children, migrants subjected to torture and violence). According to this, special procedures and guidelines could be useful in order to assess mental health.
How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
Interpreters and cultural mediators are provided in the hotspots and first reception centres depending on the capacity of the place. The provision of interpreters and cultural mediators is managed at a local level, by local institutions and organizations.

Regarding the presence of interpreters and cultural mediators in the Local Health Units, hospitals and first aid services, this is extremely variable depending on the territory.
On average, the workers we have interviewed were satisfied by the effectiveness of the service. For example, the Careggi Hospital (one of the main hospitals in Florence) has 4 languages present in the service: Chinese, Arab, Romanian and Albanian. Interpreters and cultural mediators are not available 24 hours a day but only in limited time slots, mainly in the morning. There is also a service of telephone mediation, called Help Voice.
Health workers mainly facing with urgencies (e.g., first aid, women giving birth, urgent necessity of informed consent) judged the service of cultural mediation insufficient.

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(1) National Institute for Health, Migration and Poverty, http://www.inmp.it/index.php/ita/Servizi-Socio-Sanitari/Modalita-di-accesso/La-mediazione-transculturale/Progetti-sul-territorio

(2) Azienda Ospedaliera Universitaria Careggi, http://www.aou-careggi.toscana.it/internet/index.php?option=com_content&view=article&id=3018&Itemid=1016&lang=it

Biggest challenges and barriers for primary health care providers?

According to health workers we interviewed, biggest challenge are considered language barriers and lack of sufficient cultural mediation; migrants difficulties in acceding health assistance; bad use of first aid services; lack of specific guidelines for vulnerable migrants (pregnant women, unaccompanied children, migrants subjected to torture and violence); lack of specific guidelines for mental health assessment; management of severe pathologies.
We have noticed that the perception of the barriers and challenges is considerably variable according to the qualification of the health worker and to the context he's/she's working in. The perception varies depending on the specialization of the health workers and on the context they are working in. For example, people working in first aid services and people working in hospital wards or GPs have different perceptions because they deal with different situations and necessities.

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

There are no data available on this issue. Anyhow, every health worker we have interviewed agrees on the fact that migrants with health care experience could surely represent an important resource. Nonetheless, according to recent data, the majority of migrants arriving to Italy in the last years is assumed to have a very low level of education, however, there is no data on that. In this sense, it could be difficult to involve them in projects for migrants' health assistance.

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

The number of migrants arriving to Italy in the last two years has extremely increased. For this reason, the whole refugees reception plan has been reorganized. The creation of hotspots and Regional Hubs wants to represent a solution for the increasing number of arrivals. Simultaneously, the number of available places in the SPRAR Project has definitely increased in the last two years. Nonetheless, there are still situation of overcrowding, mainly in the hotspots and in the government centres, and access to the SPRAR Project is not so easy. Situations of inhumanity have been denounced by NGOs involved.

Since Primary Health Care staff is not provided in the reception centres for asylum seekers and refugees, it seems difficult to analyze the situation in terms of capacity. What needs to be taken into account is the possibility migrants have to access to health assistance, and the effectiveness of the service given.

According to our research and to the results of the interviews, and considering the peculiarity of the Italian situation, these are a few recommendations.

The service of interpreters and cultural mediation should be improved and should be available to every GP. Often, GPs are not able to communicate with their patients because they do not speak English and because the service of cultural mediation is not provided.

It is essential to provide special procedures and guidelines in order to assess mental health. Considering the dramatic nature of the trip people make to arrive in Italy, traumas and mental health issues are extremely common. At the moment, health workers do not have the instruments to recognise them.

It should be important to set up a better communication between the Local Health Units and migrants' users, in order to make a proper use of the services given (e.g., first aid services).

A4. Country Report Croatia

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 for Croatia – Version 15/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Authors:

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Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?

- **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**

According to the data provided by the Croatian Ministry of Interior and The United Nations High Commissioner for Refugees (UNHCR), the estimated overall number of refugees and other migrants who entered Croatia was 558.242 in 2015, and 100.487 in 2016[1]. This leads to a total of 658.729 persons that passed through Croatia on their way to Western Europe in the period from September 2015 to March 2016 during which the Balkan route was open.[1.1]. Of these, 152 persons applied for asylum in 2015 and 379 from the beginning of 2016 until March 31st.[1.2,1.3] Throughout most of the crisis, Croatia remained a transit country for refugees and migrants traveling to other European countries. Only after the introduction of more restrictive measures for the control of refugee and migrant influx in mid-February, the number of people expressing intention to apply for asylum increased (between the start of the crisis and February 16th 2016 only 29 requests were filled)[1.4]. A more detail overview of the number of refugees and other migrants who came into Croatia since 1st of March 2016 can be found in the Table 8. Following the closure of the Balkan route on March 8th, Croatia also closed its borders on March 9th and was no longer receiving new refugees and migrants.

Table 8 Daily number of refugees and migrants who came to Croatia during March 2016[2.1]

Date	Number
1.3.2016	436
2.3.2016	476
3.3.2016	0
4.3.2016	410
5.3.2016	253
6.-31.3.2016	0
Total	**1,575**

References:
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1.3 Croatian Ministry of Interior (2016). International protection statistics for the first quarter of 2016. http://www.mup.hr/UserDocsImages/Publikacije/2016/3_16_mz.pdf
1.4 Friedrich Ebert Stiftung. (2016). At the gate of Europe: A report on refugees on the Western Balkan Route. http://www.irmo.hr/wp-content/uploads/2016/05/At-the-Gate-of-Europe_WEB.pdf
2.1 United Nations High Commissioner for Refugees. (2016). Daily estimated arrivals per country-flows through Western Balkans route. http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=94&Type[]=3

Main countries where refugees and other migrants come from?

A majority of refugees and migrants who arrived in Croatia during 2016 have had a Syrian background, followed by people arriving from Iraq and Afghanistan. This structure of refugee and migrant population by nationality was probably caused by the Government of Slovenia's request on November 18th 2015 for readmission of people from non-war torn countries (all nationalities except Syrians, Iraqis, and Afghans), which lead Croatia to no longer accept such people. From the total number of refugees and migrants that came to Croatia in January 2016, 47% were Syrians, 32% were Afghans and 21% were Iraqis. Similar percentages by ethnicity remained in February during which there were 47% of Syrians, 28% of Afghans and 25% of Iraqis. Given that the Macedonian and Serbian authorities have decided to close the border for individuals from Afghanistan on 22nd of February[2.1], the percentage of Afghan refugees and migrants in March dropped down to 0%, while the percentages of Syrian and Iraqi arrivals were 85% and 15 %, respectively. [1.1]

References:
1.1 United Nations High Commissioner for Refugees. (2016). Croatia snapshot YTD 2016. https://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Org%5B%5D=77
2.1 Kantouris, C. & Testorides, K: (2016). Greece: FYROM has closed its borders to Afghan migrants. http://www.ekathimerini.com/206204/article/ekathimerini/news/greece-fyrom-has-closed-its-borders-to-afghan-migrants

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

The massive influx of refugees and migrants traveling across the Balkan migrant route and entering the territory of Croatia through the border crossings with Serbia began on September 16th. During the first few days all the people crossing the Croatian border (including refugees and migrants passing through Croatia on their way to other destination countries as well as those who expressed their intention to apply for asylum) were transferred by buses and trains organised by the Croatian Ministry of Interior to several temporary

reception centres in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo and Sisak. As the influx of refugees and migrants continued to grow, the Croatian Government decided to open a large reception centre in the village of Opatovaci in eastern Croatia on September 21st. All centres established during the first few days have been completely vacated as migrants left for Hungary and Slovenia and all people entering the border since September 21st were transferred to the Reception Centre Opatovac. [1.1] In order to provide adequate conditions for a large number of refugees and migrants during winter months, the Government opened a Winter Reception and Transit Centre in Slavonski Brod on November 3rd. On the same day the Reception Centre in Opatovac was closed while the 2000 remaining refugees and migrants from Opatovac, as well as all of the equipment, were transferred to Slavonski Brod. After November3rd, the Winter Reception Transit Centre Slavonski Brod remained the only functional transit centre in Croatia where all new refugees and migrants arriving in Croatia from the Serbian border were directly transported. [1.2] After the Balkan migrant route was officially closed on March 30th, Croatian authorities closed the Winter Reception Transit Centre Slavonski Brod on April 15th and the remaining refugees and migrants were transferred to existing long-term accommodation facilities for foreigners in Croatia.[2.1] Individuals who applied for asylum in Croatia were moved either to Reception Centre for Asylum Seekers Kutina (mostly vulnerable groups of asylum seekers) or to Reception Centre for Asylum Seekers Porin in Zagreb (single men and other categories of asylum seekers). A majority of individuals who did not apply for asylum were directly moved to Detention Centre for Irregular Migrants Ježevo, except for those pertaining to vulnerable groups such as families who were transferred to a separate part of the Reception Centre Porin. As of the closure of the borders, all new refugees and migrants that come to Croatia mainly due to readmission from other EU countries are situated in one of these long-term accommodation facilities

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1.2 International Federation of Red Cross and Red Crescent Societies. (2016). Emergency plan of action final report, Croatia: Population movement (April 2016).

2.1 News that moves. (2016). Croatia closes SlavonskiBrod transit centre. file:///C:/Users/Kerumica/Downloads/Croatia%20Closes%20Slavonski%20Brod%20Transit%20Centre.pdf

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved)

Provisional reception centres in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo and Sisak that were active during the first few days of migrant surge in Croatia, served only as a temporary point where The Croatian Ministry of Interior officials registered newly arrived people and The Croatian Red Cross staff provided humanitarian assistance. Once registered, migrants and refugees were transported by bus or train directly to the Slovenian or Hungarian border.[1.1]

Reception Centre Opatovac was a temporary tent settlement opened from September 21st to November 3rd near the Croatian border with Serbia (where the majority of refugees and migrants at the time entered

Croatian territory). The camp had a capacity of maximum 4000 people. The refugees and the migrants stayed in the centre for no more than 36 to 48 hours during which they were registered and provided with primary assistance and were subsequently transported to the borders.[1.1]

Winter Reception Transit Centre in Slavonski Brod was opened by the Croatian Ministry of Interior to ensure more appropriate short term accommodation during cold weather and heavy rainfall. Since its opening on November 3rd 2015 until March 5th 2016, when last arrivals were reported by the Croatian Ministry of Interior, the centre was the main transit point for migrants and refugees passing through Croatia. The centre was set up on a rearranged warehouse near the railway in the industrial zone of the city Slavonski Brod with a capacity to accommodate 5000 people. It was divided in several sectors including two halls for reception, registration and distribution of humanitarian aid. Each sector had air-heated tents, separate housing containers for families and particularly vulnerable individuals, child friendly spaces, special mother-baby areas, medical assistance unit and several heated hygiene facilities with warm water. On average, refugees and migrants stayed in the centre for four to five hours during which they would register, receive medical assistance if needed and use the needed services (food, clothes, sanitary facilities etc.) and boarding the train that would bring them directly to Slovenian or Hungarian border.[1.2] Since late November the centre also had closed sectors (sector 3 and 4) under the control of the Croatian Ministry of the Interior which was used to separate individuals that were returned from Slovenian border because they did not meet the conditions that Slovenian Government had implemented as of November 18th 2015.[1.3] At the time when the Balkan route was closed, there were approximately 320 individuals stranded in the closed sector of the centre who were presented with an official ban from leaving the centre and could only apply for asylum in Croatia or leave the European Economic Area voluntarily. Out of these, 224 individuals expressed their intention to apply for asylum and were subsequently transferred to Reception Centres for Asylum Seekers Kutina and Porin to wait for the resolution of their asylum application. However, many of them illegally left Croatian territory within a short period of time.[3.1] The centre in Slavonski Brod was closed on April 15th, and all people who had been placed there were transferred either to Detention Centre in Ježevo or to the Reception Centre Porin in Zagreb. 62 family members who did not apply for asylum were transferred to Porin and 21 single men not applying for asylum were moved to Ježevo.[3.1]

The “permanent” Reception Centre for Asylum Seekers Kutina was opened in June 2006 in the Traffic Police building in the town of Kutina, located 80 km east from the capital of Zagreb. It was briefly closed due to devastation in 2013 and opened again after renovation in 2014 to provide long term accommodation for vulnerable groups of asylum seekers such as unaccompanied minors, families, pregnant women, persons with disabilities and persons suffering from mental disorders.[1.4] This is an open type of facility so that the residents can go outside whenever they want but they have to be back by 10pm. If they want to leave the centre for a longer period of time they have to get permission from the administrator of the facility. The centre can accommodate up to 100 people in 22 two-bedded rooms and family members are always accommodated in the same room. It has several sanitary facilities, sports hall, playground and child friendly spaces, infirmary, TV room, restaurant, small kitchen and laundry service. Residents receive three meals per day and can get specific diet food if necessary (e.g. halal, vegetarian, diabetic etc.). They can prepare meals by themselves in the small communal kitchen. [3.2] Before the surge of refugees and migrants had reached Croatia, there were approximately 10 asylum seekers already accommodated in Kutina.[3.3] In September 2015, when Croatian authorities closed the second reception centre for asylum seekers (Porin), 45 single male

asylum seekers were moved from Porin to Kutina and since then everyone who applied for asylum until March 2016 was placed in Kutina. [3.3] When the Balkan route was closed and Porin was reopened, refugees and migrants who remained in Slavonski Brod were transferred to Reception Centres in Kutina and Porin whereby the majority of vulnerable individuals were placed in Kutina until the capacity of the centre was reached. In addition, approximately 30 single men that were at that time located in Kutina, were moved to Porin.[3.3] At the moment of writing this report there were 54 individuals at Kutina, mostly particularly vulnerable individuals.[3.2]

Because of the increased number of asylum claims, in 2011 Croatian Ministry of Interior opened a second Reception Centre for Asylum Seekers, initially intended to accommodate single male asylum seekers, in a leased part of the former railways hotel Porin located in Zagreb's neighbourhood of Dugave. In 2013, the centre was expanded to us the whole hotel space and adapted so that it can accommodate up to 600 persons.[1.4] The centre can be reached by public transport and it takes about 45 minutes by bus or a tram to get from the centre of Zagreb to Porin. In addition to the reception of refugees and migrants, Porin is also a registration centre where asylum seekers provide their fingerprints, submit asylum applications and receive their seeker's identity card. Just like in Kutina, the residents of the centre are free to go outside and are entitled to similar conditions (four bedded rooms, meals three times a day, restaurant, sanitary facilities, gym, laundry service, room for creative workshops, room for educational activities). They also receive primary health care on the location. According to the people we interviewed and our own observations, asylum seekers often complain that there is not enough space around the centre for a playground or to engage in outdoor activities.[3.4, 4.1] The centre was briefly closed at the beginning of the Croatian migrant crisis in September 2015 because most of its staff were detached to work in Opatovac and Slavonski Brod reception centres, so that the few previously present asylum seekers in the centre were moved from Porin to Kutina. The centre was reopened in March 2016 when the authorities started planning to close the transit centre in Slavonski Brod. A majority of refugees and migrants who were returned from Slovenian border and at the time stranded in Slavonski Brod were transferred to Porin because Kutina and Ježevo had almost filled up their capacities. [1.3] Besides the individuals who decided to seek asylum while staying in the Slavonski Brod transit centre, approximately 60 irregular migrants who refused to seek asylum in Croatia but belonged to a vulnerable group (mostly families with children) were moved to Porin to stay in a separate part of the centre but without restrictions to movement or services. [3.3] As in the case of other individuals who do not apply for asylum in Croatia, these refugees and migrants can voluntarily return to a safe country of origin or third safe country from which they entered Croatia or they will be forcibly deported after a maximum of 18 months in Croatia. The centre currently accommodates 221 persons in total, including 169 asylum seekers and 42 family members who did not apply for asylum and are located in the separate part of the centre.[3.4]

Detention Centre for Irregular Migrants Ježevo is located in outskirts of the village Ježevo (next to the highway), 30 km east from Zagreb. It is a closed detention facility with permanent solid-built structure for people who did not apply for asylum and are awaiting deportation due to illegal residence or work in Croatia or for asylum seekers who for some reason specified by law had their freedom of movement limited. Maximum detention time is 3 months, with the possibility of further prolongation for another 3 months and two further prolongations each for 6 months. The capacity of the centre is around 100 persons.[1.5] The refugees and migrants located in Ježevo are not allowed to leave the complex at any time, but they can spend

few hours a day outside in the yard. Their personal belongings (e.g. mobile phone) and money are taken away upon registration and their possibilities of contact are reduced to one phone call with the embassy or representatives of the country of origin, additional phone call in maximum duration of 3 minutes and one visit in duration of up to one hour.[1.6] The centre is under the strict control of Croatian Ministry of Interior so that non-governmental organisations (NGOs) can only do an external monitoring of the centre. Therefore, it is difficult to gather additional information about the number of people detained, overall conditions in the centre or available services. The only information currently available is that the majority of people transferred from Slavonski Brod have expressed intention to voluntary repatriation to their countries.[1.7]

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1.5 Migreurop. (2014). Croatia – Country fact sheet. **http://www.migreurop.org/IMG/pdf/fiche_pays_hrvatska_version_finale.pdf**

1.6 No border Serbia. (2015). Detention in Croatia. **https://noborderserbia.files.wordpress.com/2015/03/zine-detention-in-hr.pdf**

1.7 International Federation of Red Cross and Red Crescent Societies. (2016). Combined monthly Europe population movement update (April 2016).

3.1 Interview with a volunteer coordinator from the Centre for Peace studies

3.2 Interview with occupational therapist (CRC) working in Reception Centre for Asylum Seekers Kutina

3.3 Interview with a psychologist from the Society for psychological assistance

3.4 Interview with a social worker from CRC working in Reception Centre for Asylum Seekers Porin

4.1Participatory observation of the Reception Centre for Asylum Seekers Porin

How is Primary Health Care provided in your country in general?

The health care system in Croatia is organized by the Ministry of Health, which is responsible for monitoring health condition and needs of the population, health care legislation, health policy planning and evaluation, regulation of standards for health services and training, public health programmes, implementation and regulation of standards in health facilities and supervision of professional activities.[1.1] The system is based on the principle of social health insurance by which citizens are required to participate in the expenses for basic health care services with an exception for certain categories of insured persons (e.g. children under the age of 18 years, those suffering from certain diseases such as malignant diseases or chronic mental illnesses). The main financing body for financing health services is the Croatian Health Insurance Fund, which provides

universal health coverage to the whole population, defines basic health services and prices covered under the mandatory, as well as voluntary health insurance. Basic health insurance is mandatory for everyone in Croatia, including temporary residents. All employed citizens and their employers pay health care directly from the salaries while dependant family members are covered through the contributions made by working family members. Vulnerable groups of citizens such as retired, disabled, unemployed, students, war veterans and those on low income are exempt from paying and their health services are funded from the state budget.[2.1] Although the scope of mandatory health insurance is broad, patients must participate towards the costs of many medicines and services, either through co-payments or through the purchase of complementary voluntary insurance covering user charges (except the unemployed, disabled, children under 18, students, war disabled, and regular blood donors). Besides that, all patients pay for non-prescription drugs.

Primary health care in Croatia includes general practice (family) medicine, school medicine, hygienic and epidemiological care, dental care, emergency health services, and occupational health, primary healthcare of women and children, community nursing and pharmacies. It is provided by various health service institutions such as private practice offices, larger units comprising several offices (including small laboratories), community health clinics, institutions for emergency medical care, institutions for home health care and pharmacies. The primary care physicians are usually patients' first point of contact and each insured citizen has to register with a general practice doctor, a paediatrician, a gynaecologist and a dentist of their choice. If necessary, primary health care physicians refer the patient for further treatment to secondary or tertiary specialist health care facilities. Secondary health care includes specialist-consultative healthcare, hospital health care in general and specialized hospitals and health resorts. Tertiary health care refers to most complex forms of health care in specialised clinical centres and national health institutes. Mental health services are mainly provided within institutions such as general and university clinical hospitals as well as specialist psychiatric hospitals. Local county governments own most of the public primary and secondary health care facilities while the state owns and controls tertiary health care facilities.[1.1] Provision and funding of health services are largely public, although there are private providers in the market. Privately owned facilities can be contracted by the Croatian Health Insurance Fund and become a part of the publicly funded system or they can choose to operate on their own and charge private fees.

Health care standard in Croatia is mainly satisfactory, with better accessibility to health care facilities in major cities. For example, the largest number of hospitals is located in central Croatia, mainly in the capital of Zagreb, while the remote parts of the country and the islands have considerably less access to health care. However, primary health care and emergency medicine facilities are available in all parts of the country. In 2015 the healthcare facilities included 77 hospitals and clinics with 25.219 beds, 21 institutes of emergency medicine, 49 health centres and 22 institutes of public health. There were a total of 65.757 health workers in the country, including 14.057 medical doctors of which 9.538 specialists.[1.2] Due to rising costs of health care, especially expenditure on drugs, Croatian health care system suffers from lack of funding, which so far has not affected drug supply within public health care institutions.[2.1]

Regarding the health care for refugees and migrants, it is necessary to distinguish different categories of protection depending on their legal status in Croatia. According to the Croatian Act on International and Temporary Protection[1.3], applicant for international protection is a third country national or stateless person

who has applied for international protection up until the final decision on the application. International protection in Croatia includes asylum and subsidiary protection. Asylum is granted to applicants who are outside the country of their nationality or habitual residence and have a well-founded fear of persecution owing to their race, religion, nationality, affiliation to a certain social group or political opinion, as a result of which they are not able or do not wish to accept the protection of that country. Subsidiary protection is granted to an applicant who does not meet the conditions to be granted asylum if justified reasons exist to indicate that if returned to his/her country of origin he/she would face a real risk of suffering serious harm (threat of death, torture, inhuman or degrading treatment or punishment and serious threat to the life) and who is unable, or, owing to such risk, is unwilling to avail himself/herself of the protection of that country. Applicants for asylum and subsidiary protection have a right to emergency medical assistance, and necessary treatment of illnesses and serious mental disorders. Applicants who need special reception and/or procedural guarantees, especially victims of torture, rape or other serious forms of psychological, physical or sexual violence, should be provided with the appropriate health care related to their specific condition or the consequences of those offences. Foreigners who have already been granted asylum or subsidiary protection and their family members have the right to health care to the same extent as a person insured under mandatory health insurance in Croatia. Beside international protection, foreigners can be granted temporary protection in situations of a mass influx of displaced persons from third countries who cannot be returned to their country of origin, especially if it is not possible to conduct an effective procedure for approval of international protection. Health care for foreigners under temporary protection includes emergency medical assistance and, for vulnerable groups, appropriate medical and other assistance. Costs of health care for all of the above mentioned categories of foreigners are paid by the national budget of Croatia.

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2.1 Croatian Health Insurance Fund. Croatian health care system. http://www.hzzo.hr/en/croatian-health-care-system/

Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

The primary health care in temporary reception centres that were active at some point in the refugee and migrant crisis in Croatia was provided by several international and civil society organisations and agencies. The Croatian Ministry of Interior appointed the Headquarters for Crisis Coordination to coordinate all activities related to the arrival of refugees and migrants in Croatia and Croatian Red Cross (CRC) to coordinate all other organisations involved in providing care for refugees and migrants in temporary reception centres

and border crossings. CRS staff and volunteers were present at all reception centres as well as at the entrance and exit border crossings providing food, water and hygiene items to refugees and migrants in cooperation with State Commodity Reserves. In addition to CRS, The United Nations High Commissioner for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF) provided psychosocial assistance and child friendly corners, Caritas Croatia provided relief items and additional assistance on field operations, Zagreb Islamic Community Mesihat ensured food and recruited Arabic and Farsi speaking volunteers. International Organisation for Migration (IOM) with their expertise on the population movement crises on large scales conducted migration flow surveys, Jesuit refugee Service (JRS) provided interpreters for Arabic and Farsi and assisted in the distribution of food, water, hygiene items and medications, while local NGOs, such as Centre for Peace Studies (CPS) and Society for Psychological Assistance (SPA) provided volunteers and psychosocial support. [1.1,1.2] In the Winter Reception Centre Slavonski Brod the Government established a well organised system for providing humanitarian response and health care for refugees and migrants in transit, which included 20 organisations and around 320 volunteers and staff members.[2.1] National health system employees (physicians, nurses and medical technicians) organised by the Croatian Ministry of Health provided immediate medical services with the support of CRC and Magna. In the case of a more serious medical problem medical staff transported the patients to a nearby hospital in Slavonski Brod with a dedicated ambulance vehicle. Interpreters from various organisations assisted medical personnel during medical interventions in the centre and local hospitals. UNICEF, Save the Children International and Magna were responsible for providing specialised care for children and babies in child friendly spaces and mother-baby areas. UNHCR had a permanent presence in the centre in order to identify people with specific needs or at risk and to refer them to other organisations and services if needed and also provided the majority of non-food necessities.[1.2] CRC and other NGOs (ADRA Croatia, Volunteer Centre Osijek, Volunteer Centre Slavonski Brod, Intereuropean Human Aid Association, JRS, Caritas Croatia, Union of Baptist Churches in Croatia, Samaritan's Purse, CPS, SPA) provided food, water, blankets, raincoats, hygienic kits, specific children supplies and psychosocial support. Considering that the transit centres in Croatia are now closed and that a part of the staff now work in the two Reception Centres for Asylum Seekers in Kutina and Zagreb, in the remaining part of the report we will focus on these, currently active centres.

The primary health care in both reception centres for asylum seekers is provided by a nurse who is a full-time employee of the Ministry of Interior, a general physician (GP) from the local medical health centre (also has a contract with the Ministry of the Interior) and several NGO workers in the helping professions. Nurses in the centres are usually present for eight hours a day, but at the moment they are both on a maternity leave and they have not yet been replaced. The GP in Reception Centre Kutina comes when the centre employees call him (usually 2-3 times a week)[3.1] and the one in Reception Centre Porin provides medical examinations 2 times a week for 4 hours and is also on call for emergency cases.[3.2] According to the GPs working in these centres, the level of medical care currently provided is sufficient considering the number and the severity of health problems of asylum seekers.[3.1,3.2] Besides the medical staff, CRC and JRS have contracts with the Ministry of Interior in both centres which allow them to employ full-time staff working on distribution of necessities and medicines, translation, transportation of people to medical examinations and treatments outside of the centre, organisation of medical records and the provision of psychosocial support.[3.3] In addition, staff and volunteers from the CPS and SPA, although they're not full-time employees, often provide psychological assistance and organise various activities with asylum seekers (workshops, language courses, recreational activities…).[3.4,3.5]

References:
1.1 International Federation of Red Cross and Red Crescent Societies. (2016). Emergency plan of action final report, Croatia: Population movement (April 2016).
1.2 United Nations High Commissioner for Refugees. (2016). Regional refugee and migrant response plan: Eastern Mediterranean and Western Balkans route. http://www.unhcr.org/570669806.pdf
2.1 Intereuropean Human Aid Association. (2016). Slavonski Brod: Our first cooperation with big organizations and local government – and a small story of success. http://www.iha.help/news
3.1 Interview with the GP working in Reception Centre for Asylum Seekers Kutina
3.2 Interview with the GP working in Reception Centre for Asylum Seekers Porin
3.3 Interview with occupational therapist (CRC) working in Reception Centre for Asylum Seekers Kutina
3.4 Interview with the volunteer coordinator from the Centre for Peace studies
3.5 Interview with the psychologist from the Society for Psychological Assistance

Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?

As already stated, medical staff at each reception centre for asylum seekers is composed of one nurse working full time and one general practitioner from the local community health clinic who provide medical examinations several times a week.[3.1, 3.2] In addition, one social worker and one occupational therapist from CRC are also working full time in every reception centre and the CRC psychologist comes on a weekly basis.[3.3,3.4,] Finally, SPA teams visit the centres every week to provide counselling and psychosocial support mostly consist of psychologists and interpreters who are specially trained to translate psychological counselling.[3.5]

References:
3.1 Interview with the GP working in Reception Centre for Asylum Seekers Kutina
3.2 Interview with the GP working in Reception Centre for Asylum Seekers Porin
3.3 Interview with the psychologist from CRC
3.4 Interview with the occupational therapist (CRC) working in Reception Centre for Asylum Seekers Kutina
3.5 Interview with the psychologist from the Society for Psychological Assistance

Primary health care staff situation (numbers, capacity, payment, safety, …)? If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

As previously mentioned, the only medical staff available in Reception Centres for Asylum Seekers includes one medical nurse in charge of basic medical care (e.g. monitoring and administering medication, measuring temperature and blood pressure) and a general practitioner who provides primary medical care as necessary. The GP in Reception Centre Porin has a small office in the centre supplied with typical medicines (funded by the Croatian Health Insurance Fund) and he is responsible that the necessary medications are available.[3.1]

The Reception Centre in Kutina has a contract with a local pharmacy so when the GP writes a prescription, the centre puts an official stamp and JRS or CRC workers pick up the necessary medication at the pharmacy whose costs are covered by the Croatian Health Insurance Fund.[3.2] Typical health problems of asylum seekers include common cold and viral infections. There is a small number of patients with chronic diseases, especially in Reception Centre in Kutina (e.g. heart conditions and diabetes). When needed, the GPs refer patients with chronic diseases, acute mental disorders and pregnant women to specialist treatment in community health clinics or hospitals .[3.2] JRC or CRC personnel accompanied by an interpreter (if available) transport them to the hospital and, when possible, cover the costs of specialized medical examinations and treatments, which are not provided by the national insurance.[3.3] Although no paediatricians or other children's health specialists are present in the centre, the GPs refer children to appropriate specialist in the community health clinic or hospital.[3.1] If a medical intervention is needed outside the doctor's working hours and the nurse alone is not able to help, asylum seekers are transported to the nearby hospital and provided with emergency medical help.[3.2] SPA also sees the asylum seekers in need of psychological therapy and counselling in their offices in the centre of the city for free. CRC employees and volunteers as well as psychologists from SPA provide psychosocial support and counselling. Given that asylum seekers are not entitled to dental care, but only tooth extraction, two dentists with private practices in Zagreb provide free dental services to asylum seekers from Porin and Kutina. There is also a general practitioner who works in a county health centre but, as she is not allowed to receive asylum seekers there, they usually meet outside of working hours and a gynaecologist who provides free services mostly to non-pregnant women in her private practice. Unfortunately, primary medical providers who, unlike health personnel working in the reception centres, do not have a contract with the Ministry of Interior are not allowed by the law to provide services to refugees and migrants. However, volunteers in reception centres usually find a way to contact and organise appointments with several external health care providers who volunteer to give free medical examinations and treatments of asylum seekers[3.4]

References:

3.1 Interview with the GP working in Reception Centre for Asylum Seekers Porin
3.2 Interview with the GP working in Reception Centre for Asylum Seekers Kutina
3.3 Interview with the volunteer coordinator from the Centre for Peace studies
3.4 Interview with the volunteer from the Centre for Peace studies

Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?

According to the general practitioner from Reception centre Kutina, all asylum seekers have gone through an initial health screening during their stay in Winter Reception Centre Slavonski Brod and they carry their medical records (in Croatian) with them[3.1]. Because of this, the doctor in Kutina doesn't carry out a thorough medical examination of asylum seekers once they arrive at the centre, but only inquires whether they have some kind of a medical problem or take any medication. The general practitioner from Reception Centre Porin claims that all refugees and migrants in Porin, not only asylum seekers, are offered to take an initial check-up. Although there is no special protocol for initial health screening of asylum seekers, these check-ups usually include a clinical interview about the health status and possible complaints, taking blood pressure

and pulse, mouth and throat inspection and examinations of lung and hearth functions using a stethoscope. He also mentioned that the asylum seekers have had initial health assessment while staying in Slavonski Brod. However, there is no initial assessment nor screening for mental health issues. Also, no recommendations for triage are formalized specifically for asylum seekers.[3.2]

References:
3.1. Interview with the GP working in Reception centre for Asylum Seekers Kutina
3.2. Interview with the GP working in Reception centre for Asylum Seekers Porin

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?

Some asylum seekers in Kutina and Zagreb speak English well and can mostly communicate on their own. When this is not the case, there are enough interpreters from different organisations that can help asylum seeker communicate their needs, especially during medical examinations which are always done in the presence of an interpreter. According to CRC social worker whom we interviewed, around 30 interpreters are available in Reception Centre Porin only.[3.1] Croatian Ministry of Interior provides official interpreters for various languages free of charge but only during the asylum application procedure or other legal issues. However, CRC and JRC both have unofficial interpreters in their teams who regularly visit the centres Porin and Kutina, although these are mostly people who are fluent in the required languages but not trained for translation. CRC has 6 interpreters (3 for Arabic, 1 for Urdu, Pashto and Farsi)[3.1] and JRS employs 5 native speakers of Arabic and Farsi who have been granted asylum in Croatia few years ago (before the European migrant crisis started) and are now helping in translation and communication with the medical staff. SPA provides 8 interpreters for various languages who are specially trained for interpretation during psychological counselling.[3.2]

References:
3.1 Interview with the social worker from CRC working in Reception centre for Asylum Seekers Porin
3.2 Interview with the psychologist from the Society for Psychological Assistance

Biggest challenges and barriers for primary health care providers?

Although both GPs working in the Reception Centres for Asylum Seekers think that the available medical care in centres is generally sufficient, they point out that the greatest current difficulty is the absence of medical nurses which have still not been replaced.[3.1, 3.2] Another specific issue is that the medical data on the asylum seekers is not entered into an official, national data base such as those of regular Croatian patients. Although CRC keeps some kind of a medical record, this complicates the work of the GPs and prevents establishing continuity of care and easy access to health records that GPs want to have each time they see the same patient.[3.2] In addition, asylum seekers often expect the GPs to help them understand their legal situation, their future and the options they have, even though doctors have no knowledge of it. There are also a number of highly distressed, apathetic or tense individuals in the centre who require help that is outside of the primary domain of work of the GP or a nurse.[3.2] These problems require additional mental health services that are not covered by the national insurance. According to the volunteers from CPS, there are external

health care providers who would like to help asylum seekers free of charges but they are forbidden by the law to do so and they don't have the right of access to the reception centres.[3.3]

3.1. Interview with the GP working in Reception centre for Asylum Seekers Kutina
3.2. Interview with the GP working in Reception centre for Asylum Seekers Porin
3.3 Interview with the volunteer from the Centre for Peace studies

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

According to the people we interviewed, no primary medical care staff among the asylum seekers in reception centres have been identified. However, there is a dentist from Syria in the Reception Centre Porin who consults the GP in the centre when the patients suffer from acute dental conditions.[3.1]

References:
3.1 Interview with the GP working in Reception centre for Asylum Seekers Porin

Conclusions

From the total number of refugees and other migrants that are currently located in Croatia, around 300 have applied for asylum and are located in Reception Centers for Asylum Seekers in Kutina and Zagreb. Families and vulnerable groups are mostly located in Kutina, while Porin currently accommodates different profile of refugees and migrants, including single men and vulnerable individuals, some of which have not applied for asylum (mostly families with children) and are located in the separate part of the reception center. According to country of origin, most refugees and other migrants come from Syria, Iraq and Afghanistan. Reception Centers for Asylum Seekers in Kutina and Zagreb together have the capacity and the necessary staff to accommodate and care for approximately 700 people, which is sufficient only for the current needs. However, due to the Dublin Regulations which state that the member state where the asylum applicant first entered Europe is responsible for its accommodation, there is a possibility that a large number of asylum seekers will be transferred to Croatia from other EU countries. It is unlikely that Croatia's asylum system in its current state will be able to take care for additional asylum seekers. The Croatian Government is therefore preparing for such a scenario, so that two additional reception centers in Tovarnik and Trilj are currently under construction (each with the capacity to receive approximately 100 people.

Residents of both reception centers usually have sufficient access to primary health care which is provided by a nurse who is present in the center for 8 hours a day and a local general medical practitioner who provides service in the center a few times a week. There are a significant number of interpreters for various languages, especially in Porin, who are present during medical examinations, although they are mostly not professionally trained for translation. Psychosocial and logistical support is provided by several NGOs, predominantly CRC and JRS. Currently, a big barrier

to providing continuous health care is the temporary absence of nurses in both centers due to maternity leaves.

Asylum seekers have right to emergency medical care and treatments for chronic conditions but other medical services (e.g. dental care, gynecological examinations, mental health services) are not covered by the national insurance until they're granted asylum.

Although there are a number of external health care providers who seem to be willing to volunteer services, they are limited by the law to do so. Two GPs who have been interviewed consider the level of medical services appropriate and comment that the majority of refugees and migrants in the two reception centers are young and healthy. In this sense they agree that their general health status is better than the rest of their regular, local patients. However, they consider that a large number of refugees and migrants could benefit from psychological assistance.

A5. Country Report Slovenia

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) – Version 15/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Name of authors Danica Rotar Pavlic, Mateja Žagar, Alem Maksuti, Eva Vičič, Erika Zelko

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"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."

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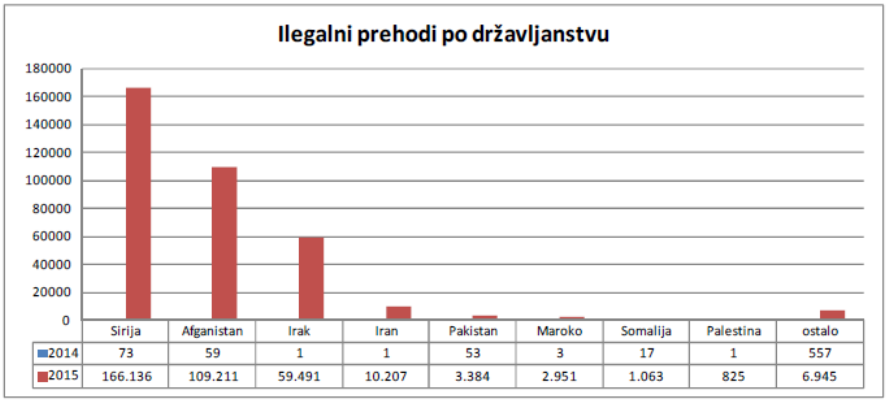
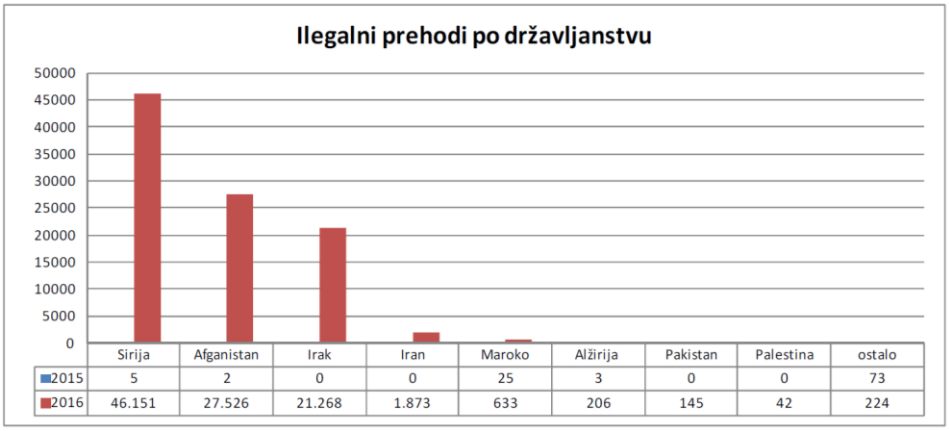
Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
Over the last year, the work was mainly dictated by the intensified security situation caused by masses of migrants entering Slovenia. It appears that the situation, which Slovenia has so far managed with great efforts, began to ease. Table 1: Number of refugees to Slovenia by country of origin, 1.1.2015-31.12.2015    It could be seen that Slovenia was a country which 360.213 migrants reached in the year 2015. Data about the migration flow from 1st of January till 31. March 2016 are presented in table 2. Table 2: Number of illegal migrants to Slovenia by country of origin, 1.1.2016-31.3.2016

	Sirija	Afganistan	Irak	Iran	Pakistan	Maroko	Somalija	Palestina	ostalo
2014	73	59	1	1	53	3	17	1	557
2015	166.136	109.211	59.491	10.207	3.384	2.951	1.063	825	6.945

(obdobje od 1.1. do 31.3.2016)



	Sirija	Afganistan	Irak	Iran	Maroko	Alžirija	Pakistan	Palestina	ostalo
2015	5	2	0	0	25	3	0	0	73
2016	46.151	27.526	21.268	1.873	633	206	145	42	224

Slovenia has been doing its best to ensure that the entrance of migrants is effectively directed, controlled and coordinated with the neighbouring security authorities. Only in this way, we can, in fact, manage the security situation, provide appropriate care to migrants and ensure the safety of both migrants and residents of Slovenia. Unannounced, disorganised and uncontrolled arrivals of large groups of migrants outside the designated entry points were creating significant security and logistics problems since we didn't want the migrants to spend hours waiting out in the cold and rain without protection. Our capacities allowed to daily receiving, in an organised and orderly way, between 2,000 and 25,000 migrants and new groups could enter only after previous groups left for Austria. We would like to draw the attention to the fact that already upon arrival in Slovenia a large number of migrants were in 'bad shape' since previous countries did not ensure optimal care to them. Therefore, they had first be provided with food, clothes, accommodation, and, where needed, medical assistance.

Reference: http://www.policija.si/index.php/statistika/mejna-problematika/622

At the end of March 2016 Slovenia closed a temporary accommodation center in Vrhnika. On Monday 21. 3. 2016 at 19.00 last migrants left temporary accommodation center in Vrhnika. The statistics about migrants settled in the center of Vrhnika is as follows:

- On Thursday 17. 3. 2016 at 10:00 9 migrants (family) accommodated including 2 women, 3 men and 4 children.
- On Wednesday 16. 3. 2016 at 14:00 12 migrants (family) accommodated including 4 men, 3 women and 5 children.
- On Tuesday, 15. 3. 2016 at 8:00 am 11 migrants accommodated. At 12:30 pm 5 left center. On Monday 14. 3. 2016 at 8:45 Vrhnika 13 migrants accommodated. At 11.30 they 11 migrants left.
- On Sunday 13. 3. 2016 at 14:00 33 migrants accommodated, 10 men, 10 women and 13 children, respectively. 25 citizens of Syria, 6 citizens of Afghanistan and two Iraqi citizens.
- On Saturday 12. 3. 2016 at 14:00 43 migrants accommodated, of which 16 men, 12 women and 15 children.
- On Friday 11. 3. 2016 at 19:00 52 migrants accommodated, of which 18 men, 15 women and 19 children.
- On Thursday 10. 3. 2016 at 17:40 52 migrants accommodated of which 18 men, 15 women and 19 children.

- On Wednesday 9 3 2016 at 10:00 am 68 migrants accommodated, of which 15 women, 30 children and 23 men.
- On Tuesday, 8. 3. 2016 at 18:00 82 migrants accommodated, including 20 women, 40 children and 22 men. Most of them are citizens of Syria, Afghanistan, 4 are from Iraq .
- 6. 3. 2016: 93 migrants accommodated; 42 children 17 men and 24 women.
- On Saturday, 5. 3. 2016 at 11:00 107 migrants accommodated.
- On Friday, 4. 3. 2016 at 18:00 121 migrants accommodated. According to data published on Friday www.policija.si at 6:00 pm in Vrhnika there were 135 migrants.
- On Thursday 3. 3. 2016 at 18:00 there were 135 migrants. According to data published on Thursday www.policija.si 3. 3. 2016 at 6:00 pm in Vrhnika were 117 migrants.
- On Wednesday, 2. 3. 2016 at 8:00 am 128 migrants accommodated. According to data published on Wednesday www.policija.si 2. 3. 2016 at 6:00 pm in Vrhnika were 144 migrants.
- On Tuesday, 1. 3. 2016 at 18:00 143 migrants accommodated.
- On Monday, 29. 2. 2016 at 18:00 141 migrants accommodated.
- On Monday, 29. 2. 2016 at 8:30 am 125 migrants accommodated.
- 28. 2. 2016 at 18:20 129 migrants accommodated.
- On Saturday 27 2nd 2016 133 migrants accommodated.
- On Thursday 25. 2. 2016 84 migrants were accommodated. At 16.00 there were transported another 49 migrants from home for foreigners in Postojna, who were in the process of removal from the country. Emergency health care team treated 8 migrants with different problems, two of them were referred to further treatment in hospital.

Reference: http://www.vrhnika.si/?m=news&id=16034

Current situation:

Place	Type of centre	Number of people
Asylum Home in Ljubljana (AH LJ)	Accommodation	189
Kotnikova-part of AH LJ	Accommodation	63
Logatec – part of AH LJ	Accommodation	29
Youth Crisis Centre	Accommodation	10
Private flats and houses	Accommodation	11
Foreigners Centre in Postojna	Accommodation	38

Total Number	340

On 11 May 2016, there are 340 migrants on subsidiary protection in Slovenia.

Table 3: Number of migrants housed in the Centre for Foreigners (CT) and the Asylum Home (AD) and their branches

Reference: http://www.policija.si/index.php/component/content/article/35-sporocila-za-javnost/84145-tevilo-migrantov-nastanjenih-v-sloveniji-podatek-za-11-maj-2016

European relocation plan: The first 10 asylum seekers will be transferred to Slovenia in the coming days

Slovenia will be part of a plan transfer of 567 refugees in the coming days most of these will be men from Eritrea. The Secretary of State in the Ministry of the Interior Bostjan Šefic said "The Italian colleagues are already very far. I'm counting to ten, fourteen days, this group of ten people will come from Italy to Slovenia," he said.
Most of the Eritreans, mainly men, among them also claimed to be a woman.
"In Greece, we already send basic parameters, but from there we do not have all the answers. For Greece this moment difficult to tell the exact date," he commented a relation with Greece, where Slovenia is sending material assistance. Slovenia is committed to take 567 people from the relocation project, and 20 of the project of permanent migration, in addition to compliance with the agreement between the EU-eat and Turkey is drafting a new mechanism. The Slovenian Press Agency reported that there were, only 17 applications for asylum in January were in February there were already 270 and in April 350, what was the reason for exceeding the accommodation capacity of the asylum home. It was for this reason that the government decided to establish two branches of asylum in Kotnikova in Ljubljana and Logatec. On April 13 th , in Slovenia was 350 asylum applicants, among them 90 children. In 2015 were 385 asylum applicants (90 Syrian, 75 from Afghanistan, 25 from Pakistan, 20 from Iran, 20 from Kosovo and 15 other) in Slovenia and 44 of them became a asylum in our country.

References:

http://www.policija.si/index.php/statistika/mejna-problematika/622

http://www.vrhnika.si/?m=news&id=16034

http://www.policija.si/index.php/component/content/article/35-sporocila-za-javnost/84145-tevilo-migrantov-nastanjenih-v-sloveniji-podatek-za-11-maj-2016
http://www.rtvslo.si/begunska-kriza/prvih-10-prosilcev-za-azil-bo-v-slovenijo-premescenih-v-prihodnjih-dneh/390496,
siol.net/.../slovenija/slovenija-v-stevilkah-koliko-tujcev-koliko-prosilcev-za-azil-kolik...

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

Main countries where refugees and other migrants come from?

Most transit refuges in Slovenia (1.1- 31.3.2016) were from Answer: use as much space as necessary

Syria (47%), Afghanistan (28.3%), Iraq (21.6%), Iran (1.9%), Pakistan (0.14%), Morocco (0.6%), Algeria (0.2%), Palestine(0,04%) and 0.22% others.

Reference: http://www.policija.si/index.php/statistika/mejna-problematika/622

160429_002 Interview:
"Most of them were from Syria, some were also Iraqis, from Afghanistan."

160505_001 Interview:
"The first wave was more varied. Most of them were, of course, Syrians and Pakistanis but included others, such as from the countries of North Africa, Lebanon. Some children were, so they say, born in Lebanon in refugee camps. Mainly Syria and Pakistan. In the second wave only from Syria and Pakistan."

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible (4) Result from participatory observations
What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
With various solutions and, in cooperation with local communities, the Police and the Ministry of the Interior addressed the problems caused by the arrivals of a large number of migrants to the Slovenian residents of places situated near the border crossings and accommodation and reception centres. At Šentilj, an emergency makeshift railway platform was set up for the arriving migrants to get off the train in the immediate vicinity of the overburdened Šentilj accommodation centre and avoid crossing the settlement itself. The accommodation centre in Šentilj, the point of exit from Slovenia with the heaviest refugee traffic, has up to 7000 people passing through it each day. According to the staff running the centre, all the people accommodated there were/are well taken care of. Some 160 to 200 people are caring for the refugees at the centre each day, not counting members of the police. The refugee reception procedure is conducted by the police with the support of the Armed Forces and at least one Arabic, Kurdish and Iraqi interpreter was assisting at all times. The tents were/are heated and have wooden floors. In addition to a total of 2,000 beds, refugees could also make use of shower facilities. A regular routine has been established at the centre; refugees were/are provided with all the necessary care, and once the tents are vacated, they are thoroughly cleaned. There are adequate supplies of food to ensure that no refugee goes hungry. Four thousand hot meals are cooked each day at lunchtime, normally pork-free. If possible, everyone is provided with three meals. Refugees are also given medical care at the centre. During the day, regular medical teams, each comprising a physician and two nurses, are assisted by volunteers, whose ranks include paediatricians and infectious disease specialists. Together, they are able to examine 100 to 150 people in eight hours. The most common medical issues are respiratory infections, diarrhoea and colds, along with frequent reports of fatigue and aggravated chronic conditions. Since most patients can be treated on site, transportation to hospitals is not needed. The situation is manageable. Refugees' families are often separated along the way, mainly because women with children are frequently given priority, causing the men to be left behind. A vital role in reuniting them is played by the Slovenian Red Cross, who are doing their best to find missing family members in other countries in collaboration with partner organisations. They receive 40 to 50 new cases every day and have been very successful in resolving them. Food and clothing is distributed by volunteers, who work in two shifts, with a night shift soon to be introduced. Each shift has around 20 volunteers, most of them regulars. Every new volunteer is first familiarised with the work and briefed on the rules they need to follow. There are adequate supplies at the moment, as they are constantly replenished, the only exception currently being men's shoes.

Photo: Tents in accomodation transit center Šentilj

Reference: http://reliefweb.int/report/slovenia/care-and-treatment-refugees-accommodation-centre-entilj At Dobova the migrants were arriving by a Croatian train first underwent the security check at the Dobova railway station, were they also received medical assistance. Then, they boarded the Slovenian train and were transferred to accommodations centres, where they underwent the registration procedure; with a view to simplifying and speeding up the registration of migrants, some technical improvements have been introduced, such as e-application, which enables fast entry of personal data into the police records; the procedure also includes the taking of fingerprints and photographs. The number of registration points has also been increased. The camp of Dobova is the major and only camp at the border of Croatia. It is close to the train station where the trains from Croatia are arriving and the refugees are transferred to the authority of the Slovenian government. Recently, the camp was enlarged with new tents for food distribution and sanitation, and the floor was concreted to avoid mud and flood. On Thursday 19. november 2015 about 2000 refugees were expected to transit through Dobova (camp). When the refugees arrived at Dobova station, they were separated in two groups in order for the police to proceed with the registration. The first one was going to the camp Livarna in Dobova, while the other group remained at the train station. Registration included identity controls and issuing of “permission to remain” on the Slovenian territory. After registration, refugees were transferred to other camps in Slovenia (mainly Šentilj, or they were taken by train through Jesenice to Austria). The general situation in the camp was good. Food distribution was done efficiently, but water bottles could also be distributed when refugees are leaving the camp. Refugees were first given food and water when they were arriving into the camp, before going to the registration procedure. After registration, they could rest and eat in one of the heated tents. Sanitation in Dobova: Sanitations (toilets, water valves and sinks) were installed inside of two tents in the camp. Restoring Families Link in Dobova: The Red Cross RFL was providing wifi and hotspot signal for refugees who were searching for their family members. They could connect to internet in order to communicate and transmit information about their location to their family members. However, this service was available just for the persons who were searching for their family at the RFL container and not as a general service for the whole camp. Lack of translators and doctors in Dobova: Sometimes there was just one doctor and one translator for Arabic available per shift. It means that when the refugees were arriving at the camp, the medical tent was saturated with requests. Many refugees did not have time to see a doctor before leaving the camp. The

translator could not come to help the medical staff with translation as he was constantly needed at the registration.

Photo: Dobova transit center

Reference: http://www.mirovni-institut.si/en/report-from-dobova-2/

Refugees who apply for international protection or asylum in Slovenia are transported in receiving asylum home, where there are also health controls, carry out the entire procedure for obtaining asylum and the favorable settlement of such persons housed in asylum centers. The majority of refugees only transit, so most of refugees do not apply for international protection (asylum).
Persons who cannot be returned and who do not apply for asylum can apply for a 6-month permit of the retention in Slovenia. They are provided with accommodation and basic care in accommodation centers. Those persons whose return to the neighbor or the country of origin can temporarily stay in the centers for foreigners.
Slovenia has 3 asylum homes/centres (2 in Ljubljana, 1 in Logatec) and one national Centre for foreigners in Postojna. 342 migrants were accommodated on in these centers on 28 April 2016. There were 10 young people accommodated at Youth Crisis Centre.
Table 3: Number of migrants housed in the Centre for Foreigners (CT) and the Asylum Home (AD) and their branches in April 2016.

Place	Type of centre	Number of people
Asylum Home in Ljubljana (AH LJ)	Accommodation	187
Kotnikova-part of AH LJ	Accommodation	65
Logatec – part of AH LJ	Accommodation	29
Youth Crisis Centre	Accommodation	10
Private flats and houses	Accommodation	11

Foreigners Centre in Postojna	Accommodation	40
Total Number		342

Asylum Home Ljubljana is located on the southwestern edge of Ljubljana on the road Cesta v Gorice 15. Accommodation of the Asylum Home is composed of following divisions: for families, for single men, unaccompanied minors, for single women, persons with disabilities. Total number of possible accommodation is 203 persons. The asylum home daily organise diverse activities such as: Slovene and English courses, sports activities, creative workshops for children and adults, excursions and visits to interesting places in Slovenia, computer courses, photography courses, editing of internal magazine Voice of asylum etc. They carried out by the psycho-social service of the Asylum Home and various NGOs as a rule through the programs co-financed by the European Refugee Fund (ERF).

Because of the needs of asylum seekers and the Government of the Republic of Slovenia 22 April 2016 adopted a resolution on the establishment of two new branches asylum home Ljubljana. The two new branches are in a home for single people on Kotnikova in Ljubljana and Training Centre for Civil Protection and Disaster Logatec. There were 342 asylum seekers in all asylum homes in April 2016. 10 young asylum seekers are accommodated in a crisis center for young people, which is not part of asylum home.

The Centre for Foreigners in Postojna is intended for foreigners who are illegally staying in the Republic of Slovenia, namely the following: foreigners who have failed to depart from the country within a specified period and who cannot be removed immediately; foreigners whose identity has not been established; foreigners for whom expulsion has been ordered; unaccompanied minor foreigners; foreigners who are staying illegally in Slovenia and are awaiting extradition to foreign law enforcement on the basis of a bilateral agreement; foreigners who are to be deported; and foreigners who have not departed from the country and reapplied for international protection. The Centre also provides accommodation for applicants for international protection who have been issued with either a decision restricting their freedom of movement in line with the International Protection Act or a decision based on a Council Regulation (EC). The Centre for Foreigners provides basic care for foreigners in respect of their religious and cultural habits, healthcare services and psychosocial care. In this context the Centre works hand in hand with healthcare providers, the National Institute of Public Health, the Sanitary Inspectorate, non-governmental organisations, other authorities and organizations, Slovenian embassies, foreign law enforcement agencies and international institutions.Foreigners have visiting rights in accordance with the rules on residing at

the Centre. Visits are allowed to relatives, friends, acquaintances and other persons wanting to visit them. Visits are also paid by NGOs performing voluntary work or providing legal aid (e.g. PIC) and by the International Organization for Migration. Read more about the Centre for Foreigners: http://www.policija.si/index.php/delovna-podroja/mejne-zadeve-in-tujci/241

What is the procedure for minors?
First, a minor is subject to procedure under the *Protocol on cooperation between social work centres and the Police in providing assistance to unaccompanied foreign minors*: According to the Aliens Act, a foreign minor who is not accompanied by his parents or a legal representative may not be deported to his country of origin or a third country which is willing to accept him until reception is ensured for him there. Prior to deporting a foreign minor, it needs to be ascertained that he will be returned to a member of his family, a nominated guardian or adequate reception facilities in the country of return. Prior to deporting an unaccompanied foreign minor, the police must immediately inform a social work centre, which must immediately assign a special case guardian to the foreign minor. The police may deport a foreign minor only after the special case guardian, having carefully considered all circumstances, establishes that this is in the best interest of the foreign minor. Article 82 of the Aliens Act also stipulates that a foreign minor must be accommodated, in agreement with a guardian for special case, at adequate accommodation facilities for minors, where he is guaranteed all the rights and freedoms laid down in conventions and in the Protocol on cooperation between social work centres and the Police in providing assistance to unaccompanied foreign minors. On apprehending an unaccompanied minor who illegally entered the country or has resided in the country illegally, the police station immediately notifies the territorially competent social work centre during their opening hours. If a foreign minor has been travelling for a long time with a group with people he personally knows (neighbour, second degree of kinship), he is considered accompanied. Outside opening hours (afternoon, night, Saturday, Sunday and holidays), the police station notifies the intervention social work service that covers the area of the police station and requests the cooperation of a social worker. The social work centre is briefly informed of the current findings, the condition of the unaccompanied foreign minor and of the planned action. Then the social work centre appoints a social worker and immediately sends him to the police station. The social worker conducts an interview with the foreign minor, provides him with the first social aid and acquires his statement on assigning a special case guardian. Where necessary, the social worker accompanies the foreign minor in his transfer to the adequate accommodation facilities.

According to the aforementioned Protocol, such a person is subject to special treatment (the processing of unaccompanied minors). But he has every right to express his intention to apply for international protection. We observed that most minors have a good command of the English language. In the event of problems in communication, official interpreters are provided. The age of minors is determined on the basis of the submitted identification documents (passport) or other documents they have, as well as on the basis of data a minor provides to the Police. Physiognomy recognition (age comparison) is also carried out. If a person is presumed to be a minor, actions to his benefit are taken in compliance with the Protocol. The length of procedures of establishing data authenticity may vary considerably. It depends on whether the minor has a document that can be used to verify data authenticity (officially issued documents) or not. If the minor does not have such a document, the procedure of establishing data authenticity is longer. There are also cases where the identity cannot be established as data cannot be verified in the country of origin (the reasons may include war or no concluded agreement on data exchange or cooperation). In any case, the foreign minor is accompanied by a social worker, who offers psychosocial assistance at all times.

Photo: The branch of asylum home in Logatec

Photo: The asylum home Ljubljana

At the end of March 2016 Slovenia closed a temporary accommodation center in Vrhnika. On Monday 21. 3. 2016 at 19.00 last migrants left temporary accommodation center in Vrhnika.

Reference: http://www.policija.si/index.php/component/content/article/35-sporocila-za-javnost/83923-tevilo-migrantov-nastanjenih-v-sloveniji

http://www.vrhnika.si/?m=news&id=16034

http://www.mnz.gov.si/si/mnz_za_vas/tujci_v_sloveniji/mednarodna_zascita_azil/azilni_dom/

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(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be “detention centres”, immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

Table 4: **Total Capacity of beds in Accommodations and Asylum homes (AH) in Slovenia**

Place	Type of Centre	Number of beds
Šentilj	Accommodation	4152
Dobova	Reception and Accommodation	4000
AH Ljubljana	Accommodation for Asylum seekers	203
AH LJ Kotnikova	Accommodation for Asylum seekers	90
Logatec	Accommodation	220

Postojna	Accommodations for foreigners and asylum seekers	50
Total		8715

The first group of migrants reached the Logatec Accommodation Centre on 19th September 2015. The five buses brought 131 people, mostly citizens of Syria, Iraq, Afghanistan, Lebanon and Somalia. **Health Centre Logatec** was informed about the upcoming group of refugees a few hours before the arrival of the first bus. Some health workers from HC Logatec come back from their homes outside their working hours and prepared appropriate protective equipment, medicines, dressings, instruments and other medical devices and appliances for which they assumed that they will need. Health workers were immediately ready for work with so far unknown population. The teams of GPs included the pediatrician, who took over the medical care of children. Refugees were helped by a Slovenian citizen, Syirian by origine, who has long been living in Slovenia. At the arrival the staff gave instructions to refugees concerning the place of accommodation and they presented the possibilities offered by the accommodation center. This was followed by a medical examination of all incoming refugees. Support was given to those who need medical assistance. People were then assigned to rooms and staff invited them to have a hot meal. Within a few hours all the incoming refugees were offered appropriate clothing and provision of medical and psychological assistance. Refugees stayed the Logatec Accommodation Centre all the night. In the morning, soon after breakfast there left complex and went to the station to continue their journey.

By each new arrival of refugee groups Health workers from HC Logatec involved in the process of supplying migrants gained new experiences. Health Centre in Logatec established a well-functioning system of organized health care of migrants. 10 Gps, nurses and paramedics who already regularly work on call had been prepared to accept the increased workload. Health Centre organized a permanent medical standby from September to December 2015. Notifications regarding possible new influx of migrants were given by the Civil Protection administration twice a day. In the case of the announced arrival of a new group a team of GPs on call, along with the nurse or technician went to the accommodation center and then inspected all incoming refugees.

The Ministry of Health was regularly sending new directions on admission and medical treatment of migrants.

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Accommodation center in Logatec is an example of good practice in cooperation with the local community. Department of Defense. Media center. Available at http://www.mo.gov.si/nc/si/medijsko_sredisce/novica/article/12332/7526/ Date: 04/30/2016

Refugees: According to Postojna in Logatec. Inner Sky News. Available 04/30/2016 at:http://notranjskoprimorske.si/2015/09/begunci-po-postojni-aktiviran-tudi-logatec-v-pricakovanju-dveh-avtobusov-najranljivejsih/

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In Logatec peaceful, immigrants are slowly integrated into the local environment. Portal of RTV Slovenia. Available 05/01/2015 at:http://www.rtvslo.si/begunska-kriza/v-logatcu-mirno-prebezniki-se-pocasi-vkljucujejo-v-tamkajsnje-okolje/388388

160501_004 Interview (Dobova) »At the beginning, approximately one week, we operate two technicians without a doctor on site. The police have not yet had established dispensaries. We work without doctors at the beginning. We did what was within our competence. “Load ang go” system. Then the system slowly began to develop and different doctors have come, we have had some volunteers like Doctors without Borders. We worked well with them. They came from different places, from different areas of family medicine specialists, internists, pediatricians, and some were also surgeons. But we would need more paediatricians. We had a good pediatrician who was trainee from Ljubljana – she has worked with us for one week continuously. Then we called around ... if anyone knew any doctor, he called him, if she or he can come to help. We did not have any psychiatrist. We would have to go to a psychiatrist because we were quite tired. There was no one who would deal with them via social care. We did not have any protocols at the beginning. Nothing. I, too, personally, I repeatedly called on the Ministry of Health and talked to them - they did not believe that such a situation. For all we used our own cars. We did a lot of kilometers.”

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

How is Primary Health Care provided in your country in general?

Health care in Slovenia is funded by a mix of public and private spending. The public sector is the primary source of health care funding. On average across EU countries, three-quarters of all health care spending was publicly funded in 2012. Slovenia's health system is funded by compulsory health insurance for everyone meeting statutory requirements, by state revenues, voluntary health insurance, and out-of-pocket spending.

The delivery of PC is organized in health care centers and health stations and independent contractors, so called concessionaires.. Health care personnel involved in PC include Family Practice (FPs)/ General Practice (GPs), primary gynecologists, and pediatricians, specialists in occupational medicine, and nurses with diploma in model practices. There are pomologists in some health centers . FPs in Slovenia act as "gatekeepers," controlling access to secondary services. Patients must choose their own personal FPs, who is responsible for providing PC for their patients, including emergency care 24 hours a day provided by physicians working in rotation outside regular office hours. This requirement has had a great impact on both the quality and cost of health care. Most first-patient contacts are made by FPs, and continued good access is of the utmost importance. Low or unequal access results in low patient satisfaction. Previous studies have examined several factors affecting access: having a relationship with a PC source with characteristics of a medical center, the availability of timely and/or easy phone access, after-hours care, physician knowledge of the patient's medical history, adequate time allotted to consultation, the attitude on the phone of the doctor's assistant, patient opinion of FP treatment, waiting time, the ability to obtain an outpatient appointment for the same or following day, time spent in the waiting room, and seeing the same FP most of the time.

There are 7,153 physicians registered with the Medical Chamber of Slovenia. At the primary level, there are 1,057 FPs working at health centers and around 343 FPs in the form of independent contractors. The Health Insurance Institute of Slovenia (HIIS) concluded contracts with 1,784 providers: 224 public institutions and 1,560 concession-holders in 2011. The number of contractors fell by six in 2011 compared with 2010.

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ROTAR-PAVLIČ, Danica, SEVER, Maja, KLEMENC-KETIŠ, Zalika, ŠVAB, Igor, KERSNIK, Janko, BOERMA, Wienke. Do the experiences of patients of state-employed family physicians and concessionaires in Slovenia differ? = Ali se izkušnje bolnikov z zdravniki družinske medicine, zaposlenimi v javnih zavodih, in s koncesionarji v Sloveniji razlikujejo?. *Zdravniški vestnik*, ISSN 1318-0347. [Tiskana izd.], okt. 2015, letn. 84, št. 10, str. 670-678. http://vestnik.szd.si/index.php/ZdravVest/article/view/1108. [COBISS.SI-ID 32313049]

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Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

Slovenia have ensured that the migrants get the medical care that is provided by the medical teams in the reception and accommodation canters. This has been organized in cooperation with the health canters from individual regions. The coordination on the ground is in the hands of health canters closest to the reception canters; if necessary, other health canters in the vicinity are set in motion. Representatives of the Slovenian and Hungarian Caritas, volunteer health professionals and Doctors Without Borders are also engaged in providing medical care to the migrants on the ground. The head of a reception centre informs the nearest health centre about the arrival of the migrants. If it is not possible to assemble a medical team of professionals on regular duty or volunteer doctors, such a team is sent to the reception centre by the head of the emergency medical service. All persons who are assessed to urgently need medical help are examined. If there is a suspicion of any contagious disease among the migrants, the Epidemiological Service of the National Public Health Institute is activated. Migrants from the reception canters who are in need of emergency treatment in a healthcare institution are accompanied there by the medical staff. The health care workers attend to the reception centers always wen a new contingent of refuges was arriving the point and stayed there 2 to 8 hours. At the accommodation canters were the healt care providers present according the number of migrants there (Šentilj and Dobova 24 hours; Gornja Radgona and Lendava 4 hours per day and later on call if they were needed; Logatec and Vrhnika on call) If the staff was on call they manage the work additionally to their usual workload, but at the places were the hours were fix the work every day at the fix hours and were extra paid for their work in the receptions or accommodations canters.

Reference: http://www.policija.si/eng/index.php/component/content/article/13-news/1753-police-work-during-the-intensified-security-situation-caused-by-the-escalating-migrant-crisis-in-recent-weeks-explanations-and-answers

Different health workers had difference experiences. Some of them have witnessed good organization of work without problems with necessary equipment and logistics, while others mentioned inadequate organization and problems with medical equipment and other supplies. Here are two completely different experiences: "*My impression is the camp as a whole functioned perfectly and was very well organized, all services. I would say everything was perfect, as far as possible*" (HW6); "*In the camp health care was not adequately provided". There was something but definitely not enough for routine care standard for refugees, as we know it today*" (HW2).

160505_001 Interview (Vrhnika): "The Ministry of Health - when he came the first migrant wave - ordered the directors of the local health centers to organize the entire primary health care for refugees. This includes urgent medical care, the implementation of emergency medical aid and a continuing everyday health care. Which organizations were therefore involved: Health center Vrhnika. Then wen called neighboring health centers from our region, including the Health Centre and Ljubljana University Medical Centre. From civil organizations they were involved mainly the Slovenian Red Cross, Association of Fire Fighters Vrhnika and Caritas. In principle, we need two teams per day, this means two doctors and two nurses. We helped you with volunteers, including specialists pediatrics and trainees, who entered into our system as an additional physicians. We had an extended network. Mostly they were doctors and nurses from our health center, as well as dealers in our region, then we become a matter of expanding to other health centers. Figures I would not be able to tell. Probably it was a network of 40 people."

160501_004 Interview (Dobova) »At the beginning, approximately one week, we operate two technicians without a doctor on site. The police have not yet had established dispensaries. We work without doctors at the beginning. We did what was within our competence. "Load ang go" system. Then the system slowly began to develop and different doctors have come, we have had some volunteers like Doctors without Borders. We worked well with them. They came from different places, from different areas of family medicine specialists, internists, pediatricians, and some were also surgeons. But we would need more paediatricians. We had a good pediatrician who was trainee from Ljubljana – she has worked with us for one week continuously. Then we called around ... if anyone knew any doctor, he called him, if she or he can come to help. We did not have any psychiatrist. We would have to go to a psychiatrist because we were quite tired. There was no one who would deal with them via social care. We did not have any protocols at the beginning. Nothing. I, too, personally, I repeatedly called on the Ministry of Health and talked to them - they did not believe that such a situation. For all we used our own cars. We did a lot of kilometers."

160505_001 Interview (Vrhnika): We are providing primary health care 24 hours a day, but for this there was no need. Realistically speaking, there was no need. Our way of working was that we have adapted to the needs that stand out on the ground. We referred seriously ill patients to the clinical center in Ljubljana. Some children were hospitalized at the Clinic of Infectious Diseases because they were so dehydrated that otherwise would not survive. One of the children had a much osteosynthesis material inserted in the leg, which was damaged in the war. The child had wires in the leg for 7 months – this osteosintetic material should be removed after one or two months ... We

then arranged together with pediatrics and trauma specialists that they removed osteosintetic material. The child was a few days in the hospital, then returned back to the accommodation center. For refugees we have provided the same level of care as for our residents. As if they were our residents ... if they had to be moved to a secondary or tertiary level, they get referrals. **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
ATŠ interview (Logatec): "The Health Care Centre in Logatec established a well-functioning system of organized health care of migrants. Ten family doctors, nurses and paramedics who already regularly work in the call had been prepared to accept the increased workload, so the Health Centre Logatec from September to December 2015 organized a permanent medical standby. Notifications regarding possible new influx of migrants were received from the Civil Protection administration twice a day. In the case of the announced arrival of migrants a new group of doctors on call, along with the nurse or technician went to the accommodation center and then inspected all incoming refugees." The organisation shema of other centres is described in other part of the report. 160505_001 (Vrhnika) Interview: "GPs took over the entire health care refugee center, which meant that we had to provide medical care. In the first wave, especially for emergencies, in the second wave as well as a continuous treatment with prevention included. In the first migrant wave there was a day from 300 to more than 1000 (I think it was more than in 1100), the second migrant wave is approximately 150 refugees. They are the ones who have been staying for three weeks respectively. On average, we had somewhere between 15 to 20 medical treatments per day in the first wave, when there were very large, as well as 120 in one day. Given that we receive mostly families with children and the elderly, almost one third of children. According to sex but hard to say." References: (1) Report/Publication: Authors, year, name of report/article, link if possible (2) Web based report/article: Title, Link (3) Result from interviews, also quotes are possible (4) Result from participatory observations

Primary health care staff situation (numbers, capacity, payment, safety, …)?

If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

Centre	**Staff**	**Hours of health care providers presenc**
Dobova	GP and nurse, paramedics, Red Cross workers,interpreters	24
Vrhnika	GP, nurse, pediatrician, psychologist, interpreters	24 in of call commbination
Ljubljana	GP, nurse, emergency medicine, psychologist, interpreters	24 in of call commbination
Šentilj	GP and nurse, paramedics, Mobile Czech Republic Military Hospital, Red Cross workers, interpreters	24
Gornja Radgona	GP and nurse, paramedics, pediatrician, Red Cross workers, interpreters	4 every day
Lendava	GP and nurse, paramedics, Red Cross workers, interpreters	2-4 at the arrival time of refuges and every day on call if there were people at the centre
Postojna	GP and nurse, paramedics, interpreters	24 in commbination of call
Logatec	GP and nurse, paramedics, social workers, interpreters	24 in commbination of call

160501_002 Interview (Dobova):« If the health care team has to go on the field or in a case that there was only a team from the Red Cross – they always had phone numbers of doctors and nurses and they can call. But there was always one of the health technicians stayed in the center, we did not leave nonmedical staff alone. Regardless of external experts, we had a lot of Médecins Sans Frontières, a lot of doctors from other places from Slovenia came to help us. Voluntarily, really a lot of doctors." **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
ATS Interview (Logatec): "There is no initial health assessment for persons who applied for asylum. February 2016, the Government of the Republic of Slovenia due to the increased number of applicants for international protection activated contingent plan and as a branch of the asylum home also providing complex in Logatec. Eearly in March 2016 Logatec accepted the first 5 families. At the end of April 29 refugees were accommodated in an asylum home Logatec. They feel good, some of them have in the vicinity of the complex arranged garden plots, school-age children are already involved in a local primary school and is already starting to learn the Slovenian language. Health care is organised in the health center Logatec. When they need medical help, the head asylum home announce their arrival to medical personnel in Health Center Logatec. Social workers from the asylum home accompany the ill person to the medical center, where, if necessary, over the phone they contact the translator and thus agree on health issues and guidelines for treatment." References: (1) Report/Publication: Authors, year, name of report/article, link if possible (2) Web based report/article: Title, Link (3) Result from interviews, also quotes are possible (4) Result from participatory observations
How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators? **In every place (reception, accommodation) are present the translators, but not the cultural mediators or intrepreters.**

160508_002 Interview (Logatec): »Communication. Sometimes it has been difficult to explain where the dining room is, to translate what hurts and how. In principle, it was interesting, because the young or. minor were able to speak English much better than the older, including for example persons of 25 plus. So minors they also help with the translation. The main problem was the communication."
160429_002 Interview (Dobova): »The biggest challenge and thus an obstacle is because a refugee does not understand. In a case if a refugee does not speak English or speak very badly, and you are in situation that currently you do not have a translator available. It's really challenging because you do not know what and how to help him."

160501_005 interview (Dobova):«In the refugee camps the availability of interpreters and mediators was very scarce at the very beginning. With time, when things were more organized it was better. UNHCR, the Organization for Refugees United Nations High Commissioner for Refugees provided interpreters. They provide a lot of translators. In principle, they were primarily planned to help in police operations and people seeking asylum, to inform them. But they were also constantly available for health care. When there were large numbers of refugees - refugees themselves helped us if they were able to speak English. At the beginning, definitely a shortage of interpreters."
After the begging's problems with interpreters (lack of them), were later in every place the interpreters present, but not always in the appropriate number they were needed.

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

Biggest challenges and barriers for primary health care providers?

In our research we identified four problem areas: communication (language barriers); refugees' social deprivation and traumatic occurrences; negative attitudes among health workers and refugees; and cultural differences. Those categories are broad and comprehensive, and they include different problems we recognized though coding interviews.

Probably the biggest and most common were communication problems. Data obtained in some of the previous studies (e.g. 3) indicated that language barrier is a biggest obstacle for comprehensive health service provision for refugees. Our study showed that making a diagnosis, due to language difficulties, was real challenge for health workers. The latter were in permanent stress due to incomplete communication and possible wrong diagnosis or misidentified treatment of refugees that needed health service provisions.

Some interviewees outlined translators while other used different techniques to communicate with refugees. Present translators were mostly volunteers, which means health workers did not have translator as an integral part of their medical team. In that context some interviewees engaged "*Google translate and tried to pronounce some Arabic words*" (HW 6), other have tried to improvise and use "*arms and legs to explain something*" (HW 10).

Next problem was refugees' social deprivation and traumatic occurrences. Those people have come from war zones and besides medical problems they survived different war situations, which resulted in a social deprivation and traumatic occurrences. This was additional problem for health workers because people were therefore suspicious and introverted. Majority of interviewed health workers outlined greatest need of those people was psychological (moral) support, understanding, and a sense of security and acceptance. Most common diseases, injuries and other problems were: malnutrition, injured foot, diarrhoea and vomiting, respiratory infections and colds. For the majority of refugees medical treatment was less important that best illustrated by the statement of one of the interviewees: "*migrants are mainly healthy, but exhausted*" (HW 6).

The results of social deprivation and trauma experiences were negative attitudes among health workers and refugees. The latter did not want to be separated from the group; they have mostly rejected hospitalization and more detailed medical examination because of fear. Partly this could be also explained through cultural differences. Majority of refugees were Muslims from socially deprived parts of Syria, Afganistan and Iraq. According to their cultural heritage those people sometimes have different understanding of illness and treatment. Some of interviewees emphasized issues about privacy, family ties and ethical dilemmas (should they stay in the camp or should they go further; should they leave their children in a hospital etc.). All of this further hampered the work of health workers at the ground.

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

In Šentilj and Gornja Radgona we met some migrants they worked themselves like health care staff in land of origin, but we didn't documented them.

160429_002 Interview (Dobova): »I worked in Brežice and Dobova and I do not have any information about people who have applied for asylum and what their education."

160505_002 Interview (Logatec):"I think I did not have contact with any such person. So I do not know."

160505_001 Interview (Vrhnika):"This did not happen. Sometimes they are involved as interpreters, especially in the first period. I remember a veterinarian who was six hours with us, when we reviewed the people, because he knew Arabic and some small even medicine. Maybe this is happening now with what, who applied for asylum."

160501_002 Interview (Dobova):“ I remember at the beginning of anesthetists, father and son. But they two have been in Slovenia for a long time, so they come here to help. Others did not.”

160501_001 Interview (Dobova):“Among migrants, there were some doctors who then helped us with translations because there have not had enough translators. There were a father and son, father was anesthesiology specialist ... But they were not now a migrant, but already before.”

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

In Slovenia, we therefore once again demonstrated that we can be sympathetic and humanitarian, that we can stand together and help people in distress. We can be proud that refugees feel happy and retain fond memories of Slovenia.

1. Health workers have to be trained for mindful of refugee specific difficulties and barriers
2. The communication barrier is the biggest obstacle in the work with refugees on the ground and should be systematically solved.
3. Financing of the health care teams should be better defined and should be conducted on time.

The main problem area was communication between health workers and refugees. Other problem areas included refugees’ social deprivation and traumatic occurrences, negative attitudes among health workers and refugees and cultural differences. The European values, such as human dignity, solidarity, freedom, democracy and equality were tested when the migration flow began to increase. The fact is that national governments were not well prepared and/or did not show enough interest for the huge number of refugees that crossed the transit countries, which led to inefficient organisation and lack of human resources, medical equipment and other supplies. The health workers involved however have proven to be extremely philanthropic and provided great moral support. They served not only as medical professionals but also as psychologists and social workers. Refugees were proven to be friendly and grateful for the help they got, although they sometimes rejected hospitalisation and detailed medical examination because of fear and/or in order not to be separated from their families.

A6. Country Report Hungary

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 on HUNGARY(rev) – date 31st May 2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, HUNGARIAN National report for Deliverable 6.1

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Historical overview. Hungary and the migration.

After the 1st World War Hungary, previously a joint-kingdom of the Austrian-Hungarian Empire had been detruncated. While the country becomes independent again, most of the territories were lost. All of *Transylvania* went to the Romanian Kingdom, the Northern part of Hungary went to the freshly established Czechoslovakian Republic (*Upper-Hungary*) and the bigger part of the southern counties were occupied by the freshly created Yugoslavia, that was merged from Serbia, Croatia Slovenia, Macedonia and Montenegro. In this decade (1919-1929) the flow of Hungarian refugees from the occupied part of the country become a political and economical issue. The general population was very helpful toward the freshly arrived families.

In the 2nd World War Hungary, helped by Germany reoccupied these areas.

After the lost war, some of the Easter counties were occupied by the Soviet Union and other parts were annexed again to the neighbouring countries. Some part of the population went to Hungary again. The most serious and systematic repatriation was performed by the Czechoslovakian government, forcing ten-thousands of inhabitants of Hungarian origin to leave that part of Slovakia, which belonged earlier to Hungary. Based on governmental regulations, some of German-origin people (schwabisch) were forced to leave Hungary; most of them went to Germany (Bundesrepublik Deutschland)

During decades of socialist-and communist regime, a systematic migration was only in 1956, but out of the country and not within.

At the late 80s thousand of people of Hungarian origin escaped from Romania, where the Caucescu-regime followed a brutal policy, including repression of other nationalities. (In these decades, ten-thousand Saxon origin people moved to Germany based on the deal between the governments of Romania and Germany who paid for every refugee to let out from Romania). The actual Hungarian government opposed this incoming migration; it was not supportive toward arriving people of native Hungarian origin. The Hungarian population and individuals accepted this serious situation as reason for migration and helped the incoming people. They got job and accommodation as well.

The incoming migration of non-Hungarian people started in the early 90th as consequence of civil war when Yugoslavia disintegrated.

These were the first “strange” arrives (*Croatians, Kosovians*) while Hungarian also come from Serbia, families and young men who did not want to be recruited by the Serbian army.

In this time the government helped to solve this situation new camps were established and organized support was provided. The first refugee camp (Debrecen) has been established in this time

Since then, in the last 2 decades the numbers of people arrived in Hungary was manageable by the government, and by local authority and by the population as well. Asylum seeker was used as terminology, because almost all wished to remain in Hungary.

The Office of Immigration and Nationality (in Hungarian: ***Bevándorlási és Állampolgársági Hivatal,*** abbreviated later as ***BÁH***) was established in 2000. This governmental office coordinates every new citizenship application countrywide, closely supervised by the Ministry of Interior.

Results

Changes in 2015, thousands of migrant coming to Hungary.

In Hungary, the problem of migrants and refugees become an important issue mainly since 2015, when hundred-thousands of people came to Hungary.

It was unexpected previously that thousands of people were crossing the border that was not defended by soldiers or policemen; there were no fence or any technical barrier.

The government was also not ready to manage this emerging situation. Many “rightist” or nationalist politicians tried to influence the public media and thorough this, the whole population of Hungary.

By the middle of 2015, temporary residency places (public parks, around railway stations) were established spontaneously, mainly in Budapest had catastrophic circumstances regarding hygiene and personal care. Thousands of people spent open air nights, without housing opportunities.

Government was in delay to manage this humanitarian situation. It lasted weeks when police organized accommodations, establishing places and replacing shelters for a temporary stay of refugees.

Most part of the population was compassed when seeing women with newborns and taking small children. Thereafter many people become upset when media presented atrocities and violence when young refugee attacked the police.

It was a real fact that many Hungarian made their own business when taking the refugees with their cars toward Austria. Shop owners had also a big deal when sold their items, mainly foods and cigarettes at the highest price they could achieve.

(Hungarian Tax Authority regularly controlled the shop owners around cities where refugee stayed, whether they issue an invoice or receipt when selling items).

- Bicske
- Debrecen
- Körmend
- Nagyfa
- Vámosszabadi
- Békéscsaba
- Győr
- Kiskunhalas
- Nyírbátor

By the middle of 2015, almost all Hungarian camps were opened for refugees (see map). Four of them were a closed area, supervised by the police, for those persons who were ordered for expulsion by the authorities or curt. These persons did not get a permit to stay in Hungary and they had to wai for the transport to their countries of origin.

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

The **transit zones** are legal open points of entry into Hungary. They will be registered, they can claim asylum. They only stay for a short period there (hours, max. days), before they go to one of the centres. There are living containers also available for them in the transit zones.

The main types of reception centres: open (they can leave the centre whenever they want) and closed (they cannot leave the centre, maximum stay 12 months, mainly for detained asylum-seekers and for the majority who are people waiting for their deportation). Community shelter (semi-open camp): maximum stay 2 months, they can leave the camp during the day but must return before 10pm).

There were some changes last months. According to the latest official data and terminology, there are 3 main types of reception facilities: *Open reception centres*, *Closed asylum reception centres* and *Community shelters*.

Transit zone are: at *Röszke, Tompa, Letenye, Beremend.*

Open reception centres operate in Hungary (with a maximum capacity) in *Bicske* (439) and in *Vámosszabadi* (216).

Nagyfa (300) is the newest reception centre which opened on 12 January 2015, which was initially meant as a temporary facility but since September 2015 it is being used as a regular reception centre. The centre consists of heated containers. *Nagyfa* is located inside the territory of a penitentiary institution and it is far away from the nearest settlement.

Refugees how are accommodated in open camps have to register, they can apply for asylum. While it is an open camp, they can leave the camp and some of them really leave before the end of the asylum process.

Closed asylum reception centres operate in *Békéscsaba, Nyírbátor* and *Kiskunhalas*. They could be leave upon permission only.

The biggest reception centre in *Debrecen* was closed in October 2015 one new open centre just was opened in *Körmend.* There were approximately 200 people in *Körmend* in May 2016, the capacity can go up to approx. 300-500 people.

The **Community Shelter** in *Balassagyarmat* (111), co-operates with different societies, NGOs, charity, international, partner, local governmental and law enforcement organizations.

Among others with the Hungarian Red Cross, the Menedék as an NGO (Association for help of migrants, in the field legal assistance with the Hungarian Helsinki Committee).

This community shelter works for asylum seekers, persons tolerated to stay, persons in immigration procedure and foreigners who have exceeded 12 months in immigration detention, and now also receives beneficiaries of international protection.

The centres are managed by the **BÁH**. The reception centres operate financially under the direction of the Director-General as an independent department and perform their professional tasks under the supervision of the Refugee Affairs Directorate of the **BÁH**. Thus, only one central body is responsible for the financial operation and the professional duties of the reception centres. Nevertheless, NGOs who work in the field of asylum cooperate with the refugee authority in providing supplementary services for applicants. The **BÁH** coordinates their activities carried out in the reception centres.

Migrants asking for asylum at the border zones are kept inside the transit zones, unless they are exempted from the border procedure, whereby they are transferred either to the asylum detention centre or are directed to go to the open reception centres. Where the detention grounds do not apply, they are given a train or bus ticket and are taken to the closest station so as to travel to the designated reception centre. Those asking for asylum at the airport can stay in a small facility (maximum capacity of 8 persons) within the airport transit area up to 8 days.

Asylum seekers can also request to stay in private accommodation at their own cost; however, they are then not entitled to most of the material reception conditions.

As of 1 November 2015, there are 2 homes for **unaccompanied children** in Hungary. They are not placed together with adults but are accommodated in specialised structures. *Fót* is a home for unaccompanied children, which belongs to the Ministry of Human Resources.

Hódmezővásárhely is a small house for unaccompanied children maintained by a Catholic charity under a contract with the Ministry of Human Resources.

2016

The situation changed significantly in the last month. Hungary has erected a fence on the Serbian-Hungarian border and it stopped the movement of migrants in the country. People who crossed legally the border here are transported to the open camps. Most of them did not stay long here, they are moving toward Austria.

The Austrian government started controlling the border in the last months and they do not allow crossing persons without official documents.

Since last Autumn, refugees have chosen alternative routes, through Croatia and Slovenia. The direction of official transfers have therefore changed, busses and train, organized and financed by the government were taken persons toward Austria and the smallest part to the Hungarian camps.

It is planned erecting a fence between Hungary and Rumania as well, closing predictable alternative routes. Between Hungary and Croatia the border is supervised most seriously as on the Slovenian border. There are the first technical barriers between the countries of European

Union and “Schengen” countries.

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How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year?

The equipment was a little bit improved. Almost all centres provide a free wifi- network for inhabitants.

Meals are served 3 times a day, religious expectations are considered regarding food choices.

Most of the families are allowed to stay in common rooms, while independent asylum seekers are staying in bigger sleeping rooms. (more information was provided in our WP2 Local report).

In open camps, other items could be purchased in the nearby shops. There is an unofficial trade within camps; some are selling items for the rest, making good financial benefits for themselves. The homepage of BAH provide updated information for asylum seekers.

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March

2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?

This huge number could be only estimated. According to some observers and media sources, the overall number of migrants could have been above half million. There are no official estimation

available, while nobody counted it properly, only those who were officially transported by trains and busses. Approximately ¾ of them passed Hungary in 2015.

The available official data are presented below. These figures present the official data, issued by the BÁH. As seen, 95 thousand persons were allowed to stay legally in Hungary, temporarily for a limited periods or permanently.

Name of status	**State of 30/04/2016**
Immigration permits issued by the OIN	4 994
Permanent residence permits issued by the OIN	2 641
Residence permits	50 550
National residence permits	195
Registration certificates	116 190
Permanent residence cards	18 994
Residence cards for third country national family member of a Hungarian citizen	3 611
Residence cards for third country national family member of an EEA citizen	402
EC permanent residence permits	597
National permanent residence permits	12 982
Interim permanent residence permits	7
Having an identity card as refugee**	1 804
Having an identity card as subsidiary protected person**	1 366
Persons authorized to stay***	62

Total	**214 395**

***Data of Central Office for Administrative and Electronic Public Services; State of 31/12/2015,*

****State of 31/12/2015*

The situation in the camps at the moment (April 2016).

In the largest Hungarian camp (*Bicske*), 41.700 persons were stayed in the first quarter of 2016. The average *daily/night* number of inhabitants was 456; therefore it means an enormous turnover in this open camp, where people can walk out as well. In the *month of March*, the distribution of nationalities were (Afghanistan 727, Algeria 85, Bangladesh 22, Egypt 37, Eritrea 19, Iraq 652, Iran 351, Morocco 128, Pakistan 495, Turkey 40, Syria 198, Somalia 47).

These ratios reflect to the date of other camps, but no comparable to not-registered data of people who were not involved in the official procedures.

Health services delivery and expenditures in 2015

During the busiest days in 2015, some of the migrants needed medical services provided by hospitals and ambulatories of the National Health Insurance Fund (NHIF). There are no data how much expenditure was for OTC products and private medical providers.

It is visible that primary care was not significantly involved in the care of migrants.

NHIF expenditures 2015	**in Million HUF**
total expenditures	62.479
primary care	**19**
Inpatient care (hospital)	30.390
Outpatient care (secondary)	24.219
dialysis	2.748
drugs, medications, healing aids	4.078

exchange rate: 1 million HUF = 3200 EUR

How is Primary Health Care provided in your country in general?

Primary care in Hungary has been reorganized in 1992. The traditional service is provided by a one doctor (GP), one nurse system, based on a single handed practices of 6800 GPs. Half of them serve for an adult population, a quarter for children only and the last quarter cares a mixed population, from newborn to elderly. There are no group practices in Hungary. They mostly are working as private enterprisers contracted with the local municipalities for services and with the NHIF for financing. It is based mostly on capitations with other elements and small quality incentives.

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Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

Health services are provided in the official camps by doctors employed or contracted with the BÁH. There are also nurses and medical assistants as well. In some camps, NGOs provide specialists (paediatricians, gynaecologists, psychiatrists).

There is continuous access to medical care in all facilities (centres, shelters ...etc). There is a nurse 10 hours a day in *Bicske* and *Vámosszabadi*, who triaging the cases and she informs the GPs or paediatricians, who do surgery according to the needs (approx. 4-8 hours a day, sometimes more). There is access to urgent-emergency medical care 24/7, every day in the nearby location (village or city), if required.

The situation in the camps remained the same level, but more effort is needed by the staff because of the turnover of inhabitants. Recently, in the last month this turnover decreased. People who wanted to move to Western countries left and the remaining inhabitants asked for asylum or temporary permit for staying in Hungary.

Primary health care staff situation (numbers, capacity, payment, safety, …)

We do not have exact information about their payment, but were told unofficially that their payment is higher, when compared to other GPs, while all are below the average salaries of doctors in the western countries. The permanent or contracted staffs of each centre include 4-6 doctors, usually in daily changes, 2-3 in each shift, during the opening hours.

If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

The biggest challenges were defined as the cultural barriers and language barriers.

"There is continuous medical care, a nurse there for 10 hours a day available, the doctors seeing patient as many patients as necessary a day, from I see from 50 up to 200 patients a day, depending how many refugees need treatment. "

Experiences of volunteers who served in the middle of 2015 will be summarized later,

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum? In what way are these resources documented and used already?

"Approximately 1% in healthcare and primary care, about 2000 people last year, there was surgeons and whole surgical ward from Iraq, health masseuse, psychologist, nurse, and dentist. We could not get them involved in the care of the refugees, sometimes they did not tell us, what their job was."

Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?

Firstly, there is quick general health assessment in the transit zones, than another health assessment in the centres, for all migrants/refugees/asylum seekers. The health assessment includes more tests in the centres (blood test, X-ray, screening for infectious diseases, other investigations if necessary). The documentation is paper and computer based.

"They receive the same medical care, as the Hungarian population; there are also special operational plans, regulated by the National Public Health and Medical Officer Service. The care starts when they get off the bus-there is general health assessment, test for infectious diseases eg. , screening for parasites, x-ray, general health check-dehydration, malnutrition of if there is a need for hospital admission."

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?

The staff is usually helped by interpreters, who are available in all centres/camps for certain time if required, but not all the times (not day and night).

"There are native language interpreters, we (the doctors and nurses) also speak basic Farsi, Arabic.etc or English if they speak English. "

Biggest challenges and barriers for primary health care providers?

"Most of them never received any treatment from primary care in their country. Some of them don't cooperate and don't understand why these examination investigations needed."

Experiences of health professionals who worked in the summer of 2015 on voluntary basis.

They joined spontaneously to others providing humanitarian aid when governmental and official bodies did not. These happened mainly in Budapest around the railway stations where migrants stayed for days or often longer without any appropriate infrastructure.

There was a lack of professional organization while the Association of the Primary Care Paediatrician cooperated with NGOs and other charity organisations. People who lived in the nearby areas often taken alimentary and clothes, playmates for children.

They reported that paediatricians should be more professionally involved in any type of humanitarian aid, even organized by official bodies. They often claimed that governmental behaviour was not supportive. In theory, the so-called ambulatory log recorded the events, but because of the mass care, language barriers, access to information was communicated by generalising fear of the documentation was incorrect and superficial ". (by the volunteers, at the railway station transit zone). Most of the patients were young men, with women and children. Two doctors are worked usually together, a specialist and a trainee, helped with nurses, Red Cross people, in addition to Migration Aid volunteers.

Primary care profile cases have been seen: respiratory, enteric diseases, dermatological problems, mild traumatic injuries. Most of the refugees were young men, but there were, women and middle-aged ones, we have seen, although initially organized child care. 4 hours per day, alternating each day, we were on duty, we saw an average of 30 cases a day. Following the closure of some transit zones mainly helped organize workers involved in supplying financial assistance to Hungary, Croatia, Greece, between children of refugees, support groups activities." "…

"with the help of competent professional organizations care much more structured been able to provide"….

"Without public support, volunteer groups only unsuitable for the task".

"Stunned, we found the lack of child care professionals trained in collaborative, professional, voluntary (NGO) organization gained a lot of experience in care catastrophe. Equally strong, but the experience was a positive sign to help those who want a large number of refugees and their satisfaction section of the (then) behaviour and the results of their work."

Please, summarize the capacity situation and suggest a few recommendations.

The recent capacity of the Hungarian primary care is insufficient to manage a higher amount of patients, with different origin, having quite different cultural background, and high linguistic communication barrier.

If more people will arrive in Hungary their care should be much better organized and more financial resources will be needed. Beside this, more professional support is also requested, about never seen morbidities and developing communication skills with people having different languages.

Reference:

Kórász K. Asylum-seekers'mental and physical health problems: practices and recommendations. Orv Hetil 2016; 157(1):23-29.

Conclusion

The „migrant crisis“resulted big social, emotional, political and professional disputes in Hungary. Data and personal opinions, presented in this report could be diverse and we were unable to solve some of discrepancies. Government keeps these „crisis“always on the stage and politicians forced a national referendum about the management of deployment of upcoming refugees, supported by a visible part of the population.

We cannot predict what the summer of this year brings, perhaps other and bigger wave of refugees and asylum seekers.

In 2015, the medical care for refugees was provided mainly by volunteers and contracted staff in different camps. Hungarian primary care system was only partially involved in the migrant care and our colleagues need more professional help in this topic. Perhaps in the future they have to use new knowledge and skills.

Debrecen, 31th May, 2016.

A7. Country Report Austria

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) – Version 07/04/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Elisabeth Sophie Mayrhuber, Elena Jirovsky, Kathryn Hoffmann

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."

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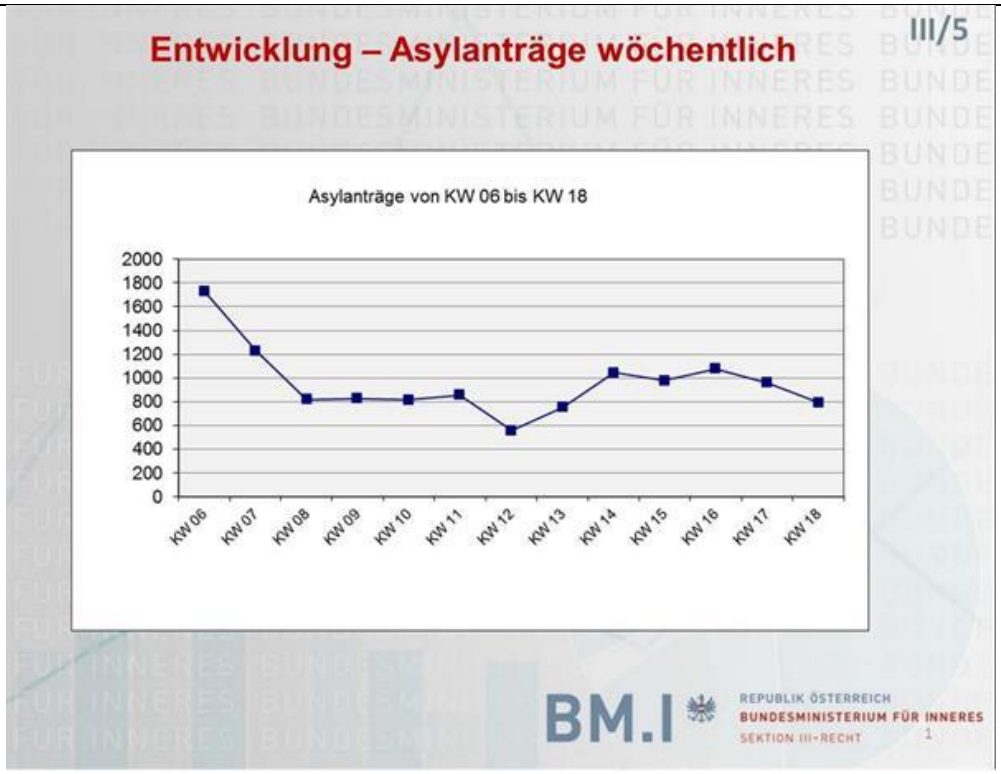
Results

The situation should be described like it is at the moment (March/April/May 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of April 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
As of March 8th the Western Balkan corridor has been officially closed for all refugees. The EU-Turkey agreement was signed on March 18th and intends for legal channels of resettlement of persons, for every Syrian being returned to Turkey, another Syrian from Turkey will be resettled to the EU directly (1). According to several humanitarian organisations the situation at the border between Greece and Macedonia near the village of Idomeni is disastrous, as thousands of refugees are waiting there (1). According to reports, on March 9th there were already approximately 14.000 people in the "camp", but more people are arriving every day. As "Europe's biggest favela" the Guardian reports on the camp's chaotic scenes, not only the hygienic situations is devastating also officials to medics warn of a health time-bomb (1). Humanitarian problems also deteriorate also in Greece as arriving refugees have limited options for onward travel and more and more persons are "trapped" in the country (1). The data on refugees who applied for asylum in Austria is provided through the MoI statistical recording. The department III/5 (asylum and alien matters) of the MoI reports that 793 asylum applications were registered in week 18 (02.05.-08.05.2016), after 961 asylum applications in week 17 (25.04.-01.05.2016), 1079 asylum applications in week 16 (18.04-24.04.2016), 977 asylum applications in week 15 (11.04.-17.04.2016), 1.045 in week 14 (04.04.-10.04.2016) and 752 in week 13 (28.03-03.04.2016) (1). The following graphic gives an overview of the weekly asylum applications from week 6 to week 18.



Detailed monthly records show that in March 2016 a preliminary total of 3.265 asylum applications were submitted, in February 2016 a preliminary total of 5.112 and in January 2016 a total of 5.951 asylum applications. Statistical records from 2015 show that 7.282 applications were submitted in December 2015, 12.079 in November, 12.288 in October, 10.666 in September, 8.556 in August, 8.802 in July, 7.682 in June, 6.405 in May, 4.038 in April, 2.941 in March, 3.283 in February and 4.129 in January 2015 (1).

How long an asylum application takes depends on different factors, e.g. the date of application, the place of application and the nationality of an asylum seeker, until a decision is made asylum seekers are entitled to receive care according to the Basic Welfare Support Agreement 2004 (1).

With regards to transit persons who travelled through Austria, numbers are only available from newspaper articles and NGO reports. On December 18th 2016 *the Standard* newspaper reported that according to the MoI more than 600.000 refugees travelled through Austria since 5th September 2015. The MoI ministerial spokesman Karlheinz Grundböck indicated that as of 18th December 2016 around 2.000 to 5.000 refugees would use Austria as transit country on a daily basis (2), however, these numbers were not confirmed anywhere else officially. The Austrian Red cross reports on January 25th 2016 that since September 4th 2015 about 730.000 persons have crossed the border

into Austria (1). According to UNHCR statistics from January 2016 until the end of March 2016 there were 114.124 persons arrivals to Austria recorded (1).

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(1) Report/Publication:

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Foitik, Gerry. 25.01.2016, Menschen auf der Flucht, Flüchtlingshilfe, Österreichisches Rotes Kreuz, Power Point Präsentation (only accessible internally)

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Europe Refugee and Migrants Emergency Response – Daily Estimated Arrivals per Country – Flows through Western Balkan Route. 1. October 2015 – 23 April 2016. UNHCR.

(2) Web based report/article:

APA/derStandard Newspaper, 18.12.2015, „85.000 Asylanträge in Österreich, weltweit so viele Flüchtlinge wie nie", www.derstandard.at/2000027777432/Bereits-rund-85-000-Asylantraege-2015-in-Oesterreich, (last access: 12.05.2016)

Main countries where refugees and other migrants come from?

Based on the data provided by the MoI the majority of refugees who applied for asylum between January 2015 and February 2016 in Austria came from Afghanistan (28.070), Syria (27.111), Iraq (14.611), Iran (4.410) and Pakistan (3.303) (2).

	2015												2016	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Afghanistan	677	433	582	772	1506	1834	1781	1892	2314	3999	5516	3169	2037	1558
Syria	894	665	836	1018	1822	2429	2429	2694	3703	3796	2833	1529	1272	1191
Iraq	291	204	311	606	1138	1268	1268	1283	2763	2171	1482	789	524	513
Iran	104	70	86	111	98	120	212	158	320	781	757	615	599	379
Pakistan	82	67	97	207	329	415	548	948	120	71	67	72	109	171

The chart is based on the numbers by the MoI on persons who applied for asylum in Austria; there are no numbers available on countries of origin of transit refugees.

References:

(2) Web based report/article: Title, Link

MoI, 2015, Vorläufige Asylstatistik Dezember 2015, http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/Asylstatistik_Dezember_2015.pdf; MoI, 2016, (last access: 12.05.2016)

Vorläufige Asylstatistik Februar 2016, http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/Asylstatistik_Februar_2016.pdf, (last access: 12.05.2016)

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

In the case of Austria we differentiate between facilities that are intended for refugees who seek asylum in Austria such as federal refugee centres, initial reception centres, distribution centres, refugee camps and on the other hand facilities, which primarily aim at transit persons, such as emergency shelters, transit centres and other temporary emergency structures. Additionally, there are also detention centres, for persons who receive a negative asylum decision and are obliged to return to their country of origin.

It is important to note that we found different organisations also using different terms for respective centres/ camps/ shelters, and as the following description shows a clear distinction between such facilities sometimes proves to be difficult since facilities were also converted from (temporary) emergency shelters to longer-term facilities for persons who then applied for asylum. From a procedural point of view the asylum procedure is a multi-stage process, at the beginning at the initial registration (at an initial reception centre or a distribution centre or at a BFA site) the person gets a procedure card (*Verfahrenskarte*, a green coloured card). After the person is admitted to the asylum procedure he/she gets a white card, an asylum application card, which is a residence permit for the length of the asylum proceeding.

As of May 2016 there are five federal refugee centres in Austria (*Bundesbetreuungsstellen*), whereof two are located in Lower Austria Traiskirchen (Bundesbetreuungsstelle Ost) and Reichenau an der Rax (Bundesbetreuungsstelle Süd), and two in Upper Austria Thalham in Str. Georgen in Attergau (Bundesbetreuungsstelle West) and Bad Kreuzen (Bundesbetreuungsstelle Nord), and in Vienna Alsergrund (Bundesbetreuungsstelle Mitte). Two of these federal refugee centres also function as initial reception centres (*Erstaufnahmeeinrichungen*), and additionally, there is an initial reception centre at the international airport Vienna Schwechat, which is directly run by the Federal office for Immigration and asylum (.BFA), an authority directly reporting to the MoI and the final authority conducting first instance asylum procedures (2). Until summer 2015 the initial reception centres were responsible for the registration procedures for refugees who want to seek asylum in Austria. Refugees stayed there for the time that was required for checking if a person is admitted to asylum procedures in Austria (Dublin III). An asylum application can also be submitted at any police department or police officer and the first inquiry takes place. In the admissibility procedure
an examination takes place to find out whether a person is admitted to the asylum process in Austria (Dublin III) (1).
Around summer 2015 with the increasing number of refugees coming to or transiting through Austria, seven so called distribution centres (*Verteilerzentren*) were established in several federal states, in order to disburden the two overcrowded initial reception centres Traiskirchen East and Thalham West. Not all of these distribution centres were newly established, some existed already as federal refugee centres and were converted into distribution centres. The distribution centres are set up by the federal government at the following locations: Bad Kreuzen (Upper Austria), Vienna Alsergrund/Nussdorferstraße (in charge of Burgenland and Vienna), Traiskirchen East (Lower

Austria), Gaisberg (Salzburg), Innsbruck (in charge of Tyrol and Vorarlberg), Fehring (Styria), and Ossiach (Carinthia). Through the adoption of a new law Fremdenrechtsänderungsgesetz 2015 (BGBI. I Nr. 70/2015) asylum seekers do not need to be initially registered in one of the two initial reception centres, but can directly be brought to any of the distribution centre, where the first registration, first inquiry and the initial health assessment takes place. After the admissibility procedure, which should in principle only take 2 days, but can in fact take up to several weeks, the refugee either enters the basic welfare support scheme and is brought to a permanent refugee camp, or, if it is decided that Austria is not competent to examine the application of asylum, the person is transported to the initial reception centre Traiskirchen or Thalham, and is brought back to the country where he/she was first registered (Dublin III). The MoI reports that currently (May 2016) asylum seekers are only transferred to one of the initial reception centres if it is expected that another EU country is responsible for the asylum proceedings (1) (Dublin III) or if the person is identified or presumed to be an unaccompanied minor (1).

In addition to general federal refugee centres there are also UMR federal refugee centres (specific focus on unaccompanied minor refugees) (UMF-*Sonderbetreuungsstellen*), these are also supervised by the MoI. As of January 15th 2016 there were 8 UMR federal refugee centres operated by the ORS Service GmbH: SBS Korneuburg, SBS Hörsching, SBS South-Reichenau an der Rax, SBS Mondsee, SBS Finkenstein, SBS Steyregg, SBS Lower Austria-Mödling, SBS Styria-Spital am Semmering (1.9). However, there are also 5 federal refugee centres, which are not designed and identified as UMF-federal refugee centres but still accommodate unaccompanied minors. According to the ORS Service GmbH these are the following federal refugee centres: Leoben, Magdeburg, the centre Traiskirchen East, Schwarzenberg-Wals-Siezenheim and the federal refugee centre Graz/Andritz (1). It is assumed that the centre East-Traiskirchen was in the meantime converted into an UMR federal refugee camp, details on this are unknown.

Asylum seekers (except they are identified as or assumed to be unaccompanied minors), who are admitted to the asylum procedure in Austria, ought to be directly transferred from a facility by the federal government (distribution centre) to one of around 700 different refugee facilities in one of the nine provinces. These facilities are thereinafter referred to as refugee camps, which can be differentiated in different types of camps with different kinds of places. They are either categorized as a) organized refugee camps or as b) private refugee accommodations. In the case of organized refugee camps, the provincial authority makes an agreement with an NGO, an association or a

business either under a full-supply contract or under a self-supply contract. The organized refugee camps are differentiated as either UMR places, as places solely for women (with children) or for men, or as places for families. In each province a different official authority has an overview of the different capacities of places (3). In the case of private refugee accommodations asylum seekers themselves search for an apartment and sign a tenancy agreement (3).

The asylum seekers staying in either one of the aforementioned forms of camp are entitled to receive basic welfare support called "*Grundversorgung*". The provisions include food supply, accommodation, health insurance, medical services, services for persons in need of care, clothing, information and legal advice, interpreting costs, leisure activities, pocket money, school supplies, special demands, care for unaccompanied minors, costs for transport, German courses, funerals as well as administrative costs (1). The Basic Welfare Support Agreement was contracted between the federal government and the nine Austrian provinces, and regulates the basic welfare support scheme "Grundversorgungsgesetz – Bund 2005" (BGBI. Nr. I 100/2005 idF BGBI. I Nr. 122/2009). Thus, the Basic Welfare Support Agreement defines the kind of reception conditions and maximum allowances to be provided, also the special conditions for UMRs are therein outlined in Article 7 and Article 9. The provisions are transposed into the respective provincial laws as well as the Federal Government Basic Welfare Support Act. According to Article 5 of the Basic Welfare Support Agreement in each province, a federal government/ -province government –coordination council has been set up, which coordinates the interpretation and implementation of the Basic Welfare Support Agreement (1). Based on the Federal government-Provinces-Agreement various NGOs work on a contractual basis for the federal government/provinces, and provide mobile social support services for asylum seekers both hosted privately and in organised camps (3).

The provinces are responsible for the operative work (finding places in refugee camps). The federal government refunds 60% of the costs for the camps while the other 40% comes from the province budget (3: Interview 6, stakeholder). This 60:40 distribution is valid for one year of basic welfare support, if there is no asylum decision reached after 12 months procedure the federal government refunds 100% of the costs to the provinces. While asylum seekers are then in this basic welfare support scheme in one of these refugee camps, a comprehensive inquiry is made by the Federal Office for Immigration and Asylum (BFA), which then will ultimately lead to a decision upon the asylum claim. In January 2016 there were 85.000 asylum seekers in the basic welfare support scheme in Austria (1) housed in various different forms of refugee camps.

In terms of provision of refugee camps a huge political debate between the federal government (*Bund*) and the provinces (*Länder*)- proceeded in Austria and intensified in summer 2015. Several provinces did not provide/ refused to provide enough refugee camp facilities or spaces for setting up refugee camps. On August 18th 2015, a new constitutional law was adopted in Austria, which now provides the federal government with a right to house refugees in the provinces in federally owned buildings (1). Thus, facilities-, such as barracks etc., that are owned by the federal government can be opened up for refugees to be accommodated without the consent of the province – provided that the number of asylum seekers is not yet equalling the benchmark of 1,5% of the resident population (1).

We found that the capital city Vienna, which at the same time is a province, accepts a much higher quota of asylum seekers in refugee camps than all of the other provinces. As of April 5th 2016 a total of 21.100 refugees were in the basic welfare support scheme in the capital city (1). In May 2016, the FSW reported that in Vienna currently 56% of the asylum seekers in the welfare support scheme live in organised refugee camps (about 9000 persons), and 44% of asylum seekers live in privately organised accommodations (3). Before the summer 2015 a much larger number of asylum seekers lived in privately organised accommodations but due to the housing shortage in the capital city, private accommodations become increasingly hard to find (3: Interview 6, stakeholder).

As of April 6th 2016 there were currently 4890 asylum seekers in camps in Salzburg, whereof 323 were located in federal refugee camps (*Bundesbetreuung*), which also include distribution centres (1.). In Vorarlberg, there are 3.820 refugees accommodated in 558 camps, on average 40 continue to arrive on a weekly basis as of beginning of April (1). In Lower Austria, there are currently 15.200 persons in refugee camps, out of which 11 camps are container villages (2). From Upper Austria, it is reported that 12.438 places in refugee camps are available. Additionally it is noted that 3.900 places in transit quarters are available, however these are not counted as permanent camps (1). In Styria, about 12.000 asylum seekers are in permanent camps (2). No reliable data was found on asylum seekers accommodated in refugee camps in Burgenland, Carinthia or Tyrol. Overall, the exact number of refugee camps existing all across Austria remains relatively due to the different responsible authorities on a federal and a provincial level. Furthermore the number of camps is constantly changing with the changing number of asylum seekers as decisions on asylum applications are made. The basic welfare support scheme also regulates that if the decision on asylum applications is positive, a person can still stay at the refugee camp within the basic welfare support for up to 4 months (3).

Unaccompanied minor refugees are admitted to the asylum process in Austria and are assigned to UMR camps in the provinces. There they are accommodated in three different categories of reception facilities, depending on the degree of care and supervision they need (1: cf. Koppenberg 2014). The facilities are apartment-sharing groups, residential homes, or supervised accommodations (Art. 7 para 1 and 2 of the Basic Welfare Support Agreement). According to the UMR report 2014, the majority of facilities are apartment-sharing groups (1: cf. Interview Glawischnig, in: Kloppenberg 2014). The UMR camps are refugee camps which are also provided and organised by the provinces with special arrangements. Specific accommodation and reception arrangements are provided for unaccompanied minors, such as material reception conditions, care supervision and health care. However, these arrangements differ for unaccompanied minors who are covered by basic welfare support and for those who are in care of the Children and Youth Service (1: cf. Koppenberg 2014: 50). Exact numbers on UMF camps in the different provinces was equally impossible to obtain.

After an asylum seeker gets a negative decision on the asylum claim he/she can file a complaint against the decision, yet after it is final and negative the person has, under certain circumstances the obligation to leave. In this case he/she is admitted to one of the 18 police detention centres across the provinces. These detention centres are administered by the federal government (MoI) whereof 17 independent police detention centres and one sole detention centre in Vordernberg exist. The 17 police detention centres hold detainees who were charged with administrative penalties, while the detention centre Vordernberg in Styria is in principle also a police detention centre, but exclusively designed and built for detainees pending deportation after a negative asylum procedure, thus holds a special position. The detention centre Vordernberg is officially subordinate to the Styrian provincial police headquarters (*Landespolizeidirektion*) and was opened in January 2014.

Emergency shelters/ transit centres: Emergency shelters/ transit centres are primarily intended for transit refugees and emergency situations.

> *"There are shelters which were set up in the course of the transit refugee situation. Thus between September 4th and December 9th, or 1st [2016]. The shelters were set up because the people who were fleeing and had the goal to go to Germany, Sweden or wherever, could often not immediately travel further to Germany, but were forced to spend one night in Austria. Either because the transport capacity was not enough to get them to Germany or later because the German authorities only accepted a*

certain quota of people in 24 hours. The shelters were set up just along the routes." (Interview 6, stakeholder)

In principle, a division between disaster relief (emergency shelters and transit centres) and refugee camps (described above) that are formally intended and legally required for asylum application proceedings (initial reception centres and refugee camps/*Grundversorgungseinrichtungen*) is essential. The Austria Red Cross (ARK) representative explained that shelters were also set up in existing buildings, which were more or less suitable for this purpose, such as vacant office buildings, commercial properties, shopping centres, sports halls, vacant shopping halls, or other vacant often federally owned buildings, often with a very short lead time of only several hours (3). Furthermore, shelters were set up as tents directly at border crossings (*Grenzbetreuungsstellen*). The emergency shelters/ transit centres are usually characterised by a short duration of stay. Persons stay there only until onward transport continues, therefore, the emergency shelters are only equipped for one night stays (3). It was explained that the Red Cross made a distinction between transit centres which were only suitable for one night and transit centres which were suitable for up to 3 nights, as longer backlogs occurred (3). During 2015 and 2016, various emergency shelters were set up and run by different organisations, or as a collaboration of different organisations. About 80% were set up and run by the Austrian Red Cross, the rest was set up and run by the Samariterbund, Caritas, Diakonie and other NGOs (3). In order to coordinate emergency shelters/ transit centres and adapt to the changing situation. The ARK set up a sort of core coordination team in Inzersdorf, which coordinated transport and free shelters, capacities of the regional associations from September until December 2015 (3).

Around 80 emergency shelters/ transit centres were set up in Austria along the transit routes, either directly at border crossing points, such as e.g. Nickelsdorf at the Hungarian border in the east, Spielfeld at the Slovenian border in the south or around Rohrbach at the north-west of Austria at the German border. Obviously the emergency shelters were set up according to the number of people in transit and because the situation was very dynamic the setting up of emergency shelters was run flexible and according to demand. Due to the political changes the hot spots shifted over time. For example while the region around Nickelsdorf was the main emergency hot spot in September 2015, after Hungary closed its border the emergency shelters in and around Nickelsdorf (e.g. Nova Rock) were shut down. In the period thereafter the border crossing point Strass/ Spielfeld in Styria became the central hot spot in Austria (Oct, Nov, Dec, Jan). As of March 31st also the last emergency shelter in Styria, the Euroshopping-Hall, which has a capacity of 2000 beds, was put on stand-by-status. The other two larger emergency shelters in Styria (Schwarzlhalle in Premstätten

with a capacity of around 1.000 beds, and the Bellaflora hall in Feldkirchen with a capacity of 800 beds) were also closed in the beginning of 2016. In Bad Radkersburg, another entrance hot spot at the Slovenian border, emergency shelters were built up in tents, these were also closed after transit refugees stayed away (unclear on what date exactly closed). In the province of Salzburg, three emergency shelters were set up, and all of them are already closed. They were located at the main train station (closed at the beginning of November), at the old Asfinag-Autobahnmeisterei (closed on March 21st 2016) and at the old Zollamtsgebäude (closed on December 18th 2015) which was close to the border from Salzburg to Freilassing in Germany. On peak times up to 3.000 persons spent the night in the emergency shelters in Salzburg (1). In Vorarlberg, Austria's most western federal state, one refugee emergency shelter exists, which, however, has never accommodated any refugees until April 2016. Its capacity amounts to 200 persons (1). In Carinthia, three emergency shelters/ transit camps were set up that accommodated 1.500 refugees on peak times, the Dilling-Hall in Klagenfurt with a capacity of 1.000 persons, and two halls in Villach, all of which were closed in the first couple of months of the year 2016. In Upper Austria, several emergency shelters were set up, some of which were entirely removed, while others still exist but are empty. The shelter in Rohrbach was closed, in Braunau there are still two tents, which are not operating, also in Schärding there is still a built up tent (1). The Postverteilerzentrum in Linz was put up for a capacity of 900 persons and was now decreased to a capacity of 200 persons (2). Equally in Tyrol, the emergency shelters for refugees are not accommodated at the moment; their capacity is 400 persons (2). According to the *Fond Soziales Wien* (FSW) there are 25 emergency shelters still operating in the capital Vienna as of April 6th 2016. They provide a maximal capacity of around 6.000 places, whereof 4.200 are still currently occupied by asylum seekers who have not yet admitted to a refugee camp. As these emergency shelters were set up as temporary facilities they are actually not adequately equipped for long term stays for people who applied for asylum (3). In Vienna these emergency shelters continually close one after the other and as soon as a permanent refugee camp place (*Grundversorgungseinrichtungs* place) is made available, the person is transferred to the permanent refugee camp. In other cases emergency shelters were adapted and rebuilt until they fitted the standard of (permanent) refugee camp places (3). These transition from emergency shelters into refugee camp spaces occurs gradually (3). In Vienna, two of the largest emergency shelter/ transit centres that were set up were the Dusika Stadium and the nearby Sport and Fun Halle; both first opened up in September 2015 as emergency shelters mostly for transit refugees. Persons would only stay there around 1 night or 1 to 2 days and then continue to travel further to Germany,

however, also people who applied for asylum in Austria and followed the proceedings described above were sheltered there as permanent refugee camp places were unavailable. And although right from the beginning, the Dusika Stadium was set up as an interim solution and as a transit centre, it was reported that it became a permanent shelter for more than 300 asylum seekers who live there since November 2015 (1).

The Austrian Red Cross also set up 6 emergency shelters in Vienna, some of which are now operated as permanent centres, PWH Baumgarten Pav.6, Leystraße 2, Vordere Zollamstraße (opend in September 2015 and will close on May 31st 2016), Kurierhaus (was set up as transit centre, but some persons stayed there for several months), Primavesigasse (used as transit centre for up to 160 persons which already applied for asylum), Gasgasse (transit centre opened December 1st 2015 and closed 14th March).

The Samariterbund ran the emergency shelter/ transit centre Unionsstraße in Upper Austria (opened 5th of September 2015 and closed 30th of March 2016) where up to 450 people were housed daily, other locations were the main train station in Linz and others. In total the Samariterbund estimates to have cared for about 50.000 refugees, the shelters were run by employees and volunteers (2).

NGOs and aid organisations (Red Cross, Caritas, Diakonie, Hilfswerk, Samarterbund and Volkshilfe) highly criticise the fact that huge numbers of asylum seekers are still housed in emergency shelters although they ought to be in refugee camps. On December 15th 2015 it was reported that around 7.000 refugees still lived in emergency shelters in Vienna (2). On April 13th 2016, only 4200 persons were reported to still live in emergency shelters (2). The number continually decreases as more and more refugees are accommodated in permanent camps that fulfil the standards for being such a camp according to the Basic Welfare Support Agreement. The housing shortage is particularly severe in Vienna, on the one hand this province has the highest quota of asylum seekers in refugee camps and on the one hand a large number of persons, who gained the refugee status or subsidiary protection status, decide to move to Vienna (3).

During autumn 2015 and beginning of 2016, especially train stations turned out to be important hubs mainly due to the high number of refugees passing through Austria. Therefore, various transit structures were set up at highly frequented train stations. In Vienna, at the Westbahnhof (literally the Western train station), the Caritas provided and organised emergency relief for the arriving refugees. The refugees received food and clothing, and basic medical care was organised. A huge

number of volunteers were mobilised. They made donations, such as clothes, toys or food, assisted with distributing food and with arranging and distributing the aforementioned donations (1). At the Hauptbahnhof, the main train station Vienna, the emergency relief was exclusively provided by a group of volunteers, who then founded the politically independent association "Train of Hope" (2). The association received donations, collected and organised food and clothing, but also organised basic medical care for arriving refugees on transit to Germany. Both train station transit centres in Vienna ceased their work when less and less refugees were passing through Austria via Vienna. Other temporary transit structures were set up at the train station in Linz, the train station in Salzburg and the train station in Graz, these were often initiated by volunteers who brought and organised donations.

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How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention

centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

The capacity and the operation of the above described facilities for refugees vary. As by Art. 3 para 5 and Art. 4 para 2 of the Basic Welfare Support Agreement the federal government as well as the provinces can outsource these provisions of basic welfare support services to companies, NGOs and other institutions. The majority of provinces have outsourced the basic welfare support to NGOs and church-based organisations (1: cf. Interview Glawischnig, in: Kloppenberg 2014). In 2010, the federal government, the MoI has contracted a private company, the ORS Service GmbH, to provide health care and other support services in the federal refugee centres, the initial reception centres, the distribution centres and the UMR federal refugee centres since 2010. The ORS Service GmbH thus operates on behalf of the federal government and the MoI; in some cases also on behalf of some individual provinces (at provincial level) (2).

According to the ORS Service GmbH website the company is currently in charge of 34 facilities (2).

	Type	Level	Place/ Name
1	distribution centre	Federal government	Salzburg/ Gaisberg
2	federal refugee centre/ initial reception	Federal government	West/ Thalham
3	refugee centre	Federal government	Tyrol
4	refugee centre	Federal government	Styria
5	federal refugee centre	Federal government	South/ Raichenau an der Rax
6	federal refugee centre/ initial reception/ distribution centre	Federal government	East/ Traiskirchen
7	refugee centre (special)	Federal government	Lower Austria
8	refugee centre	Federal government	Erdberg
9	federal refugee centre/ distribution centre	Federal government	Mitte*
10	federal refugee centre/ distribution centre	Federal government	Nord/ Bad Kreuzen*

11	refugee centre (special)	Federal government	Upper Austria
12	refugee centre	Federal government	Hörsching
13	refugee centre	Federal government	Linz
14	refugee centre	Federal government	Mondsee
15	distribution centre	Federal government	Innsbruck/ Tyrol
16	refugee centre (special)	Federal government	Ledenitzen, Finkenstein
17	refugee centre	Federal government	Villach
18	distribution centre	Federal government	Kärnten, Ossiachersee
19	distribution centre	Federal government	Steiermark, Fehring
20	refugee centre	Federal government	Klingenback
21	refugee centre	Federal government	Eisenstadt
22	refugee centre	Federal government	Gaboikovo
23	refugee centre	Federal government	Magdeburg, Klosterneuburg
24	refugee centre	Federal government	Salzkammergut, Ohlsdorf
25	permanent camp	Province level	Haus Bildgasse, Götzis
26	permanent camp	Province level	Haus Mösleweg, Dornbirn
27	emergency shelter	Province level	Krumpendorf
28	permanent camp	Province level	Haus Graz
29	refugee centre	Federal government	Althofen
30	refugee centre	Federal government	Steyregg
31	refugee centre	Federal government	Korneuburg
32	refugee centre	Federal government	Schwarzenbergkaserne
33	refugee centre	Federal government	Postalm am Wolfgangsee
34	refugee centre	Federal government	Nofels

* both were federal refugee camps before they were converted to distribution centres. (1)

The two initial reception centres have different capacities: Traiskirchen is the largest with about 1500 to 1800 places, while Thalham has about 120 to 150 places (1). The two initial reception centres reached their capacity during the summer months of 2015. With 3.800 asylum seekers Traiskirchen was severely over-occupied reached; up to 1.600 people were housed in tents (2). Extra tents were also set up in the second initial reception centre Thalham. As of May 14th 2015, Thalham accommodated around 200 asylum seekers and additional tents were set up close to the site. These tents were removed around July 2015 and distribution centres were occupied to receive asylum seekers. Currently, it is unclear how the capacity of the two initial reception centres is utilised.

The initial reception centres were over-occupied and received huge media attention, therefore, the MoI converted several federal refugee centres into distribution centres and set up new distribution centres in the provinces. Exact capacity of the distribution centres are as follows: Bad Kreuzen 180 beds, Vienna 150 beds, Traiskirchen EAST 180 beds, Gaisberg 160 beds, Innsbruck 200 beds, Fehring 150 beds, and Ossiach 200 beds (1).

It was impossible to get information about the exact capacity of the remaining federal refugee centres because the MoI did not respond to email inquiries and the question for an interview (3).

During an interview, the Red Cross representative reported that the distribution centres currently have free capacities after the influx of refugees stopped with the closing of the Austrian borders and the deal between the EU and Turkey (3).

For UMFs, the Traiskirchen East facility has specific divisions: male minors above the age of 14 are accommodated in a separate wing of the building (referred to as “house 5”), while male minors below the age of 14 and female minors are accommodated in a designated wing for women (referred to as “house 8”) (cf. Interview Malz, in: Koppenberg 2014). Exact numbers on the capacity of Traiskirchen for the UMFs or the capacity of other UMF federal refugee centres were not available.

The detention centre Vordernberg has a capacity of 200-220 persons covering an area of 9.500 square meters. It is operated by the MoI (1). Since its opening in January 2014 it was frequently in the news because its low level of utilisation and its high personnel costs (2). Towards the end of 2015 and the beginning of 2016 newly arrived refugees were accommodated there up to a maximum of 2 days (2).

The minimum standards for accommodation in refugee camps and UMR camps, including their capacity, are defined in the Basic Welfare Support Agreement (*Grundversorgungsvereinbarung* Art. 15.a B-VG, BGBl. I Nr. 80/2004). The agreement refers to different requirements and can vary slightly

in the different provinces. For instance, it ensures that a central point of contact is established in every province: in Vienna it is the Mariannengasse, on behalf of the Fond Soziales Wien it is operated by the Caritas; in the other provinces the central point of contacts are often integrated in the provincial government departments. Generally, in each case before opening the location for camps are checked if they meet the minimum standards. According to a Red Cross documentation, a camp location has to fulfil space requirements (per person/ child about 4 m^2, and one bed per person/ child). It has to have adequate sanitary facilities (per 20 persons one toilet is required; additionally 1 urinal per 15 men; sufficient toilet paper; soap and disposable towels have to be provided; per 25 persons there has to be 24/7 water supply; per 20 persons one shower has to be provided; per 20 persons one washing machine has to be provided), relates to food (there should be kitchen facilities for the refugees to prepare their own food), fire protection needs to be available, as well as communication facilities, in particular internet access points (1). In all camp locations, the accommodated refugees should clean the facilities and organise a cleaning plan by themselves (1). This list of requirements provides only an overview (1). According to one of the interviewed stakeholder, the list of criteria for minimum standards for accommodation of refugees in permanent camps varies in each federal state (3).

The number of personnel that has to be present in the camps depends on the nature and the size of the camp, from 50 people onwards one permanent staff has to be present in the camp (3). There is no nationwide standard. Large privately run permanent camps often employ staff themselves and also offer social support services for the asylum seekers (3). In smaller privately run camps often NGOs provide the necessary social support. For example, mobile teams visit the camps on a regular basis (3). These organized refugee camps are supported by the different social service organizations of the different provinces. The camp administration also administers the monthly allowance and assist with immediate question on social services. In the section below (‘Primary Health care staff situation,. If there is no…’) there is a detailed description of the organizations and the kind of mobile social support services they provide in the different provinces.

During the recruitment for the PLA-Sessions for WP2, we visited three refugee camps, one was run by the Caritas, and two by the Arbeiter-Samariterbund (4). Each camp had a form of reception desk or administrative office where staff in charge provided support services, information and logistical support. For example, according to the head of one of the houses of the Arbeiter-Samariterbund, the facility, which still was considered an emergency shelter, housed 257 people at the point of our visit. There were approximately 100 people more at the time of opening in October 2015. However, people

left and returned to their home countries or moved to other facilities. Two floors of the building were reserved for families, who each had their own bedroom and some of them also their own bathroom facilities. One floor of the building was reserved for male refugees, who then shared the rooms. The camp had 15 staff. There was a laundry and the NGO was in the process to set up kitchen facilities in each floor. A fitness room had already been established, as well as a playroom for children. The staff planned on organizing gardening on the surrounding property. Various courses took place in-house. The other camps we visited differed in terms of leisure facilities and room size due to the conditions and location of the building used for camp purposes (3, 4).

In terms of emergency shelters/ transit centres the capacity is based on the capacity of the location and the number of persons who are in need of emergency shelters/ transit centres. One GP who was actively involved in the transit centre along the German border reported the following:

> *"The decisions are made from one day to the other – there was no plan behind it. The ministry took the easy way out. They called those responsible and said okay we need within 1 to 2 days a transit centre and then it continuously grew. And the police got orders and the Red Cross was commissioned, and then they said this, this, this has to happen and has to be organised. You never knew how many would come […] busses were directed from Spielfeld according to free capacity […] it was very improvised." (Interview 3, GP)*

According to the Austrian Red Cross the personnel requirement during set up/registration is 1:10 and in operation it is 1:20 – 1:50 (1). In personnel intense phases this personnel requirement is often covered through volunteers but should soon be covered by professional staff, while continuous support through volunteers and "Team Austria"[9] members is advisable (1). The capacity of the main emergency shelters/ transit centres during 2015 and 2016 is already identified in the section above. In total around 730.000 individuals entered and often passed Austria as transit refugees (3). One GP who worked in an emergency shelter/ transit centre describes the situation as follows:

> *"[…] there was this Medical Aid for Refugees, I registered there, and they had different locations, and I registered for the Dusika stadium. There was this huge stadium accommodating male refugees and next to it this Sport and Fun hall for the families. There were about 400 or 500 men in the stadium and about 300 families and that was … I don't want to day difficult, but it was incredibly hard because they started off as a mattress camp. Just imagine one mattress next to the other, one blanket next to*

[9] Team Austria is a project between the popular Austrian Radio Station Ö3 and the Austrian Red Cross starting 2007 with the aim to motivate many people to help and volunteer in times of natural disasters.

the other. Few showers for many people, few toilets for many people. […] after a while they managed to hang up partitions with sheets" (Interview 2, GP)

It is important to note that since the official closing of the Western Balkan corridor on March 8th 2016 (1), the number of transit refugees decreased, but those who still transit are not visible any more. The interviewed Red Cross stakeholder mentions that refugees still transit through or enter Austria, however now they do it clandestinely, unnoticed and often with the help of traffickers (3). Because of the decline of numbers of incoming refugees, transit structures at train stations withdrew their work and remain inactive.

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(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Participatory observation on February 16th, 17th and 18th

How is Primary Health Care provided in your country in general?

The Austrian health care system provides universal coverage for a wide range of benefits, there is a free choice of providers, unrestricted access to all care levels such as general practitioners, specialist physicians and hospitals and population satisfaction is well above EU average (1). However, income-related inequality in health has increased in the last years, although it is still relatively low compared to other countries (1). The health care system is by constitution a federal responsibility and overseen by the Federal Ministry of Health assisted by a range of national institutions. The implementation of

health insurance has been delegated to social security institutions brought together in a national Federation of Austrian Social Security Institution (HVSV) (1). In terms of finance, the social insurance funds are the largest source accounting for about 52% of current health expenditure in 2010, while the federal level, the provinces and local authorities covered approximately 24% of expenditure on health care but also debt covers the cost (1). In 2011 almost the entire population (99,9%) had health insurance coverage, membership of a specific scheme is determined by place of residence and/or occupation and social insurance contributions are determined at federal level by parliament; there are also private health insurance funds made use of only by a small part of the population (1.1).

According to WHO definition there are three level of professional health care, primary, secondary and tertiary health care (1). In Austria a clear distinction on the three level of health care is lacking, e.g. it is unclear whether hospital outpatient departments or registered specialist (paediatrics or dentists) also belong to the primary health care system or not (1). In literature on Austria's health care differentiation is reduced to outpatient/ambulatory sector and impatient sector (1), which is why different data exists on use, employment rates and financial expenses exist (1). Based on the Primary Health Care Activity Monitor for Europe Austria's primary health care system was rated lacking in terms of:

- Structural training in general medical practice, which is no specification and which can still be entirely fulfilled in the hospital sector
- Weak coordination possibilities, as there is exists no gate-keeping function for general practitioners and no/ or patient list systems
- Structural difficulties to establish Primary Health Care Teams and the lack of a morbidity register for the primary health care sector
- Enough university departments for general practice and academic career and research possibilities
- The weak status, earning and the low number of general practitioners in comparison to specialists in the outpatient sector
- The lacking "community orientation" and the hardly existing financing of health promotion and prevention activities (1)

Furthermore the lack of a clear distinction of what accounts for primary health care and the weak primary health care development status of Austria negative effects on health and costs are observed (1). Consequently a negative development in terms of human resource development is reported, especially defined through quality of education and training, career possibilities, occupational

profile and possibility for professional practise as well as status within the medical profession and society (1). According to Hofmacher the income for GPs in Austria is around the average for OECD countries, yet, the income of specialist physicians is amongst the highest in the OECD (although behind that in Germany and the Netherlands) (1). As a matter of priority also the number of GPs is decreasing steadily and it becomes more and more difficult to find GPs especially who want to work in rural areas (1).

From a patient point of view it is remarkable that the free choice of provider incorporates that besides only a few exceptions (e.g. radiology or labour medicine) a person can seek out to extra- as well as intramural working specialists directly and without medical referral at the primary care level. Thus, if a person consults with a general practitioner first, is solely based on their own estimation of the disease situation (1). Unlike in other countries primary health care physicians are not always patients' first point of contact and persons are also not registered with a GP, paediatrician, gynaecologist or dentist of their choice. However, GPs as well as the other mentioned health care workers are often those who refugees or asylum seekers consult with, since they are sent there by camp managers (3). The challenges for primary health care providers in Austria exist on a structural level, and is also linked to invoicing modalities as small entrepreneur, with the care for refugees and asylum seekers these challenges become even intensified.

In general terms there are important structural imbalances in health care provision in Austria have to be noted as there exist an oversized hospital sector and insufficient resources available for ambulatory care and preventive medicine (1).

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(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

Division of competences: Federal Ministry for the Interior (MoI) is responsible for the primary care (*Erstversorgung*) of transit refugees and carrying out an initial health assessment in federal refugee camps and initial reception centres. After an asylum seeker is admitted to the basic welfare support scheme, the provinces are responsible and the asylum seeker has access to the conventional Austrian health care system. The Federal Ministry for Health (MoH) together with the Federal State Public Health Authorities (*Landessanitätsbehörden*) are responsible for public health concerns, especially in terms of disease prevention in the case of outbreak of infectious disease (disease law, tuberculosis law). Furthermore the MoH is responsible for developing professional and health related guidelines and recommendations (3).

In the Basic Welfare Support Agreement Art. 15.a B-VG, BGBl. I Nr. 80/2004 several passages mention the provision of primary health care in the different settings and describe it along competences.

According to Art. 3, para 2, 3., the federal government is responsible for registration, deregistration and re-registration of health insurance, as far as the registered foreigner is recorded by the federal government or is located at a refugee centre operated by the federal government. According to Art. 4. Para 1, 5., the provinces are responsible for registration, deregistration and re-registration of health insurance, as far as the registered foreigner is admitted by the province or in a facility operated by the province. According to Art 6. (1) 4.-7. The basic welfare support includes:

- Conduction of a medical examination if necessary at the initial reception according to the guidelines by the health authority,
- securing of health care provision for the purpose of the General Social Security (ASVG) with payment of health insurance contributions,
- granting if need be the expenses in excess thereof necessary services, which are not covered by health insurance, after individual assessment,
- measures for persons in need of care; (translated from Basic Welfare Support Agreement Art. 15.a B-VG, BGBl. I Nr. 80/2004)

The federal government and more precisely the MoI, is required to provide health care for transit refugees as well as for asylum seekers who are located in federal facilities (both UMF and federal refugee centres), initial reception centres and distribution centres). According to the guidelines provided by the MoH, after a person has asked for asylum in Austria, and is admitted to the asylum process in Austria an initial medical assessment (dt. *Medizinische Untersuchung bei der Erstaufnahme*) is mandatory within 72 hours (3). (Also see below section: "Initial health assessment for persons who applied for asylum"). The initial medical assessment includes a physical examination, a mental health evaluation, a review of the vaccination records and an x-ray based screening for active TB (1). The MoI commissioned the ORS Service GmbH company (following a tender procedure), to conduct the initial medical assessment as well as to provide primary health care to refugees located in federal facilities. The government was criticized for preventing charitable institutions (NGOs) to participate in the tender procedure by the terms of the public call, as reported in the Viennese monthly Newspaper "Falter" (1).

The ORS Service GmbH officially provides primary health care in these federal facilities, but based on contractual provisions regarding confidentiality the company is not obligated to reveal the specific contractual content (1). In terms of UMFs, the federal reception facility east in Traiskirchen provides a 24 hours a day supervisor to whom she/he can refer with any questions or problems for

each UMR, and a special practice to be applied to UMFs below the age of 14[10], as they are taken care of additionally by selected women who function as so-called remuneration mothers (cf. Koppenberg 2014). The 24-hours care, psychological care and day-structuring measures, etc. were also reported in a response to the parliamentary question PA 7312/J dated January 26th 2016, where the MoI identifies all federal refugee centres (both UMF federal refugee centres and normal federal refugee centres) to be operated by ORS Service GmbH (1). Based on a care-giving contract and a "comprehensive care concept" for unaccompanied minor refugees the ORS Service GmbH is responsible for provision (1), however, details of what is included in the "comprehensive care concept" are again unclear and not accessible to the public. With regards to the situation in Traiskirchen and especially in the case of UMFs the ORS Service GmbH is caught in crossfire of criticism, children who were supposed to be transferred from Traiskirchen to Vienna could not be found, the NGO Amnesty International refers to the private institution as vicarious agents of the ministry (2). A particular problem in this context is that when the MoI engages a private service provider, they can require the agreement to be subject to non-disclosure, an obligation that is also imposed to subcontractors and employees (2).

As of August 17th 2015, the ORS Services GmbH employed 75 social workers and 6 educators in Traiskirchen (1). Details on medical health care workers were only found in NGO reports. The primary health care provision in the initial reception centre is in the following described based on a comprehensive report by Doctors without Borders (MSF) on Traiskirchen. As of August 2015, MSF reports that the medical care in Traiskirchen was provided by 11 doctors, who were employed by ORS Service GmbH. Provisions are made that four general practitioners are present on weekdays from 9am to 5pm. At the first MSF visit (Aug. 6th 2015) it was observed that on weekends there are three doctors (GPs) present, who are primarily occupied with the revision of the initial medical assessment. They are supported by three qualified nurses and several nursing assistants. During the night no medical personnel is present in the centre. In case of emergencies during the night the ORS-personnel calls an ambulance (1). One day before the MSF's second visit (Aug. 19th 2015) it was announced that increasing support of the medical team at the federal refugee centre Traiskirchen will be provided through mobile doctors teams of the Lower Austrian emergency physicians and the Lower Austrian Arbeits-Samariterbund (NGO) starting with August 20th 2015. This was based on an emergency-directive by the MoI as the precarious medical care gained further attention. In the MSF

[10] For unaccompanied minor refugees who are underage, thus under 14 years old, there are special provisions in the Basic Welfare Support Scheme 2004.

report it is quoted that the head of the ORS-medical team emphasizes the need of a psychiatric/ neurological service in Traiskirchen as well as the early access of persons from the centre to dental care (1). Additionally the pediatric care of young children and the counselling of pregnant women and mothers through midwives is stated to be desirable as well as the setting up of a ambulant polyclinic within the centre as a meaningful measure (1).

Towards the end of August 2015 the MoI instructed the Red Cross to set up a care and nursing station for around 40 patients as an international module "Advanced Medical Post (AMP)" in order to improve on-site primary health care (1). Together with regional Red Cross associations the unit is run, medical personnel came from all across Austria and also material was provided by the Red Cross regional associations. One Viennese GP reported from her work assignment there:

> *"During summer [2015] I registered again at the Red Cross for Traiskirchen, I worked at three weekends […] There they have this huge tent, also with in-patient beds. They provided sufficient personnel as well as drugs. They had a doctor and a paramedic who also walked through Traiskirchen in order to attend hidden sick persons who did not made it to the central tent. At the same time the ORS organization provided primary health care, but they were not there in Saturday and Sunday […] after the massive crowds decreased this has ceased" (Interview 2, GP)*

Summing up, primary health care in federal facilities is provided generally by the ORS Service GmbH. Due to the exceptionally large influx of refugees last summer and the overcrowding in Traiskirchen, these conventional structures were far from sufficient to provide appropriate (primary) health care for the refugees in these facilities. Various initiatives were started to meet the needs of refugees coming to Austria, in terms of health care provision the "Medical Aid for Refugees" (MARF) initiative is probably the most important one. They started in September as an initiative for medical care in Traiskirchen, sending persons to Traiskirchen, and aiming at continuous health care for refugees (1). The MARF initiative also provided care at emergency shelters and transit centres, and set up a mobile unit for various centres/camps/shelters (1). In the press release declaring the provision of (primary) health care has to be again ensured by regular operation within the federal government and the provinces, they announce that 250 voluntary doctors were working in over 500 missions, and a total of 2100 hours of medical care for in Austria arriving refugees was provided (1).

In three of Austria's initial reception/distribution centres a syndrome based surveillance system was established, Traiskirchen (1800 beds) was the first starting on 8th September 2015, after Innsbruck (200 beds) at 2nd of October 2015 and Thalham (180 beds) at 21st of October 2015 (1). The syndrome reporters are the centre physicians, the case detection occurs at the arrival examination or

consultation, they report daily to the surveillance department at the Austrian Agency for Health and Food Safety (AGES) who conducts a daily syndrome specific analysis for alerts and alarms (1). The alerts are reported to the public health districts and the MoH. The SbSS should complement and not substitute the national epidemiological case-based surveillance system (CbSS) in Austria, aiming at timely detection of potential public health emergencies caused by infectious diseases in order to take action for control and prevention of infectious disease spread in centre resident population and local population (1). Syndromes to consider include: upper and lower respiratory tract disease, bloody and watery diarrhea, fever and rash, meningitis/encephalitis or encephalopathy/delirium, lymphadenitis with fever, botulism-like illness, sepsis or unexplained shock, hemorrhagic illness, acute jaundice, cutaneous infection and unexplained death (1). As of 24th March 2016 AGES reported based on the SbSS that refugees present no relevant risk in terms of infectious disease, although cramped conditions during refugee treks and in refugee reception centres favor the transmission of pathogens (1).

In the detention centre Vordernberg the municipal authorities are the general contractor acting on behalf of the MoI. For the care of the detainees the municipal authorities made a contract with the private security service provider G4S. It is reported that around 100 employees were recruited. G4S is also responsible for the provision of health care (2). The detention centre Vordernberg also provides repatriation counselling co-financed by the European Return Fund and the MoI and the Caritas is commissioned with the task (2).

In facilities of the provinces, such as refugee camps and UMR camps, the asylum seekers have access to the conventional social security system, and no provisions to additional health care support is provided in the camps. Thus, every person who is admitted to the asylum process in Austria is entitled to the basic welfare support scheme, as defined by the "Grundversorgungsgesetz – Bund 2005" (BGBI. Nr. I 100/2005 idF BGBI. I Nr. 122/2009) and can access the conventional health care system. Based on that, asylum seekers who are admitted to the process are also automatically covered by the general social security system and are insured by the respective regional health insurance. There is no specific provision for provision of health care for asylum seekers and they fall under the conventional system of primary health care in Austria (3) (see above).

> *"Because they are all health insured the access to health care is in principal not a problem, they just go to .. in some provinces they have e-cards, in other provinces they have e-card alternatives [e-card Ersatzbelege] and with them they can go to*

any physician and GP. Thus, as soon as they have a social security number and it is activated this runs unproblematic." (Interview 4, stakeholder)

"They receive an e-card relatively quickly. They get it when they are registered in the initial reception centre, there they get a provisory social security number, and within a short time they get the e-card" (Interview 3, GP)

Sometimes, health care workers are also present in refugee camps. For instance, during recruitment of participants for WP2, we observed that in one of the refugee camp we visited two paramedics were present 24/7. Both of them had a migration background; one of them spoke Arabic and the other one Farsi (4). For refugees seeking health care while living in a refugee camp transport to the health care facilities is a problem: on the one hand people often do not receive transportation tickets (financial barrier), on the other hand most GPs do not have translation facilities, and few of them speak the languages of the asylum seekers (3).

In some larger refugee camps there is an emergency medical service (*Ärztefunkdienst*) available:

"So generally everyone has health insurance, and we have twice a week a sort of visiting doctors team, they are well equipped, they can treat people or refer people further. We have the problem that the persons do not know where to go if they are in pain, and of course the language. And within the camp they can translate for each other […] when the doctor comes there directly, of course this is much easier/more convenient" (Interview 7, camp manager)

The GPs come 2-3 hours twice a week and it was reported that this is sufficient for the 200 person refugee camp (3).

In UMR camps the supervision depends on the category of the facility but is equally ensured 24 hours a day. In apartment sharing groups the supervision rate is 1:10 (one supervisor for 10 UMRs), 1:15 in residential homes and 1:20 in supervised accommodation (Art. 9 Basic Welfare Support Agreement) (cf. Koppenberg 2014). The supervision teams consist of social workers, psychologists, socio-pedagogues, etc. depending on the organisation and category.

In terms of emergency shelters and transit centres the health care provision differed from one to another setting, first settings where people only stayed for a very short time, passed through quickly, or waiting only for further transport, is described.

At the time of high influx of transit refugees emergency hospitals were set up by the Red Cross in order to ensure that persons who enter Austria have access to urgent emergency health care.

> *"A mobile ambulance [was set up]. A tent with large marking, that there is first aid and a physician and those who have a need they got in and went in and they were treated, there we had volunteer physicians and nurses" (Interview 6, stakeholder)*

Later it was explained that this is a sort of first contact resembled to a sort of self-triage, and primarily was about providing health care to allow the persons further travel, people did not want to stay in a facility or loose time, their main concern was to get to their final destination (3).

In Upper Austria directly at the German border, one GP who worked in the transit centre that was set up by the Red Cross also described that the provision was not complete:

> *"At the beginning we started to organise medical care for the transit refugees […] I organised that many of my colleagues took part in this and we organised an ambulant service […] at the beginning we started that always one of us was there for 3 hours, and looked at transit refugees who were ill or who needed anything. The drugs we got from the province, we could give it to them without prescription. We did not note down the name even, only if male, female, approximate age, what he had and what he got and one Red Cross person wrote down everything […] but then when more and more people came we needed to be there the whole day until 10, 11pm because busses would come continuously. […] The Red Cross also employed around 17 or 18 persons for support because it was not manageable with only volunteers any more. Still around 30 volunteers were there all the time." (Interview 3, GP)*

In terms of triage transit refugees were attended *"who needed anything"* and health care was to a large extent provided with a focus on rapid emergency health care and which was possible with the available means.

> *„It was very overcrowded around 1000 to 1500 passed through per day, the tents were full, sometimes there were more than 100 persons inside, they lied on top of each other […] then once I was asked to come and see a sick women in a tent, then I saw it and there were 8 persons in it, it was a two persons tent, only their feet looked out, I could not even go in" (Interview 3, GP)*

Emergency organisations possessed different capacities and were often supported by private initiatives and individual primary health care workers who showed up at the spot and worked alongside the organisations. Progressively a structure developed where doctors and other medical personnel worked under e.g. the Red Cross, online voluntary service plans were sent out and fixed services were scheduled (3). In Kollerschlag the interviewed GP coordinated the medical service plans, the GP estimated that around 40 doctors were active whereof half of them were GPs, a quarter were doctors from the nearby hospital Rohrbach, and a quarter were other volunteers, who came from somewhere else and some also came from Germany (Interview 3, GP). Other health care

workers also helped at the emergency and transit centre, paramedics who assisted and some nurses, sometimes also practice assistants (Interview 3, GP).

It is noteworthy that mobile teams were appointed to visit large emergency shelters and transit centres in Vienna, as one of the questioned stakeholder reported: during the huge influx of refugees mobile teams were reaching out to emergency shelters/ transit centres such as the Medical Aid for Refugees initiative (MAFR), to provide additional medical support in these settings. After MARF finished their work the medical director of the Caritas Vienna explained that they could convince the Vienna Regional Health Insurance Scheme (WGKK) to provided budget for mobile teams to continue the reaching out to large camps until now (3).

At transit structures, especially highly frequented train stations basic medical care was provided by the Red Cross and other medical first aid organisations and the professional rescue (Berufsrettung).

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(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?

As outlined above, only in selected centres/camps/shelters primary care staff is available, in federal refugee camps, distribution centres, initial reception centres the ORS Service GmbH does not provide concrete numbers or details on composition of staff.

In the refugee camps, usually no primary health care staff is available in the facility as asylum seekers have access to the conventional Austrian health care system. Depending on the size, from 50 persons onwards one permanently present person needs to be in the facility, assisting with administration, questions, etc. (3).

In terms of emergency shelters and transit centres the composition of the health care staff was first of all covered with personnel from the emergency service, a Red Cross stakeholder explained:

> "In the autumn phase it was like this, about 60.000 people which are trained and working in emergency services, for the whole emergency care we always had our emergency paramedic or our emergency medical technicans, or our emergency physician. And for the provision of basic medical care we also use them. And as the case may be, there were many physicians, who contacted us and said they wanted to help and we integrated them respectively into our system" (Interview 6, stakeholder)

Thus, volunteers and voluntary primary health care staff worked within NGO structures, a crowd management was used to allocate capacities of refugees as well as health care staff (3). For health care staff allowance schemes were adopted and physicians from all kind of disciplines could charge a certain tariff (3). At the German border a GP reported on the situation:

> "After a while we could issue a fee invoice to the Red Cross, in emergency cases there is a standard tariff depending on hours, thus you get for the whole day around 700 or 800 euros" (Interview 3, GP)

In terms of different health care staff the GP reported:

> "There were not enough GPs available. Then they tried to ask hospital physicians to support us. They even appointed foundation doctors (Turnusärzte), who have no Ius Practicandi" (Interview 3, GP)

Later it was also mentioned that retired GPs helped in health care provision, also paramedics were there who assisted them and nurses as well as practice assistants (Interview 3, GP). We also know that in emergency shelters/ transit centres paediatrics were involved and for example the interviewed Syrian dentist explained that he was more involved in translation, as he could not provide his dental services in these settings (3). We have no information on involvement of psychologists or psychotherapists in emergency shelters and transit centres.

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Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Primary health care staff situation (numbers, capacity, payment, safety, …)?

If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

The primary health care staff situation in refugee health care is complex and provision varies in terms of numbers, capacity, payment and probably also in terms of safety in the different centers.

One important initiative already mentioned above was Medical Aid for Refugees (MARF), an alliance of various aid organizations, private initiatives and volunteers. In mid-August 2015 already the initiative Medical Advice for Traiskirchen started where medical aid was provided for refugees in Traiskirchen, furthermore medical personnel was connected to the border crossing Nickelsdorf, to Wiesen, at the Nova-Rock-Hall, at the Viennese West train station and in various emergency shelters (1).

The initiative states that they provide additional services to existing structures, and started around September 2015 and announced on January 15th 2016 to stop their activities in refugee emergency

care, as the need for care was decreasing towards the end of the year. In their press release they state: “From that point onwards care and medical services need to be provided within the regular services of federal and regional authorities. Until then 250 doctors worked voluntarily, over 500 missions, provided 2100 hours of medical health care for refugees arriving in Austria” (1). When shortages occurred in primary health care for refugees the initiative connected voluntary doctors in a fast and un-bureaucratic way and also provided necessary drugs and medical products (1). The following organisations were part of this initiative: Ambermed, Doctors without Borders, Medical Association for Vienna, Asylcoordination, Caritas, Diakonie Flüchtlingshilfe, Happy thank you more, Johanniter, Red Cross, Austrian Association for Pediatrics and several private initiatives (1).

A primary challenge for asylum seekers who are in the basic welfare support scheme is accessing the conventional Austrian health care system because of insurance uncertainty and other barriers. In principle are the GPs in Austria “external” primary health care providers, as the situation differs in the nine provinces the situation is portrayed for each province. Since January 2016 all refugees located in Vienna are insured through the MoI, before some were insured and had a valid social security number, some had e-cards, and others had neither a valid number nor an e-card. The social insurance agency varies between the provinces and differences are primarily in the provision of e-cards and alternative health insurance documents and the assignment of mobile service partners (3). In the case of Vienna, various problems emerged at the beginning. Based on the findings from WP2 we know that in Vienna asylum seekers first get a service-card with an insurance number by the Fond Soziales Wien, and to some extent doctors and hospitals accepted it when the social security number was registered and activated. After a while (several weeks or months) they get an e-card, which is the standard personal smart card in Austria. It was reported that many of the refugees that lived in camps in Vienna faced huge problems with access to e-cards, activation of e-cards but also with seeking treatment without good German skills (WP2). In Austria there are several free clinics for people without insurance, such as Ambermed, FEM and Hemayat, doctors, social workers, psychologists, psychotherapists, psychatrists and nurses treat patients there without insurance or e-cards. In all other provinces the asylum seekers are insured through the provincial/regional health insurance fund (GKK) and usually do not receive e-cards but health services are accessed mostly with the help of e-card alternative documents (E-card-Ersatzbelege). In Upper Austria they receive a note with their social security number, which is put forward at e.g. the GP practice, the mobile social support service is commissioned to Caritas and Diakonie,

depending on geographical proximity. In Styria asylum seekers receive e-card alternative documents, mobile social support services are commissioned to the Caritas. Similarly is the situation in Lower Austria, asylum seekers receive their social security number and then e-card alternative documents, mobile support is commissioned to the Caritas in the east and the Diakonie in the west. Asylum seekers in Burgenland also receive e-card alternative documents, and a mobile social support service in organised camps is commissioned to the Diakonie. In Tyrol asylum seekers only receive an e-card if they had worked e.g. as harvester, otherwise they only receive their social security number, the note with the number is often stuck on the white card, and e-card alternative documents are used for billing, mobile support is provided by the Tyrolian Social Services and not commissioned to NGOs. Similarly to that receive asylum seekers in Salzburg a social security number and billing works through e-card alternative documents, and mobile support is commissioned to Caritas. In Vorarlberg asylum seekers also receive social security numbers and billing is through e-card alternative documents, mobile support services are provided by the Caritas. Carinthia constitutes an exception as asylum seekers receive an e-card and the mobile support is provided by the respective regional consultant. Additionally to mobile social service support NGOs and other organisations also operate refugee camps in the various provinces, amongst others Caritas, Red Cross, Diakonie, regional social service providers, the institutes for social services, and ORS Service GmbH operate camps (3).

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Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR

Protocol, student (4) Result from participatory observations
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
For persons who seek asylum in Austria and are admitted to the asylum process and who entered Austria as refugees[11] there is an initial health assessment required. It is a standardized assessment procedure which is supposed to take within 72 hours after the registration process, in German it is called: *Medizinische Untersuchung bei der Erstaufnahme* translated as initial health assessment (3). According to the guidelines provided by the MoH an operational plan is followed and the assessment is free for the asylum seeker (3). As the federal facilities are operated by ORS Service GmbH, the ORS is responsible for the initial health examination as well as the provision of primary health care in these facilities, commissioned by the MoI and the MoH (3). The initial health assessment includes a self-anamnesis, an x-ray of the lung (obligatory) and a (voluntary) vaccination (Po-Di-Te & Ma-Mu-Rö). In an interview and informal meeting with a representative of the ministry of health, it was reported that as of March 2016 there is a huge backlog with initial health assessment, and that the ORS Service GmbH is several months behind (3). Furthermore it was reported that the ORS would not particularly propagate vaccinations and only few persons were actually vaccinated (Protocol 1, stakeholder). However, at the same time the MoH is not in the position to control the ORS or has no insight in how many people receive vaccinations. Overall the MoH representative estimates that around 4500 persons never had an initial health assessment although they are already in refugee camps, as the ORS was overwhelmed with the number of persons (3). Also a representative from the FSW reported that initial health assessments were conducted incompletely and sporadic during autumn months 2015, as the high number of asylum applications overstrained personnel and infrastructural capacities of BFA, MoI and FSW (3). Starting with March 14th 2016 the Austrian Red Cross was assigned to additionally conduct initial medical examinations (3) at one designated floor in the same building where the emergency shelter

[11] For persons who entered Austria through a Visa (e.g. student visa, working visa, etc.) and only after entering Austria applied for asylum there is no initial health assessment required.

Lindengasse is located, was set up. According to the agreement this Red Cross Unit is set up solely for initial health assessments, and an employed medical team conducts the assessment. The vaccines are covered and delivered by the federal government, thus no extra costs emerge for the Red Cross Unit whether they immunize or not (Interview 6, stakeholder).

As the situation in Traiskirchen worsened dramatically during summer 2015 and it remains relatively unclear how complete the initial health assessment was conducted. In terms of documentation, no information from the ORS Service GmbH was available, and a Red Cross stakeholder explained that until now there is no coherent documentation on who received the initial health assessment, not to mention the vaccination rates (3). Due to that, primary health care providers are particularly challenged when they later treat asylum seekers (see section below). One GP explicitly refers to the risk of not vaccinating refugees, other migrants and asylum seekers:

> *"In my view it was a catastrophe that there was no vaccination program started. I mean this is… measles, mumps and then meningococcal should have been vaccinated. We are very fortunate that nothing had happened." (Interview 2, GP)*

In the MSF report of August 2015 the medical care situation in Traiskirchen is described, the principal health care workers (11 doctors, of which 4 general practitioners are present on weekdays from 9 to 5, and on weekends there are three doctors (GPs) present), are primarily occupied with the revision of the initial health assessment. They are supported by other health care workers (three qualified nurses and several nursing assistants) (1). According to interviewed doctors the MSF report outlines, that the physicians start their working days with initial health assessments, only afterwards persons with acute problems are attended. For acute problems a numbering system is in place which, however, according to reports by inhabitants, is not functioning because "by far not all numbers are attended until 5pm, at the next day a new number has to be taken" (1). A triage system in order to detect acute diseases, which have to be treated as a matter of priority, is not in place as the priority is given to initial health assessments (1).

An interviewed GP indicates that he can only assume the initial health assessment took place:

> *"The district authorities (Bezirkshauptmannschaft) assured me that they all were assessed. Thus, we can assume that an x-ray was made and that they were examined for TBC. But we can only trust that, because there is no medical evidence of that which we could access." (Interview 3, GP)*

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(1) Report/Publication: Ärzte ohne Grenzen Österreich, August 2015, Bericht zur medizinisch-humanitären Lage im Erstaufnahmezentrum Traiskirchen, https://www.aerzte-ohne-grenzen.at/sites/default/files/msf_traiskirchen_bericht_2015.pdf; (last access: 12.05.2016) (2) Web based report/article: Title, Link (3) Result from interviews, also quotes are possible Interview 1, GP Interview 2, GP Interview 3, GP Interview 4, stakeholder Interview 5, dentist Interview 6, stakeholder Interview 7, camp manager Interview 8, camp manager Protocol, MoH Protocol, MAFR Protocol, student (4) Result from participatory observations
How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
In the asylum process, the asylum seeker is inquired about her/his personal circumstances, travel to Austria and the reasons for flight by a person from the Federal Office for Immigration and Asylum. This inquiry is conducted in a language which is understandable to the asylum seeker and translated by interpreters under oath (1). In detail, first the fingerprints and interview is made at the police, an interpreter should be present, then at the Federal Office for Immigration and Asylum an admission procedure is undertaken, inquiries on travel route, etc., an interpreter is present, after admission is granted the asylum procedure takes place, the interview on the reason for fleeing the home country, and again an interpreter is present (1). In the different other settings described above, outside of the interrogation for the asylum process, interpreters or cultural mediators were solely available on a voluntary and sometimes sporadic basis and the organisation in charge organised these services as voluntary work (for more details see below section: challenges for primary health care providers) (3). The self-anamnesis document which is to be filled out by the asylum seeker at the initial health assessment was reported to be available in various languages, certainly in Arabic, Farsi and English (3).

In emergency shelters/ transit centres a lot of volunteers, who had themselves migratory background worked as translators and helped out with their bilingual skills (4).

> *"Arabic from Tunisia is something completely different than Arabic from Iraq or from Syria and if sometimes then even little dialects came it was certainly a huge challenge [for the people who volunteered as translators]. I would say for acute symptoms it is not even necessary because we had really good pictograms" (Interview 2, GP)*

In cooperation with Red Cross, Caritas and Medical Aid for Refugees there were pictograms developed by buero bauer (http://buerobauer.com/projekte/first-aid-kit/)

Generally the GPs and other health care providers can use video or telephone translation systems. Salzburg is the first province who offers from March 2016 onwards telephone translation systems for resident doctors/GPs the province co-finances this with the Medial Association Salzburg (2). This 6 months pilot project is exceptional in Austria as in all the other provinces the expenses have to be covered by the GPs themselves. There is neither a refunding for purchase of the device nor for the actual translation service in all other provinces in Austria (3). The application of video translation systems are still in their infancy in the Austrian health care system, also in hospitals video translation tends to be the exception rather than the rule (1). In the federal government detention centre Vordernberg in Styria video translation is available since October 2014, on the website it reads: *"the introduction of video translation in the ambulance of the AHZ Vordernberg was a very good decision. The medical care of our clients is very important to us in our facility and through the quick availability and the linguistic diversity the provision of care is ensured"* (1).

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(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Biggest challenges and barriers for primary health care providers?

Challenges and barriers exist for primary health care providers at different levels, first at the level of emergency shelters/ transit centres, 2nd at the triage and first assessment at entry point, and 3rd at the first contact with the primary health care system and at the level of long-term primary health care.

According to the interviewed stakeholders and our findings from literature there are particular challenges at the first level of emergency shelters/ transit centres. The logistical challenge to ensure that all different kinds of drugs are available in these settings was noticed (Interview 3, GP), and on the other hand the challenge to provide the adequate care and medical treatment for the refugees in a very short-time frame. For example some diseases require close monitoring and treatment, which is not possible when people only accommodated shortly:

> *"Such a continuous treatment is very difficult if the people often change their place of stay. That is why I said to all people who had a chronic disease: Please we do that now like this and that and if you have a fix [GP] another plan has to be made." (Interview 2, GP)*

The Medical Aid for Refugees initiative also reported on the medical-humanitarian situation in different emergency settings, they elaborate on emergency care challenges with complex problems like chronic diseases such as poorly controlled diabetes mellitus, hypertension or joint pains after

trauma lasting for weeks, which can often not be treated adequately (1). In other cases people would require immediate inpatient care, however, their main concern was to transit further:

> *"Again and again we had problems because the refugees did not want to go to a hospital. We really often had someone … okay if we do not get him into the hospital he might die, and maybe with stomach-ache, pregnant women with heavy pain and these stories. From the newly born baby who was born during the flight until the 81 year old men we had seen everything over there. And then we sometimes had discussions, they would not want to go to the hospital because they were afraid that their family would be separated and that they could not get to Germany. This was really their main concern that they would not get to Germany." (Interview 3, GP)*

A Red Cross representative refers to the medical care in transit settings as *"doping for further travel"*, he describes that refugees had clear priorities in what was of main importance to them, often this was in the first place reaching their target country and their second priority was their health condition (Interview 6, stakeholder). In response to the warning *"you might not survive if you continue your travel without proper treatment"* they explained it is a matter of reaching *"Germany"* this is their first priority, *"if I die, I die"* (Interview 6, stakeholder).

In this context physicians working in emergency settings also reported cases in which cooperation with border authorities were hindering provision of adequate health care:

> *"The German authorities were relative restrictive. Once they even would not let a colleague pass the border to Wegscheid [in Germany], who treated a heart emergency patient. Because Wegscheid is only 5 kilometres away from there and they have a hospital there and he wanted to go there with the patient. And the German authorities said: no he is not allowed to pass the border. Only after 15 minutes of discussion and with the threat of informing the press the German policemen agreed that he can pass the border." (Interview 3, GP)*

Another huge challenge was the lack of documentation of disease cases in emergency shelters/ transit centres, in a press release the MARF initiative stresses the necessity of a standardised form to document patients brought to hospitals, or for patients who have chronic disease, such as dialysis patients, for onward journeys (1). On the one hand this would also be helpful for hospital personnel, which often lack interpreters, and anamneses would be made easier while additionally it would decrease the barriers to provision of (primary) health care (1). The difficulties in documentation of diseases as well as health care provision in general was also identified by GPs who worked in emergency shelters, initially set up only for transit refugees, but slowly converted into an emergency reception centre for people who applied for asylum in Austria:

> *"… we had to ensure that a certain registration takes place. […] There were some sort of securities, they ensured that everyone had a wristband with a number, and that these data were recorded and that they receive any sort of card as soon as possible ... a refugee identity card, and that took 2 months, until they receive this card where a social security number is on. […] that was the most difficult task in terms of organisation. […] of course we treated everyone but we checked closely, I mean we were many doctors, but I first asked anyone for some sort of ID, or number. It was less about if he was entitled to receive treatment or not but we tried to write a protocol so we can reproduce: he was here daily and needed painkillers. Or he has some other health needs. So that we have less chaos in medical treatment." (Interview 2, GP)*

From a health care standpoint documentation was one thing, but then also division of competences posed a challenge:

> *"For example with wound care. Well some wounds need daily wound bandaging and some were not so special cases however sometimes they require Betaisadonna or Octenisept. Thus medical products, yet there were enough paramedics there but it is not allowed for them to apply medical products. When they were alone then they could not even hand out drugs, nothing, they only could apply a dry bandage, nothing else, not even disinfect […] I inquired at different places, yet even after an exact instruction they are not allowed to do it. […] I mean that is just crazy in regards to the structures, and hierarchies and limitations. These things complicate the treatment, and that is the problem, you need unnecessary huge personnel for nothing. (Interview 2, GP)*

In addition, the challenges that emerged for provision of health care in emergency settings were linked to the fact that facilities were to some extent converted from emergency shelters into emergency reception centres for asylum seekers, especially in Vienna (3). The most prominent example is the Kurierhaus at the Lindengasse in Vienna, where the vacant building was operated by the Red Cross and the Fond Soziales Vienna as an emergency shelter and after a high number of people decided to apply for asylum in Austria it reception structures were established. The police and the FSW made a cooperation agreement and a temporary BFA office, where people could directly apply for asylum was established in the 5th floor, the FSW administered the asylum seekers and organised their placement in refugee camps, and several months later the Red Cross also set up their Unit for the initial health assessment there (3). According to the FSW the follow up work with registration of asylum seekers is not yet finished until May 2016 (3).

The MARF initiative emphasises that these emergency shelters often lacked sufficient material and medical equipment in first medical supply points, and furthermore, sanitary facilities were not adequate for longer stays in emergency shelters (1). In this regard it should be noted that

additionally to limited spatiality and unclear documentation which increase health risks, also the difficulty to respond to and address psychological concerns and the lack of access to water can lead to overmedication:

> *"More and more the psychical component appeared; with families it was the case that the parents were really concerned. With the slightest rhinitis they came, which is understandable, or also with a small cough or if the child was tired or it cannot walk any more, or I don't know. This overreaction, but understandably that they are so worried, who could calm them down and payed attention that we would not over medicate them." (Interview 2, GP)*

> *"Also in the Dusika stadium there was a strong desire for painkillers. But this is with too little water, or too little liquid not always favourable. […] we saw that people with too many painkillers developed stomach problems" (Interview 2, GP)*

From an operational perspective the challenges for health care providers are strongly linked to the inadequate accommodation situation, a stakeholder explains this as follows:

> *"The biggest challenge was in fact that there were two situations, which occurred parallel. The one is an accommodation crisis, what the republic of Austria did not manage, because of the political hickhack in the last months and years. […] The federal government and the provinces could not agree collaboratively that the number on persons [who applied for asylum] were adequately housed. And from September, October together with the refugee wave [sic!], that Traiskirchen was reduced and the person which still arrived and applied for asylum, could not be brought to refugee camps [in the provinces] but to emergency shelters. […] The huge difficulty was that persons who came longer than 3 nights, because they applied for asylum, these shelters are not adequate for them, that was a huge problem for our people. That is unacceptable but on the other side you don't have an alternative." (Interview 6, stakeholder)*

In terms of direct challenges for health care providers working in emergency shelters/ transit centres, one interviewed GP identified work overloading and burn out prevention of physicians as important:

> *"There are colleagues they see it … and then they put all their power into that. And I observed that this has to have boundaries and I said: okay once or twice a week and if you were there more often we said: no you have to have a break. It is not possible, because it is also not good for your own psychical health […] especially when it was all additionally to the work in the practice." (Interview 3, GP)*

Additionally it was relevant that a balance was found between health care provision for the local population and health care provision for transit refugees:

> *"Because no one had time or was there and then we also had on-call duty for the whole district, but they have duty for the whole district, and some thought they attend the people [in the transit centre], but then they had to leave again [when someone called] And then I said, I ordered: under no circumstances can we ignore the health care of the local population or attend a patient later or not at all because we provide health care for refugees. Except there is an emergency, no question there… " (Interview 3, GP)*

Two GPs also raised concerns about their legal standing as health care providers, how their insurance was, and how they informed themselves (Interview 2, GP; Interview 3, GP).

The interviewed red cross stakeholder emphasised particularly on the legal framework challenges for providing primary health care at first level emergency shelter/ transit centres:

> *"Austria is a well administered/managed country, but it has fair-weather-legislation. That means when something is written down in the law, then public management which implements it can work fairly well accordingly. Yet if there is a case which is not provided by law […] then everyone says, what do wo do now? And there is no flexibility […] What we need urgently in Austria is a legislative framework, so that we remain capable of acting in exceptional situations. […] And especially that there are political and administrative proceedings and competences for exceptional occurrences" (Interview 6, stakeholder)*

At the 2nd level at the triage and first assessment at entry point we found partially overlapping barriers and challenges for provision of (primary) health care as well as providers. After registration the arriving refugees are provided health care in a federal refugee facility by the ORS Service GmbH, the main challenges are assumed to be limited human resources and high workloads, however, employees are under duty of confidentiality. MSF recommends in their report that the provision of health care to ill and vulnerable persons, to pregnant women, children, as well as to old and disabled persons should be prioritized over the initial health assessment (1).

For external or additional health care providers at the level of triage and first assessment at entry points several other issues were raised. For example it became apparent that because of the often long flight the people had no treatment for several months, as for example:

> *"asthma, which was not treated for a very long time, and from time to time also metabolic diseases which existed before already, but which were ignored during the flight" (Interview 2, GP)*

Also the interviewed dentist explained, that people who often come after a long time without treatment to his practice (Interview 5, dentist). He specifically refers to the crisis in Syria which has been going on for 5 years:

> *"Most people come here with problems, with huge problems, not only regarding their teeth, really with all sort of health situations, yes. […] with no dental check-up for years, or an open tooth for years, or I don't know how many problems. It starts with children, adults, all. And before they come to Europe most of them stayed in camps e.g. in Greece or in Turkey or I don't know where they were, and also there they did not have treatment." (Interview 5, dentist)*

At the same time delays in health seeking are indicated in the MSF report on the medical-humanitarian situation in Traiskirchen:

> *"Many persons are hesitant to visit a doctor, not only because of the long waiting hours, but above all because they fear the transfer of personal medical data to the authorities and a delay of their procedure or a transfer caused by that." (MSF 2015)*

Similarly it is reported that refugees are reluctant to visit a physician or a dentist:

> *"There are a lot of people who do not want … they are ashamed, they would not come, I say why did you not come? Why did you wait? Because I have no insurance, I have no money, I cannot come. […] but there are larger problems than with dentists, with women there have a lot of problems, children, etc." (Interview 5, dentist)*

In terms of challenges similarities to emergency settings were described, and apparent challenges and barriers again have to be considered together with shelter capacities and access to water and tea:

> *"In Traiskirchen when temperatures came down they got colds, we advised them to drink a lot of warm tea. One asylum seeker explained, that would be wonderful, I would love to but I am glad if I even get a cold tea after I wait in line in from the early morning onwards. But we don't have nothing, only cold water." (Interview 2, GP)*

Another aspect was the difficult for primary health care providers to transfer refugees and registered asylum seekers to specialists, or hospitals, as these referrals were mostly informally organised:

> *"I tried to send all people to the medical specialists at the Engertstraße. There is a huge eyes clinic, there the Ms. Dr. xxx is the head of the medical specialists from the Medical Association and they have a huge practice and I think her husband was Iraqi or Syrian […] I tried to send as many as possible to GPs and not to outpatient departments, unless it was immediately required. (Interview 2, GP)*

> *"I treat all refugees also when they have no insurance or if they are just transit. There were a lot of them in Austria, now it is less… we do what is necessary for individuals or sometimes whole groups come, because of the Diakonie, Caritas and other organisations, […] I said all people who speak Arabic and who need dental care, I am a dentist and I will take them without insurance, no problem. And there are also*

other doctors, GPs and other people, so we established a network." (Interview 4, dentist)

In some cases the cooperation with surrounding hospitals who were equipped with the necessary medical devices or laboratory was difficult:

> *"In Traiskirchen we had mainly new injuries, exhaustion, pain from walking for days, etc. Viral infection, very rarely a pneumonia, an exsiccosis, but also things where you do not know how to proceed for example recurrent fewer attacks over 40 degrees. We send them to the hospital in Baden, but they did not lift a finger. In Traiskirchen we had enormous cooperation difficulties with the surrounding hospitals, or also with medical tests. There is just a certain border where we cannot do anything further. We do not have a roentgen available or could we do a blood count or other of those things. We could decide based on what we saw, heard, felt and smelled but sometimes other medical tests are required. Thus that was very difficult, and sometimes patients were sent back [from the hospital] which were not checked." (Interview 2, GP)*

Especially problematic was the situation for persons who required special assistance, such as children and pregnant women or especially vulnerable persons:

> *"In Traiskirchen I can remember an especially dramatic case. That was a young man, in a wheelchair user, with a huge decubitus. He changed his catheter himself and this decubitus was a festering whole to the bone. That is something that you cannot really treat in a refugee camp. We sent his to the hospital 2 or 3 times, I don't know what happened to him. We thought he should be hospitalised and this has to be treated properly and plastically supported and I don't know what. But there on a camp bed… really catastrophic. And it is the same in the case of providing health care for pregnant women. Some are just hospitalised shortly for delivery and after 2 hours they were released again, with their child to the refugee camp. In Traiskirchen the cooperation with the surrounding hospitals was not good. That was bad." (Interview 2, GP).*

The MSF report identifies specific barriers and challenges for providing (primary) health care in Traiskirchen with regard to vulnerable persons, amongst other things the absence of a women- and children-specialist medical care, the lack of dental acute-care as well as the lack of a psychiatric-neurological service as well as psychological crisis intervention available on a 24 hours basis (1).

After a registered asylum seeker who is admitted to the asylum procedure in Austria is transferred to a refugee camp or lives in a privately organised accommodation, he/she has the same access to the health care system as Austrian citizens. Nevertheless, at the 3rd level which is the first contact with (conventional) the primary health care system and at the level of long-term primary health

care there exist specific challenges for the (primary) health care providers. The most frequently identified barriers in the long-term primary health care are subsumed by GP:

> *"The biggest barrier is the difficulty in remuneration. The second is the language barrier, which only can be solved through appropriate interpretation services and if they are not available it becomes quite difficult. And the third is also – let's put it this way, the learning needs of the practitioners. Hence not every single one of them is familiar, […] with the post-traumatic stress disorder." (Interview 1, GP)*

The difficulty or rather impossibility to get remuneration for the additional time effort was mentioned by several interviewees (Interview 1, GP; Interview 2, GP; Interview 3, GP; Q3). Challenges in remuneration of services were also reported by the interviewed Arab speaking dentist. He explained that he handles this quite flexible, generally he treats all patients independent of asylum or insurance status, for transit emergencies remuneration is in principle never possible, however, for others who are asylum seekers in Austria and who e.g. need several sessions over a longer periods of time he can settle the costs via health insurance afterwards (Interview 5, dentist). From a GP perspective:

> *"If you take up the effort, the increased time requirement and the communication problem and interpretation and all that, and then you don't even get the fees for that – that is quite odd." (Interview 1, GP)*

As one of the biggest challenges for health care providers was the language barrier identified while there were no free translation services available to them (Interview 3, GP; Q1; Q2; Q3; Q4). With regards to first anamnesis and explanation of diagnosis and treatment the physician faces this barrier and often has to rely on Google translate, which is experienced as tedious and no proof of correct translation is given (Q1). The head of the MARF initiative also reported that the situation for pediatrics is especially problematic and challenging, as the first anamnesis takes even more time with children and without translation services, and also because it is often unclear and undocumented what medical assessment occurred beforehand.

Another GP explained that in emergency situations they worked with pictograms and similar to that also in long-term care translation is necessary:

> *"Communicating with hands and feet worked very well, I mean for acute things. Whenever there is a longer explanation then of course a translator is very helpful. With translators you have to … I sometimes felt there were ambivalences. The translator was not sympatric to the asylum seeker" (Interview 2, GP)*

The lack of freely available interpretation service is basically a decision of the health insurance services, a pilot project was started in October 2013, however, an extensive implementation across the country is not envisaged.

> *"In the entire health care system no interpreting services are available, either you have someone who joins you and translates or you have nothing, that is a huge problem and it does not only affect refugees but also all migrants" (Interview 4, stakeholder)*

Furthermore culture related communication differences are mentioned and the challenge for the GP to interpret traumatising experiences of patients (Q2) as well as cultural differences in non-verbal communication (Q4). Another GP refers to his lack of knowledge in terms of possibilities for psychological support for refugees and how such further care can be organised (Q4). In this context the challenge that the primary health care provider faces is that even if he/she knows how to organise appropriate further care especially psychological care the facilities that provide that are very busy. Facilities such as Hemayat (http://www.hemayat.org/) or the Trauma Centre you-are-welcome (http://www.you-are-welcome.at/) have long waiting lists up to several months or even years. As a GP elaborates there are relevant directors in the health care sector, which are the health insurances. According to the design of the honoraria they reinforce certain activities of GPs:

> *"People who suffer from PTSD for decades, because they are not treated, they cost a lot of money to the health insurances. In these cases a reasonable period of let's say 1 to 2 years intensive therapy would be absolutely cost-effective." (Interview 1, GP)*

With regard to the information and documentation about the initial health care assessment, several primary health care providers and stakeholders point to the huge challenge that results from the lack of knowledge about the assessment and specifically the vaccination status (Protocol 1, Ministry of Health; Protocol 2, stakeholder; Interview 3, GP; Interview 6, stakeholder; Q1; Q3;). One GP asks if it can be expected that children are in a vaccination program like in Austria (Q1), it was noted that an Arabic explanatory information sheet for vaccination would be helpful to overcome vaccination barriers (Q3) and generally the lacking information flow as well as documentation of initial health assessments poses challenges for the primary health care providers:

> *"The initial health assessment is made, and sometimes they also get vaccinated if they are unvaccinated. But the thing is, they don't get any information. They do not get the anamnesis document, they don't receive any document, they might get the vaccine pass but then they say, yes I got immunisation but we [the GPs] don't know what and how. There is no information flow whatsoever. Actually I think the persons*

should get a copy of the anamnesis document and which vaccination they got, so that we, who continue to care for them know what he received or what is the medical history behind it. That would make our job a lot easier." (Interview 3, GP)

It was mentioned that costs for vaccination are also a barrier and basic vaccines should be provided for free (Q3) also lacking information about vaccine status of children seemed obstructive:

"As far as I know the children are not immunised, they hardly have vaccination passes from Syria or Afghanistan… you try to find out which ones they received and when, this is all quite tedious" (Interview 3, GP)

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 (Q2, Q3). Then also knowledge about nutrition habits and taboos of refugees were mentioned to be helpful to overcome health related barriers (Q3).

As one GP explained many refugees have developed post-traumatic stress disorders (PTSD) and he was glad he knew how to deal with psycho-trauma in order to provide specialised health care for refugees, which was hardly a focus when he studied medicine:

"Gladly I had experience with psycho-trauma, because before it was only necessary on a marginal level. Now due to the mass movement of people fleeing they see the need. And of course it would be very good if there are GPs who open up for this issue and continually learn and then also develop capacity for these patients, which is a precondition…" (Interview 1, GP)

"In principal doctors are not really aware, that the somatic symptom disorder has an important role in medicine. Many people manage, the majority of people manage to prevent psychological symptoms to come out. But then they suffer tremendously from pain in all body parts, they think that their heart is ill, they have horrible stomach problems and pains, all sorts of things, back- and neck-pains, headaches, migraine. That is a somatic symptoms disorder, which occurs as a consequence of psycho-traumatisation. Now these patients who suffer so heavily are many, and they attend the ambulances and then the doctors there know already, that they are physically not really ill, but still they cannot help them, because they don't understand anything about PTSD. I would say this is […] a huge obstacle, so to say the limitation of medical-psychological knowledge, or psychiatric [knowledge]. (Interview 1, GP)

For an asylum seeker in the asylum process, who suffers from mental health problems a primary health care provider can make a referral to a psychotherapist, with the same procedure as with persons with Austrian origin. But what remains problematic is that in fact services are quite limited, as in the conventional system there are not enough places covered by health insurance, and waiting

periods are long (e.g. Hemayat). Apart from language barriers for treating mental health problems, the limited therapy places need to be recognized in this context.

A challenge in staying healthy for the refugee has also structural roots, as a GP explains:

> *"I was well aware even before studying medicine, that the medical profession also involves dealing with psychological and social matters. Refugees are characterized by a high degree of social problems. Therefore they develop psychological problems and furthermore an exacerbation of their physical health, health problems. I have seen many refugees who became seriously ill due to the actual stress, the longstanding sometimes harassing handling by the authorities, … thus not only having psychiatric illnesses but also serious physically illnesses." (Interview 1, GP)*

From the point of the refugees/ asylum seekers one stakeholder argues that a huge problem and health provision challenge are transportation costs. As the people are sometimes located in very suburban areas and often no budget for public transport tickets is provided which effects on the primary health care:

> *"A specialist visit is then a matter of 2 to 3 months, nothing is quick, and that I have also seen in practice, that things are delayed when you first need someone who looks after the children, and someone who makes an appointment and so on." (Interview 3, stakeholder)*

Overall the systemic challenge of the asylum procedure, inherent in the procedure as such should not remain unmentioned,

> *"The really heavily traumatized people cannot talk about it [their flight history]. There are very few who can right away narrate that and that has happened. They are affected by the PTSD to such an extent that they will not find the words. Also the flash backs and the torture procedures … people can only bear it by dissociating. […] This explains the mental blanks, which then become an obstacle when the asylum judge demands a coherent narrative." (Interview 1, GP)*

The specific challenges and barriers for primary health care providers who treat refugees/asylum seekers and other migrants as well as for receiving (primary) health care are illuminated based on the findings; in part they are overlapping in all different levels. Recommendations to meet these challenges and respond to the barriers are provided below in the last section.

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(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

Similar to other countries, in Austria the occupational status is only officially registered at the Public Employment Service Austria (AMS) after an asylum seeker receives international protection status or subsidiary protection or another residence permit due to extenuating circumstances. There was an *AMS competence check* introduced for this group of people and in January 2016 there were already 898 registered persons with asylum status who attended the competence check and the AMS planned to extend it to 13.500 persons until the end of 2016 (1). As of March 2016, there were 112 persons who were granted asylum or subsidiary protection who were medical professionals, whereof about 83 in Vienna, three quarters are from Syria, after Iraqis and Afghans (1). Many of these persons as well as asylum seekers who are still in the asylum process are preparing for the validation of foreign studies and degrees, referred to as *Nostrifikation*. Up to now these people had

the possibility to work as assistants in refugee camps, however, without treating patients they often fulfilled merely a translator function (1). Furthermore these professionals could do a traineeship (*Hospitanz*) at hospitals and from the next asylum novella onwards it should be provided that they can also engage in occupations as they are possible within clinical traineeships (*Famulaturen*) (1).

Additionally to the official data from the AMS on persons with asylum status, there exists also an informal network of Arab speaking doctors, whereof most of them are still in the asylum process (3). The network includes doctors and other health care workers mostly from Syria, but also from Iraq, Egypt and Libya, the communication is all in Arabic (3). The network goes back to the interviewed Syrian dentist who established this group as an WhatsApp group, for the purpose of networking, information exchange and service provision, it is now operated and organised by around 7 to 8 persons, who organise events and collect primary contact data of members. As of May 2016, there are already around 180 contacts in the overall group registered with number, email address, time of arrival in Austria, level of German and date which they are planning to make the *Nostrifikation*. Out of those there are around 65 dentists, 50 pharmacists and around 60 general practitioners (3) and the remaining contacts consists of specialists (Interview 5, dentist). The group organizers arranged meetings with the Ministry of Health, the Medical Association of Vienna, the Medical Association for Dentists, with the Medical University of Vienna and with NGOs and the AMS to negotiate about validation of foreign studies and diplomas and increase the information flow between asylum seekers and authorities (Interview 5, dentist). There are regular meetings monthly where all group members can attend. This network appears to function very well as direct support and is extended continuously.

> *"We built a huge group with around 200 doctors in Austria who came as refugees. We collected their name, data, telephone number, address […] We started to hold meetings every month, regularly […] We explain, where to go for the papers, where you can learn, where you find translators, many things we assist with in this group." (Interview 5, dentist)*

When there is new members who are not in the group yet, one of the members will ask the doctor responsible for the group to add the person, with a very low threshold the number of members is steadily increasing. From the network there are around seven members who already finished their *Nostrifikation*, mostly general practitioners and pharmacists. Some persons who are already registered at AMS were reported to be pushed into work in different kind of professions far from their original specialization: "there are some doctors when they apply for the AMS and they reach a

specific level of German they are pushed to work as taxi drivers, cleaning dishes or other unskilled workers job" (3).

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(3) Result from interviews

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

The Austrian national report points to some of the crucial capacity challenges in terms of primary health care provisions for refuges and asylum seekers.

Various primary health care workers were active during the high influx of refugees and the time when thousands of persons transited through Austria. The distinction between emergency situation, and emergency health care measures compared to provision of health care for persons who apply for asylum in Austria, is quintessential.

Generally there is a lack of multi-professional teams, which would be most perfectly suited to care for the needs of refugees. In terms of long term care, specific challenges were observed especially

in terms of the initial health assessment. This first assessment would need to become more transparent, and documents should be available to GPs who will treat the asylum seekers at a later stage. This applies also to vaccination status and a vaccination pass could be introduced and distributed wherever this is not already done.

Comprehensive information for doctors, GPs and other health care workers on health issues of refugees and asylum seekers as well as the Austrian health care system would be essential. Another aspect which poses huge challenges is translation and language barriers. We would suggest the Federation of Austrian Social Security Institution (HVSV) to provide cost coverage for video interpretation for GPs, hospitals, etc. Additionally, it would be pivotal to establish contact with health care workers who are asylum seekers in permanent refugee camps and integrate them earlier into the workforce. In Germany for instance, health care providers (GPs, dentists, etc.) can already work while being in the process of nostrification. Furthermore, we argue that specifically in terms of psycho-social needs, the extension of existing and setting up new care support institutions in this area is crucial. Lastly we believe the provision of scaled training offers for persons who work with refugees, supervision, etc. would also help health care workers to better care for asylum seekers.

D6.2 Summary report on the interventions that were implemented.

Ref. Ares(2016)7201579 - 30/12/2016

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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Disclaimer

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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

List of Contributors 2

Executive summary 4

Introduction 14

Tasks 6.8 – 6.13 18

Specific objective for task 6.8 – 6.13 18

Timeline for the different steps of the implementation phase 18

Methods 22

Results 23

Part I: Intervention development phase 23

EUR-HUMAN Online course 24

Online course development 24

Online course content 26

Online course adaptation and translation 30

Online course communication strategy of MUW (WP leader) with partners 30

Part II: Intervention implementation phase 33

Online course 33

1. Selection 33

2. Adaptation 35

3. Preparation 37

4. Training 39

5. Implementation 41

Add ons to the online course intervention and underlying training 44

Training lecture videos (YouTube channel) and GoToMeeting session in Greece 44
Pilot implementation of these learned in the on-line course 47
Face-to-face training additionally to the online course in Italy 49
Face-to-face training additionally to the online course in Slovenia 50
Face-to-face training additionally to the online course in Hungary 52
Piloting of the mental health screening (RHS-13) and referral procedure 52
1. Selection 52
2. Adaptation 56
3. Preparation 56
4. Piloting 58
5. Implementation 59
Face-to-face training about mental health of refugees and other migrants 60
1. Selection 60
2. Adaptation 62
3. Preparation 62
4. Training 62
5. Implementation 65
Discussion 66
Online-course 66
Recommendations Online Course 72
Piloting of the mental health screening (RHS-13) and referral procedure 73
Recommendations 74
Face-to-face training about mental health of refugees and other migrants 75
Recommendations 75
Further recommendations 76

Conclusion 79

List of abbreviations 82

Annex 84

A1. Implementation protocol WP6 (04.04.2016) 85

Overview 86

Existing capacity of local primary health care for refugees (task 6.1) 89

Development of an e-curriculum (task 6.2 – 6.7) 90

Implementation of interventions (tasks 6.8 – 6.13) 92

Appendix 94

A2. Overview of the intervention phase of WP6 (27.06.2016) 96

Overview of the intervention phase of WP 6 tasks 6.8 – 6.13 97

Overview of the timeline, tasks and responsible partner 98

A3. Template for the implementation protocol of the intervention(s) (12.09.2016) 103

Introduction 105

Description of the target group and intervention site in Austria 106

Description of the intervention in Austria 106

Overview of the modules of the two courses 108

Description of the intervention implementation process (task 6.13 AUSTRIA) 109

Ethical approval 111

References 111

A4. Adaptation and translation guideline (02.08.2016) 113

A5. Template for the national report for deliverable 6.2 (25.10.2016) 116

Introduction 118

Tasks 6.8 – 6.13 120

Specific objective for task 6.8 – 6.13 120

Timeline for the different steps of the implementation phase 120

Method 123
Results 125
1. Description of the selection step 125
2. Description of the adaptation step 126
3. Description of the preparation step 127
4. Description of the training step 128
5. Description of the implementation step 129
Conclusion 130
A6. National Report Austria 132
Introduction 134
Tasks 6.13 136
Specific objective for task 6.13 136
Timeline for the different steps of the implementation phase 136
Method 140
Results 141
1. Description of the selection step 141
2. Description of the adaptation step 148
3. Description of the preparation step 150
4. Description of the training step 155
5. Description of the implementation step 163
Conclusion 164
A7. National Report Croatia 166
Introduction 168
Tasks 6.10 169
Specific objective for task 6.10 169
Timeline for the different steps of the implementation phase 169

Method 172

Results 174

1. Description of the selection step 174

2. Description of the adaptation step 182

3. Description of the preparation step 184

4. Description of the training step 186

5. Description of the implementation step 193

Conclusion 194

A8. National Report Greece 195

Introduction 197

Tasks 6.8 198

Specific objective for task 6.8 198

Timeline for the different steps of the implementation phase 198

Method 201

Results 203

1. Description of the selection step 203

2. Description of the adaptation step 209

3. Description of the preparation step 213

4. Description of the training step 215

5. Description of the implementation step 222

Conclusion 226

A9. National Report Hungary 233

Introduction 236

Tasks 6.8 – 6.13 237

Specific objective for task 6.8 – 6.13 237

Timeline for the different steps of the implementation phase 237

Method 240
Results 241
1. Description of the selection step 241
2. Description of the adaptation step 242
3. Description of the preparation step 244
4. Description of the training step 245
5. Description of the implementation step 245
Conclusion 246
A10. National Report Italy 247
Introduction 250
Task 6.13 251
Specific objective for task 6.13 251
Timeline for the different steps of the implementation phase 251
Method 254
Results 255
1. Description of the selection step 255
2. Description of the adaptation step 260
3. Description of the preparation step 262
4. Description of the training step 263
5. Description of the implementation step 267
Conclusion 269
A11. National Report Slovenia 271
Introduction 274
Tasks 6.10 275
Specific objective for task 6.10 275
Timeline for the different steps of the implementation phase 275

Method 279
Results 280
1. Description of the selection step 280
2. Description of the adaptation step 285
3. Description of the preparation step 286
4. Description of the training step 287
5. Description of the implementation step 289
Conclusion 291

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

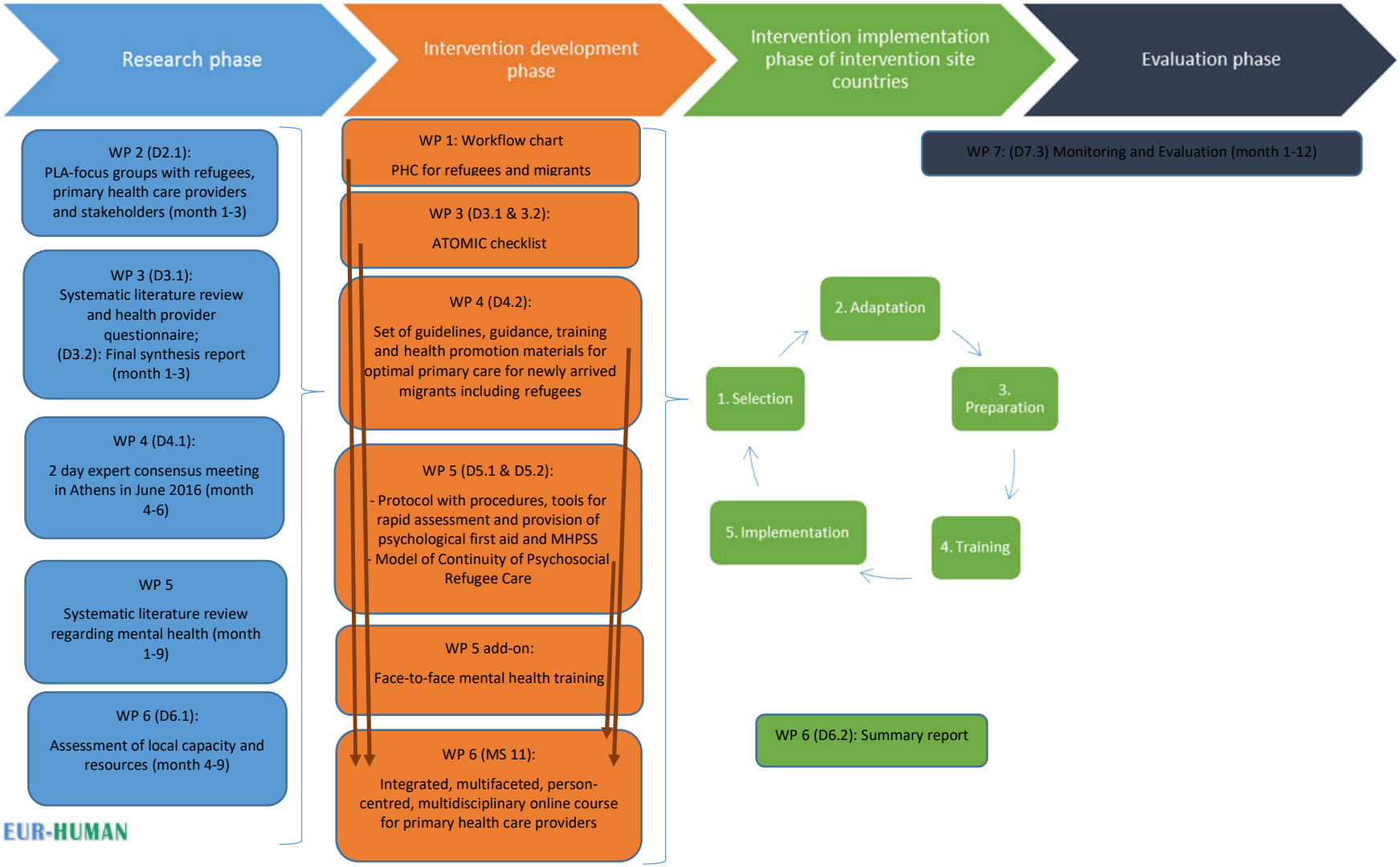
stakeholders, the consensus expert meeting held in Athens on 8th and 9th of June 2016 (WP4 with deliverable 4.1 – lead by RUMC jointly together with UoC and Univeristy of Liverpool (UoL)), the mental health assessment and intervention (WP5 with deliverable 5.1 – lead by FFZG), the model of integrated 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

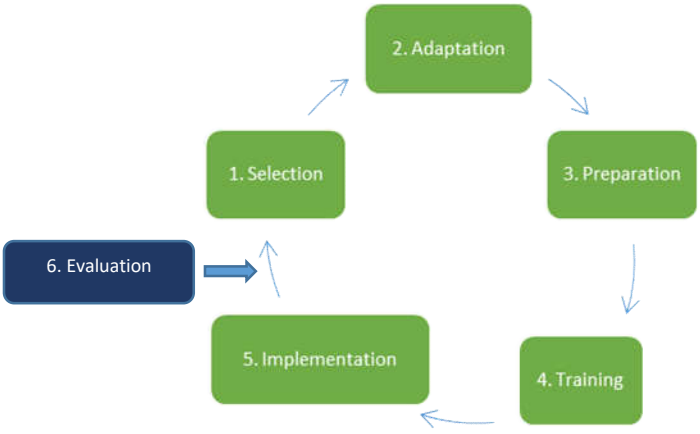


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

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

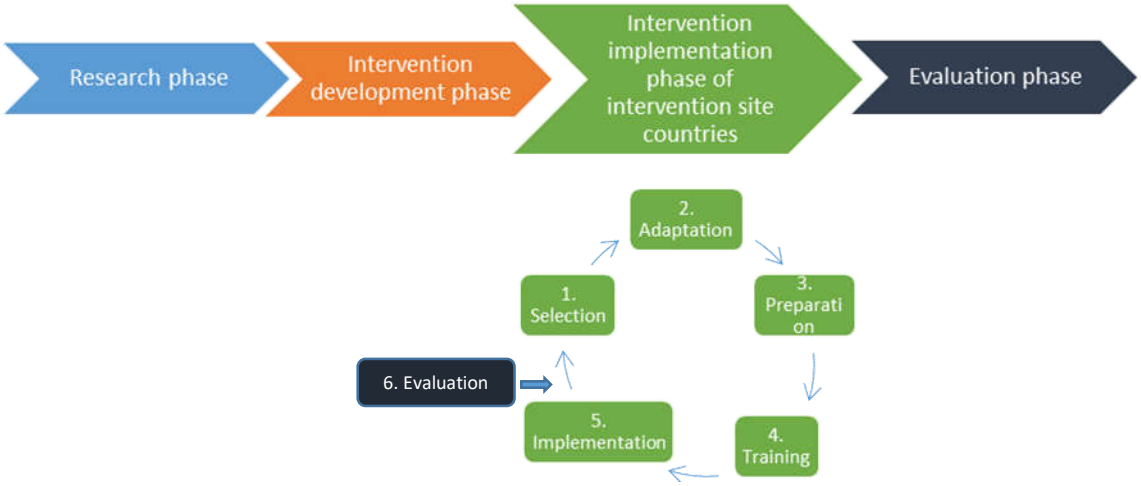
	• Pre- and post-tests • Certificates Other training(s) • Regional and local one day train the trainers meetings Evaluation of the intervention and underlying training with questionnaire provided by EFPC and UoL	
November 2016	Participants apply the new learned content into their specific working setting 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).

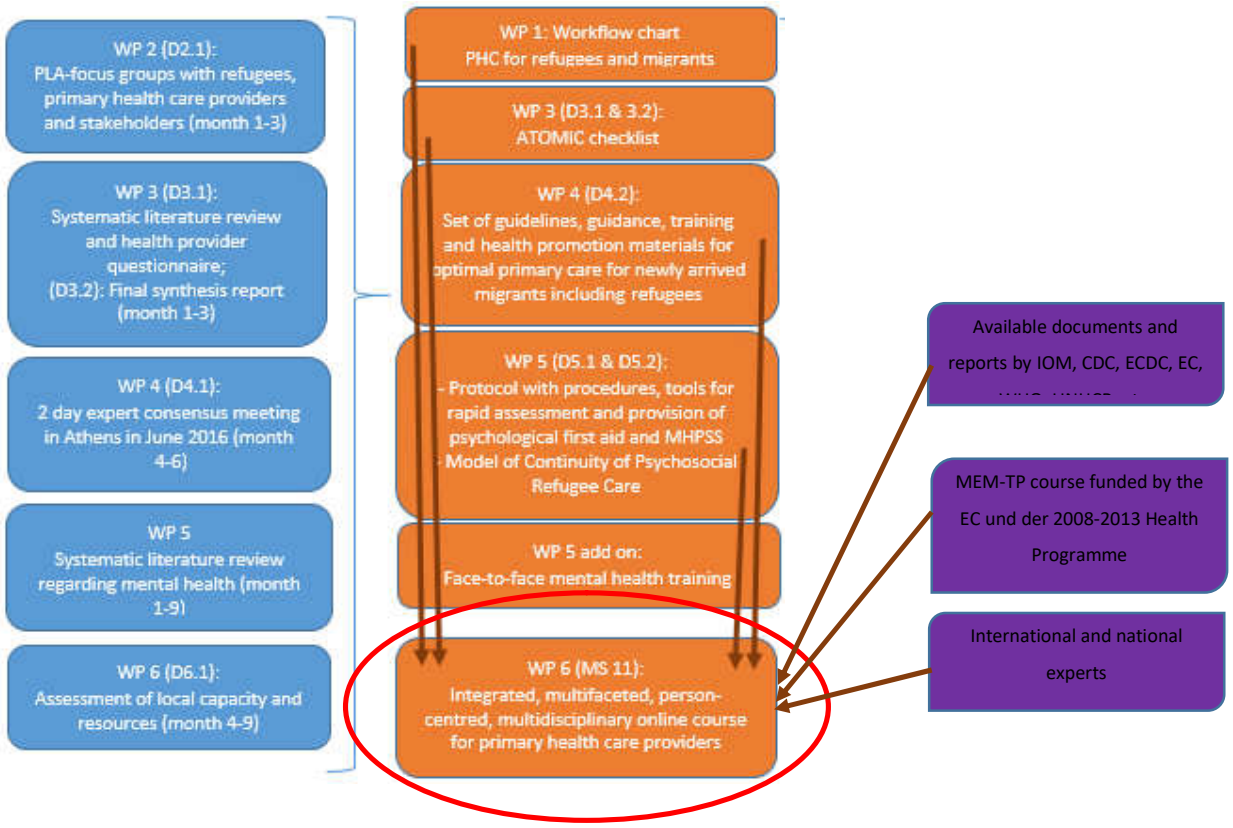
The course also, includes the checklists, guidelines, tools, training material and interventions described in table 2 which are based on the data collection phase results:

- 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

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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

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

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Content

Overview 86

Existing capacity of local primary health care for refugees (task 6.1) 89

Development of an e-curriculum (task 6.2 – 6.7) 90

Implementation of interventions (tasks 6.8 – 6.13) 92

Appendix 94

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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

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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 105

Description of the target group and intervention site in Austria 106

Description of the intervention in Austria 106

Overview of the modules of the two courses 108

Description of the intervention implementation process (task 6.13 AUSTRIA) 109

Ethical approval 111

References 111

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)

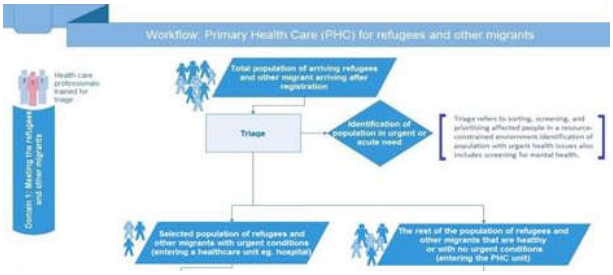
Therefore, the online course consists of eight modules. Altogether, after the online-registration the course will take two to four weeks. Since one module will take about one hour the participant has to dedicate two hours per week to the course. At the end of the course participants will receive a certificate.

Overview of the modules of the two courses

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

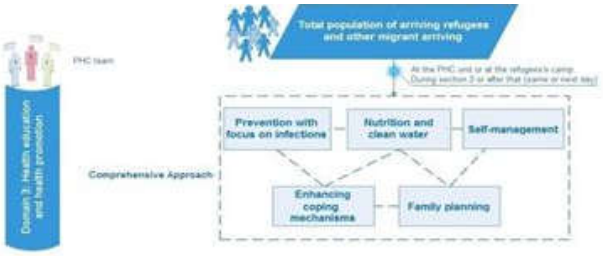
1. Introduction (with explanation which chapters are recommended for which of the three settings described in the operational handbook) **T**=triage; **F**=First contact with PHC; **L**=Long-term PHC
2. Initial health assessment, acute conditions and infectious diseases: red flags; travel disorders, 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.

References

1. Gushulak BD, Pottie K, Roberts JH, Torres S, DesMeules M. Migration and health in Canada: health in the global village. CMAJ 2010. DOI:10.1503/cmaj.090287
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6. Hoffmann K, Wojczewski S, George A, Schäfer WLA, Maier M. Stressed and overworked? A cross-sectional study of the working situation of urban and rural general practitioners in Austria in the framework of the QUALICOPC study. Croat Med J. 2015 Aug;56(4):366-74.

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

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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

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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 118

Tasks 6.8 – 6.13 120

Specific objective for task 6.8 – 6.13 120

Timeline for the different steps of the implementation phase 120

Method 123

Results 125

1. Description of the selection step 125

2. Description of the adaptation step 126

3. Description of the preparation step 127

4. Description of the training step 128

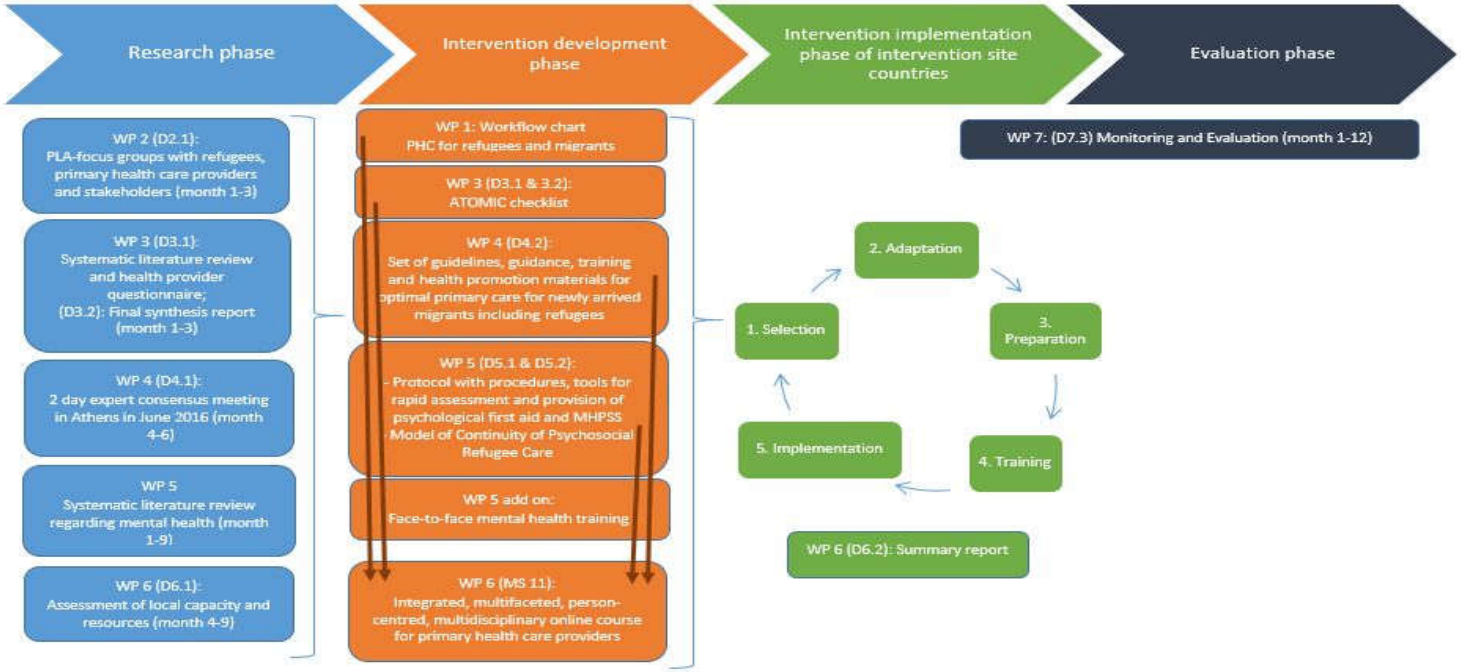
5. Description of the implementation step 129

Conclusion 130

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

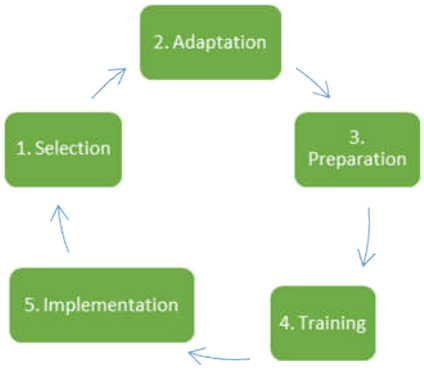


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

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

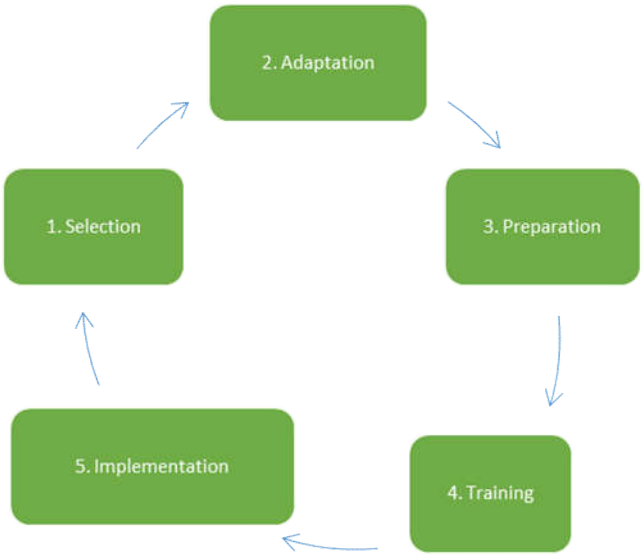
Commented [M3]: Please add if necessary

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

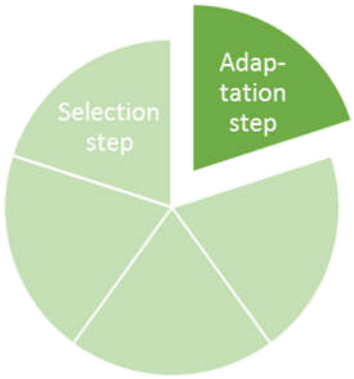
1. **Intervention and underlying training:**
    a. **Description of the first intervention and underlying training: …**
    b. **Description of the setting where the first intervention and training takes place: …**
    c. **Description of why did you choose this intervention for this setting (*there 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:

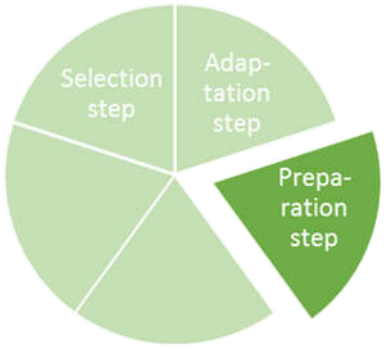
1. Intervention and underlying training:

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

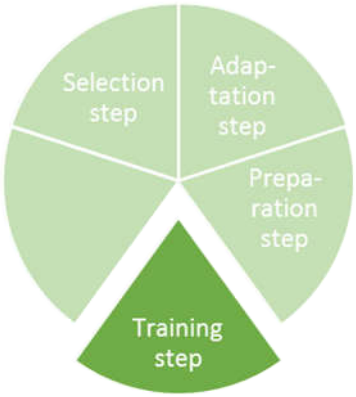
1. **Intervention and underlying training:**
   a. **Recruitment process of target-group: …**
   b. **Invitation of experts, speakers, etc. : …**
   c. **Location for training: …**
   d. **Negotiation process for CME points: …**
   e. **Kick-off event: …**

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.:**

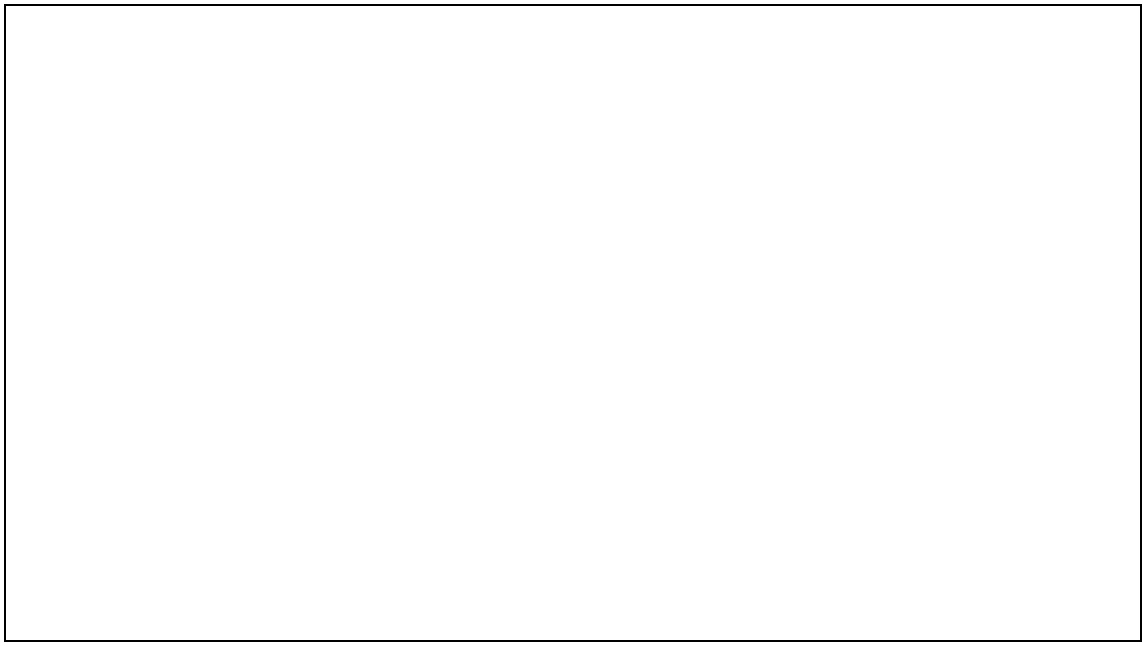
5. Description of the implementation step

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

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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 134

Tasks 6.13 136

Specific objective for task 6.13 136

Timeline for the different steps of the implementation phase 136

Method 140

Results 141

1. Description of the selection step 141

2. Description of the adaptation step 148

3. Description of the preparation step 150

4. Description of the training step 155

5. Description of the implementation step 163

Conclusion 164

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.

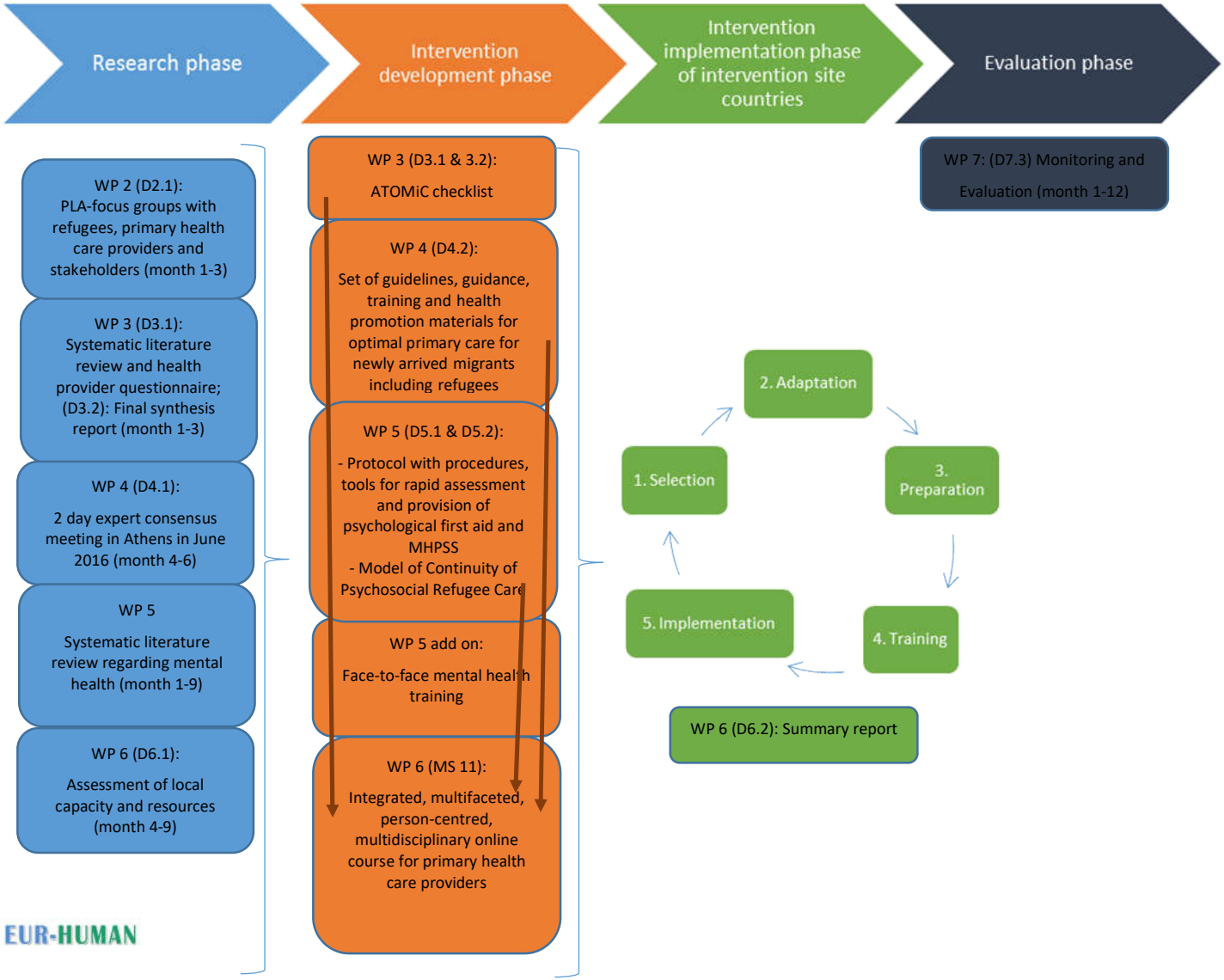
Picture 1 on the next page shows the detailed workflow process of the project.

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

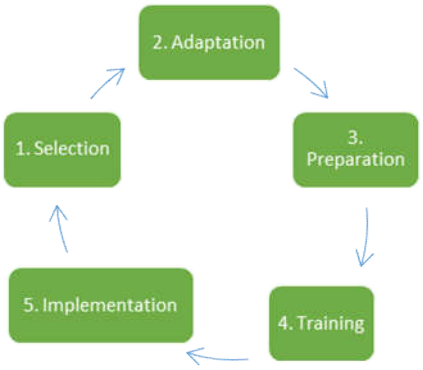


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

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

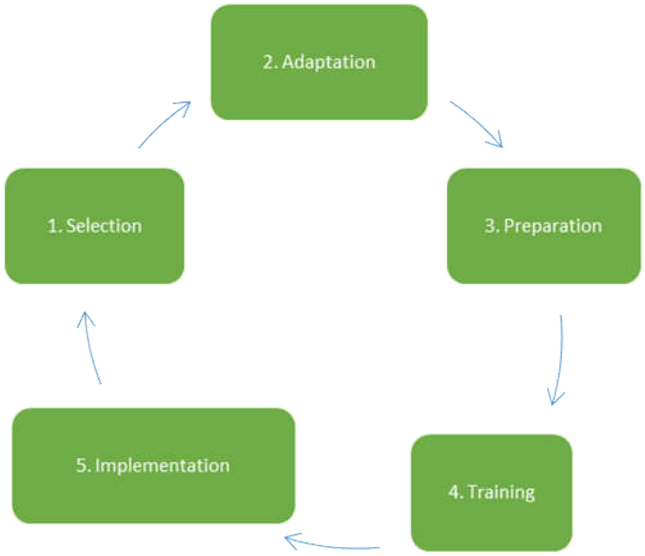
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc.	Preparation
15. Sep – 01. Nov 2016	Preparation of the training(s) • Location • Invitations of speakers, experts	Preparation
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

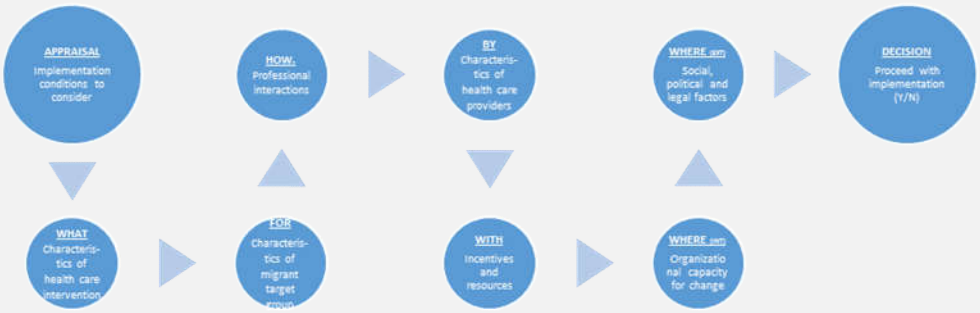
What kind of intervention(s) and underlying training(s) did you choose (out of D 4.2, D 5.1, D 5.2, online course, face-to-face training) for your specific setting and why (what was the necessity/the need to choose exactly this intervention(s))? Please also add how you used the ATOMiC Model checklist.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

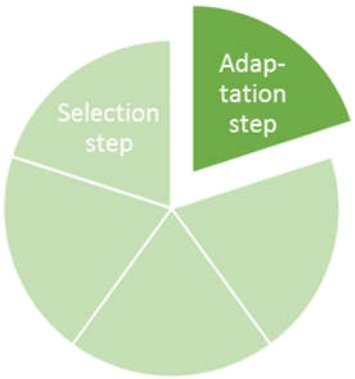
The inclusion of primary health care providers into the primary health care workforce of specific countries is of major importance. Among the refugees there are numerous trained health providers; they face a long transition period before they are able to practice their profession in the destination country. 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.

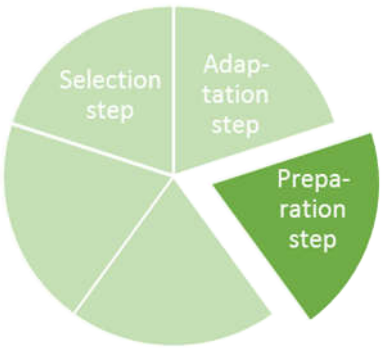
An abbreviated version of version 2 was also translated into Arabic; this is referred to as the

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:

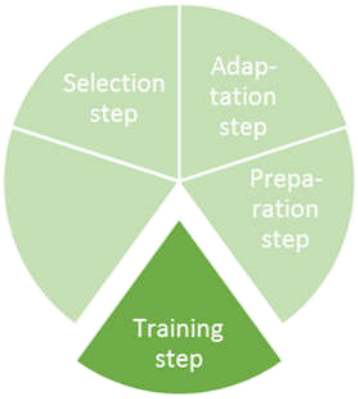
The kick-off event was organized by the MUW team in close collaboration with members of the informal network of the Arab-speaking health care providers. The district government of the 7th district of Vienna (Neubau) kindly made the district's conference hall available to us pro bono.

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. Training: online course for Austrian PHC providers (GPs) **a. Timeframe of the training (dates, hours):** **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. Learning hours for the participants:** **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

"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

Introduction 168

Tasks 6.10 169

Specific objective for task 6.10 169

Timeline for the different steps of the implementation phase 169

Method 172

Results 174

1. Description of the selection step 174

2. Description of the adaptation step 182

3. Description of the preparation step 184

4. Description of the training step 186

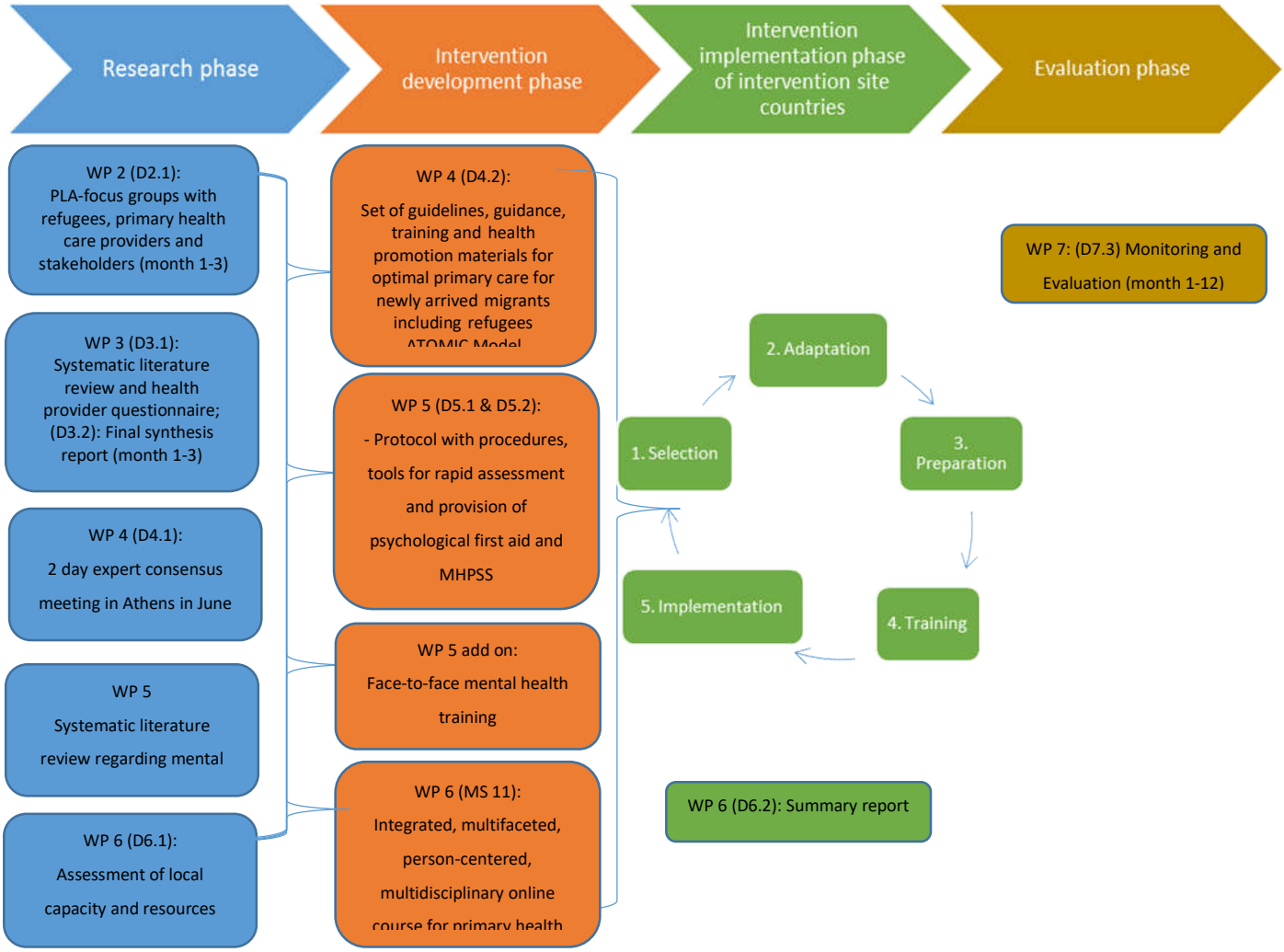
5. Description of the implementation step 193

Conclusion 194

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

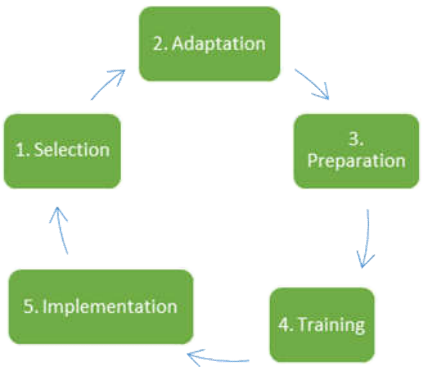
Croatia has selected, prepared and implemented at least one interventions that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and other migrants.

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

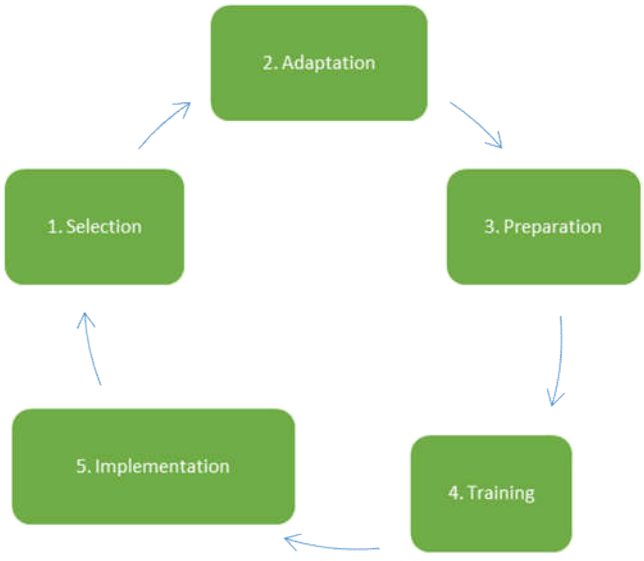
	13. Target-group specific context adaptations 14. Translation (and editing)	
01. Aug. – 01. Nov 2016 (depending on the delivery of the country-specific versions to eHF)	**Programming of the online versions of the country-versions of the online course by e-Health Foundation (MS 13)** Cross-checking and 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.

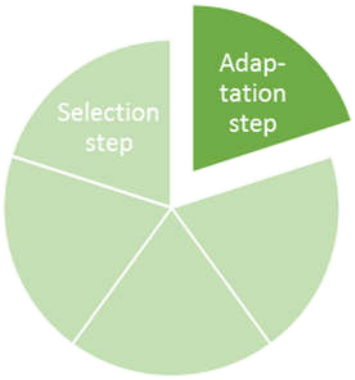
The aim of piloting the MH screening and referral procedure was to screen all adult refugees and other migrants who agree to participate. From the total number of 200 adults in the reception centre at that time, 123 participated (61.5%). Participants were primarily male (86.2%), aged between 18 and 50 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

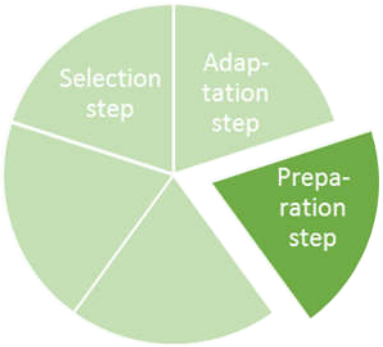
3. Evaluating the results and immediate assistance (referral if needed)

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.

Training

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

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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."

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Content

Introduction 118

Tasks 6.8 – 6.13 120

Specific objective for task 6.8 – 6.13 120

Timeline for the different steps of the implementation phase 120

Method 123

Results 125

1. Description of the selection step 125

2. Description of the adaptation step 126

3. Description of the preparation step 127

4. Description of the training step 128

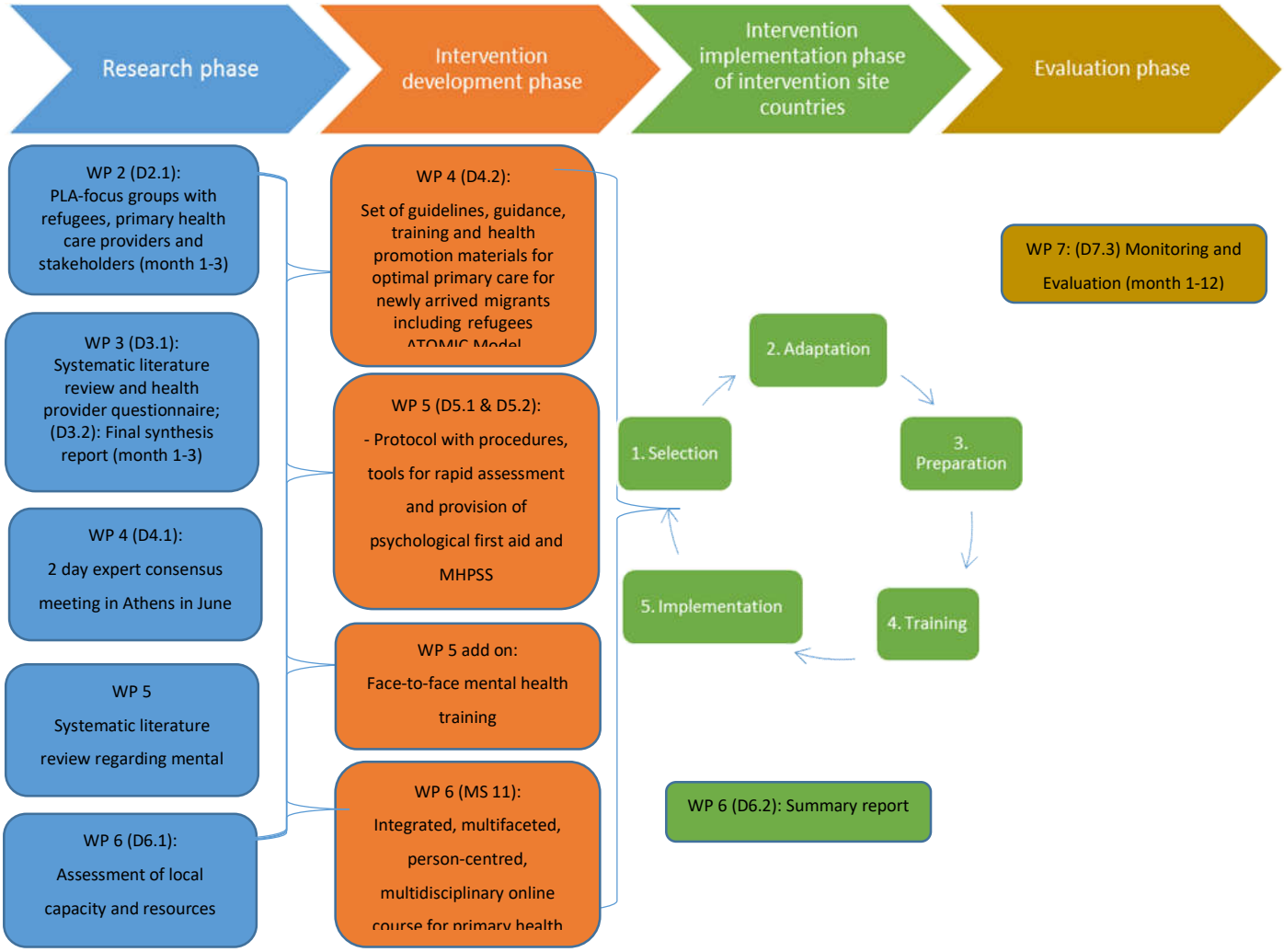
5. Description of the implementation step 129

Conclusion 130

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

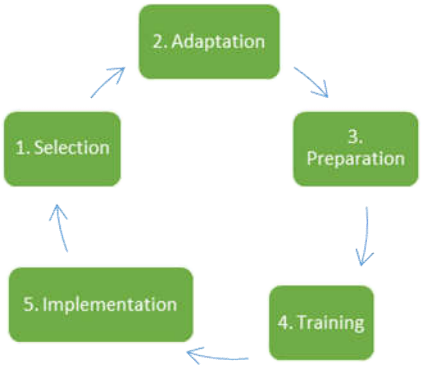


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

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

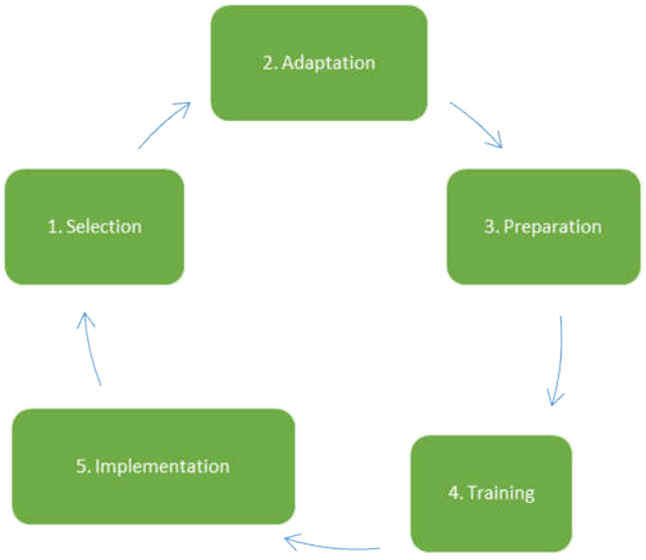
the delivery of the country-specific versions to eHF)	Cross-checking and last editing	
15. Sep – 01. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc. • …	Preparation
15. Sep – 01. Nov 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.**

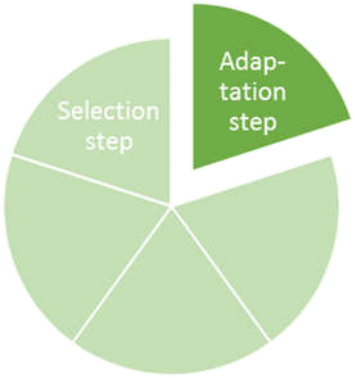
d. Detailed description of the target group in this setting (number, profession, etc.):

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.**

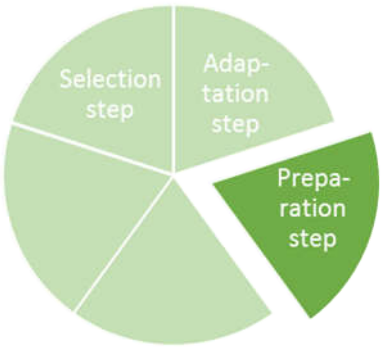
After the translation and adaption by the Greek team (since August 2016 until end of September 2016), the material was crosschecked for errors and possible improvements by the UoC member Enkeleint-Aggelos Mechili. The programming of the online course was realized in close collaboration with Judith de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

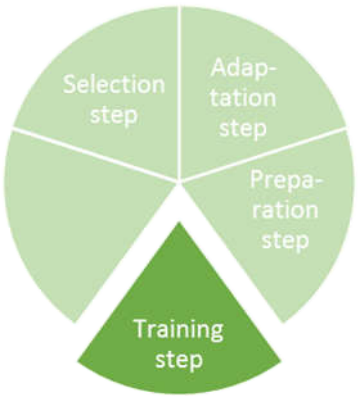
d. Negotiation process for CME points:

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*		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***
'no' indicates that the target group requires special attention		the intervention can be applied regardless of cultural and religious characteristics of the target group (e.g. sensitivity to stigma, shame) ***YES***
		the intervention can be applied regardless of the level of knowledge and education of the target group ***YES***
HOW - *Professional interactions*	applying the health care intervention requires	awareness of particular symptoms or signals (e.g. psychological and physical trauma, child maltreatment, infectious diseases)? ***NO***
'yes' indicates that patient contact requires special attention		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*	professionals applying the intervention, interacting with the refugee/migrant target group, require	specialized knowledge and education (incl. women, children and elderly) ***NO***
'yes' suggests that care givers should meet particular requirements		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

"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

Introduction 118

Tasks 6.8 – 6.13 120

Specific objective for task 6.8 – 6.13 120

Timeline for the different steps of the implementation phase 120

Method 6

Results 125

1. Description of the selection step 125

2. Description of the adaptation step 126

3. Description of the preparation step 127

4. Description of the training step 128

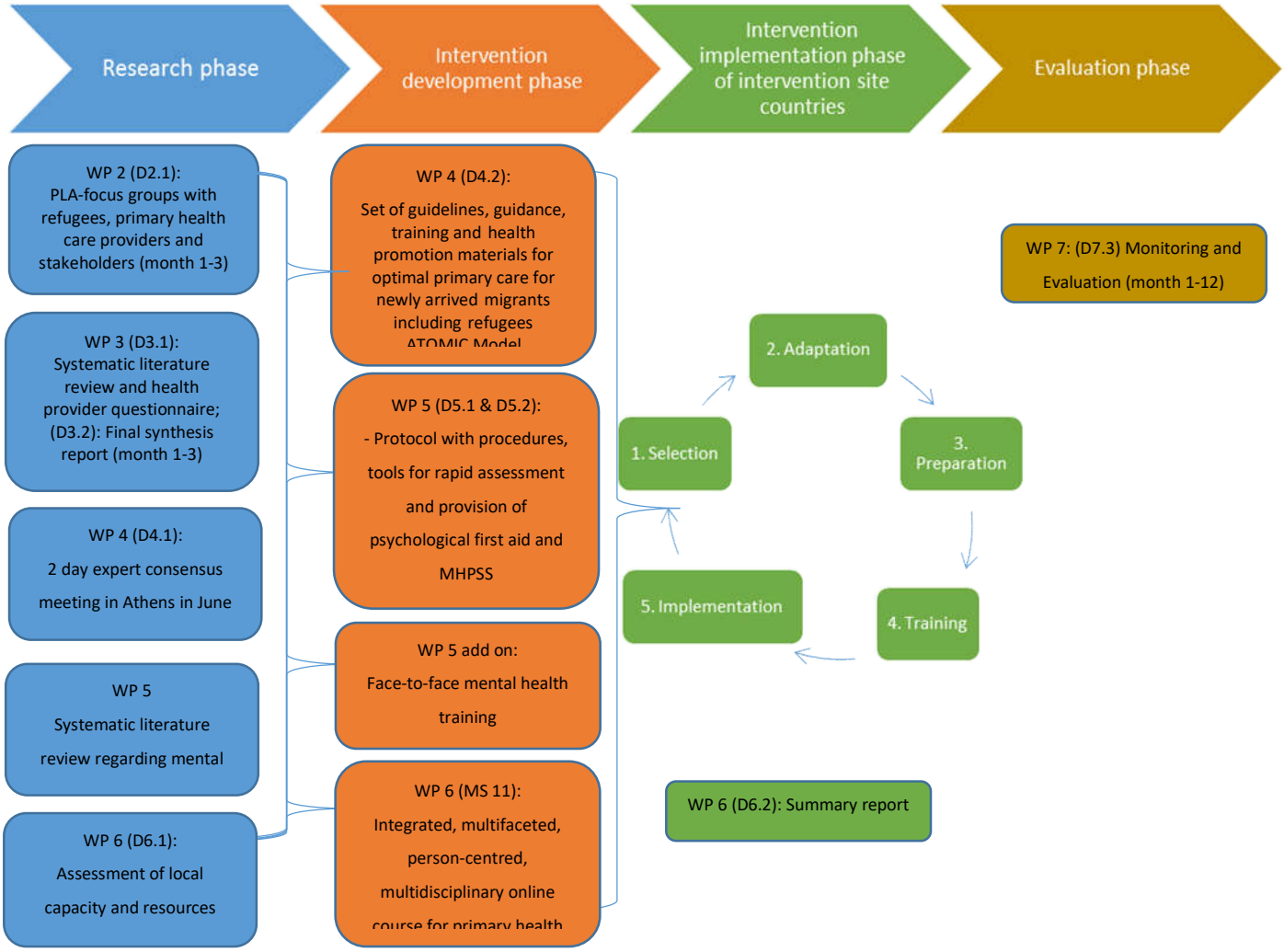
5. Description of the implementation step 129

Conclusion 130

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

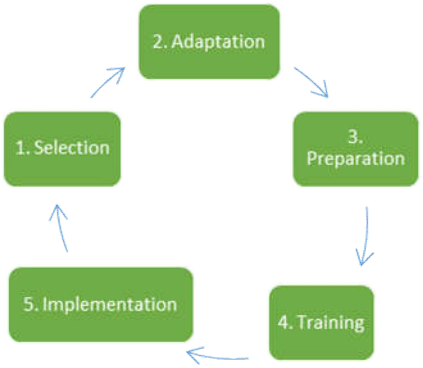


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

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

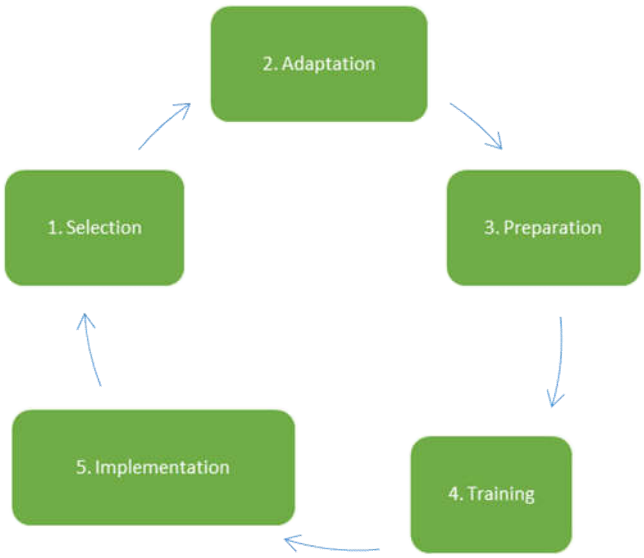
to eHF)		
15. Oct – 10. Nov 2016	Recruiting of the participants for the training(s) and following implementation of the intervention • Recruitment • Kick-off events, warming-up sessions, etc. • …	Preparation
15. Sep – 01. Oct 2016	Negotiation about CME credit points for the training(s)	Preparation
15. 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*:

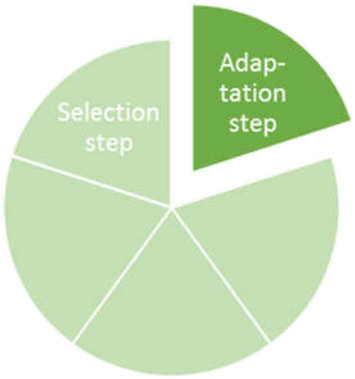
Detailed description of the target group in these settings (number, profession, etc.):

- 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:

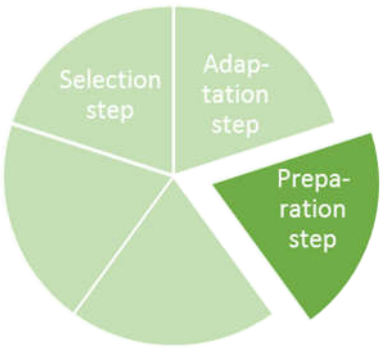
Office has a power to facilitate employers to be attended.

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

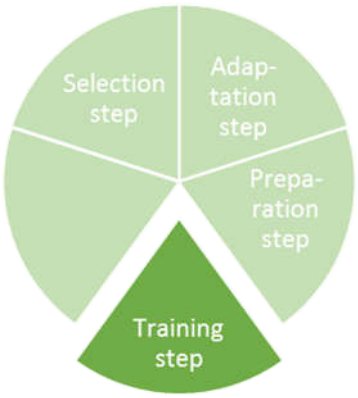
The target groups for the online course are the PHC providers who have experience of working with migrants and refugees or interesting for this information and knowledge.

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

Introduction 118

Task 6.13 120

Specific objective for task 6.13 120

Timeline for the different steps of the implementation phase 120

Method 123

Results 125

1. Description of the selection step 125

2. Description of the adaptation step 126

3. Description of the preparation step 127

4. Description of the training step 128

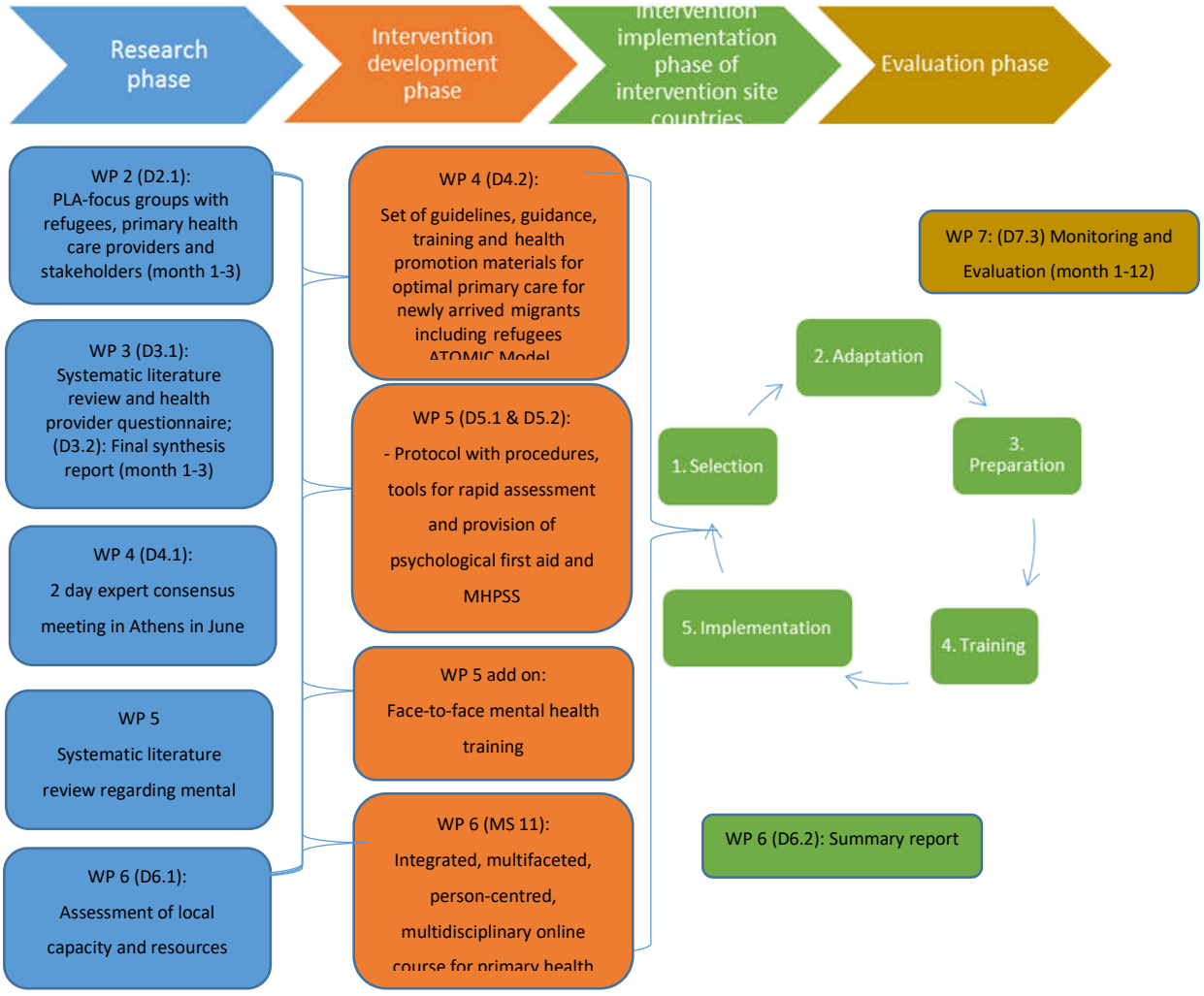
5. Description of the implementation step 129

Conclusion 130

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 (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

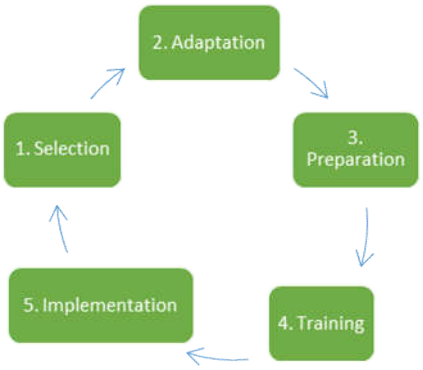


Table 1: Timeline for the different steps of the implementation phase in accordance with the work cycle

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

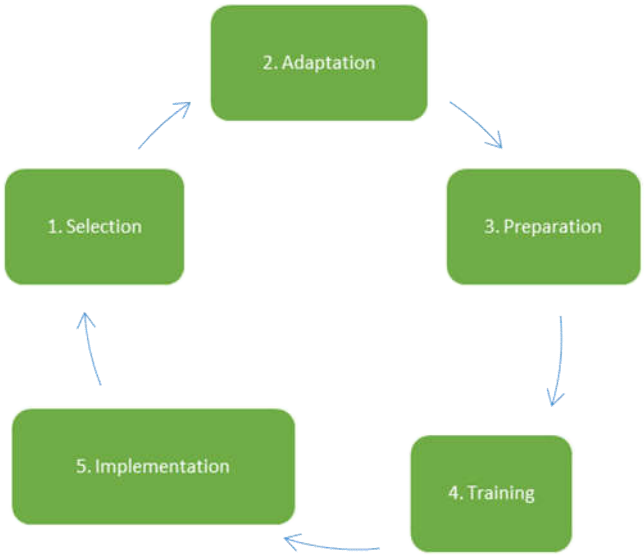
01. Aug – 01. Oct 2016	Country-specific adaptations of the interventions described above 21. Country-specific context adaptations (such as country specific legal system, epidemiological picture, etc.) 22. Target-group specific context adaptations 23. Translation (and editing)	Adaptation
01. Aug. – 01. 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).

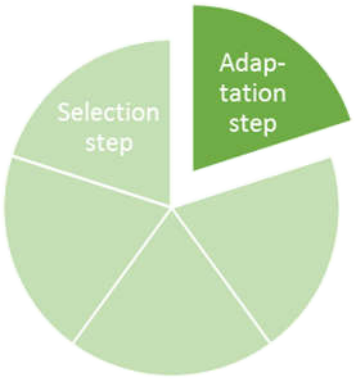
The Central Tuscany Local Health Unit covers the territories of Florence, Prato, Pistoia and Empoli, and it is the area where the majority of refugees and asylum seekers live.

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.

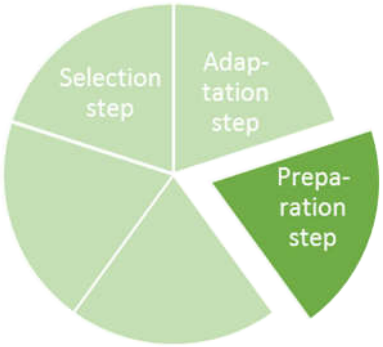
8. Intervention and underlying training:

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

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Erika Zelko

Alem Maksuti

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

Introduction 274

Tasks 6.10 275

Specific objective for task 6.10 275

Timeline for the different steps of the implementation phase 275

Method 279

Results 280

1. Description of the selection step 280

2. Description of the adaptation step 285

3. Description of the preparation step 286

4. Description of the training step 287

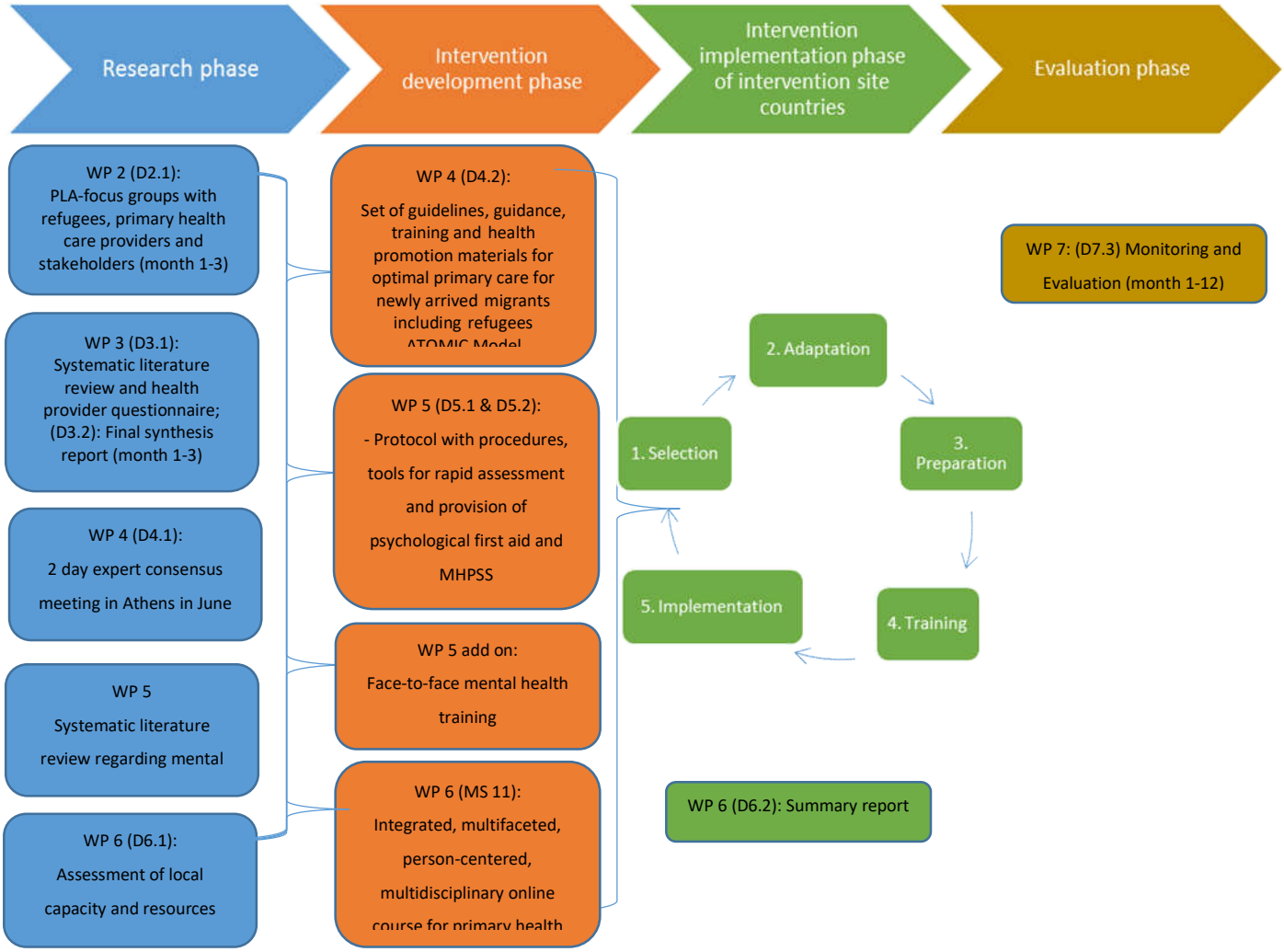
5. Description of the implementation step 289

Conclusion 291

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

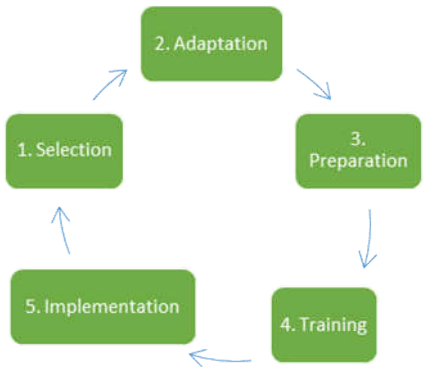
Slovenia has selected, prepared and implemented at least one interventions that has emerged from WP 4, 5 or 6 in a well-defined setting for refugees and migrants.

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

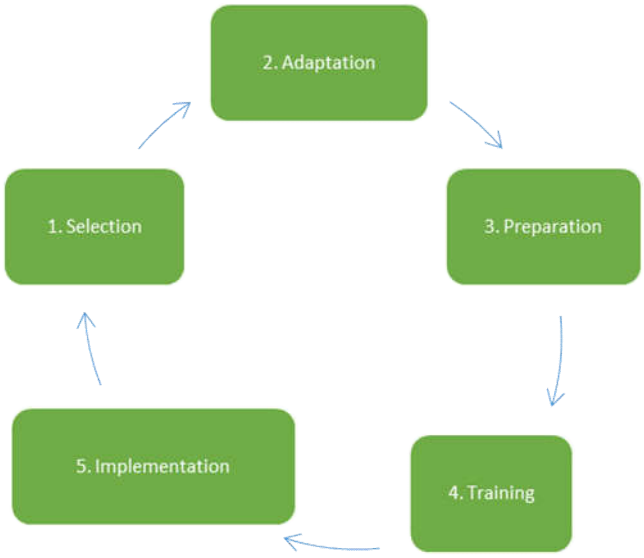
28 November	November 2016 in Izola.	meeting with nurses
1. Sep – 01. Nov 2016	Negotiation about CME credit points for the training(s) with the Medical Chamber and the Nurses and Midwives Association of Slovenia. Case number: 623-334 / 16-3 Decision number: 2016-311-311 Date: 21. 11. 2016	Finished
15. 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.

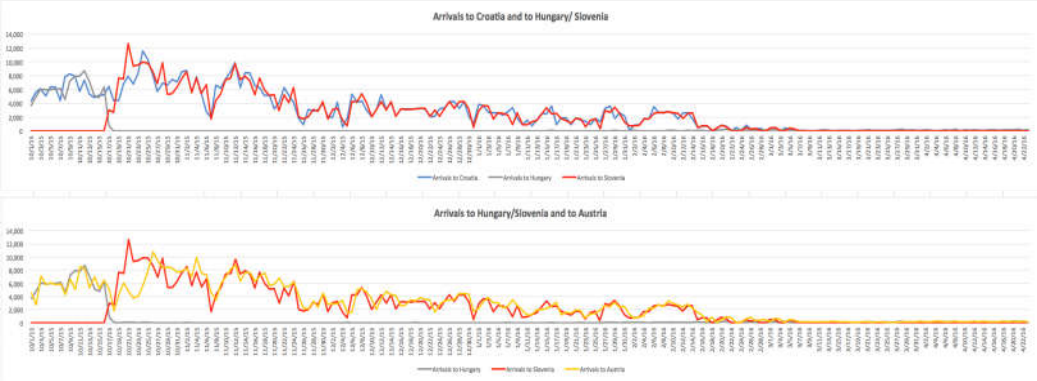
<u>The results of workshop in Logatec:</u> Refugees/migrants are one of the most vulnerable groups in our society, presenting high levels of exposure to traumatic events. The participants agreed that high levels of refugees/migrants required professional psychological distress, but only a small percentage 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.?

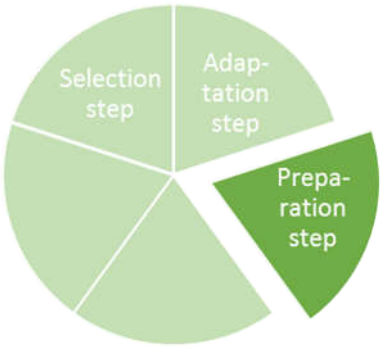
4. Online course

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:

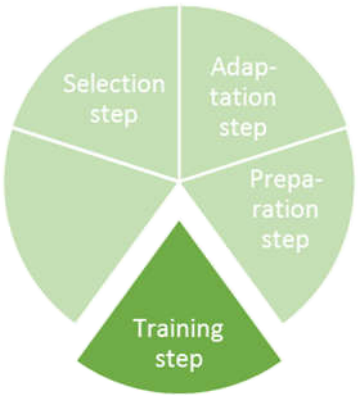
The target groups for the online course were primary health care providers who have experience of working with migrants and refugees. Before the online course, we tried to organise a face to

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!

APPENDIX 12. DELIVERABLES OF WP7.

D7.1 Monitoring and Evaluation Framework.

EUR-HUMAN

EUropean Refugees - HUman Movement and Advisory Network

Monitoring and Evaluation Framework

WP7, Deliverable 7.1
Pim de Graaf & Sanne Snoeijs

Co-funded by the Health Programme of the European Union

"*This EUR-HUMAN Monitoring & Evaluation Framework is part of the project / joint action '717319 / EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020).*"

"*The content of this EUR-HUMAN Monitoring & Evaluation Framework 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*." them the right to exclusive use.

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Content

Status of this document 4

Introduction 5

Aims 5

Contents and steps 5

Part 1: Monitoring & Evaluation Framework 7

WP1: Coordination, Dissemination and Management of Project's Execution *8*

WP2 Communicating and liaison with stakeholders and refugees *13*

WP3 Review of literature and expert knowledge *20*

WP4 Developing tools and evidence-based practice guidelines for health care practitioners *24*

WP5 Mental health psychosocial support (MHPSS) and first aid for refugees *30*

WP6 Enhanced capacity building strategy for primary care staff, as well as preparation and implementation of recommended interventions in selected implementation sites *35*

Part 2: EUR-HUMAN Deliverables and output 44

Part 3: EUR-HUMAN Critical issues 46

Part 4: EUR-HUMAN Summary of modifications and actions 48

Appendix 1: List of milestones 48

Status of this document

This M&E Framework is for use by EUR HUMAN project consortium members and for information to Chafea. It is a document that will be under constant development throughout the duration of the project, with updates provided at the end of M1; M3; M5; M8; M12. In M13 the document will be used as input for the final evaluation report as part of the final project report.

	D7.1	**M1** **Febr 4, 2016**	**M3**
WP1	Framework accepted	Seen, no comments	
WP2	Framework accepted	Discussed and agreed	
WP3	Framework accepted	Content in progress.	
WP4	Framework accepted	Discussed and agreed	
WP5	Framework accepted	Seen, agreed	
WP6	Framework accepted	Comments in process	
WP7	Framework accepted	Content in progress	

	M5	**M8**	**M12**
WP1			
WP2			
WP3			
WP4			
WP5			
WP6			
WP7			

Introduction

Aims

The main aim of monitoring of the EUR-HUMAN project is to provide support to the consortium members. An important aspect is to prevent overlap and to strengthen the alignment between the different Work Packages. Monitoring also aims at learning of all stakeholders. Not only in terms of optimizing the project itself, but also in terms of how best to provide primary health care to refugees and migrants, in general.

Further, monitoring provides an regularly updated overview of adaptations of the activities, outputs and (expected) results and outcomes. This allows all stakeholders to understand the implementation process and its challenges and to adapt, where necessary. It also supports the overall coordination (WP1) in assessing the need for amendments of the Grant Agreement.

Finally, evaluation contributes to accountability of the project, by assisting the Work Package coordinators in describing the outputs and results in terms of outcomes and impact. Evaluation helps to asses in how far the objectives have been achieved and identify learning points, both for the consortium partners and CHAFEA and for health care providers in general.

Based on the above, WP7 developed the M&E Framework below, that aims to provide answers to the following questions:

Process:
- How well was the process of the project and the implementation of the tools and guidelines at the selected implementation sites in line with what was proposed in the Grant Agreement?
- In case of deviation from what was proposed in the Grant Agreement, what is the rationale behind the change and what are the results of the changes made?

Outcomes:
- To what extent did the project meet the overall needs of the stakeholders (refugees and migrants, primary care professionals, local stakeholders) at the selected intervention sites?
- To what extent did the project meet the overall aims on European level as described in the Grant Agreement?
- What is the uptake of the tools/guidelines by organizations/ stakeholders in the Member States?

Learnings:
- What worked and what did not, and why?
- What were (un)intended consequences that resulted from the project?

Contents and steps

This Monitoring and Evaluation framework contains

1) an overview of commitments per Work Package, as described in the Grant Agreement. The commitments are reviewed in relation to clarification and modification (when applicable) of the following aspects:

- Objectives
- Tasks
- Deliverables
- Milestones
- Indicators of process, output and outcome/impact

At the end of M1; M3; M5; M8; M12 comments, changes and actions with regards to the listed aspects are described and discussed with each WP leader. Aspects are clarified and adaptations are

systematically described, which allows for monitoring the alignment between Work Packages. The systematic description of adaptations and possible amendments will provide justification for the evaluation as part of the final project report.

2) A list that shows the progress of deliverables during the lifetime of the project

3) A list with critical issues that emerge during the project

4) A summary of modifications, that serves to keep track of what changed and what actions need to be undertaken.

As part of the process of M&E, an interim evaluation report will be issued at M6, aligned with the mid-term review.

At M12, an evaluation meeting will discuss, amongst others, in how far outcomes have been achieved, learning points and suggestions for further activities and collaboration.

At M13, a chapter in the final project report will contain the final evaluation.

Monitoring & Evaluation (M&E) is steered by WP7 with the intention to put a minimum of strain on time and resources of the WP leaders.

Part 1: Monitoring & Evaluation Framework

Framework for monitoring & evaluation - to be filled in for each Work Package.

Timing: at the end of M1; M3; M5; M8; M12 AND on indication of WP leaders

WP1: Coordination, Dissemination and Management of Project's Execution

In the Grant Agreement, the Work Package is described. The items below refer to this section.		
What	**When; subject**	**Comments – changes - actions**
Clarification of original objectives and later modification of objectives , if any.	M1: no clarification needed	
Clarification of original tasks and later modification of tasks, if any.	M1: no clarification needed	
Clarification of original deliverables and later modification of deliverables, if any.	M1: no clarification needed	
Clarification of (timing of) milestones and later modification of (timing of) milestones, if any.	M1: no clarification needed	
In the Grant Agreement, one section describes the specific objectives, process/output and outcome/impact indicators of each Work Package. The items below refer to these.		
Specific objectives	See above	
Clarification of process indicators and targets, and later modification, if any	M1: no clarification needed	
Clarification of output indicators and targets, and later modification, if any	M1: no clarification needed	
Clarification of outcome/impact indicators and targets, and later modification, if any	M1: no clarification needed	

Work package number [9]	WP1	**Lead beneficiary** [10]	1 - UOC
Work package title	Coordination, Dissemination and Management of Project's Execution		
Start month	1	**End month**	12

Objectives

To supervise, manage and coordinate the EUR-HUMAN project in order to assure that the EUR-HUMAN project is implemented according to plan.
To disseminate the results, conclusions, guidelines and recommendations to the stakeholders, national and international authorities, health policy makers, refugees, migrants and to the public, through professional networks, meetings and conferences, website and printed material in various languages.

Description of work and role of partners

WP1 - Coordination, Dissemination and Management of Project's Execution [Months: 1-12]
UOC, RUMC, UoL, NIVEL, FFZG, MUW, UL, EFPC, ARQ, AUSL 11, UoD
The coordinator will be responsible for organising the meetings of the steering committee, the kick-off meeting (to be held in Crete, Greece) and an interim meeting in month 6 and the final meeting with representatives of all EUR-HUMAN project participants. All beneficiaries will be involved in all tasks, of WP1 that will be coordinated by Prof. Christos Lionis. During the kick-off meeting the aims and outline of the project will be discussed with attention for the planned roles and activities of all partners. All participants will reach to an agreement regarding the limitations of the project, internal reports, and evaluation plan of the project, means of communication, dissemination strategies, publications rights, financial matters and administrative tasks.

Task 1.1: Kick-off meeting (M1)
A meeting between the WP Leaders, together with personnel significantly involved in the project will take place within the first month of the official project start date. The overall project strategy and timetable will be framed and arrangements for effective communication will be agreed.

Task 1.2: Steering committee and Advisory board (M1)
A steering committee will be established consisting of the EUR-HUMAN project coordinator, a representative of each beneficiary (preferably the WP leader), and a member of the management team. The steering committee will meet to monitor the progress of the project, and to discuss budgetary issues, milestones and deliverables. Minutes of the meetings will be made. A first task of the steering committee will be to reach consensus about a consortium agreement to be signed by all partners involved in the EUR-HUMAN project. The consortium agreement includes articles about e.g. responsibilities of the partners and the steering committee, (co-) authorship, and rules how to cope with potential conflicts or disagreements. Possible conflicts that cannot be solved otherwise will be decided upon by the steering committee. The Advisory Board will be established and consist of the coordinator and the leader or a scientific representative of each partner organization. This board meeting would be held twice via a teleconference or in person, over the twelve months of the project. The Advisory board will establish an international consulting body for the project and will offer feedback on the direction and progress of work on the project as well as guidance on quality assurance for the main deliverables of the project. The Advisory board will communicate with the Steering Committee after each meeting.

Task 1.3: Meetings of the project (M12)
The coordinator will be responsible for organizing the meetings of the steering committee, the kick-off meeting and the final meeting with representatives of all project participants. During the meetings, agreements will be reached on boundaries of the project, uniformity of definitions, internal communication, potential dissemination strategies, authorship of publications and financial and administrative affairs as already mentioned in Tasks 1.1 & 1.2.

Task 1.4: Dissemination plan (M1)
The dissemination plan has to ensure both a specific and more general use of the results, conclusions and recommendations of the project. The utilization of a project website and project leaflets will be central to the plan. There will also be at least two project newsletters produced during the EUR-HUMAN to demonstrate advances

made in the project. The newsletters will be translated into the languages of partners and the emergent key languages in each project

site. The key aim is to publish project results to stakeholders, national and international authorities health policy makers in countries mainly affected by the refugees' crisis and to the public.

Task 1.5: Project website (M1)
A project website will be established and maintained with a public and password protected areas. The EUR-HUMAN website will incorporate both public and private access areas. The public area will include information concerning the project purposes, its objectives, contact details of the partners, the results, conclusions and recommendations of the project etc. The protected part will only be accessible for the project partners and is meant to facilitate the communication between partners and archive projects' documents and databases related to project meetings. The website will also be used as a dissemination mean of the progress of the project as well as the results, conclusions and recommendations of each work package.

Task 1.6: Project leaflet (M3)
A project information leaflet will be prepared describing the project, its objectives and activities, recommendations, guidelines of best practice and the results of the project. This leaflet will be used for promotion of the project at conferences and meetings where relevant and for providing guidance to the refugees and migrants in the implementation sites. The leaflet will be translated into the appropriate languages spoken by the refugees and migrants using the implementation centers.

Participation per Partner

Partner number and short name	WP1 effort
1 - UOC	10.00
2 - RUMC	3.00
3 - UoL	2.50
4 - NIVEL	3.00
5 - FFZG	3.00
6 - MUW	1.50
7 - UL	3.00
8 - EFPC	1.50
9 - ARQ	3.00
10 - AUSL 11	3.00
11 - UoD	3.00
Total	36.50

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D1.1	Final report to CHAFEA	1 - UOC	Report	Confidential, only for members of the consortium (including the Commission Services)	12

D1.2	Project website	1 - UOC	Websites, patents filling, etc.	Public	1

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D1.3	Project leaflet	1 - UOC	Report	Public	3

Description of deliverables

Deliverable MD.1.1 Final report to CHAFEA (M12)
Deliverable 1.2 Project website (M1)

D1.1 : Final report to CHAFEA [12]

This report describes the project implementation and the results achieved. The deliverables are annexed.

D1.2 : Project website [1]

Project website realized

D1.3 : Project leaflet [3]

A leaflet to promote the project

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS1	Advisory board meeting	1 - UOC	4	Meeting with the board online.

WP2 Communicating and liaison with stakeholders and refugees

In the Grant Agreement, the Work Package is described. The items below refer to this section.		
What	**When; subject**	**Comments – changes - actions**
Clarification of original objectives and later modification of objectives, if any.	M1: clarification of: "to facilitate the sense of coherence and community engagement". M1: clarification of: "refugees and other migrants".	The sense of coherence and community engagement of the refugees. This is an effect that can result from the PLA technique, especially when multiple sessions are performed. However, due to the specific context of the target group who are on the move, it will not be feasible to aim for multiple sessions with the same group at all sights . At sites where refugees are staying for a longer period and where multiple sessions will be held specific attention will be paid to this aspect. The aim is to do so at 3 sites. Need to describe manifestations of this sense of coherence and community engagement. There is no clear specification in the GA regarding the terms: "refugees and other migrants", nor does CHAFEA specify the terms. For the purpose of M&E we propose not to make that distinction at present. Based on the experiences with WP2 and general information, WP7 could write a short review of this distinction in the context of EUR-HUMAN, around M3 or M4. This review can be attached to EUR-HUMAN reporting and shared with all partners. The preliminary hypothesis is that the distinction only can be made later in the process of migration, not in the hotspots yet.
Clarification of original tasks and later modification of tasks, if any.	M1: Task 2.1 M1: Task 2.3	The PLA brokered sessions will be facilitated by a local team selected by each country representative. Suggestions for the composition of a local team would be mix of health care professionals and bilingual staff members. At least one, but preferably all staff members who will facilitate these PLA-moderated sessions will be present during the PLA training day in Ljubljana (Slovenia) on Saturday/Sunday the 6th + 7th of February 2016. The number of sessions held with each group of refugees depends on context and time availability of the refugees who are on the move. In some cases (likely at the Hotspot sites) it is only feasible to hold 1 session per group. While at transit sites it might be feasible to hold more sessions per group. In order to fulfill GA targets, we now propose to aim for 3 hotspots where in total 4 sessions will take place with 2 different male and 2 different female groups, during which sessions different topics can be addressed and different groups of refugees are reached, and for 3 sites where refugees stay for a longer period where 2 groups of respectively men and women are formed with whom 3 sessions take place. As required for this type of qualitative

		research, in this way sufficient diversity in gender, age, country of origin can be reached as well as theoretical saturation of the data. Therefor we do not think an official amendment to the GA will be required. This approach is described in the document "Strategy for sampling and recruitment" that was circulated on February 1.
Clarification of original deliverables and later modification of deliverables, if any.	M1: no clarification needed	There is one formal deliverable: the synthetic report at the end of M3
Clarification of (timing of) milestones and later modification of (timing of) milestones, if any.	M1: training session	Due to planning and availability of training location, the training session is planned on Saturday February 6th 2016.
In the Grant Agreement, one section describes the specific objectives, process/output and outcome/impact indicators of each Work Package. The items below refer to these.		
Specific objectives	See above	
Clarification of process indicators and targets, and later modification, if any	M1: PLA sessions and training	The process indicators in the GA can remain as they are. However, for later understanding of results of the PLA brokered dialogues, we record: 1) how many staff of how many sites are trained; 2) how many sessions with how many refugees/migrants each the staff performs; 3) how many reports are timely sent to WP leader. Assumption: these items are naturally registered by the WP leader. It would be good to have some indication of the quality of each of the PLA brokered dialogues and of their contribution to insight on health issues of refugees/migrants. This may transpire from the session reports. Separate male / female groups of approx. 5 participants: a smaller group enables participants to build trust and facilitate engagement despite the limited amount of sessions per group.
Clarification of output indicators and targets, and later modification, if any	M1: no clarification needed	
Clarification of outcome/impact indicators and targets, and later modification, if any	M1: no clarification needed	

Work package number	WP2	Lead beneficiary	2 - RUMC
Work package title	Communicating and liaison with stakeholders and refugees		
Start month	1	End month	3

Objectives

To facilitate the sense of coherence and community engagement and to assess with a democratic dialogue the views, wishes, beliefs and attitudes of refugees and migrants.

To gain insight in the health needs and social problems, experiences and expectations of newly arrived migrants; in the experiences, expectations and barriers regarding accessing primary health care and social services in the guest country.

Description of work and role of partners

WP2 - Communicating and liaison with stakeholders and refugees [Months: 1-3]
RUMC, UOC, UoL, NIVEL, FFZG, MUW, UL, EFPC, ARQ, AUSL 11, UoD
Task 2.1: PLA is a research methodology which uses specific techniques that enable all people to be meaningful engaged, despite language or educational differences. Local researchers from all intervention sites will be trained in the application and ground rules of PLA methods (O'Reilly-de Brun 2010). (M1)
Work RUMC: planning and conducting the one-day training
Local teams: attend the training (include budget for travel expenses and for the an expert group of Acıbadem University from Turkey).

Task 2.2: At the intervention sites, by purposive sampling, refugees of different age, gender, educational and geographical background will be recruited to participate in the local stakeholder group. Such a group will consist of approximately 10 persons. For this step, local research teams will have to be sensitive of regulations and governance of the refugee camps, and arrange the necessary permissions to enter the camps and recruit refugees. Local health professionals working in the camps can facilitate the recruitment. (M3)
RUMC: developing instruction for recruitment, and guidance for the
fieldwork Local teams: recruiting participants, organising the meetings

Task 2.3: PLA moderated sessions will take place to generate data on views, experiences and expectations of the refugees regarding their health and social needs, access and use of healthcare and social services. The amount of sessions will depend on when theoretical saturation is reached, presumably after 5-6 sessions. All sessions will be audiotaped and transcribed ad verbatim; these transcriptions together with materials produced during the sessions (e,g, stickies, option assessment tables etc.) form the data that will be coded and analysed by the research teams in each setting following the principles of a deductive framework analysis, using the same coding framework in all sites. This coding framework will be constructed and circulated by the WP leader, with input of all local teams. (M3)
RUMC: provide support during the fieldwork + coding framework
Local teams: attending the meetings (include in budget fee for participants) ; coding and analysis of local data resulting in local report

Task 2.4: Based on the local reports, the WP leader will write a comprehensive report on the views, experiences and expectations of the refugees. This report will be translated to a scientific paper and published to inform the community of researchers and policy makers in the field of refugees, and for primary care / public health professionals. On top of this, according to the moral duty when studying vulnerable populations, the results will be made public and accessible for refugees, migrant communities and NGOs supporting refugees. (M3)
RUMC: drafting overall report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services

Participation per Partner

Partner number and short name	WP2 effort

1 - UOC	1.50
2 - RUMC	8.00

Partner number and short name	WP2 effort
3 - UoL	5.00
4 - NIVEL	1.50
5 - FFZG	1.50
6 - MUW	1.50
7 - UL	1.50
8 - EFPC	0.50
9 - ARQ	1.50
10 - AUSL 11	1.50
11 - UoD	1.50
Total	25.50

List of deliverables

Deliverable Number	Deliverable Title	Lead beneficiary	Type	Dissemination level	Due Date (in months)
D2.1	Report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services	2 - RUMC	Report	Public	3

Description of deliverables

Deliverable 2.1 Report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services (M4)

D2.1 : Report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services [3]

Report as a basis for the meeting of experts

Schedule of relevant Milestones

Milestone number	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS2	Local researchers are trained in PLA	2 - RUMC	1	Training sessions with researchers
MS3	PLA moderated meetings have taken place between researchers and refugees	2 - RUMC	3	Meetings between researchers and refugees
MS4	Report on the views, experiences and expectations of the refugees and the stakeholders	2 - RUMC	4	Written document

Specific Objective Number	1 (Work Package 2)
Specific Objective	This Work Package is primarily seeking the refugees' voice. Among its objectives, one is to facilitate sense of coherence and community engagement and to assess with a democratic dialogue the views, wishes, beliefs and attitudes of stakeholders and focus groups of refugees and other newly arriving migrants. Particularly issues for the women, the elderly, the very young, or those previously suffering from poor health. Another aim is to gain insight into the health needs and social problems, experiences and expectations of newly arriving migrants; their experiences, expectations and barriers regarding accessing primary health care and social services in the guest country.

Process Indicator(s)	**Target**
Participatory and learning action research of all intervention site countries and transfer of results to WP2 leader	A list of needs containing an overview of healthcare assessment of the newly arriving refugees, migrants and stakeholders
	All implementation sites have completed at least five PLA brokered dialogues meetings per implementation site

Output Indicator(s)	**Target**
At each implementation site PLA brokered dialogues have taken place between refugees and other newly arriving migrants of different background, healthcare workers and researchers; the amount of sessions depending of the time needed to get the requested insights	Introducing a dialogue between stakeholders and focus groups tailored upon refugees of different background A report with the results of the brokered dialogue

Outcome/Impact Indicator(s)	**Target**
Insight into: - Health needs and social needs as experienced by the migrants - Experiences and expectations of migrants regarding accessing health care and social services at the site - Barriers and facilitators in accessing health care and social services	Overview of perceived and non-perceived needs, beliefs, preferences and attitudes in terms of comprehensive and holistic care of refugees A report is to guide the work in WP 3 and WP4 and the implementation of good practices in WP6

WP2: Framework for recruitment, composition of targeted groups of migrants/refugees

	Syrian	Afghan	Iraqi	Other	other	Syrian	Afghan	Iraqi	other	other
	male	male	male	male	male	female	female	female	female	female
Country 1										
Country 2										
Country 3										
Country 4										
Country 5										
Country 6										

Origin:

- Syrian
- Afghan
- Iraqi
- Eritrean
- Bengali

Age: WP2: no minors to be included since that will require a more complicated ethical permission..

- >18 with family responsibility
- >18 without family responsibility

Medical background:

- With / without chronic disease

WP3 Review of literature and expert knowledge

Tasks:
Systematic literature review
Online network survey: "what does (not) work and why?"
Interviews with 10 to 15 international experts
Summary of preliminary findings and practical recommendations
Final synthesis report

In the Grant Agreement, the Work Package is described. The items below refer to this section.		
What	**When; subject**	**Comments – changes - actions**
Clarification of original objectives and later modification of objectives , if any.	M1: no clarification needed	
Clarification of original tasks and later modification of tasks, if any.	M1: no clarification needed	
Clarification of original deliverables and later modification of deliverables, if any.	M1: no clarification needed	
Clarification of (timing of) milestones and later modification of (timing of) milestones, if any.	M1: no clarification needed	
In the Grant Agreement, one section describes the specific objectives, process/output and outcome/impact indicators of each Work Package. The items below refer to these.		
Specific objectives	See above	
Clarification of process indicators and targets, and later modification, if any	M1: no clarification needed	
Clarification of output indicators and targets, and later modification, if any	M1: description of output	Add: publication of report on EUR HUMAN website (M3)
Clarification of outcome/impact indicators and targets, and later modification, if any	M1: dissemination of output	Suggestion to disseminate report through conferences etc., which reaches another audience than a scientific publication.

Work package number	WP3	Lead beneficiary	4 - NIVEL
Work package title	Review of literature and expert knowledge		
Start month	1	End month	4

Objectives

To provide a comprehensive overview of effective interventions to address health needs and risks of refugees and other migrants in European countries, focusing on short-term arrival as well as long-term settlement. Existing knowledge from the literature and experts is collected and synthesized systematically. Practical implications and implementation challenges are addressed, whilst taking into account characteristics of health systems in different countries (including the roles of health care professionals), the position of countries in the cross-European migration and settlement chain, and relevant contextual factors.

The WP is implemented by NIVEL as a lead partner, in close cooperation with other partners. Assistance is provided by Acıbadem University from Turkey, featuring know-how from Family Medicine, Public Health and Sociology. FFZG will assist with the literature review in particular based on recent experience with an extensive systematic review of long-term health consequences of disasters conducted in the context of the FP7 project OPSIC.

Description of work and role of partners

WP3 - Review of literature and expert knowledge [Months: 1-4]
NIVEL, UOC, RUMC, UoL, FFZG, MUW, UL, EFPC, AUSL 11, UoD
Task 3.1: Completion of data collection strategy (M1).
In the first month a detailed plan is worked out to collect data from three sources, because by focusing solely on the literature it is very likely that valuable, practical information is going to be missed:
- **A systematic search** will be performed in several literature database (including Medline, PsychINFO, Embase, Scopus and PILOTS), covering the different language areas of the partners (Croatian, Dutch, English, German, Greek, Italian and Slovakian). Keywords will reflect the core themes, questions and challenges the EUR-HUMAN project seeks to address. Publications will be judged using pre-defined inclusion- and exclusion criteria.
- **An online survey "what does (not) work and why?"** will be administered broadly via networks of partners, representative organizations, ministries and social platforms (like Researchgate and LinkedIn) to capture additional information on practices in Europe, to disentangle promising best practices, practice guidelines, and problems to avoid, and to collect additional references to relevant publications and unpublished works. The survey will result in quantitative data and open answers. It is a low-threshold opportunity to get advice from different perspectives.
- Based on the dialogue with partners and the conversations within WP3, **10 to 15 international experts are invited to participate in an interview.** The qualitative information forms an addition to the findings from the literature and the survey. It will help in describing the contexts, meaningful structure and process characteristics, and challenges of refugee health care in a European setting.
The plan is developed using insights from the partners, apart from ARQ.

Task 3.2: Produce input for other working packages (M3).
In M2 and M3 the data is collected according to the plan. At the beginning of M3 the collected information is analysed and structured in order to provide practical information and advice for different target groups, useful for the tasks of the different partners. Later that month the information is presented and discussed at a partner meeting and feedback is collected.

Task 3.3: Completion of the final report (M5)
M4 and M5 will be devoted to writing the final report. This report will consist of different parts (the systematic review (scientific manuscript), the survey and the interviews), with an introduction chapter containing the background of the project, the objective and the most important lessons.

Participation per Partner

Partner number and short name	WP3 effort
1 - UOC	1.00

Partner number and short name	WP3 effort
2 - RUMC	1.00
3 - UoL	1.00
4 - NIVEL	11.00
5 - FFZG	1.00
6 - MUW	1.00
7 - UL	1.00
8 - EFPC	0.50
10 - AUSL 11	1.00
11 - UoD	1.00
Total	19.50

List of deliverables

Deliverable Number	Deliverable Title	Lead beneficiary	Type	Dissemination level	Due Date (in months)
D3.1	Summary of preliminary findings and practical recommendations	4 - NIVEL	Report	Public	3
D3.2	Final synthesis	4 - NIVEL	Report	Public	4

Description of deliverables

Deliverable 3.1 Summary of preliminary findings and practical recommendations (document with preliminary findings and practical recommendations for policy-makers, health care professionals, refugees and other relevant stakeholders) (M3)

Deliverable 3.2 Final synthesis report (combining information from the three sources) (M5)

D3.1 : Summary of preliminary findings and practical recommendations [3]

Document with preliminary findings and practical recommendations for policy-makers, health care professionals, refugees and other relevant stakeholders

D3.2 : Final synthesis [4]

Document with the final synthesis of the review

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS5	Presentation and discussion of preliminary findings at partner meeting	4 - NIVEL	3	Presentation and discussion of preliminary findings
MS6	Final synthesis report available online	4 - NIVEL	5	Online report

Specific Objective Number	2 (Work Package 3)
Specific Objective	To provide a comprehensive overview of effective interventions to address health needs and risks of refugees and other migrants in European countries, focusing on short-term arrival as well as long- term settlement. A systematic strategy is followed to identify and summarize existing knowledge from the literature and experts. Practical implications and implementation challenges are addressed, whilst taking into account characteristics of health systems in different countries (including the roles of health care professionals), the position of countries in the cross-European migration and settlement chain, and relevant contextual factors

Process Indicator(s)	**Target**
Shaped in cooperation with the other partners: - Systematic searches of literature databases (Medline, PsychINFO, Embase, Scopus, PILOTS) using with a structured search strategy, and inclusion and exclusion criteria, and via experts and snowballing to collect grey literature. - Online survey "what does (not) work and why?" via networks of partners, representative organizations, ministries and social platforms (Researchgate and LinkedIn). - Interviews to collect relevant structure and process descriptions from 10-15 international experts on refugees health care.	Multiple data Sources explored And using a systematic methodology
Output Indicator(s)	**Target**
All relevant publications identified and reviewed for findings and recommendations.	A report summarizing key findings Manuscript of systematic literature review to be submitted to a scientific journal
Outcome/Impact Indicator(s)	**Target**
Synthesis of literature and available best practices, focusing on short-term arrival as well as long-term settlement, presented in a way that is practically useful for the next steps in EUR-HUMAN and other initiatives aimed at enhancing health and health care.	A state of the art report on key findings and recommendations to be disseminated to all European stakeholders.

WP4 Developing tools and evidence-based practice guidelines for health care practitioners

Tasks:
Collection of guidelines, guidance
2 day expert meeting, incl delegates of local teams use of IOM's "personal medical record"
Report on content of optimal primary care for refugees and
Online set of guidance and template for adaptations

In the Grant Agreement, the Work Package is described. The items below refer to this section.		
What	**When; subject**	**Comments – changes - actions**
Clarification of original objectives and later modification of objectives , if any.	M: concepts and definitions	Clarification required whether (and how) "integrated primary care" will be part of the definition of ***optimal content of healthcare and social services.*** Clarification required whether access to health and social services will be part of the content definition as well. Include comments on "integrated primary care" in report of expert meeting and in guidelines etc. (as appropriate).
Clarification of original tasks and later modification of tasks, if any.	M1: no clarification needed	
Clarification of original deliverables and later modification of deliverables, if any.	M1: no clarification needed	
Clarification of (timing of) milestones and later modification of (timing of) milestones, if any.	M1: no clarification needed	
In the Grant Agreement, one section describes the specific objectives, process/output and outcome/impact indicators of each Work Package. The items below refer to these.		
Specific objectives	See above	
Clarification of process indicators and targets, and later modification, if any	M1: criteria expert meeting M1: (additional target) valuation of PMR	Clarification of the criteria for success and completeness for the expert meeting. For example: attendance from 6 sites, coverage of all relevant expertise by participants, completeness of areas covered and degree of agreement between experts and WP4 and WP5 on content of guidelines etc. Although not in scope of the EUR HUMAN project, the opinions of the experts on the practical use of the personal medical record help to

		assess its value.
Clarification of output indicators and targets, and later modification, if any	M1: output indicator	The report of the expert meeting (M3) is an output indicator and should be included as such. Does the internet platform refer to the EUR HUMAN website developed by WP1?
Clarification of outcome/impact indicators and targets, and later modification, if any	M1: outcome indicators M1: output indicators	Clarification of intended outcomes to be achieved by WP4: A. The extent to which WP6 is supported and enhanced by the output of WP4 (the extent to which the interventions sites are able to use the document to select tools and guidelines). B. The extent of consensus that is reached on the Expert Meeting regarding the range and applicability of the tools and guidelines. Clarification of the output indicator: the output indicator is the availability of the report and the internet platform for the purpose of supporting and enhancing WP6. Consideration of including an assessment of the use of the materials. Relevant for impact beyond the scope of the EUR HUMAN project as well, as the materials will be available freely on the internet platform. Planning by WP4 and WP7 regarding this type of monitoring and evaluation of the use of materials should be done before implementation. This could include: monitoring the number of hits or downloads of the EUR-HUMAN website documents, a web based response form for users (e.g. who, from which country, what is the intended use).

Work package number	WP4	Lead beneficiary	2 - RUMC
Work package title	Developing tools and evidence-based practice guidelines for health care practitioners		
Start month	3	End month	6

Objectives

To arrange an international consensus panel meeting for development and approval of best practice guidelines and tools.

To define the optimal content of healthcare and social services needed to prevent infectious diseases, chronic diseases and further mental health damage in newly arrived migrants; and to provide good care for acute and chronic physical and mental health conditions in concordance with professional standards

To identify and define necessary knowledge, skills, training and other support and resources (eg interpreter services) needed for professionals to enable them to provide above mentioned good comprehensive care

Description of work and role of partners

WP4 - Developing tools and evidence-based practice guidelines for health care practitioners [Months: 3-6]
RUMC, UOC, UoL, NIVEL, FFZG, MUW, UL, EFPC, ARQ, AUSL 11, UoD
Task 4.1: : Based on results of literature review and the report on health needs (WP2) of relevant guidelines, guidance, training and health promotion materials will be gathered; hereby materials from other EU projects will be used, such as the training developed in the MEMPs project and C2Me
Work: RUMC with contribution from all partners

Task 4.2: Organising and chairing of two-day expert meeting with approx. 30 experts in the field of: refugees (IOM, UHNCR etc.), primary care (EFPC, WONCA), contagious diseases (ECDC), chronic diseases and migrant care, mental healthcare for refugees, women's health etc. (M5)
Work: RUMC
Local teams: to send delegates to the expert meeting

Task 4.3: Drafting a report on the content of optimal primary healthcare for refugees, based on the outcomes of the expert meeting (M5)
Work: RUMC with contribution from all partners

Task 4.4: Produce an provide online a set of guidelines, guidance, training and health promotion materials to support the local sites (M6)
Work: RUMC with contribution from all partners

Task 4.5: Produce a template for local adaptation and implementation of these guidelines, training etc.
(M6) Work: RUMC with contribution from all partners

We do not intend to dedicate time to discuss the type of the health data that the project aims to collect since we will utilize the "personal medical record" that was developed by the Migration Health Division of the International Organization of Migrants (IOM) with the support of the European Commission and the contribution from the European Centre for Diseases Prevention and Control. The "personal medical record" will be a key source of information for assessing refugee health status and health care needs. The "Handbook for Health Professionals" developed by IOM with the support of the European Commission would be utilized in this effort.

Participation per Partner

Partner number and short name	WP4 effort
1 - UOC	1.50
2 - RUMC	8.50
3 - UoL	3.00
4 - NIVEL	1.00

Partner number and short name	WP4 effort
5 - FFZG	1.50
6 - MUW	1.50
7 - UL	1.50
8 - EFPC	0.50
9 - ARQ	4.50
10 - AUSL 11	1.50
11 - UoD	1.50
Total	26.50

List of deliverables

Deliverable Number	Deliverable Title	Lead beneficiary	Type	Dissemination level	Due Date (in months)
D4.1	Report of expert meeting	2 - RUMC	Report	Public	5
D4.2	Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees	2 - RUMC	Report	Public	6

Description of deliverables

Deliverable 4.1 Report of expert meeting (M5)

Deliverable 4.2 Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees (M6)

D4.1 : Report of expert meeting [5]

Document of the development and the approval of best practice guidelines and tools.

D4.2 : Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees [6]

Document with the Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees

Schedule of relevant Milestones

Milestone number	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS7	Expert meeting	2 - RUMC	5	Organization of a meeting of experts
MS8	Set of guidelines, guidance, training and health promotion	2 - RUMC	6	Written Set of guidelines, guidance, training and health promotion

Milestone number	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
	materials for optimal primary care for newly arrived migrants including refugees			materials for optimal primary care for newly arrived migrants including

Specific Objective Number	3 (Work Package 4)
Specific Objective	To arrange an international consensus panel meeting for development and approval of best practice guidelines and tools. To define the optimal content of healthcare and social services needed to prevent infectious diseases, chronic diseases and further mental health damage in newly arrived migrants; and to provide good care for acute and chronic physical and mental health conditions in concordance with professional standards To identify and define necessary knowledge, skills, training and other support and resources (e.g. interpreter services) are needed for professionals to enable them to provide the above mentioned good comprehensive care 1. To define what materials and tools for health assessment and promotion are needed and which of these need to be developed. To develop: a. a freely accessible low barrier internet platform for dissemination of the identified all such deliverables including b. a comprehensive set of training materials using present multimedia formats; c. a template for adaptation of materials specific to the respective country

Process Indicator(s)	Target
The outcome of the literature review and PLA-brokered dialogue with refugees is discussed with an expert panel of refugees, health care professionals, experts in the fields of infectious diseases, ethnic and cultural health differences, mental health, women's health and migrant care in general, researchers of refugee studies, experts in teaching migrant care and cultural competences, expert in social services, NGO etc. Involvement of all intervention site countries in the development of tools and guidelines (with respect to the results of WPs 2 and 3). Adaption of tools and guidelines to the national and regional situation (with respect to the results of WPs 2 and 3). This process will be guided by the principles of NPT, making use of NoMAD, a new quantitative measure that investigates implementation processes using NPT to evaluate the proposed tools and guidelines. We do not intend to dedicate time to discuss the type of the health data	Global organizations, experts in refugees' care and representatives from selected countries to jointly synthesize and integrate the results of the systematic review and the outcomes of focus groups

that the project aims to collect since we will utilize the "personal medical record" that was developed by the Migration Health Division of the International Organization of Migrants (IOM) with the support of the European Commission and the contribution from the European Centre for Diseases Prevention and Control. The "personal medical record" will be a key source of information for assessing refugee health status and health care needs. The "Handbook for Health Professionals" developed by IOM with the support of the European Commission would be utilized in this effort.	
Output Indicator(s)	**Target**
1. The panel has defined the content and structure of care, prepare best practice guidelines, protocols and clinical pathways and training schemes, teaching conditions, educational support and materials. 2. A freely accessible low barrier internet platform is established for dissemination of all such deliverables including. 3. There is available a comprehensive set of training materials using present multimedia formats. 4. There is available a template for adaptation of materials specific to the respective country including a multilingual database of health care term.	Propose a strategic plan for meeting refugees' healthcare needs and prepare tools and guidance
Outcome/Impact Indicator(s)	**Target**
Development of practice guidelines, on which basis intervention sites can be trained, adapt and implement the materials adjusted to their situation, training materials and tools.	Manual with evidence-based practice guidelines and tools for optimum healthcare assessment of refugees needs. State of the art document to be used for the assessment of vulnerable groups including children, women and elderly.

WP5 Mental health psychosocial support (MHPSS) and first aid for refugees

Tasks:
protocol for rapid assessment of MHPSS
selected tools for rapid
description of short-time interventions that can be implemented at successive locations
cumulative records of successive assessments and received MHPSS interventions
data base accessible at each next location and ready for use at the final destination and PASR;
information provided to a refugee how to seek MHPSS
IT communication protocol providing seamless transfer of and access to cumulative data records
guidelines regarding privacy, confidentiality, culturally specific needs for MHPSS providers and staff.

In the Grant Agreement, the Work Package is described. The items below refer to this section.		
What	**When; subject**	**Comments – changes - actions**
Clarification of original objectives and later modification of objectives , if any.	M1: coherence other WPs	The relationship and coherence with objectives of WP2, 4 and 5. Model of Integrated Continuity of Psychosocial Refugee Care and the guidelines and protocols of WP2 and 4 need to be available as one package for the medical teams at the sites. The integration of services provided at the intervention sites (WP5 and WP6). Against the overall background of integrated primary care, the question is how the psychosocial assessment and services are integrated in the overall primary care.
Clarification of original tasks and later modification of tasks, if any.	M1: no clarification needed	Alignment with other WP's is critical.
Clarification of original deliverables and later modification of deliverables, if any.	M1: no clarification needed	Alignment with other WP's deliverables is critical.
Clarification of (timing of) milestones and later modification of (timing of) milestones, if any.	M1: no clarification needed	The Model is available by M6, this aligns well with the availability of the set of guidelines guidance, training, etc. of WP4.
In the Grant Agreement, one section describes the specific objectives, process/output and outcome/impact indicators of each Work Package. The items below refer to these.		
Specific objectives	See above	
Clarification of process indicators and targets, and later modification, if any	M1: process indicators	Integration / alignment with WP2 and 4 and with WP6 also is a process indicator

Clarification of output indicators and targets, and later modification, if any	M1: continuity of care by means of a database will not be strived for. M1: dissemination of material is an output as well.	As discussed during kick-off: IT solution for continuity of care through database is not feasible in the timeframe of the project. Alternative solutions to be explored and phrased as parts of the model. Rephrase what the model of continuity will look like.
Clarification of outcome/impact indicators and targets, and later modification, if any	M3: outcome/impact indicator	The outcome/impact indicator is not phrased as an indicator – that assesses in how far the outcome/impact actually is achieved. The question that needs to be answered here is: how does the project show that Mental health and psychosocial needs of refugees are identified early and lower costs of health and social services for the hosting societies, improved working capacity, lower incidence in domestic violence and abusive behaviors. For the mental health assessment it may be possible to show that needs of refugees are identified early, through a survey around M10-12. For the lowering of costs, improved working capacity, lowering of domestic violence, etc., it will not be possible to do an assessment during the timeframe of the project.

Work package number [9]	WP5	**Lead beneficiary** [10]	5 - FFZG
Work package title	Mental health psychosocial support (MHPSS) and first aid for refugees		
Start month	3	**End month**	6

Objectives

To develop the protocol for rapid assessment of mental health and psychosocial needs of refugees.

To develop the Model of Integrated Continuity of Psychosocial Refugee Care from the point of entry into EU to final destinations.

Description of work and role of partners

WP5 - Mental health psychosocial support (MHPSS) and first aid for refugees [Months: 3-6]
FFZG, UOC, RUMC, UoL, NIVEL, MUW, UL, ARQ, AUSL 11, UoD
Task 5.1: Select appropriate approaches and methodology regarding rapid assessment of mental health and psychosocial support needs to be used in the implementation settings (M3)

Task 5.2: Develop protocol which includes procedures, tools for rapid assessment and provision of psychological first aid and MHPSS interventions to newly arriving refugees (M4)
Task 5.3: Adapt protocol, assessment tools, interventions to respective national and regional situation in collaboration with local stakeholders and provide input into WP6 for implementation (M5)

Task 5.4: Develop model of Integrated Continuity of Psychosocial Refugee Care from Early Hosting and First Care Centres to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee destinations (M6)

The WP 5 coordinator will lead all 4 tasks with contribution from all partners, apart from EFPC.

Participation per Partner

Partner number and short name	WP5 effort
1 - UOC	4.00
2 - RUMC	4.00
3 - UoL	4.00
4 - NIVEL	4.00
5 - FFZG	15.50
6 - MUW	2.50
7 - UL	4.00
9 - ARQ	4.00
10 - AUSL 11	4.00
11 - UoD	4.00
Total	50.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D5.1	Protocol with procedures, tools and interventions	5 - FFZG	Report	Public	4
D5.2	Model of integrated care	5 - FFZG	Report	Public	6

Description of deliverables

Deliverable 5.1 Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS (M4)

Deliverable 5.2 Description of the Model of Integrated Continuity of Psychosocial Refugee Care and its components (M6)

D5.1 : Protocol with procedures, tools and interventions [4]

Protocol with procedures, tools for rapid assessment and provision of psychological first aid and MHPSS

D5.2 : Model of integrated care [6]

Description of the Model of Integrated Continuity of Psychosocial Refugee Care and its components

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS9	Protocol with procedures, tools and interventions completed	5 - FFZG	4	Written protocol
MS10	Model of Integrated Continuity of Psychosocial Refugee Care described	5 - FFZG	6	Written description of model

Specific Objective Number	4 (Work Package 5)
Specific Objective	To develop the protocol for rapid assessment of mental health and psychosocial needs of refugees. To develop the Model of Integrated Continuity of Psychosocial Refugee Care from the point of entry into EU to final destinations.

Process Indicator(s)	Target
Intervention site partners contribute to selection of appropriate approaches and methodology regarding rapid assessment of mental health and needs for psychological support to be utilized in the implementation settings. Intervention site partners provide input into the draft protocol for rapid assessment, psychological first aid (PFA) and to the model of continuity	Draft document about approaches and methodologies agreed

of psychosocial refugee care from the points of Early Hosting and First Care to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee destination. All partners adapt the protocol, assessment tools, interventions and Model of Integrated Continuity of Psychosocial Refugee Care to their respective national and regional situation in collaboration with local stakeholders and provide input into WPs 6 and 7. This process will be guided by the principles of NPT, making use of NoMAD, a new quantitative measure of the implement ability of proposed tools and guidelines (Finch et al.,2013)	Draft protocol for rapid assessment, psychological first aid (PFA), assessment tools and MHPSS interventions, and model of continuity of psychosocial refugee care
Output Indicator(s)	**Target**
Protocol for rapid assessment of MHPSS needs of a refugee / family is developed, including selected tools, preferred procedures and practical short-time psychosocial interventions at the locations of first hosting as well as appropriate mental health and psychosocial interventions at the community of final destination and PASR, including procedures for screening for perinatal mental health needs and appropriate interventions, for promotion of women's mental health. Model of Integrated Continuity of Psychosocial Refugee Care is developed. This model will ensure continuity of mental health and psychosocial care starting with rapid assessment and psychological first aid (PFA) at the point of entry into EU, and building up assessment information and follow-up interventions as the refugee individual transits towards the final destination. At the same time this model will ensure that information relevant to the MHPSS providers are available at each point of contact (such as refugee transit camp and Early Hosting and First Care locations) in transit countries and at final destinations (such as Psychosocial Advice and Support Points for Refugees - PASR). The developed model will include at least the following components: 1) protocol for rapid assessment of MHPSS needs that can be used at all locations of first hosting and transit camps in succession, resulting in additive information about a refugee status and needs; 2) selected tools for rapid assessment that can be administered in succession at each transit location, resulting in comprehensive information readily available at the point of final destination and PASR for immediate use; 3) description of short-time interventions that can be implemented at successive locations of first hosting in each transit country by local MHPSS providers; 4) cumulative records of successive assessments and received MHPSS interventions of a refugee at each transit location, entered by authorized MHPSS providers into a data base accessible at each next location and ready for use at the final destination and PASR; 5) information provided to a refugee how to seek MHPSS assistance at each transit location and at final destination and PASR; 6) IT communication protocol providing seamless transfer of and access to cumulative data records between Early Hosting and First Care point of entry into EU, each transit location to final destination and PASR by authorized MHPSS providers; 7) guidelines regarding privacy, confidentiality, culturally specific needs and other relevant issues for MHPSS providers and staff	Protocol agreed by the partners Model of Integrated Continuity of Psychosocial Refugee Care approved by site partners
Outcome/Impact Indicator(s)	**Target**
Mental health and psychosocial needs of refugees are identified early and appropriate interventions and services delivered, leading to their shorter period of recovery from incapacitating consequences of adverse life experiences and exposure to trauma. Lower health and social services for the hosting societies, improved working capacity, lower incidence in domestic violence and abusive behaviors. Successful integration into hosting societies, decreased social isolation and lower risk for political radicalization.	Lower health and social services costs for the hosting societies Improved work capacity and lower incidence of problem behaviors Improved integration into hosting societies, lower social isolation and decreased risk of radicalization

WP6 Enhanced capacity building strategy for primary care staff, as well as preparation and implementation of recommended interventions in selected implementation sites
Greece, Italy, Croatia, Slovenia, Hungary, Austria.

Tasks:
Assessment
Curriculum development with WP2, 4 and 5 for professionals and refugees, includes e-learning modules
Support to 6 intervention sites
Summary report

In the Grant Agreement, the Work Package is described. The items below refer to this section.		
What	**When; subject**	**Comments – changes - actions**
General clarification of Work Package description in Grant Agreement	M1: Presentation of activities and phrasing of tasks	Various corrections and clarifications are proposed by the WP leader, not pertaining to the activities, outputs and deliverables themselves but pertaining to the way how the activities are presented and to phrasing of tasks, deliverables, milestones and various indicators. Suggestion: to ask WP leader to re-formulate
Clarification of original objectives and later modification of objectives, if any.	M1: objectives UNHCR M1: WP 6 Leader	Clarification of the positioning of the 10 UNHCR objectives Suggestion to consider the 10 UNHCR objectives as underlying vision for all health services; not particularly for WP6. WP2 is asked to define integrated primary care as part of the expert meeting in M3. Part 3 mentioned in the objectives in fact belongs to part 1, is not separate.
Clarification of original tasks and later modification of tasks, if any.	M1: coherence between WPs	Clarification of how the overlap between task 6.2 and the deliverables of WP3, 4 and 5 is optimized so as to benefit from the combined expertise. WP6 leader: Task 6.2 is an additional intervention to the interventions developed in WP 4 with synergies regarding the training material (WP4). We will - like the interventions in WP 4 - take the (preliminary) results of WP 2, 3 & 6.1 into account. Additionally, we will work closely together with the WP4 leader to exploit synergistic benefits. A draft version of the e-Curriculum should be ready at the time of the expert meeting in WP 4 (M6) to give the experts the chance to comment on it like on the other interventions developed. It is the aim that the six intervention countries can, in M7, choose one out of the interventions developed in the WPs 4,5 and 6.1.

	WP6 leader:	Task 6.3: This task is not clear yet since the majority of primary health care professionals from Syria can perfectly speak English. Additionally, it is not clear if at all by whom this will done (by Arq for the e-Curriculum?) tasks 6.5 and 6.6: These tasks are not necessary anymore since the curriculum will result in an e-Curriculum which is also a milestone (MS 13)
Clarification of original deliverables and later modification of deliverables, if any.	M1: deliverables	Clarification of the deliverables of tasks 6.2 to 6.7 and how they relate to the deliverables of WP 2 and 4. WP6 Leader: deliverable 6.3 is the same as 6.2
Clarification of (timing of) milestones and later modification of (timing of) milestones, if any.	M1: no clarification required	
In the Grant Agreement, one section describes the specific objectives, process/output and outcome/impact indicators of each Work Package. The items below refer to these.		
Specific objectives	See above	
Clarification of process indicators and targets, and later modification, if any	M1: process indicators	Alignment with WP2, 4 and 5 is a part of the project process and the indicator is written agreement on alignment (or coordination) steps.
Clarification of output indicators and targets, and later modification, if any	M1: no clarification required	
Clarification of outcome/impact indicators and targets, and later modification, if any	M1: no clarification required	WP6 leader: It is more an overall indicator for the project, not specifically for WP6.

Work package number [9]	WP6	**Lead beneficiary [10]**	6 - MUW
Work package title	Enhanced capacity building strategy for primary care staff, as well as, preparation and implementation of recommended interventions in selected implementation sites (Greece, Italy, Croatia, Slovenia, Hungary, Austria)		
Start month	4	**End month**	11

Objectives

WP 6 has two specific objectives since the work-package is divided into two different parts:

Part 1 with the specific objective 1 aims to enhance the capacity building of the primary care workforce through the assessment of the existing situation and the development of a curriculum and training material for local primary care professionals and refugees who are primary care professionals. For part 1 the MUW is responsible with the support of the intervention site countries (Greece, Italy, Croatia, Slovenia Hungary and Austria) regarding the assessment.

Part 2 with the specific objective 2 is the part where the six intervention site countries (Greece, Italy, Croatia, Slovenia Hungary and Austria) select, prepare and implement one intervention that emerged from WP 4, 5, or 6 part 1 in their respective centres. For part 2 each implementation site country is responsible (management, implementation, finances) for the preparation and implementation of their respective intervention. MUW only writes the summary report about the interventions implemented with a strength and weaknesses analysis (deliverable 6.3).

Part 3 Development of the e-training modules. One basic module and 6 specific modules for the pilot countries. ARQ will develop these e-training modules together with Health[e] Foundation.

Specific objective 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.

Specific objective 2:
To select, prepare and implement an intervention that emerged from of the WPs 4, 5, 6 part1 in a well-defined setting in existing Early Hosting and First Care Centres for refugees (Greece, Italy, and Croatia are responsible for the realisation) 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 realisation).
The WP 6 coordinator will lead all tasks with contribution from all partners, apart from EFPC.

We have also made clear in the revised proposal that the ten strategic primary care focused objectives would be undertaken in WP6 in all implementation sites and more specifically those proposed by the UNHCR. These are:
1. Support adequate triage, health screening, and age appropriate immunization in all new arrivals;
2. Support access to comprehensive primary health care;
3. Decrease morbidity from communicable diseases and outbreaks;
4. Support childhood survival and expanded programme for immunization;
5. Support integrated prevention and health promotion;
6. Support access to comprehensive reproductive health care services;
7. Support access to nutrition services;
8. Support access to secondary and tertiary health care services;
9. Maintain and expand health information systems, including information on access, uptake and coverage of services; and
10. Coordination of services.

Description of work and role of partners

WP6 - Enhanced capacity building strategy for primary care staff, as well as, preparation and implementation of recommended interventions in selected implementation sites (Greece, Italy, Croatia, Slovenia, Hungary, Austria) [Months: 4-11]
MUW, UOC, RUMC, UoL, NIVEL, FFZG, UL, ARQ, AUSL 11, UoD
Description of work for objective n°1:
MUW will coordinate and lead the tasks described under objective n°1 in WP6.

Task 6.1: Identification and assessment of existing capacity of local organisations (e.g. Red Cross, Caritas, local authorities, local primary care professionals) and of refugees who have themselves worked in primary care. (M6)

Task 6.2: Development and drafting of a curriculum and training material in English for primary care professionals and refugees who have themselves worked in primary care in two settings (M6):
- Staff in Early Hosting and First Care Centres as well as Transit Centres (insurance status, trauma, wounds, travel disorders, acute infections, chronic diseases, communicable diseases, identify risks faced by women during perinatal period, promote breastfeeding, provide ongoing perinatal care, emergency transport and clean delivery kits, family planning services.)
- Staff working in or health professionals living in the region of centres/homes for refugees and migrants with uncertain residency status who have applied for asylum (access to local health care system, health literacy, acute and chronic diseases, psychosocial health care, post-traumatic distress conditions, integration into society, etc.)
The refugees trained, then, can be an advisory capacity for their fellow refugees (e.g. trainers, consultants, advisors, supporters etc. without taking responsibility for the medical act until the legal situation is solved (which is not part of this project).
Information regarding Task 6.2: The inclusion of refugee primary health care workers into the PHC workforce of the specific countries is of major importance. E.g. among the refugees from Syria, there are many trained health workers. At the moment, those who have already arrived in EU countries face a long transition period before being able to practice their profession in the destination country. The inclusion strategy aims to include refugee primary care professionals as consultants in refugee facilities. The refugee health workers as well as already existing primary care professionals from the specific countries have to be trained in order to serve the health needs of their communities in destination countries as cultural experts and integration facilitators. Those trained health workers will enhance health literacy of their communities in a culturally sensitive way. The newly trained health workers will be an important for the integration of refugee communities in the destination countries. They serve as bridge between the local communities and the refugees in face of the crisis, especially; medical doctors, clinical psychologists, and nurses should be mobilized and integrated in the care for refugees. The health care professionals from refugee communities will be trained with already existing training material, designed by a team of interdisciplinary researchers from the MUW, who are also involved in this project, and other important stakeholders involved in the care for refugees and traumatized persons in Austria (Welcome Zentrum, Verein Österreichischer Psychotherapeuten, Asylkoordination, Österreichische Gesellschaft für Bioanalytik, World Psychiatric Association). The material is based on the newest state-of the-art from WHO and UNHCR standards. For the purpose of the intervention, the available material will be translated in languages of refugee communities, such as Syrian Arabic. The training material used in Austria is easily adaptable to other destination country settings and implementation sides. The training for refugee health workers is designed as a basic training module about the health care system of the destination country and other specific themes important for the care of refugees: translation and accompaniment (based on UNHCR programme), dealing with stress and trauma (WPA), illness and culture in the MENA region and in Austria, documentation of experiences of violence, introduction to the Istanbul protocol and human rights standards, consultation for the recognition of the qualifications as health care workers and escape, migration and rights. Furthermore, there is a training module for translators. It will help to reduce the language barriers, which is crucial in health care for refugees. The intervention works with a low barrier, easy access approach in order to reduce fears and anxieties of refugees in the destination countries. The training that this intervention offers will have several positive effects. The health workers can be integrated in refugee transit or permanent centres. Also, as the health workers are refugees themselves there will be ongoing supervision provided.

Task 6.3: Distribution of the English curriculum and training material to the proposal-partners for feedback and integration of the feedback in the material.(M6)

Task 6.4: Translation of the training material into Arabic (Syrian refugees) (M6)

Task 6.5: Distribution of the English curriculum and training material to the partners who select this intervention for their intervention site for the translation of the documents into their mother-languages (forward-backward translation process). (M6)

Task 6.6: Establishment of an EU-wide, easy access, low barrier information platform (web-based) with the training materials as well as a comprehensive multilingual data base for health care related terms. (M8)

Task 6.7: Development of the e-learning module, that's integrate the above mentioned content. Since the capacity building and knowledge transfer is needed for a large group of first line health care workers Health-e Foundation (HeF) is offering its flexible e-learning platform. HeF has more than ten years experience in developing and implementing blended learning programs in many languages for doctors, midwives, nurses and counselors in Africa and Asia. Their blended learning format starts with a kick-off workshop (in real life or by Skype/Facetime), and is followed by self-study in the home and/or workplace for two to three months, depending of the number of modules. During the self-

study period, participants are encouraged to interact online with their peers via a participant portal and to seek e-tutor support through their personalized e-learning account. After the self-study period, a follow-up workshop takes place, during which the course is evaluated lectures are given and participants take part in interactive exercises. All of the participants who successfully complete the course, with a minimal pass rate of 60% per module, receive a certificate. In contrast to MOOCs with maximal 10% success rates, we have a minimal 85% success rate and, in most countries, this rate is 100%. (M8)
The learning management system measures results of pre- and posttests and duration of time of work. HeF staff supports participants in need on line, by email or text messages. HeF is fast and flexible, it can adapt all provided texts into e-learning and implement into the backend within three months. Logon codes and passwords to participants are mostly provided during a kickoff workshop but for efficiency can be provided online. The motivation to finish however is best by ending the e-learning with a follow-up workshop. The programs are carried out in HIV education, pregnancy and child birth, TB education etc.

Description of work for objective n°2:
MUW will prepare the deliverable 6.3 (summary report about the interventions resulting from the interventions. All intervention countries (Greece, Italy, Croatia, Hungary, Slovenia and Austria) are responsible for the realisation of their task (tasks 6.7 – 6.12) and finances regarding the preparation and implementation of the pilot interventions within their well-defined refugee sites by themselves.

Task 6.8: Greece 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. (M11)

Task: 6.9: Italy 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. (M11)

Task: 6.10: Croatia 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. (M11)

Task: 6.11: Hungary has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 part1 in a Transit Centres and/or centre for refugees and migrants with uncertain residency status who have applied for asylum. (M11)

Task: 6.12: Slovenia has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 part1 in a Transit Centres and/or centre for refugees and migrants with uncertain residency status who have applied for asylum. (M11)

Task: 6.13: Austria has prepared and implemented an intervention emerged from WP 6 part 1 in a Transit Centres and centre for refugees with uncertain residency status who have applied for asylum with the support of the Austrian Red Cross, Caritas and the Welcome Centre for refugees in Vienna (more information about these organizations see chapter 14). (M11)

Participation per Partner

Partner number and short name	WP6 effort
1 - UOC	18.00
2 - RUMC	0.50
3 - UoL	4.00
4 - NIVEL	0.50
5 - FFZG	17.00
6 - MUW	20.00
7 - UL	18.50
9 - ARQ	10.50
10 - AUSL 11	8.50
11 - UoD	13.50

Partner number and short name	WP6 effort
Total	111.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D6.1	Report about the results of the assessment of local resources available	6 - MUW	Report	Public	6
D6.2	Summary report about the run by the different implementation site countries	6 - MUW	Report	Public	11

Description of deliverables

Deliverable 6.1 Report about the results of the assessment of local resources available. (M6)
Development of actions to enhance capacity building of primary health care staff

Deliverable 6.2 Summary report on the interventions that were implemented by the different implementation site countries. (M11)
Implementation of pilot interventions in Greece, Italy, Croatia, Slovenia, Hungary and Austria

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS11	Start of development of the capacity building strategies	6 - MUW	4	
MS12	Start of the implementation in the intervention site countries	6 - MUW	6	
MS13	EU-wide adaptable curriculum and training material for local primary care professionals as well as refugees who are primary care professionals is available via an internet platform and a e-learning module	6 - MUW	8	Development of actions to enhance capacity building of primary health care staff

Specific Objective Number	5 (Work Package 6)
Specific Objective	WP 6 has two specific objectives Part 1 aims to enhance the capacity building of the primary care workforce through the **assessment of the existing situation and the development of a curriculum and training material for local primary care professionals and refugees who are primary care professionals.** For part 1 MUW will be responsible with the support of the intervention site countries (Greece, Italy, Croatia, Slovenia Hungary and Austria) for the assessment. Part 2 is where the **six intervention site countries (Greece, Italy, Croatia, Slovenia Hungary and Austria) select, prepare and implement one intervention** that emerged from WP 4, 5, or 6 parts 1 in the respective centres. For part 2 each implementation site country is responsible (management, implementation, finances) for the preparation and implementation of their respective intervention. MUW will prepare the summary report about the interventions implemented (deliverable 6.3). Specific objective 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 in Greece, Slovenia, Austria, Italy, Hungary and Croatia. This will be enhanced by using blended learning methods. Specific objective 2: To implement the intervention program defined in WP4, 5,6 and examine the feasibility and acceptability in a well-defined settings in existing Early Hosting and First Care Centres for refugees and migrants (Greece, Italy, and Croatia) and in existing Transit Centres and/or centres for refugees and migrants with uncertain residency status who have applied for asylum (Austria, Hungary and Slovenia). We have also made clear in the revised proposal that the ten strategic primary care focused objectives would be undertaken in WP6 in all implementation sites and more specifically those proposed by the UNHCR. These are: 1. Support adequate triage, health screening, and age appropriate immunization in all new arrivals; 2. Support access to comprehensive primary health care; 3. Decrease morbidity from communicable diseases and outbreaks; 4. Support childhood survival and expanded programme for immunization; 5. Support integrated prevention and health promotion; 6. Support access to comprehensive reproductive health care services; 7. Support access to nutrition services; 8. Support access to secondary and tertiary health care services; 9. Maintain and expand health information systems, including information on access, uptake and coverage of services; and 10. Coordination of services.

Process Indicator(s)	**Target**
Process Indicators for specific objective number 1: **Step 1** Identification and assessment of existing capacity of local organisations (e.g. Red Cross, Caritas, local authorities, local primary care professionals) and of refugees who have themselves worked in primary care	Objective n°1: Step 1 Completed in month 4

Step 2 Development and drafting of a curriculum and training material in English for primary care professionals and refugees who have themselves worked in primary care in two settings: - Staff in Early Hosting and First Care Centres as well as Transit Centres (insurance status, trauma, wounds, travel disorders, acute infections, chronic diseases, communicable diseases, identify risks faced by women during perinatal period) - Staff working in the previously mentioned centres or health professionals living in the region of centres/homes for refugees and migrants with uncertain residency status who have applied for asylum (access to local health care system, health literacy, acute and chronic diseases, psychosocial health care, post- traumatic distress conditions, integration into society) The trained refugees can act in an advisory capacity for their fellow refugees (e.g. trainers, consultants, advisors, supporters etc. without taking responsibility for the medical act until the legal situation is solved (which is not part of this project). Building the e-learning modules tailor- made for these specific groups and adjusts them to local settings.	Step 2 Completed in month 5 Step 3 Completed in month 6
Step 3 Distribution of the English curriculum and training material to the proposal-partners for feedback and integration of the feedback in the material. Translation of the training material into Arabic (Syrian refugees). **Step 4** Distribution of the English curriculum and training material to the partners who select this intervention for their intervention site for the translation of the documents into their mother-languages (forward- backward translation process). Distribution of e-learning modules to target groups.	Step 4 Completed in month 6
Step 5 Establishment of an EU-wide, easy access, low barrier information platform (web-based and linked to the project homepage) with the training materials as well as a comprehensive multilingual data base for health care related terms.	Step 5 Completed in month 8
Process Indicators for specific objective number 2: Greece has selected, prepared and implemented at least one intervention which emerged from WP 4, 5, or 6 part1 in an Early Hosting and First Care Centre for refugees and migrants. Italy 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. Croatia 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. Hungary has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 part1 in a Transit Centres and/or centre for refugees and migrants with uncertain residency status who have applied for asylum. Slovenia has selected, prepared and implemented at least one intervention emerged from WP 4, 5, or 6 part1 in a Transit Centres and/or centre for refugees and migrants with uncertain residency status who have applied for asylum. Austria has prepared and implemented an intervention emerged from WP 6 part 11 in a Transit Centres and centre for refugees with uncertain residency status who have applied for asylum with the support of the Austrian Red Cross, Caritas and the Welcome Centre for refugees and migrants in Vienna (more information on these organizations see chapter 14).	Completed in month 11

These processes will be guided by the principles of NPT, making use of NoMAD, a new quantitative measure of the implement ability of proposed tools and guidelines.	

Output Indicator(s)	**Target**
Output indicators for specific objective number 1:	Objective no. 1:
1. Report about the existing primary care workforce capacity and gaps of local recently involved organisations and primary care professionals (deliverable 6.1).	Completed in month 6
2. Curriculum and training materials have been developed and are ready for distribution in the partnership.	Completed in month 6
3. The training material which is easily adaptable to other European countries is available via an EU-wide, easy access, low barrier web- based, information platform as well as a comprehensive multilingual data base for health care related terms has been established (deliverable 6.2).	Completed in month 8
Output indicator for specific objective number 2:	Objective no. 2:
Minimum 1 pilot-intervention in a well-defined intervention site emerged from WP 4, 5, or 6 part1 has been implemented in Greece, Slovenia, Austria, Italy, Hungary and Croatia, respectively.	Completed in month 11
Summary report about the interventions implemented (deliverable 6.3)	Completed in month 11
Outcome/Impact Indicator(s)	**Target**
Outcome indicators for specific objective number 1:	**Objective n° 1:**
Primary care professionals and other stakeholders have access to the deliverables 6.1 and 6.2 of this WP and have been alerted to their availability	100% of the training material is available via an easily accessible webpage for all European Countries
Outcome indicators for specific objective number 2:	
Refugees, refugees who are health professionals, local health professionals and communities in the intervention sites in each country have been reached with the interventions	**Objective n° 2:** Evaluation of the interventions is completed in month 12

Part 2: EUR-HUMAN Deliverables and output

List of deliverables and output

Timing: to be expanded throughout the project.

Deliverables and other output

This section provides an overview of the official and obligatory deliverables of the EUR-HUMAN project as well as the additional outputs that will result from the project.

See appendix-1 for a complete overview of the Milestones as described in the Grant Agreement.

Table 1: official EUR-HUMAN deliverables

Deliverable number	What	By whom	Due date	Delivery date	Comments
D1.1	Final report to Chafea	UoC	M12		
D1.2	Project website	UoC	M1	M1	
D1.3	Project leaflet	UoC	M3		
D2.1	Report	RUMC	M3		
D3.1	Summary preliminary findings	NIVEL	M3		
D3.2	Final synthesis	NIVEL	M4		
D4.1	Report of expert meeting	RUMC	M5		
D4.2	Set of guidelines etc	RUMC	M6		
D5.1	Protocol	FFZG	M4		
D5.2	Model of Integrated Care	FFZG	M6		
D6.1	Local assessment report	MUW	M6		
D6.2	Summary report, implementation 6 sites	MuW	M11		
D7.1	M&E Framework	EFPC	M1	M1 + 1 day	
D7.2	Interim evaluation	EFPC	M6		
D7.3	M&E chapter	EFPC	M12		

The additional output includes papers, presentations, workshops and other activities related to the EUR-HUMAN project.

Table 2: Additional EUR-HUMAN output

Output of WP nr.	What	By whom	Due date	Delivery date	Comments

Part 3: EUR-HUMAN Critical issues

List of critical issues

Timing: to be expanded throughout the project.

Critical issues

Throughout the project issues will arise that require special attention from the consortium. These issues can be related to concepts, process as well as to outcomes of the EUR-HUMAN project. This section will describe the issues and provide solutions and a timeframe for actions to be undertaken.

1. Distinction between refugees and migrants.
   As part of WP7, a review on this subject will be developed, describing the distinction between refugees and other migrant. As discussed at the kick-off meeting, distinction is especially difficult to make at the hotspots and transition sites. Therefore it was decided to not making this distinction for the Work Packages. The document will be a review of legal and practical issues with regards to health care, for the distinction between refugees and other migrants and include a reflection of the views of all EUR-HUMAN WP leaders and is to be added to the final reporting.
   M4: delivery of document by WP7
2. Inclusion of minors
   WP2 will not include minors in the PLA brokered sessions. Ethical approval is more difficult for this group of refugees.
3. Informed consent form participants of the PLA brokered sessions
   As discussed during the kick-off meeting, informed consent from participants in PLA brokered sessions may need to be obtained. In different countries there may be different requirements for this process. Accurate documentation is required.
   WP2 leader on Febr. 3, 2016: local ethical committee, the "Commissie Mensgebonden Onderzoek Radboudumc" has decided after reading the Grant agreement , the outline for the fieldwork in WP2 and the letters of information and consent, that no formal ethical approval is required because no invasive treatment or approach will be used; the need for formal application for ethical approval is waived under the following name and number: European Refugees - Human Movement and Advisory Network Dossiernummer: 2016-2306

Part 4: EUR-HUMAN Summary of modifications and actions

List of modifications and actions

Timing: to be expanded throughout the project.

A summary of modifications is provided after each reporting period M1; M3; M5; M8; M12.
The need for amendment will be indicated by the project administrator (WP1).

Table 1: Summary of modifications and new actions after M1

	Modifications of Grant Agreement text	**Need for amendment** **By project administrator**	**Other actions**
WP1	-		
WP2	Number of participants per PLA brokered session is 5-6, not 10.		To describe manifestations of "sense of coherence and community engagement" in report at M3
	Change of number of participants per session, no change in total number of sessions: 3 sites where migrants only stay for a short period: in total 4 sessions with 2 different male and 2 different female groups, during which sessions different topics can be addressed and different groups of refugees are reached. For the 3 sites where refugees stay for a longer period to form 2 groups of men and women with whom about 3 sessions take place. In this way the per DOW agreed total amount of 30 meetings will be accomplished (3 x 4 + 3 x 6). In this way sufficient diversity in gender, age, country of origin can be reached as well as theoretical saturation of the data.		
WP3	-		
WP4	D4.1 Report of expert meeting available in M6 (changed from M5)		
	Rephrase outcome indicators		
WP5	One process indicator to add: Integration / alignment with WP2 and 4 and with WP6		
	Output indicator: One part of the described model-to-be-develop has been annulled: 4) cumulative records of successive assessments and received MHPSS interventions of a refugee at each transit location, entered by authorized MHPSS providers into a data base accessible at each next location and ready for use at the final destination and PASR.		

	Further the model will be developed as planned.		
WP6	pending		
WP7	-		To write review of the terms refugees and migrants at M3

Appendix-1: List of milestones

Milestone number [18]	*Milestone title*	*WP number* [9]	*Lead beneficiary*	*Due Date (in months)* [17]	*Means of verification*
MS1	Advisory board meeting	WP1	1 - UOC	4	Meeting with the board online.
MS2	Local researchers are trained in PLA	WP2	2 - RUMC	1	Training sessions with researchers
MS3	PLA moderated meetings have taken place between researchers and refugees	WP2	2 - RUMC	3	Meetings between researchers and refugees
MS4	Report on the views, experiences and expectations of the refugees and the stakeholders	WP2	2 - RUMC	4	Written document
MS5	Presentation and discussion of preliminary findings at partner meeting	WP3	4 - NIVEL	3	Presentation and discussion of preliminary findings
MS6	Final synthesis report available online	WP3	4 - NIVEL	5	Online report
MS7	Expert meeting	WP4	2 - RUMC	5	Organization of a meeting of experts
MS8	Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees	WP4	2 - RUMC	6	Written Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants
MS9	Protocol with procedures, tools and interventions completed	WP5	5 - FFZG	4	Written protocol
MS10	Model of Integrated Continuity of Psychosocial Refugee Care described	WP5	5 - FFZG	6	Written description of model
MS11	Start of development of the	WP6	6 - MUW	4	

D7.2 Interim Evaluation Report.

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EUR-HUMAN

EUropean Refugees-HUman Movement and Advisory Network

Interim Evaluation Report

Work package 7 title: Monitoring & Evaluation
Deliverable 7.2: Interim Evaluation Report

Co-funded by
the Health Programme
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"*The content of this EUR-HUMAN Interim Evaluation 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*."

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Content

Introduction....4
Project summary and perspectives....5
Project progress in general....7
Work Packages....9
WP1 Coordination, Dissemination and Management of Project's Execution....9
WP2 Communicating and liaison with stakeholders and refugees....12
WP3 Review of literature and expert knowledge....14
WP4 Developing tools and practice guidelines for health care practitioners....15
WP5 Mental health psychosocial support and first aid for refugees....16
WP6 Enhanced capacity building strategy for primary care staff....18
WP7 Monitoring & Evaluation....22

Introduction

EUR-HUMAN in context

The international refugee crisis has reached a critical point and many European countries are developing policies and plans to better define their role in supporting refugees entering Europe. Among refugees who have relocated to European countries, many are challenged with medical issues, economic devastation and racial discrimination. EUR-HUMAN project "EUropean Refugees - HUman Movement and Advisory Network" (Specific Call HP-HA-2015 Project Proposal number 717319), is an integrated project under the Third Programme for the Union's action in the field of health 2014-2020 with a duration of 12 months.

The overall aim of the EUR-HUMAN project is to enhance the capacity, knowledge and expertise of European member states who accept refugees and migrants in addressing their health needs, safeguard them from risks, while at the same time to minimize cross-border health risks. This initiative focuses on addressing both the early arrival period and longer-term settlement of refugees in European host countries. A primary objective of this project is to identify, design and assess interventions to improve primary health care delivery for refugees and migrants with a focus on vulnerable groups.

This report summarises activities, deliverables and other results of the first six months of Work Packages 1 to 6 of the project and is a deliverable of WP7, the Monitoring & Evaluation (M&E) package of the project.

1) An overview of the activities and results of the Work Packages.
2) A list with critical issues that emerge during the project.
3) A summary list of deliverables.

Project summary and perspectives.

The aim of this project is to enhance the capacity of European member states who accept migrants and refugees in addressing their health needs, safeguard them from risks, and minimize cross-border health risks.
It addresses the early arrival and transit periods and the longer-term settlement of refugees in European host countries.
The final result of the project is the delivery of tools, guidelines and other forms of guidance, including a training programme and materials, for primary health care workers in various countries.

The project is organised through seven different work packages and covers a time span of twelve (12) months, the year 2016.

Under coordination of the University of Crete (WP1), the existing European and international literature has been systematically reviewed to identify effective interventions to vulnerable groups and tools for the initial health care needs assessment of the arriving refugees including mental, psychosocial and physical health. Experts in these fields have been consulted as well. (WP3). The synthesis report has been delivered and in addition a checklist that helps planners to decide on choices and priorities of interventions and improvements. In order to increase understanding regarding their needs, wishes, views and expectations, group and individual interviews have been held with refugees in six countries and care providers in one country, (WP2). Using the results of WP2 and WP3, the content of the services to be offered in the various countries has been discussed and defined. An international expert panel meeting in Athens in June was a key event to discuss the choice of approaches and services (WP4, WP5). The elements and information identified through this consensus meeting combined with information received from the other sources (meetings with refugees, systematic literature review) will be translated into guidance for primary health care workers and specific pilot interventions.
This includes the protocol for rapid assessment of the mental health and psychosocial status of refugees based on a stepped up model of integrated care that was developed by WP5. As a next step, the first deliverable of WP6 was an inventory of the capacity, local situation, and needs of staff in Community-oriented Primary Care centres as well as other existing primary care settings in Greece, Italy, Croatia, Hungary, Austria and Slovenia regarding primary health care for refugees.

The project is on track, with some adaptations based on progressive insights. Deliverables are forthcoming with some delays.
On the basis of the previous WPs (2,3,4,5,6) and deliverables (D2.1, D3.1, D3.2, D4.1, D4.2, D5.1, D6.1), in the second half of the year a training programme and test protocols will be developed for interventions carried out by selected staff serving in the six countries mentioned (WP6). The results of the testing will be evaluated and a final report with recommendations and good practice for implementation in European settings will be produced to guide best practice in this important humanitarian effort (WP7).
Currently, discussions take place between WP leads on the format of the training of WP6, since the planned online-training may need to be complemented by at least some form of face to face training, for greater effectiveness.

The project has been conceived and planned in a very short period, late in 2015. It is evident that definition and planning of activities, results and complementarity between the Work Packages suffered from time pressure and has been adapted based on progressive insights and progress of the project. In combination with political changes and variations in the flow of refugees, this resulted in challenges to respect the timing of the deliverables, in redefining division of tasks with some of the partners and in a higher workload than was planned initially for several of the Work Packages. Currently, risks are addressed to avoid any delays of the final deliverables and insufficient time to evaluate the implementation of the final deliverables.

Project progress in general

The project is largely on track, without major modifications but with some adaptations based on progressive insights. Deliverables are forthcoming with some delays.

Over the first six months of 2016, major changes in the flow of refugees/migrants occurred in Europe. This is largely the result of the EU-Turkey deal of March 18. This resulted in a change of reception policies and facilities in Greece, on the islands, and a strongly reduced flow of refugees through the eastern Mediterranean and Balkan routes and different reception and access policies between Syrian refugees and refugees/migrants of other nationalities. In the western Mediterranean, the routes through Italy and Spain, changes in the refugee flows are more linked to security (North Africa) and seasonal factors and mainly economic factors.

The change and reduction of the refugee flows in the Balkan route impact on the activities of the project, since locations and opportunities for contacts with refugees and with health care providers change. In three of the project countries, primary health care for refugees is provided through specific and dedicated health services: in Greece, Croatia and Hungary; in three countries refugees use existing primary health care services: Italy, Austria, Slovenia.

WP1 coordinates the project and organises the dissemination. The WP is on track and several opportunities for dissemination have been used to date, other opportunities are forthcoming. Deliverables D1.2 and D1.3 were submitted on time and they were both reviewed and resubmitted to the portal.
WP2 has made an inventory of needs of refugees, based on interviews with refugees and care providers, using the Participatory and Learning Action methodology. It has resulted in a report that was delivered on time.
WP3 has made an inventory of (good) practice of health interventions for refugees, based on literature and expert experiences. Its draft report is delivered on time. In addition, it has produced an unplanned deliverable in the form of a checklist for implementation, called ATOMiC, to be used by planners of health services.
WP5 has delivered on time the protocol for rapid assessment of mental health and is about to deliver a description of a model of continuity of psychosocial care. There is a slight delay of one month of the second delivery, the model of continuity of psychosocial care, due to the intensive discussions with IOM's and UNHCR. The challenge regarding privacy and safety of patient mental health records will be resolved by proposing the use of a USB stick, which is, presently, the preferred information carrier across borders.
WP4 develops a 'catalogue', a set of guidelines, training and health promotion material. For this it uses the inputs of WP2, WP3 and WP5 and WP6 D6.1 and also has organised an expert meeting on June 8 and 9 in Athens. The delivery of the catalogue will be slightly delayed due to the large amount of information and data from the other WP's that needed to be processed.
WP6 prepares online training material for care providers and testing of the quality and effectiveness of that material. It designs a testing protocol in support of the testing of a selected intervention in each of 6 intervention sites in 6 countries. The insertion of (unplanned) face to face training is currently discussed among the WP leaders. Deliverables are planned for the second half of the year.
WP7 monitors the project activities and results, provides feedback to the partners and develops evaluation criteria for the results of WP6. It delivered the M&E Framework in February, with a delay of 1 week due to waiting for feedback.

The activities and deliverables of the Work Packages are strongly inter-dependent. Slight delays of activities have a cumulative effect. As a result, a delay of one (1) month of some deliverables of WP4 and WP5 occur. In a project with a duration of twelve (12) months this creates a risk of either not delivering all the results of the project in foreseen time or of results without evidence of its relevance or quality. Efforts are undertaken

to limit the delays, the risks are addressed and, to date, overall the project is largely progressing according to planning and the final deliverables are planned to be delivered on time. .

Work Packages

WP1 Coordination, Dissemination and Management of Project's Execution

General

Coordination and management of the project is intensive, due to the inter-dependence of the Work Packages, in terms of content and timing. Next to the formal Steering Committee meetings, many emails and bilateral exchanges take place.
A dissemination plan has been developed, which is a rolling plan, since opportunities for dissemination will be added as they arise. As part of the dissemination, a policy on authorship was agreed between the consortium partners.

Deliverables planned		Deliverables realised		Comments	
D1.1 Final Report to CHAFEA	M12				
D1.2 Project website	M1	Project websites	M1	http://eur-human.uoc.gr	
D1.3 Project leaflet (eight languages)	M3	Project leaflet	M3	The leaflet is available in the eight languages of the consortium members and in Farsi and Arabic. The second newsletter of the six-month progress will be available by the end of M7 (July).	
Milestones planned		Milestones realised		Comments	
Steering Committee meetings		Kick-off meeting on January 19 and 20, 2016. Further meetings at February 9, February 17 March 16, April 13, June 9			
Advisory Committee meetings	M4	Meeting at 8-9 June	M6	The meeting was scheduled later than initially planned to coincide with the face-to-face expert meeting of WP4	
Unplanned deliverable or activity					
None					

Dissemination plan
Status of June 30, 2016

What	When/where	who	how	budget
Website	http://eur-human.uoc.gr/	Rena	Online platform	UoC
Meeting in the Greek Ministry of Health and Ministry of Migration	M1 26 January 2016	Christos, Angelos and Kyriakos	Presentation of EUR-HUMAN; Establish collaboration with the Greek Government	UoC
Presentation 6th European Conference on Migrant and Ethnic Minority Health	M6 Oslo, Norway 23-25 June	Christos	Christos; abstract done.	UoC
Presentation during annual conference of EFPC	M9 Riga, Latvia September 3-5	Christos et al	Workshop; link between PHC and Personalized Health aiming in addressing refugees' care	UoC et al
Leaflet	M3	Agapi, UoC team, et al		UoC
Newsletters 2 x	M6, M12	Agapi, UoC team, et al	Translation in the languages of the consortium and in Arabic and Farsi	UoC et al
Progress report in e-newsflash and news-item on the website of EFPC (4 x) for members and consortium partners	M3, M6, M10, M13	Diederik Aarendonk		
Presentation to the conference of the European General Practice Research Network	M8	Christos et al	Christos; abstract done.	UoC
Letter to the editor of the BMJ	M13	Christos et al	With coordinators of other EU funded projects	
Letter to the editor of the European Journal for Public Health	M13	Christos et al	With coordinators of other EU funded projects	
Position Paper by EFPC (based on EUR-HUMAN and additional data)	M14	EFPC: Kate O'Donnell, Pim		
Final report EUR-HUMAN	M13	Christos et al		UoC

Preliminary list of articles to be published				
Title (type of paper)	**Accountable partner**	**Proposed Journal/s**	**Time of a potential submission**	**Notes**
Compassionate care and European refugee crisis: do we need much discussion. **(Short report)**	UoC	Journal of Compassionate Health Care	31/9/2016	
Designing and Implementing Primary Health Care services for refugees/migrants reaching A study protocol. **(Study protocol)**	UoC	BMC Health Services Research	30/7/2016	
Views, experiences, wishes and needs of refugees/migrants. The experience of seven European countries. **(Original paper)**	RUMC	Journal of Immigration and Minority Health	31/9/2016	It has been suggested by Tessa and Maria.
Implementing a patient-centered primary health care services for refugees/migrants. (A feasibility study)	MUW	Canadian Medical Association Journal	15/12/2016	It is a proposal to Kathryn.
Practical recommendations for policy makers, health care professionals, refugees and other relevant stakeholders in order to deal with refugees' crisis. (Original Policy paper)	NIVEL	Journal of refugees studies	15/9/2016	It has been proposed by Michel.
The refugees' crisis in Europe. What should change in the education of health care students? (prospective article)	UoC jointly with UoL	BMC Medical Education	15/10/2016	
Tools and guidelines for rapid assessment. What we learnt from the refugees crisis in Europe. Meeting the health care needs of refugees in Europe. (Review article)	RUMC, jointly with UoZ and UoC	American Journal of Evaluation.	30/11/2016	It is a proposal to all partners.
Letter to the editor of the BMJ: Experiences gained from EU funded projects.	UoC with coordinators of other EU funded projects	BMJ	28/2/2017	

WP2 Communicating and liaison with stakeholders and refugees

General

The overall aim of this Work Package is to gain insight in the health needs and social problems, as well as the experiences, expectations and barriers regarding accessing primary health care and social services, of refugees and other newly arriving migrants throughout their journey through Europe - from the hotspots via the transit centers to the first longer stay reception centers. The results of the Work Package feed into the development of guidance and tools by Work Packages 4, 5 and 6 in particular.

Implementation

The information and insights have been collected through group sessions with refugees in seven (7) countries: Greece, Slovenia, Croatia, Italy, Hungary, Austria and the Netherlands; the sites were chosen so as to represent a variation in contexts and to reflect a part of the journey of refugees. The group sessions were to be conducted through the Participatory Learning and Action (PLA) research methodology. Local staff members from all intervention sites had to be trained in the application and ground rules of the PLA method, and were supported in their fieldwork by the Radboud UMC team. The two day PLA training in Ljubljana, Slovenia, was attended by in total 16 participants.
Four countries acquired ethical approval of the research sessions in accordance with the legal requirements in the country, in the other three countries (The Netherlands, Hungary and Italy) ethical approval was not required.

A total of forty-three (43) group sessions were held, with a total of ninety-eight (98) refugee-participants from nine (9) countries and with twenty-five (25) health care workers in Croatia. Every participant of the PLA sessions filled in an informed consent form. The sessions resulted in an overview of main health problems and experiences, needs and barriers with health care. They also provided learning points relevant for the choice and development of guidance, tools and training.
The reports of the group sessions were aggregated in a synthesis report that serves as input for Work Packages 4, 5 and 6. For each of these Work Packages specific recommendations and learning points have been formulated.

All milestones and deliverables have been achieved as planned and in time.

Adaptations and specific learning points.

Minor adaptations had to be done with regards to the PLA sessions with the refugees: one site for the PLA sessions has been added to the original plan: a site in the Netherlands, to complete the picture of the whole journey, until the country of destination.

In Croatia, sessions with refugees could not be held due to their very fast transit. Therefore, six PLA sessions were held with experienced care providers from various agencies that had been working with refugees in the transit centers.
For the same reason, at the site in Slovenia only one session could be held with refugee groups, instead of the planned 2-3 sessions.

Deliverables	planned	delivered	Comments
D2.1 Report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services	M3	M4	
Milestones planned			Comments
2.1 Training of local researchers	M1	6-7 February 2016	16 staff members of local teams from
2.2 PLA moderated meetings	M3	M3	Due to the changing politics and closing of borders, the possibilities to interview migrants in transit were less than planned; therefore the fieldwork was adapted: a. one site was added: Nijmegen, the Netherlands, to complete the picture of the whole journey, until the country of destination b. in Croatia 6 meetings were added with healthcare providers, social workers and volunteers instead of with migrants
2.3 Report on the views, experiences and expectations of the refugees and the stakeholders	M4	M4	
Unplanned deliverable or activity			
none			

WP3 Review of literature and expert knowledge

General

The overall aim of this Work Package is to learn from literature and experts on measures and interventions and the factors that help or hinder their implementation in European healthcare settings. This is achieved by the development of a comprehensive overview of effective interventions that address health needs and risks of refugees and other migrants in European countries, focusing on short-term arrival as well as long-term settlement. The overview is a synthesis of existing knowledge from the literature and experts.

Implementation

After the development of a heuristic framework, a systematic search of literature databases and an online survey among experts were done. 81 experts and health professionals responded to the survey. This was followed by interviews with 10 international experts.

Adaptation and learning points

The original plan was to deliver a report with an overview of effective interventions that address health needs of refugees. This was delivered. However, in order to facilitate implementation, the Work Package has delivered also a follow up, a checklist, called ATOMiC: **Appraisal Tool for Optimizing Migrant Health Care**. It provides practical guidance for improving health care services for often vulnerable groups. The checklist helps users – health care professionals, managers, policymakers, implementation advisors – to consider the various contextual and resource factors and to identify priority interventions and issues that require special attention when proceeding with improving the services.

Deliverables	planned	delivered	Comments
D3.1 Summary of preliminary findings and practical recommendations	M3	M4	
D3.2 Final synthesis	M4	M6	WP3 continues to update and improve the report until M12, in order to provide the most precise information possible.
Milestones planned			Comments
Presentation and discussion of preliminary findings at partner meeting	M3	M3	
Final synthesis report available online	M5	M5	WP3 continues to update and improve the report until M12, in order to provide the most precise information possible.
Unplanned deliverable or activity			
ATOMiC checklist: Appraisal Tool for Optimizing Migrant Health Care		M6	

WP4 Developing tools and practice guidelines for health care practitioners

General

The overall aim of this Work Package is to provide a series of support tools for primary care practitioners who work with and for refugees, in the form of papers, guidelines, training and other materials. Using the results of WP2, WP3 and WP5, this WP organizes an expert meeting to make a selection of all these materials and subsequently develops a report indicating the whole set of materials. These will be made available on-line.

Implementation

The expert meeting was held on June 8 and 9 in Athens and brought together 30 experts from various countries plus 15 Greek officials, representatives of the ministry of health, the ministry of migration and other relevant organizations. The meeting report with consensus on conclusions and recommendations on Primary Care for refugees/migrants is the first deliverable of this Work Package.
The second deliverable, the resulting guidance document, will be available by the end of July, 2016.

Adaptation and learning points

No adaptation of contents has been done. The delay in deliverable was due to the fact that the expert meeting only could take place after the finalizing of WP3 and 5, which was foreseen in month 5, so the meeting had to be postponed form month 5 to month 6.
The amount of work is larger than had been planned, partially because the expert meeting took place in Athens, which was not planned initially by the Work Package lead, that is based in the Netherlands. Thanks to organizational support by WP1, the meeting proceeded smoothly.

Deliverables	planned	delivered	Comments
4.1 Report of expert meeting	M5	M6	
4.2 Online set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees; including a template for adaptation of materials specific to the respective country	M6		Will be delivered before M8
Milestones	planned	delivered	Comments
Expert meeting	M5	M6	
Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees	M6		Will be delivered before M8

WP5 Mental health, psychosocial support and psychological first aid for refugees

General

The overall aim of this Work Package is to provide a protocol for rapid assessment and provision of psychological first aid (PFA) and Mental Health Psycho Social Support (MHPSS). Also a model for continuity of care will be developed. This model allows for primary care providers along the journey of the refugees, to upload and download information, which helps to avoid repetitive interviewing of the refugees and interruptions of treatments.

Implementation

The Work Package is on track with only a slight delay of the two deliverables: a protocol for rapid assessment and a model for continuity of care.

On the model of continuity of care, discussions take place with IOM and UNHCR, that are equally working on systems to register data (IOM: Personal Health Record; UNHCR: electronic system for international transfer of data) in order to come to an agreed model of registering patient data and information. For example, the use of ICPC as coding system for complaints and diseases is discussed. These discussions require more time than initially expected.
The choice of an information carrier needed quite some time as well. Requirements had to be defined, including security and user-friendliness, for the user/patient and for health care providers. Options for an online registration system that could be used across Europe have been assessed, but the final choice will be for a USB system, password protected.

Adaptation and learning points

Complexity of recording and carrying health information that can be shared between countries and is safe and user-friendly is larger than expected, partially because it needs discussion with external partners like IOM and UNHCR.

Deliverables	planned	realised	Comments
5.1 Protocol for rapid assessment and PFA/MHPSS	M4	M4	
5.2 Description of a model of continuity of psychosocial care	M6	M6	Discussions on the adequacy of the Personal Health Record of IOM and aligning with UNHCR on the model it is developing. Expectation that model will be used with password protected USB as information carrier.
Tasks			
Task 5.1. Select appropriate approaches and methodology regarding rapid assessment of mental health and psychosocial	M3	M3	

support needs to be used in the implementation settings			
Task 5.2. Develop protocol which includes procedures, tools for rapid assessment and provision of psychological first aid and MHPSS interventions to newly arriving refugees	M4	M4	Draft protocol was shared with partners who provided valuable inputs which were integrated into D5.1
Task 5.3. Adapt protocol, assessment tools, and interventions to respective national and regional situation in collaboration with local stakeholders and provide input into WP6 for implementation	M5	M5	Partners did not provide explicit feedback if the protocol has been adapted to the national and regional situations. The protocol served for input into WP6 since the training materials for mental health are developed in line with the protocol – e-module and face-to-face training module
Task 5.4. Develop model of Integrated Continuity of Psychosocial Refugee Care from Early Hosting and First Care Centers to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee destinations	M6	M6	Description of the Model of Integrated Continuity of Psychosocial Refugee Care is being finalised. Currently close contact with IOM and UNHCR initiatives to establish e-platform for personal health data collection and transfer. Since MH is a minor part in the IOM's PHR specific contents will be provided that could complement the IOM PHR.
Milestones	planned	realised	Comments
Protocol with procedures, tools and interventions completed	M4	M4	
Model of Integrated Continuity of Psychosocial Refugee Care described	M6	M6	

WP6 Enhanced capacity building strategy for primary care staff; preparation and implementation of recommended interventions in selected implementation sites: Greece, Italy, Croatia, Slovenia, Hungary, Austria

General

The first objective of this Work Package is to enhance the capacity building of the primary care workforce through the assessment of the existing situation (leading to the first deliverable)
Another activity of the objective is the development of an online curriculum for local primary care professionals and refugees who are primary care professionals. This part of WP6 makes use of inputs of Work Packages 2 to 5: these will be translated in online training modules.

The second objective is to implement one intervention in each of six sites in six countries and to evaluate its effectiveness. In each of the six selected countries, Greece, Italy, Croatia, Slovenia Hungary and Austria, one target group of care providers is selected for training and one intervention is selected for implementation. WP6 will develop a report on the interventions implemented.

Implementation

This Work Package started activities in M4. During M5, the Work Package lead provided an overview of the intervention phase of WP 6 tasks 6.8 – 6.13 to the partners.
During M6, the sites/target groups of the care providers for the implementation of the testing have been selected and the themes for the testing have been indicated. These will be detailed later, on the basis of guidance of WP4.

	Greece	Italy	Austria	Croatia	Slovenia	Hungary
Target group of training	In total, 8-12 doctors (mainly GPs), 2-3 midwives, 2-5 community nurses, one social worker and one or two health visitors would be invited	Primary Health Care workers of the National Health Services. In particular: 20 young GPs, 20 in training GPs, 15 expert GPs, 20 paediatricians, 10 nurses, 10 obstetricians. 20 social workers from the accommodation structures.	1. GP's, paediatricians, other physicians involved in primary medical care for refugees across the country 2. Asylum seekers who were physicians in their country of origins	medical staff, psychologists, social workers, community workers and volunteers	all doctors and nurses, in the health center, about 10 persons	6 GPs/primary care paediatricians and 8-10 health care staff (nurses, medical assistants). Target group could be extended to other health care workers (more than 30 doctors / nurses), or nationwide, depending on the final intervention (with training materials on care of refugees / migrant, online training etc.).
Where is the target group based or working	Kara Tepe hosting center in the island of Lesvos	Central Tuscany Local Health Unit	The regular health care system, country wide	Reception Center for Asylum Seekers ("Porin") in Zagreb	local Health Center Logatec, central-west Slovenia	permanent open reception centers operate in **Bicske** and **Vámosszabadi** and the temporary reception facility in **Körmend**. Permanent health care staff (doctors, nurses) in these centers/facilities, who are seeing majority of the migrants/refugees entering Hungary.

Training topics	multifaceted, integrated, person-centered and multidisciplinary intervention based on the needs, problems and expectations of refugees/immigrants/ asylum	Normative and legislative framework (definition of refugee/asylum seeker status; migration routes in Europe; regulation of access to health care). Anthropological and cultural knowledge, Diseases, focus on mental health and infectious diseases.	Multifaceted, integrated, person-centered and locally adapted online course with the topics: Monitoring, initial health assessment, acute conditions, infectious diseases, vaccination, legal aspects and issues, documentation, communication, interpreters, cultural aspects, idioms of distress, mental health aspects, sexual and reproductive health, child health, chronic conditions, empowerment, health literacy, and aspects regarding prevention and health promotion	Psychological First Aid, mental health assessment and short interventions	Cultural specific issues in taking care of minorities	Training of health care providers regarding the initial assessment (general and mental health) and specific care of migrants/refugees.

Adaptation and learning points

As a result of time pressure during the development of the project proposal, the description of the Work Package in the Grant Agreement is not fully clear, although the deliverables are correctly described.

Deliverables	planned	realised	Comments
D6.1 Report about the results of the assessment of local resources available	M6	M6	Draft provided in M6, final version early in M7
D6.2 Summary report about the run by the different implementation site countries	M11		
Milestones planned			Comments
Start of development of the capacity building strategies	M4	M4	
Start of the adaptation and training regarding the implementation in the intervention site countries	M6		
EU wide adaptable e-learning course available on internet	M8		
Report for internal use: Overview of the intervention phase of WP 6 tasks 6.8 – 6.13	M6		

WP7 Monitoring & Evaluation

General

As described in the Introduction, the main aim of WP7 is to provide optimal monitoring of the project's progress and key learnings emerging from work packages and participants and to produce recommendations for health care policies and practices. These will emerge as the project progresses.

Further, monitoring provides a regularly updated overview of adaptations of the activities, outputs and (expected) results and outcomes. This allows all stakeholders to understand the implementation process and its challenges and to adapt according to local needs, where necessary.

Evaluation of the project is to be conducted towards the end of the twelve (12) month project and contributes to accountability of the project, by assisting the Work Package coordinators in describing the outputs and results in terms of outcomes and impact. Evaluation also helps to asses in how far the objectives have been achieved and identify learning points, both for the consortium partners and CHAFEA and for health care providers in general and for health policy makers as well.

Based on the above, during M1, WP7 developed the M&E Framework that aims to provide answers to questions with regards to process, outcomes and learning of the project.
This report is based on information collected from the M&E Framework and comprises:

Implementation

DuringM1 , the M&E Framework has been agreed with the partners and is used as a tool to communicate with the partners on progress of activities and challenges.
This report, issued after M6, serves to record progress of the project. It could be develop only after M6, to allow for inclusion of all activities and results of the first six months.

Adaptation and learning points.

None in particular.

Deliverables	**planned**	**delivered**	**Comments**
7.1 M&E Framework	M1	M2	
7.2 M6 report	M6	M7	
Milestones planned			**Comments**
Unplanned deliverables			
Note on refugees/migrants		M4	

Summary list of deliverables and other output

This section provides an overview of the official and obligatory deliverables of the EUR-HUMAN project as well as the additional outputs that will result from the project.

See appendix-1 for a complete overview of the Milestones as described in the Grant Agreement.

Table 1: official EUR-HUMAN deliverables

Deliverable number	What	By whom	Due date	Delivery date	Comments
D1.1	Final report to Chafea	UoC	M12		
D1.2	Project website	UoC	M1	M1	Submitted
D1.3	Project leaflet	UoC	M3	M3	Submitted
D2.1	Report	RUMC	M3	M4	Submitted
D3.1	Summary preliminary findings	NIVEL	M3	M4	Summited
D3.2	Final synthesis	NIVEL	M4	M5	In progress
D4.1	Report of expert meeting	RUMC	M5	M6	Submitted
D4.2	Set of guidelines etc	RUMC	M6	M7	In progress
D5.1	Protocol	FFZG	M4	M5	Submitted
D5.2	Model of Integrated Care	FFZG	M6		
D6.1	Local assessment report	MUW	M6	M6	In progress
D6.2	Summary report, implementation 6 sites	MUW	M11		
D7.1	M&E Framework	EFPC	M1	M1 + 1 day	Submitted
D7.2	Interim evaluation	EFPC	M6	M7	Submitted
D7.3	M&E chapter	EFPC	M12		

Additional output

Critical issues

Throughout the project issues arise that require special attention from the consortium. These issues can be related to concepts, process as well as to outcomes of the EUR-HUMAN project. This section will describe the issues and provide solutions and a timeframe for actions to be undertaken.

During the first six months, no critical issues did occur that challenge the progress of the project.

1. Distinction between refugees and migrants.
   As part of WP7, a review on this subject has been developed, describing the distinction between refugees and other migrant. As discussed at the kick-off meeting, distinction is especially difficult to make at the hotspots and transition sites. Therefore it was decided to not making this distinction for the Work Packages. The document is a rolling document and reviews issues with regards to health care, for the distinction between refugees and other migrants.
   M4: delivery of document by WP7
2. Inclusion of minors
   WP2 has included some minors in the PLA brokered sessions. Ethical approval is more difficult for this group of refugees.
3. Informed consent form participants of the PLA brokered sessions of WP2
   As discussed during the kick-off meeting, informed consent from participants in PLA brokered sessions needed to be obtained in some but not all countries.

4. The closure of borders after the EU-Turkey deal. From March 18 onwards, the number of arrivals of refugees/migrants has been reduced considerably.
5. The closure of Balkan route had as a result no more refugees in transit in some countries (i.e Slovenia or Hungary)
6.

D7.3 Chapter in the final report, containing the final evaluation, conclusions and recommendations.

EUropean Refugees - HUman Movement and Advisory Network

Title: Monitoring and Evaluation

Deliverable 7.3

Chapter in the final report, containing the final evaluation, conclusions and recommendations.

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Executive summary

The aim of the EUR-HUMAN project was to enhance the capacity of Primary Health Care in European member states who accept migrants and refugees in addressing their health needs, safeguard them from risks, and minimize cross-border health risks. A European consortium under coordination of the University of Crete carried out the project during 2016.

Needs, wishes and preferences of refugees and other migrants in six countries (Austria, Greece, Slovenia, Hungary, Italy and the Netherlands) were assessed as well as among care providers in Croatia. However, interviews with experts and was systematically revision of the existing European and international experience were conducted to identify effective interventions to vulnerable groups. Additionally, the development of a Mental Health protocol and an expert consensus meeting resulted in a guidance document for Primary Care that addresses topics such as the rapid health assessment, mental health, sexual and reproductive health, child care, infectious diseases and vaccinations. It also contains an 'Appraisal Tool for Optimizing Migrant Health Care' (ATOMiC) to provide practical guidance for improving health care services for often vulnerable groups. Furthermore, the project delivered a Model of Continuity of Psychosocial Refugee Care.

Subsequently, this guidance was used to develop, as a pilot, an online training course of eight modules for Primary Care workers in the six languages of the participating countries: Austria, Croatia, Greece, Hungary Italy and Slovenia, plus in Arabic. Initially the training material was developed in English and then each country translated and adapted it, taking always into account the delivery characteristics of primary care and legal issues. In each country, a specific intervention site or group of primary care workers was selected and offered the training. In most cases, face-to-face training sessions were conducted to introduce the training.

The online course became gradually available from the end of October 2016 onwards in the six countries, the last one was the Hungarian version, on November 30. 390 primary care workers in the six countries registered for the course and one third of them completed the coursed before January 3, 2017. The period for the uptake of the course until the end of the project was short. Of those who completed the course, most needed 16 hours or less. 97 participants took part in an online survey to evaluate the course. One of the main findings is that the current training material is considered to be possible to build, enhance and sustain the delivery of primary care service for refugees and migrants. Among the respondents, there is broad agreement that primary care services for migrants and refugees are - or can become - a normal part of work. There is wide variation in views as to whether the online course provides sufficient training for delivery of the new service. Participation in the online training course in Austria shows that Arab speaking migrants can become a valuable human resource for Primary Care.

The project succeeded in carrying out all the tasks and in achieving the expected results, in spite of the very short period of time for such a complex project and of changes in migrant flows and other context factors during 2016.

The tangible and lasting results of the project that can be also transferred in other European countries are the systematic review, the Model of Continuity of Psychosocial Care, the ATOMiC tool, the Primary Health Care structure, the guidance document and the online training course, which integrates these deliverables. These results can be used in or are transferable to other countries in Europe, with country specific adaptations. It is recommended to create a mechanism to adapt, improve and update the online training course, as a common basis for Primary Care workers in Europe who provide care for refugees and migrants. Furthermore, it is recommended to develop additional face-to-face skills training in each setting/country.

Content

Executive summary....3
Content....5
Abbreviations....6
Introduction....7
Section I: The EUR HUMAN project in short....8
Section II: Evaluation....10
Introduction....10
On-line training course....10
Evaluation methodology....*12*
A Assessment of the use of the online course and the learning effect it had....*12*
B Survey for feedback among the users of the online course....*17*
Discussion and recommendations....21
Section III: Activities, deliverables and results of the Work Packages....26
WP1 Coordination, Dissemination and Management of Project's Execution....26
WP2 Communicating and liaison with stakeholders and refugees....30
WP3 Review of literature and expert knowledge....32
WP4 Developing tools and practice guidelines for health care practitioners....34
WP5 Mental health, psychosocial support and psychological first aid for refugees....36
WP7 Monitoring & Evaluation....40
Summary list of deliverables and other outputs of the EUR-HUMAN project....41
Contact details EUR-Human Consortium partners....42

Abbreviations

CME	Continuous Medical Education
DOW	Description of Work
EUR-HUMAN	EUropean Refugees - HUman Movement and Advisory Network
HeF	Health e Foundation
MUW	Medical University of Vienna
NIVEL	Netherlands Institute for Health Services Research
NoMAD	Improving the normalization of complex interventions: measure development based on normalization process theory
PHC	Primary Health Care
PLA	Participatory Learning and Action
RUMC	Radboud University Medical Centre
UoC	University of Crete
UoL	University of Liverpool
WP	Work Package

Introduction

This final evaluation report describes the EUR-HUMAN project and its results.

The international refugee crisis has reached a critical point and many European countries are developing policies and plans to better define and carry out their role in supporting refugees entering Europe. Also in the field of health, the current refugee crisis has created a need for the design of programs to test the feasibility and acceptability of proposed actions prior to their large-scale implementation. The EUR-HUMAN project aimed to identify, design, assess and implement measures and interventions to improve primary health care delivery for refugees and other migrants. The organisation, delivery and quality of primary care varies considerably across the countries of Europe. Good primary care does not evolve spontaneously. The project intended to enhance the capacity, knowledge and expertise of European member states in order to provide holistic, comprehensive, compassionated, integrated and person centered Primary Health Care[1] (PHC) services to refugees and migrants. The EUR-HUMAN project addressed the early arrival and transit periods as well as the longer-term settlement of refugees in European host countries.
The final result of the project is the delivery of tools, guidelines and other forms of guidance, including a training programme and materials, for primary health care workers in Austria, Croatia, Greece, Hungary, Italy, Slovenia and in Arabic. Specifically, the EUR-HUMAN project intends to involve refugees/migrants who are health professionals themselves.

The objectives of this report are

- To contribute to the accountability of the project by showing the results of the project.
- To provide key learnings emerging from work packages and participants.
- To produce recommendations for health care policies and practices.

Section I summarises the EUR-HUMAN project, for easy orientation of the reader.
Section II contains the evaluation proper of the project.
Section III reviews more in detail the activities, deliverables and other results of all the Work Packages of the project.

[1] In this report, the terms Primary Health Care and primary care are used interchangeably.

Section I: The EUR HUMAN project in short

The project was organised through seven different work packages (WP) and covered a time span of twelve (12) months, the year 2016. The University of Crete (UoC) was in charge of the overall coordination (WP1).

Under coordination of the Radboud University Medical Centre (RUMC) in Nijmegen, the Netherlands, (WP2), initially fieldwork among refugees and health care workers took place in the countries mentioned above, plus in the Netherlands, to assess their health needs, experiences, wishes, preferences and expectations regarding health care and social care throughout their journey through Europe. This resulted in a report, D2.1, which served as further input in later WP's and also has stand-alone value.

The Netherlands Institute of Health Services Research (NIVEL (WP3)) has reviewed the existing European and international literature to identify success factors and obstacles as well as effective interventions for vulnerable groups and tools for the initial health care needs assessment of the arriving refugees including mental, psychosocial and physical health, maternal health etc. Interviews with international experts in these fields have also been conducted. However, PHC personnel who provide services in the field were asked and responded a questionnaire (mainly open-ended questions). The synthesis report of WP3 (D3.1 and D3.2) has been delivered and in addition a checklist 'Appraisal Tool for Optimizing Migrant Health Care' (ATOMiC) that helps planners to decide on choices and priorities of interventions and improvements. The report and Atomic tool were inputs in WP4 and WP6.

The University of Zagreb (WP5) developed the protocol for rapid assessment of the mental health and psychosocial status of refugees based on a stepped up model of integrated care, D5.1.

The content of the services to be offered in the various countries has been discussed and defined under coordination of the RUMC (WP4), by using the results of the WP2, WP3, WP5 as well as of the Deliverable 6.1 (current primary care situation in different settings). An international expert panel meeting in Athens in June (8 and 9) was a key event to discuss the choice of approaches and services. The elements and information identified through this consensus meeting, described in D4.1, combined with information received from the other sources (meetings with refugees, systematic literature review, interviews with experts) has been translated into guidance for primary health care workers and specific pilot interventions, D4.2.

As a next step, the first deliverable of WP6, D6.1, was an inventory of the capacity, local situation, and needs of staff in Community-oriented Primary Care centres as well as other existing primary care settings in Greece, Italy, Croatia, Hungary, Austria and Slovenia regarding primary health care for refugees. The inventory was carried out by EUR-HUMAN partners in these countries under the coordination of the WP6 lead (MUW team).

On the basis of the previous WPs (2, 3, 4, 5, 6) and deliverables (D2.1, D3.1, D3.2, D4.1, D4.2, D5.1, D5.2, D6.1), in the second half of the year a training programme was developed for interventions to be carried out by selected staff serving in the six countries mentioned (WP5 and WP6). The training programme is an online programme, initially written in English and then translated and adapted in the respective languages of the participating countries: German, Croatian, Greek, Italian, Hungarian and Slovenian. Also, an Arabic version was produced for refugee/migrant primary care staff in Austria. The adaptation of the training course to an online version and the management of the online version and communication with registered participants was done by Health e Foundation in the Netherlands, that is specialised in online trainings for the health sector.
In several countries a face-to-face introductory meeting was held at the launch of the online training programme. The online training programme itself was not defined as a formal deliverable of the project, but is a key result. The online and other trainings are considered as pilots that serve the provision of learning for future use. The online course will remain online after December 31, 2016, but no maintenance or communication with users is foreseen after that date.

In addition to the above deliverables, WP5 developed a Model of Continuity of Psycho Social Care, D5.2.

Additional face-to-face trainings on Mental Health and Psycho Social support were given to PHC staff in Croatia and Italy.

The workflows of the project have been described in a report, deliverable D6.2 of the project, in a diagram, showing the inter-dependence of the WP's of the project. D6.2 offers an overall description of steps taken by the project partners and the content of the training they developed and implemented. Country reports are included in D6.2.

D6.2 and the country reports show the diversity of PHC and health care in general in Europe. For example, in some countries, primary care for refugees is provided through the regular health system and in other countries through specific care for refugees/migrants. This, in combination with the different refugee/migrant flows in Europe, explains why the implementation of the project took different approaches in the six countries of the project. This is all described in detail in D6.2

The results of these efforts undertaken during the last 12 months have been evaluated by WP7 to guide best practice and to recommend further actions on behalf of primary care for refugees and migrants.

Section II: Evaluation

Introduction

This section offers an evaluation of the project.

As the previous section describes, the deliverables of WP's 2-6 all contributed to the online training course for primary care professionals and managers, which is created as part of WP6 and is the most substantive result of the project, although it was not described as a specific deliverable itself in the DOW. In addition, the other deliverables of the WP's 2-6 do have stand-alone value.

The evaluation therefore addresses the online training course and the other deliverables of project in general.

The evaluation does not address the actual service delivery of the trained (either face-to-face or online) primary care staff. Time between the training of the staff and the end of the project, which is the period of actual service delivery after training, was too short to allow the systematic evaluation of service delivery. Also, evaluation of a change in service delivery would have required baseline – data, which is beyond the scope of a one year project that is oriented towards development of practical tools rather than towards academic evidence. Finally, the primary care staff trained by the project is, in several countries, working in dispersed settings which does not allow for systematic data collection that result in comparable data. However, 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 by the UoC team. 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. Additionally, the Zagreb team piloted the screening and referral procedure.

Further, the Model of Continuity of Care was not evaluated because no implementation of the Model was planned during the project and included in the Grant Agreement.

Below, the online training course is discussed extensively. This is followed by a general discussion and recommendations of project partners.

On-line training course

General description

This training course is a key result of the project because it is available for and used by Primary Care workers that (potentially) deliver care to refugees/migrants in six

countries. The course targets various professional groups: General Practitioners, nurses, social workers, nutritionists and other staff directly providing care, but also Primary Care managers and policy makers. The course is defined as Mile Stone 13 of WP6 and results from tasks 6.1 to 6.7. The course is not defined as a specific deliverable.

The English template of the online course has been created by the MUW team with assistance of the project partners. It then was translated and adapted into the national language by the respective partners and was, for each language, customized for e-learning and put online by Health e Foundation (HeF).

The course consists of eight modules:
Module 1, Introduction
Module 2, Acute diseases – not in Italian version
Module 3, Legal issues
Module 4, Provider-patient interaction
Module 5, Mental Health
Module 6, Sexual and Reproductive Health
Module 7, Child health - not in Arabic version. Arab users in Austria use the German version of this module.
Module 8, Chronic diseases and health promotion.

The EUR-HUMAN partners have disseminated information on the online course to potential users of the course in their country through general publicity and through emails to professional groups. In Austria, Croatia, Greece and Slovenia, conferences and/or meetings have been organized to increase awareness of the course.

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.

Users of the course do register online and then study the modules at their own convenience. Users can interrupt the course and make a number of return visits. Apart from the Introduction module, all modules require a pre-test. At completion of the module, a post-test is done. The threshold for successful completion of a module is a correct answer to 75 % of the questions. When the post-test for all seven (in Italy six) modules is successfully done, the course is considered as completed and users receive a certificate from HeF. In Austria, Croatia and Slovenia , the course is accredited as a Continuous Medical Education (CME) course and the users who complete the course receive a certificate and earn CME points.

The course became available to users on different dates, as shown in the list below. Customizing the course as an e-learning course for each language specifically was a time-consuming process and explains the sequential dates the course became available in the different countries.

Austria German	October 24, 2016
Austria Arabic	November 9

Croatia	November 16
Greece	November 3
Italy	October 25
Hungary	November 30
Slovenia	November 3

As aforementioned, the online course remains available for users after December 31, 2016, but no maintenance or communication with stakeholders is foreseen after that date.

Evaluation methodology

The evaluation of the online course took two approaches:

A Assessment of the use of the online course and the learning effect it had. Data for this assessment have been generated by HeF that manages the online course and registers the users and their performance. The data cover the period from the moment the course came online in the various languages until January 3, 2017.

B Survey for feedback among the users of the online course. These data are collected through an online survey among users (by using the NoMAD questionnaire), which was organized by the WP7 with assistance of the partners in the project. The users were invited to take part in the survey, through email. The survey was open for users of the course until January 13, 2017.

A Assessment of the use of the online course and the learning effect it had

Methodology

Users of the online course registered on the website of HeF per country and were asked to identify by name and profession. The following data were reported by HeF on the use of the online course:

- Number of individuals that registered for the course, per country; names and professions of users as far as they did provide these.
- Number that completed the entire course of 7 modules (6 in Italy)
- Number that completed specific modules
- Difference in scores between pro and post-test, for each module
- Number of attempts of the post-tests per module,

Results

Users and use of the course

Most users registered their professional domain: just over 80 % was active in service delivery and just over 12 % had a management role. Of 7 % the role is not known. Of

the course users, some 50 % registered as a physician. Many users of the course did not provide information on their profession: physician, nurse, psychologist, other.

Table 1 shows the number of persons that were registered for the course, those that completed 0 modules and those that completed the course. Table 2 indicates how many users completed from 1 to 6 modules. Graph 1 shows for each module how many users completed it.

Table 1. Participants in each country

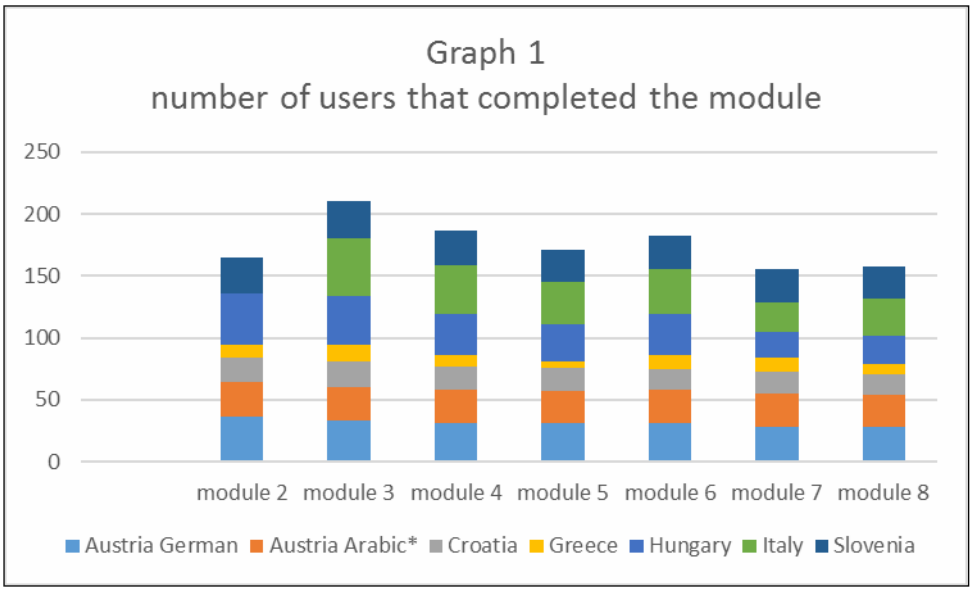
Table 1 Countries - language	Persons registered for the course	Persons that completed 0 modules	Persons that completed the course
Austria German	65	27	25
Austria Arabic	37	9	25
Croatia	36	15	14
Greece	17	3	5
Italy	112	66	20
Hungary	89	42	15
Slovenia	34	4	24
TOTAL	**390**	**166**	**128**
	100 %	**43 %**	**33 %**

Table 2. Number of users per country that completed between 1 and 6 modules, but not the entire course

Table 2	Completion of					
Countries - language	1 module	2 modules	3 modules	4 modules	5 modules	6 modules
Austria German	3	3	1	2	1	3
Austria Arabic	1	0	0	0	0	2
Croatia	1	1	0	0	1	4
Greece	0	2	3	2	0	2
Italy	4	3	3	8	8	20[1]
Hungary	8	3	4	3	5	9
Slovenia	1	1	1	0	0	3

[1] In Italy completion of 6 modules is completion of the entire course

Graph 1. Number of users that completed specific modules

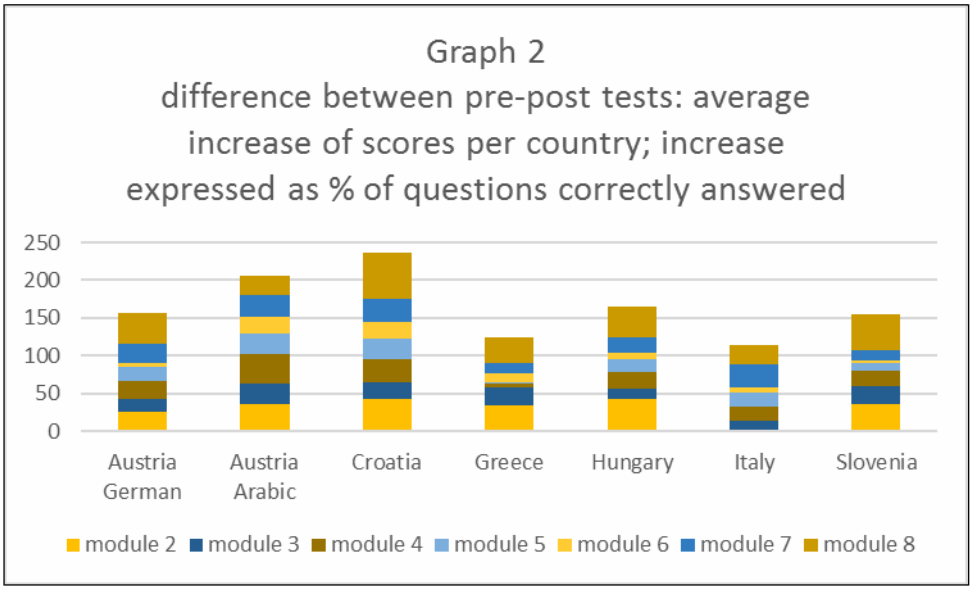


Learning effect

The learning effect can be approximated by comparing the scores of the pre-test and the successful post-tests for each module and to assess the increase of the scores. The minimum score of the post-test to pass is 75%. Graphs 2 and 3 show the results.

Graph 2 depicts the average increase of scores between the 7 pre/post-tests, approximating the learning effect, per country. Italian users only carried out pre/post-tests for 6 modules, which reduced the overall learning effect. Graph 3 depicts the knowledge-increase per module. Table 3 shows the average numbers of attempts that users needed to pass the post-test.

Graph 2 . Average of increase per country



Graph 3. Average increase per participant per module

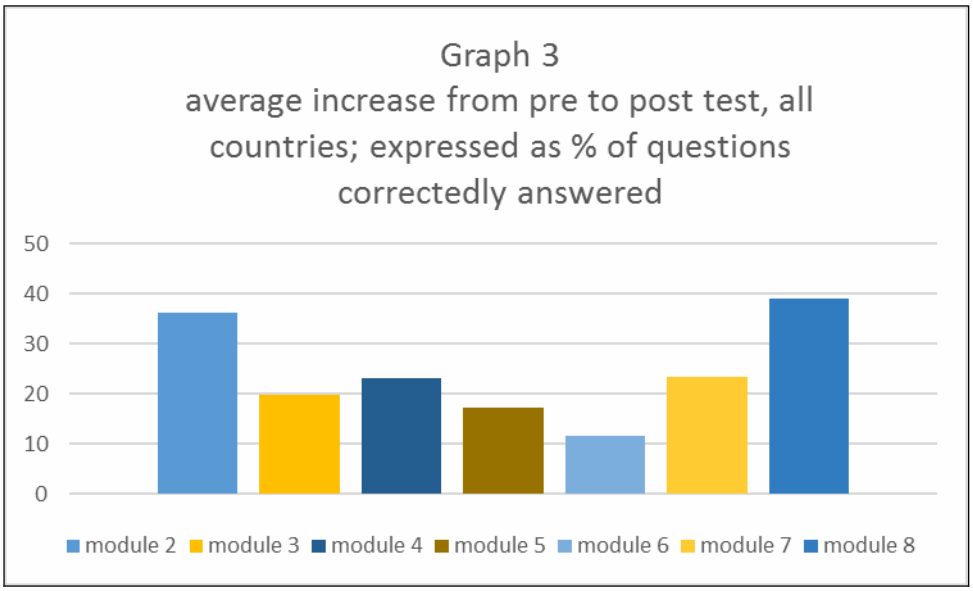


Table 3. Number of attempts to pass the Module

Table 3							
average number of attempts to pass the post-test, per module	**Austria German**	**Austria Arabic**	**Croatia**	**Greece**	**Hungary**	**Italy**	**Slovenia**
module 2	1,05	1,36	1,14	1,2	1,09	NA	1,3
module 3	1,15	1,41	1,1	1,2	**1**	1,1	1,1
module 4	1,03	1,26	1,05	1,2	1,08	1,14	1,21
module 5	1,13	1,52	1,1	**1,87**	1,22	1,31	1,25
module 6	1,06	1,19	1,1	1,07	1,06	1,03	1,44
module 7	1,57	1,59	1,2	1,47	1,64	**1,87**	1,59
module 8	1,13	1,52	1,3	1,47	1,45	1,33	1,48

Conclusions and discussion

- The online training course became available for users between October 24 and November 30, 2016. In this period, 390 professionals registered for the course. The users had between 5 to 10 weeks to complete the course until January 3, 2017, when the user-data were collected. The time to complete the course was short. According to HeF, normally e-learnings with a similar amount of content require a 3 month period for satisfactory passing rates.

- It is not possible to analyze the results according to the professions due to the limited number of users that registered their profession.

- 43% of those registered did not complete one single module, meaning that they did not start the course at all or stopped at the introductory module for which no pre/post-test is required. Hypotheses for the high percentage of registered users that did not start the course do include: the target group of users is extremely busy providing care to the refugees/migrants and cannot afford the time it takes to complete the course; limited availability of internet connectivity; after initial curiosity, lack of interest in the course either due to content or to the methodology of an online course. A motivator may be the earning of CME points in the three countries mentioned above. The first two hypotheses may especially apply to users on the Greek islands and to others who are working in refugee camps/settlements. However, one cannot conclude that higher passing rates mean lower workload (Slovenia and Arab speaking users in Austria).

- The passing rate of the complete online course was 33 %; Passing rates were highest for Slovenians and Arab speaking users in Austria, respectively 71 % and 68 %.

From a Croatian user of the online training course:

Hvala Vam, tečaj napreduje dobro, sadržaj je edukativan, testovi su lijepo napravljeni
=
Thank you, the course is progressing well, the content is instructive, tests are beautifully made.

From an Austrian user of the online training course:

….. It was exhausting, but very interesting! Although I have not had asylum seekers or refugees in my practice, I have already been able to implement a little bit of learning - especially with linguistic communication problems!
I would certainly look forward to further training courses in this form and / or on this topic!

- The participation of Arab speaking professionals in Austria and their relatively high passing rate shows that among refugees/migrants there is a considerable resource for primary care.
- Graph 2 shows that the average learning effects of the participants are largest in Croatia and lowest in Greece. With the available data conclusive explanations for these differences cannot be given. They may be attributed to a higher initial level of knowledge among Greek users or to a lower absorption of knowledge per module, or both. The inverse may be true for Croatian users.

The average learning effect across countries is highest for module 8, as shown by Graph 3. This finding is striking, since management and prevention of chronic diseases are considered as core business of primary care and one would expect high competency levels among professionals.

- The learning effect varies between modules and countries, but overall there is an important learning effect. The data also show that users benefit more from some modules than from others and more in some countries than in others. For example, the initial knowledge level of Greek users of the module on Sexual and Reproductive Health is high and increases minimally by following the module. These data however are averages and may conceal important variations between users within countries.
- Data on the number of attempts to pass the post-tests, table 3, show that module 7, child health, in most countries needs more repeat-tests and that Croatian users need relatively few repeat-tests to be able to pass. Otherwise, these data seem not to provide important clues on the use or effectiveness of the course.

B Survey for feedback among the users of the online course

Methodology

Among the users of the online course, an online survey was circulated in order to assess the course experience, the appreciation of it and to gather respondents' views on the implementation of primary care services for refugees and migrants in their countries. Respondents were asked to identify their profession as well.

We used a tailored version of the NoMAD questionnaire[2] to gather respondents' views on the implementation of primary care services for refugees and migrants in their countries.

[2] Finch TL, Rapley T, Girling M, et al. Improving the normalization of complex interventions: measure development based on normalization process theory (NoMAD): study protocol. Implement Sci. 2013;8:43.

Derived from Normalisation Process Theory, NoMAD is a generic validated tool which provides a structured framework for understanding how a new intervention may (or may not) become part of normal practice. Its questions are divided into the four domains of coherence, cognitive participation, collective action and reflexive monitoring:

- Coherence is the sense-making work that people do individually and collectively when they are faced with the problem of operationalizing some set of practices.
- Cognitive Participation is the relational work that people do to build and sustain a community of practice around a new technology or complex intervention.
- Collective Action is the operational work that people do to enact a set of practices, whether these represent a new technology or complex healthcare intervention.
- Reflexive Monitoring is the appraisal work that people do to assess and understand the ways that a new set of practices affect them and others around them.

Results

97 people responded to the questionnaire that was a modified version of measure development based on the normalization process theory to improve the normalization of complex interventions (NoMAD): 16 in Hungarian, 16 in Slovenian, 23 in Italian, 12 in Arabic, 11 in German, 11 in Croatian and 10 in English, these are Greek users of the online course. Two-thirds of the respondents were identified as physician and a number of respondents did not disclose their profession.

A summary of findings for each domain across the study centers and their implications are presented below. Not all respondents answered all the questions.

Respondents first rated their **familiarity** with the services for which EUR-HUMAN offered the online course, whether they felt these services were already a normal part of their work, and whether they considered they will become a normal part of their work:

- Overall 58% of respondents reported that they were familiar with these services, with the highest proportion in Austria (71%) and the lowest in Hungary (46%).
- Overall 52% reported that these services were already a normal part of their work, with the highest proportion in Austria (65%) and the lowest in Hungary (34%).
- Overall 59% felt they will become a normal part of their work, with the highest in Italy (65%) and the lowest in Hungary (49%).
- With regard to coherence, there was a broad agreement amongst respondents in all centres that they could make sense of the primary care services being offered to migrants and refugees.
- They could see how they differ from usual ways of working, there was a shared understanding of the purpose of these services and how they affect the nature of their work, and they could see the potential value of the service

delivery. Overall, more than 80% of respondents agreed or strongly agreed with these statements.

- There were two outliers to these views: only 33% of Austrian respondents reported that migrant and refugees services differed from usual ways of working; and only 27% of Slovenian respondents thought their staff had a shared understanding.

With regard to **cognitive participation**, there was consistently strong agreement that it is possible to build and sustain a community of practice for delivering a primary care service for refugees and migrants.

- Overall more than 85% of respondents believe there are key people who drive the service delivery for refugees/migrants forward and get others involved (though only 50% of Croatian respondents agreed with this statement) and that participating in the service delivery is a legitimate part of their work.
- Overall 90% reported being open to working with colleagues in new ways to use the service delivery and willing to support the training programme by promoting it, with no significant variation between centres.

With regard to **collective action**, there was greater variation in responses between the centres.

- More than 80% of respondents believed that that they can easily integrate the new way of working, although only 53% of Italians agreed with this statement.
- The new ways of working were thought unlikely to disrupt existing working relationships in Croatia and Austria (>90% agreed), though in the other centres there was less confidence about this, especially in Slovenia (56% agreed).
- More than 80% of respondents had confidence in other people's ability to use the service delivery.
- More than two thirds of respondents thought that work was assigned to those with skills appropriate to the service delivery, though this varied from 92% in Hungary to 57% in Italy and 54% in Slovenia.
- When asked whether the online course provided sufficient training to enable staff to implement the service delivery, there was wide variation, with 100% of Hungarian but only 20% of Italian and 22% of Croatians in agreement.
- Less than half of all respondents thought that sufficient resources are available to support service delivery: this was seen as particularly problematic in Italy (22%), Slovenia (29%) and Croatia (33%).
- The majority of respondents did not think that management adequately supports the delivery of primary care services for refugees and migrant: this was seen as particularly problematic in Croatia (22%), Italy (28%) and Hungary (36%).

With regard to **reflexive monitoring**, there was a generally positive view.

- More than 80% of respondents considered they can modify how they work with the service delivery and that feedback on the service delivery can be used to improve it in future.

- With the exception of Italian respondents, more than 90% considered that staff agreed that the service delivery is worthwhile and personally value the effects that the service has had on their work: however less than half of the Italian respondents agreed with these statements.

Some of the variations in response may be random, due to the small sample sizes in each centre. Others may be explained by differences in current working practices, for example the small proportion of Austrian respondents believing migrant and refugee care differs from their normal way of working probably reflects the fact that most are already working in this field. Other variations would benefit from detailed qualitative inquiry, for example why Slovenian respondents were uncertain about shared understanding about new services and concerned about disruption to existing relationships.

However, several broad conclusions can be drawn from these responses.

1. Most respondents understand how primary care services for migrants and refugees differ from existing ways of working.
2. There is consistently strong agreement that it is possible to build and sustain the delivery of primary care service for refugees and migrants.
3. There is broad agreement that primary care services for migrants and refugees are - or can become - a normal part of work.
4. There is wide variation in views as to whether the on-line course provides sufficient training for delivery of the new service.
5. While most respondents consider that the relevant will and skills are available, there is substantial concern in several countries that lack of resource and lack of managerial support could hinder the implementation of new services in practice.

On the basis of these responses, we would therefore predict that implementation of new primary care services for refugees and migrants is most likely to be successful in Austria but may prove more problematic in other centres, particularly Hungary.

Further, respondents indicated the time they required to complete the course.

Table 4 shows the amount of time users needed to complete the full course. Most users expressed the time required in numbers of hours while the Arab speakers expressed it in weeks. This may be due to understanding the question as asking for the period during which the course was completed. This may be the result of translation issues. Overall, most users complete the course in 17 hours or less.

Several factors may influence the number of hours it takes to complete the course: profession, level of previous training and of experience of the user of the course; familiarity with working online and availability of a computer and connectivity. Also, the Italian version is somewhat shorter than the course in the other countries: 7 versus 8 modules.

For a number of users it may take several weeks to start and to complete the course, even beyond the timelines of the project and of the evaluation. So, the numbers of

users registered and of those who completed the course may be higher than has been reported here.

Further analysis of intra-country variations in time needed to complete the course in combination with other evaluation results, may help to describe the course in further detail for potential new users. In several countries, the number of credits allocated as CME is related to the time the course takes, so the feedback from users helps to determine the number of credits.

Table 4. Time required to complete the online course

Number of hours	8 or less	9-17	18-27	28-35	36-44	45 or more
Austria German	xxxxx	xxxxxx	x			
Austria Arab				x		xxxxxxxx xx
Croatia	xxxxx	xxx				
Greece	x	xxx				x
Hungary	xxxxxxx	xxx	x			
Italy	xxxxxxxx xxx	xxxxxx				
Slovenia	xxxx	Xxxxx xxxxx				

X = person

Discussion and recommendations

An evaluation meeting took place on December 7, 2016, in Crete, hosted by the University of Crete. Advisory Board members participated also (some in person and others via on-line). The WP leaders presented their activities and results to the 33 participants presented, which was followed by discussion. On January 17, 2017, a final meeting took place in NIVEL, Utrecht, The Netherlands, with online attendance of several of the partners of the project. They considered the final data on the use of the online training course and discussed overall conclusions.

Conclusions

- On Primary Health Care for refugees and migrants

  Service delivery of PHC differs greatly between the countries taking part in the EUR-HUMAN project and in European countries in general. In some countries PHC delivery mainly is mono-disciplinary, General Practitioners, whilst in other countries multidisciplinary teams carry out the various tasks. Also, PHC organization varies greatly between countries. Profound country specific adaptation of any course or intervention therefore is required.

Provision of appropriate and tailored PHC for migrants/refugees needs training of PHC professionals as the EUR-HUMAN project has developed. In line with the above on the diversity of PHC, it is as important that the local settings / conditions satisfy a series of requirements and that they have linkages with long term care. The diagnostic ATOMiC tool supports the description of the local settings. The development of local capacity to organize PHC for refugees/migrants is a priority and support to this may be required.

Many volunteers carry out health report activities for refugees/migrants and a basic online course is an appropriate tool to reach many of them, across countries.

- On the EUR-HUMAN project

  The EUR-HUMAN project has been conceived and planned in a very short period, late in 2015. The activities and deliverables of the WPs are strongly inter-dependent. Definition and coordination of activities between the WPs had to be done under time pressure and they have been adapted based on progressive insights and progress of the project. In combination with political changes and variations in the flow of refugees during 2016 (mainly due to the EU-Turkey deal), this resulted in challenges to respect the timing of the deliverables and to redefine tasks for some of the partners and in a higher workload than was planned initially for several of the WPs. Nevertheless, all activities have been carried out and all deliverables have been satisfactory produced, with minimal deviation from the planned date of submission. The consortium showed flexibility in planning and carrying out tasks. Additionally, some of the EUR-HUMAN partners (i.e. UoC, FFZG, RUMC) performed additional work and efforts (within the same budget) that wasn't mentioned in the Grant Agreement.

  There have been many dissemination events (to national and international conferences, meetings with stakeholders and press releases) and publications of several papers in under way. Visibility of the project is substantial.

- Online training course.

  - It proved to be possible (mainly due to the huge efforts and hard work the consortium did), within the timeframe of one year, to develop an online training for PHC professionals that takes into account the diversity of PHC delivery in the various countries of Europe.

  - In general the collaboration and fine-tuning between the WP's was intense and effective. It proved not to be possible to integrate the complete guidance from WP4 into the online course, although most content of the guidance was used.

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

  - The course is predominantly oriented towards physicians and would need to be customized for other health professionals.

- Certification of the online training course did take place in three of the six participating countries and facilitates the recognition and use of the course.

- Increase of the interactivity of the online training course is likely to increase its attractiveness.
- The course remains online on the website of HeF but there is no mechanism to update or adapt the course.

- A drawback of the course for the specific target group may be technical competencies (IT skills) required for the online learning.

- Further monitoring and evaluation of the use and results of the online course in each participating country may help to adapt and improve the course.

- The online course is a good tool to pass knowledge but for skills training it is less effective. This is especially important for mental health and cross cultural communication: cross cultural competence is largely an attitude issue. These elements are much better developed by face-to-face trainings.

- While the online training course is the most visible and direct output of the EUR-HUMAN project, several WP's delivered other results of the project that have strong stand-alone value. In particular:

  The health needs, wishes, preferences assessment carried out under coordination of WP2. The methodology used, Participatory Learning and Action, and the results of the assessment itself can serve as input and support to planning of further health activities for refugees/migrants.

  A report with an overview of effective interventions that address health needs of refugees, WP2. Further, WP3 delivered a checklist, called ATOMiC: Appraisal Tool for Optimizing Migrant Health Care. This tool helps to check the local settings on their appropriateness and completeness for health care for refugees/migrants and can be used by any planner or manager of primary care interventions. The tool has been integrated in the online training course and can be used separately as a planning tool.

  WP4 developed a document called 'Tools and Guidelines for optimal primary care for refugees and other newly arrived migrants'. The materials can be used to improve PHC for refugees and other newly arrived migrants in first reception centres as well as in longer stay reception sites. It is meant for PHC providers and social workers as well as, in some cases, for the volunteers involved in the assessment of health needs or in the primary healthcare for refugees. Some content of this guidance could not be used completely for the online training course.

  The Model of Continuity of Psychosocial Care (WP5). This model contains learning points for proper and continuous provision of care.

Considerations on the future of the project and its results

- Online training course:

  - The online course should be available to the PHC providers beyond the life of the EUR-HUMAN project.
  - Beyond the EUR-HUMAN project period, further active promotion of the online training course among potential users is recommended.
  - A number of modules of the online training course needs periodic updating in order to remain effective and credible (for example, links to websites and other data).
  - The use of the course in other countries is recommended (Germany, The Netherlands, Belgium, France, Sweden, etc) . This requires at least one institute in each country to take responsibility. The online course needs adaptation to each country's language and context.
  - Translation of the course requires familiarity with medical practice and the (social) context of the migrants/refugees; specific selection of and support to translators is a general requirement with country/context specific application.
  - In the long run, the best way to sustain the training is to integrate it in the medical curriculum (plural: not only curriculum of physicians, also of other professional groups) at medical and other schools.

- Model of Continuity of Care:

  - The implementation of the model of continuity of care is best supported by active dissemination and discussion/agreement with major international agencies, like Red Cross, WHO European Region, UNHCR and other agencies or NGO's. More fundamentally: if this model is to be integrated in regular health care practice at the long run adoption by national actors like health departments and health care professionals is crucial
  - Data confidentiality is among the major issues and needs further reflection and practical measures, if portability of data is to be made feasible and acceptable.

- Overall project results:

  - Promotion/dissemination of the main results of the EUR-HUMAN project, beyond its lifetime, among the general public and (inter)national institutions will contribute to its popularity and demand for continuation and for availability in other countries. Among the tools suggested are a booklet, workshops and national high level meetings.

  - All tools developed by the EUR HUMAN project should be put online on the EUR-HUMAN website.

- EUR-HUMAN project participants from Greece, Slovenia and Austria emphasised that support to available Primary Health Care services in general is required to enable it to adequately play its role for refugees/migrants.

Recommendations

The EUR-HUMAN partners unanimously recommend to the European Commission to:

- Facilitate some mechanism of international coordination and support, in order to enable continuous availability and parallel updating / adaptation / improvement of some modules of the online training course, in the various languages of the course.
- Facilitate / support the introduction of the online training course in other European countries.
- Facilitate / support the translation in other languages of the guidance document (WP4), Model of Continuity of Care and other tools and deliverables.
- Facilitate / support the development of face-to-face skills training in parallel to the online training.
- To recognize the variations between countries in the organization and delivery of PHC in general and for refugees/migrants specifically and to allow for profound country specific adaptations of any tool or mechanism that supports PHC.

Section III: Activities, deliverables and results of the Work Packages

This section provides more detail on each of the Work Packages.

WP1 Coordination, Dissemination and Management of Project's Execution

General

Coordination and management of the project is intensive, due to the inter-dependence of the Work Packages, in terms of content and timing. Next to the formal Steering Committee meetings, many emails and bilateral exchanges took place.

A dissemination plan has been developed, which was a rolling plan, since opportunities for dissemination have been added as they arose. As part of the dissemination, a policy on authorship was agreed between the consortium partners. All partners contributed to the dissemination of the project and its results, at a number of occasions, see the overview below.

The consortium also is trying to publish papers in a number of journals. At the closure of the project, publication of several articles is in process.

Table 8. Overview of Deliverables

Deliverables planned		Deliverables realised		Comments
D1.1 Final Report to CHAFEA	M12			
D1.2 Project website	M1	Project websites	M1	http://eur-human.uoc.gr
D1.3 Project leaflet (eight languages)	M3	Project leaflet	M3	The leaflet is available in the eight languages of the consortium members and in Farsi and Arabic. The second newsletter of the six-month progress will be available by the end of M7 (July).
Milestones planned		Milestones realised		Comments
Steering Committee meetings		Kick-off meeting on January 19 and 20, 2016. Further meetings at February 9, February 17, March 16, April 13, June 9, September 12, November 28.		
Advisory	M4	Meeting at 8-9 June	M6	The first meeting was scheduled

Committee meetings		and December 7		later than initially planned to coincide with the face-to-face expert meeting of WP4	
Unplanned deliverable or activity					
None					

Dissemination plan

TABLE 9. Dissemination plan

What	When/where	Who	How
Website	http://eur-human.uoc.gr/	WP1: UoC	Online platform
Meeting in the Greek Ministry of Health and Ministry of Migration	Athens, Greece, 26 January 2016	WP1: UoC	Presentation of EUR-HUMAN; Establish collaboration with the Greek Government
EU conference on migrant care	Lisbon, Portugal May 8-9, 2016	WP2&4: RANDBOUND	Conference presentation
Presentation at WONCA Europe conference	Copenhagen, Denmark June 15-18	WP1 and WP2&4: Christos Lionis, Chris Dowrick, Maria van den Muijsenbergh	Conference presentation
Presentation at WONCA Europe conference	Copenhagen, Denmark June 15-18	AUSLTC	Conference presentation on Migrants and Refugees in Italy
Presentation during annual conference of EFPC	Riga, Latvia September 3-5	WP1: UoC and consortium partners	Workshop; link between PHC and Personalized Health aiming in addressing refugees' care
Leaflet	M3	WP1: UoC team, et al	
Newsletters 2 x	M6, M12	WP1: UoC team, et al	Translation in the languages of the consortium and in Arabic and Farsi
Progress report in e-newsflash and news-item on the website of EFPC (4 x) for members and consortium partners	M3, M6, M10, M13	WP7: Diederik Aarendonk	

Conference of the European General Practice Research Network	October, Leipzig	WP1: UoC	Presentation
6th Panhellenic Congress of Forum: Public Health and Social Medicine. Social Inequalities and Public Health	31 October – 1 November, Athens, Greece	WP1: UoC	Presentation
18th Pancretan Medical conference	4-6 November, 2016 Rethymnon, Greece	UoC	UoC
WONCA Special Interest Group on migrant care, international health and travel medicine	Rio de Janeiro, November 2016	WP2&4: Maria van den Muijsenbergh	
12th Panhellenic Conference for Management, Economics and Health Policies	13-15 December 2016, Athens, Greece	UoC	UoC
Letter to the editor of the BMJ	M13	WP1: Christos et al	With coordinators of other EU funded projects
Letter to the editor of the European Journal for Public Health	M13	WP1: Christos et al	With coordinators of other EU funded projects
Position Paper by EFPC (based on EUR-HUMAN and additional data)	M16	WP7: EFPC: Kate O'Donnell, Pim	
Final report EUR-HUMAN	M14	WP1: Christos and partners	

Papers and Publications

Table 10. Upcoming papers

Title (type of paper)	**Accountable partner**	**Proposed Journal/s**	**Notes**
Compassionate care and European refugee crisis: do we need much discussion. **(Short report)**	UoC	Journal of Compassionate Health Care	A draft prepared by UoC team is ready and partners are going to receive it within next period.
Views, experiences, wishes and needs of refugees/migrants. The experience of seven European countries. **(Original paper)**	RUMC	Journal of Immigration and Minority Health	A draft prepared by RUMC is ready and partners are working on it.

Implementing a patient-centreed primary health care services for refugees/migrants. (A feasibility study)	MUW	Canadian Medical Association Journal	Proposal done to WP6, Kathryn.
Identifying the factors that influence the implementation of health care improvements for refugees traveling through Europe: A mixed-method study in the context of the European refugee crisis (Original research paper)	NIVEL	Implementation science	A draft is being prepared by NIVEL
The refugees' crisis in Europe. What should change in the education of health care students? (prospective article)	UoC jointly with UoL	BMC Medical Education	
Tools and guidelines for rapid assessment. What we learnt from the refugees crisis in Europe. Meeting the health care needs of refugees in Europe. (Review article)	RUMC, jointly with FFGZ and UoC	American Journal of Evaluation or other.	It is a proposal to all partners.
Letter to the editor of the BMJ: Experiences gained from EU funded projects.	UoC with coordinators of other EU funded projects	BMJ	
Towards the development of person-centred and primary-care-based services for refugees: the EUR-HUMAN Project study protocol	Authors: Christos Lionis and EUR-HUMAN partners		Has been submitted to BMC Health Care Research Services

Additionally the UoC team has carry out meetings with Greek Minister of Health (Andreas Ksanthos January 26th 2016, January 27th 2017), General Secretariat of Public Health (John Mpaskozos January 26th 2016, January 27th 2017) officers at Ministry of Health (July 12th 2016), officers at Ministry of Migration (May 20th 2016 and September 9th 2016) as well as with stakeholders (March 28th 2016) on the island of Lesvos (Greece). However communication with General Secretariat of Public Health and 2nd Health Regional Governor in Greece was established as well as communication and meetings with NGOs that provide services to refugees and other migrants in Greece. Additionally, press releases has been issued to Greek media, the EUR-HUMAN site and EUR-HUMAN twitter account.

WP2 Communicating and liaison with stakeholders and refugees

General

The overall aim of this Work Package was to gain insight in the health needs and social problems, as well as the experiences, expectations, wishes and barriers regarding accessing primary health care and social services, of refugees and other newly arriving migrants throughout their journey through Europe - from the hotspots via the transit centres to the first longer stay reception centres. The results of the Work Package feed into the development of guidance and tools by Work Packages 4, 5 and 6 in particular.

Implementation

The information and insights have been collected through group sessions with refugees in seven (7) countries: Greece, Slovenia, Croatia, Italy, Hungary, Austria and the Netherlands; the sites were chosen so as to represent a variation in contexts and to reflect a part of the journey of refugees. The group sessions were to be conducted through the Participatory Learning and Action (PLA) research methodology. Local staff members from all intervention sites had to be trained in the application and ground rules of the PLA method, and were supported in their fieldwork by the Radboud UMC team. The two day PLA training in Ljubljana, Slovenia, was attended by in total 16 participants.
Four countries acquired ethical approval of the research sessions in accordance with the legal requirements in the country, in the other three countries (The Netherlands, Hungary and Italy) ethical approval was not required.

A total of forty-three (43) group sessions were held, with a total of ninety-eight (98) refugee-participants from nine (9) countries and with twenty-five (25) health care workers in Croatia. Every participant of the PLA sessions filled in an informed consent form. The sessions resulted in an overview of main health problems and experiences, needs and barriers with health care. They also provided learning points relevant for the choice and development of guidance, tools and training.
The reports of the group sessions were aggregated in a synthesis report that serves as input for Work Packages 4, 5 and 6. For each of these Work Packages specific recommendations and learning points have been formulated.

All milestones and deliverables have been achieved as planned and in time.

Adaptations and specific learning points

Minor adaptations had to be done with regards to the PLA sessions with the refugees: one site for the PLA sessions has been added to the original plan: a site in the Netherlands, to complete the picture of the whole journey, until the country of destination.

In Croatia, sessions with refugees could not be held due to their very fast transit. Therefore, six PLA sessions were held with experienced care providers from various agencies that had been working with refugees in the transit centres.

Table 11. Overview of WP2

For the same reason, at the site in Slovenia only one session could be held with refugee groups, instead of the planned 2-3 sessions.	planned	delivered	Comments
D2.1 Report on views, experiences and expectations of refugees regarding their health and social needs and access and use of services	M3	M4	
Milestones planned			Comments
2.1 Training of local researchers	M1	6-7 February 2016	16 staff members of local teams from 6 countries
2.2 PLA moderated meetings	M3	M3	Due to the changing politics and closing of borders, the possibilities to interview migrants in transit were less than planned; therefore the fieldwork was adapted: a. one site was added: Nijmegen, the Netherlands, to complete the picture of the whole journey, until the country of destination b. in Croatia 6 meetings were added with healthcare providers, social workers and volunteers instead of with migrants
2.3 Report on the views, experiences and expectations of the refugees and the stakeholders	M4	M4	
Unplanned deliverable or activity			
none			

WP3 Review of literature and expert knowledge

General

The overall aim of this Work Package was to learn from literature and experts on measures and interventions and the factors that help or hinder their implementation in European healthcare settings. This is achieved by the development of a comprehensive overview of effective interventions that address health needs and risks of refugees and other migrants in European countries, focusing on short-term arrival as well as long-term settlement. The overview is a synthesis of existing knowledge from the literature and experts.

Implementation

After the development of a heuristic framework, a systematic search of literature databases and an online survey among experts were done. 81 experts and health professionals responded to the survey. This was followed by interviews with 10 international experts.

Adaptation and learning points

The original plan was to deliver a report with an overview of effective interventions that address health needs of refugees. This was delivered. However, in order to facilitate implementation, the Work Package has delivered also a follow up, a checklist, called ATOMiC: **Appraisal Tool for Optimizing Migrant Health Care**. It provides practical guidance for improving health care services for often vulnerable groups. The checklist helps users – health care professionals, managers, policymakers, implementation advisors – to consider the various contextual and resource factors and to identify priority interventions and issues that require special attention when proceeding with improving the services.

Table 12. Overview of WP3

Deliverables	planned	delivered	Comments
D3.1 Summary of preliminary findings and practical recommendations	M3	M4	
D3.2 Final synthesis	M4	M6	WP3 continues to update and improve the report until M12, in order to provide the most precise information possible.
Milestones planned			Comments
Presentation and discussion of preliminary findings at partner meeting	M3	M3	
Final synthesis report available online	M5	M5	WP3 continues to update and improve the report until M12, in order to provide the most precise information possible.
Unplanned deliverable or activity			
ATOMiC checklist: Appraisal Tool for		M6	

Optimizing Migrant Health Care			

WP4 Developing tools and practice guidelines for health care practitioners

General

The overall aim of this Work Package was to provide a series of support tools for primary care practitioners who work with and for refugees, in the form of papers, guidelines, training and other materials. Using the results of WP2, WP3,WP5 and part of WP6 (Del. 6.1), this WP has organized an expert meeting to make a selection of all these materials and subsequently to develop a report indicating the whole set of materials. These will be made available on-line.

Implementation

The expert meeting was held on June 8 and 9 in Athens and brought together 30 experts from various countries plus 15 Greek officials, representatives of the ministry of health, the ministry of migration and other relevant organizations. The meeting report with consensus on conclusions and recommendations on Primary Care for refugees/migrants is the first deliverable of this Work Package.
The second deliverable, the resulting guidance document, was available by the end of July, 2016.

Adaptation and learning points

No adaptation of contents has been done. The delay in deliverable was due to the fact that the expert meeting only could take place after the finalizing of WP3 and 5, which was foreseen in month 5, so the meeting had to be postponed form month 5 to month 6.
The amount of work is larger than had been planned, partially because the expert meeting took place in Athens, which was not planned initially by the Work Package lead, that is based in the Netherlands. Thanks to organizational support by WP1, the meeting proceeded smoothly.

Table 13. Overview of WP4

Deliverables	planned	delivered	Comments
4.1 Report of expert meeting	M5	M6	
4.2 Online set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees; including a template for adaptation of materials specific to the respective country	M6	M7	
Milestones	planned	delivered	Comments
Expert meeting	M5	M6	

Set of guidelines, guidance, training and health promotion materials for optimal primary care for newly arrived migrants including refugees	M6	**M7**	

WP5 Mental health, psychosocial support and psychological first aid for refugees

General

The overall aim of this Work Package was to provide a protocol for rapid assessment and provision of psychological first aid (PFA) and Mental Health Psycho Social Support (MHPSS). Also a model for continuity of care will be developed. This model allows for primary care providers along the journey of the refugees, to upload and download information, which helps to avoid repetitive interviewing of the refugees and interruptions of treatments.

Implementation

The Work Package produced the two deliverables: a protocol for rapid assessment and a model for continuity of care. On the model of continuity of care, discussions took place at country level. In Croatia, with IOM and UNHCR, that are equally working on systems to register data (IOM: Personal Health Record; UNHCR: electronic system for international transfer of data) in order consult on an agreed model of registering patient data and information. For example, the use of ICPC as coding system for complaints and diseases is discussed. These discussions did not lead to final common conclusions as yet.
The choice of an information carrier needs quite some time as well. Requirements have to be defined, including security and user-friendliness, for the user/patient and for health care providers. Options for an online registration system that could be used across Europe have been assessed, but the final proposal in the Model is for a USB system, password protected.
A 2 day face-to-face training was provided to 15 participants who had worked with refugees recently. Emphasis was on Mental Health and PsychoSocial Care, including the screening.

Adaptation and learning points

Complexity of recording and carrying health information that can be shared between countries and is safe and user-friendly is larger than expected, partially because it needs discussion with external partners like IOM and UNHCR.

Table 14. Overview of WP5

Deliverables	planned	realised	Comments
5.1 Protocol for rapid assessment and PFA/MHPSS	M4	M4	
5.2 Description of a model of continuity of psychosocial care	M6	M6	Discussions with IOM and UNHCR were held on the adequacy of the Personal Health Record of IOM and aligning with UNHCR on the model it is developing. Expectation that model will be used with password protected USB as information carrier.
Tasks			
Task 5.1. Select appropriate approaches and methodology regarding rapid	M3	M3	

assessment of mental health and psychosocial support needs to be used in the implementation settings			
Task 5.2. Develop protocol which includes procedures, tools for rapid assessment and provision of psychological first aid and MHPSS interventions to newly arriving refugees	M4	M4	Draft protocol was shared with partners who provided valuable inputs which were integrated into D5.1
Task 5.3. Adapt protocol, assessment tools, and interventions to respective national and regional situation in collaboration with local stakeholders and provide input into WP6 for implementation	M5	M5	The protocol served for input into WP6 since the training materials for mental health have been developed in line with the protocol – e-module and face-to-face training module
Task 5.4. Develop model of Integrated Continuity of Psychosocial Refugee Care from Early Hosting and First Care Centres to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee destinations	M6	M6	
Milestones	planned	realised	Comments
Protocol with procedures, tools and interventions completed	M4	M4	
Model of Integrated Continuity of Psychosocial Refugee Care described	M6	M6	

WP6 Enhanced capacity building strategy for primary care staff; preparation and implementation of recommended interventions in selected implementation sites: Greece, Italy, Croatia, Slovenia, Hungary, Austria

General

The first objective of this Work Package was to enhance the capacity building of the primary care workforce through the assessment of the existing situation (leading to the first deliverable)
Another activity of the objective was the development of an online curriculum for local primary care professionals and refugees who are primary care professionals. This part of WP6 makes use of inputs of Work Packages 2 to 5: these will be translated in online training modules.

The second objective was to implement at least one intervention in each of six sites in six countries and to evaluate its effectiveness. In each of the six selected countries, Greece, Italy, Croatia, Slovenia Hungary and Austria, one target group of care providers is selected for training and one intervention is selected for implementation. WP6 has developed a report on the interventions implemented.

Implementation

This Work Package started activities in M4. During M5, the Work Package lead provided an overview of the intervention phase of WP 6 tasks 6.8 – 6.13 to provide support and guidance to the partners.
During M6, the sites/target groups of the care providers for the implementation of the testing have been selected and the themes for the testing have been indicated.
During the second half year of the project, implementation took place in the six sites; all partners have issued a site-report and the WP leader has summarized the report in an overall report, which is D6.2.
No external evaluation could take place due to the limited time and resources available.

The country reports reflect valuable experience and will be helpful in future for further work on the primary care for refugees and migrants, at country level.

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Adaptation and learning points

As a result of time pressure during the development of the project proposal, the description of the Work Package in the Grant Agreement is not fully clear, although the deliverables are correctly described.

Table 15. Overview of WP6

Deliverables	planned	realised	Comments
D6.1 Report about the results of the assessment of local resources available	M6	M6	Draft provided in M6, final version early in M7
D6.2 Summary report about the run by the different implementation site countries	M11	M12	
Milestones planned			Comments
Start of development of the capacity building strategies	M4	M4	
Start of the adaptation and training regarding the implementation in the intervention site countries	M6	M6	
EU wide adaptable e-learning course available on internet	M8	M10-11	Availability of online course is sequential for the 6 countries involved
Report for internal use: Overview of the intervention phase of WP 6 tasks 6.8 – 6.13	M6	M6	

WP7 Monitoring & Evaluation

General

As described in the Introduction, the main aim of WP7 was to provide optimal monitoring of the project's progress and key learnings emerging from work packages and participants and to produce recommendations for health care policies and practices. These emerged as the project progresses.

Further, monitoring provided a regularly updated overview of adaptations of the activities, outputs and (expected) results and outcomes. This allowed all stakeholders to understand the implementation process and its challenges and to adapt according to local needs, where necessary.

Evaluation of the project was conducted towards the end of the twelve (12) month project and contributes to accountability of the project, by assisting the Work Package coordinators in describing the outputs and results in terms of outcomes and impact. Evaluation also helps to asses in how far the objectives have been achieved and identify learning points, both for the consortium partners and CHAFEA and for health care providers in general and for health policy makers as well.

Based on the above, during M1, WP7 developed the M&E Framework that aimed to provide answers to questions with regards to process, outcomes and learning of the project.

As described in section A of this report, the end-evaluation focused on the online training course and also draws from reflections and discussions among EUR-HUMAN partners during the evaluation meeting on December 7, 2016 and later.

Implementation

During M1, the M&E Framework has been agreed with the partners and is used as a tool to communicate with the partners on progress of activities and challenges. This report serves to record progress of the project.

Adaptation and learning points

None in particular.

Table 16. Overview of WP7

Deliverables	**planned**	**delivered**	**Comments**
7.1 M&E Framework	M1	M2	
7.2 M6 report	M6	M7	
7.3 M12 report	M12	M12	Draft delivered in M12 (this report). Final deport to be delivered in M13.
Milestones planned			**Comments**
Unplanned deliverables			
Note on refugees/migrants		M4	

Summary list of deliverables and other outputs of the EUR-HUMAN project

This section provides an overview of the official and obligatory deliverables of the EUR-HUMAN project.

Table 17. Official EUR-HUMAN deliverables

Deliverable number	What	By whom	Due date	Delivery date	Comments
D1.1	Final report to Chafea	UoC	M2 2017	M12	Draft submitted
D1.2	Project website	UoC	M1	M1	Submitted
D1.3	Project leaflet	UoC	M3	M3	Submitted
D2.1	Report	RUMC	M3	M4	Submitted
D3.1	Summary preliminary findings	NIVEL	M3	M4	Summited
D3.2	Final synthesis	NIVEL	M4	M5	Submitted
D4.1	Report of expert meeting	RUMC	M5	M6	Submitted
D4.2	Set of guidelines etc	RUMC	M6	M7	Submitted
D5.1	Protocol	FFZG	M4	M5	Submitted
D5.2	Model of Integrated Care	FFZG	M6		
D6.1	Local assessment report	MUW	M6	M6	Submitted
D6.2	Summary report, implementation 6 sites	MUW	M11	M12	Submitted
D7.1	M&E Framework	EFPC	M1	M1 + 1 day	Submitted
D7.2	Interim evaluation	EFPC	M6	M7	Submitted
D7.3	M&E chapter	EFPC	M12	M12 M13	Draft submitted Final version submitted

Our plans about disseminating these deliverables as well as the results remained the same throughout the project. All deliverables have been disseminated and reported to stakeholders who are involved in the refugee's issue such as policy makers in National Ministries of Health, Migration and of Education, in Regional and Local authorities of health and administration, to other stakeholders (local, regional and national) and NGOs providing healthcare services in each participating country, to the Greek Secretary of PHC and national associations of health care providers of each participating country of the project.

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