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SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC

REPORT OF THE COMBINED SH-CAPAC WORKSHOP ON WP4 AND WP5: IMPROVING ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE

Organised on behalf of the SH-CAPAC project by Azienda Unità Sanitaria Locale di Reggio Emilia

Venue: Università di Modena e Reggio Emilia, Palazzo Dossetti, Viale Allegri, 9 - 42100 Reggio Emilia

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1 Introduction

A combined workshop on the Work Package 4 and the Work Package 5 of the SH-CAPAC Project was organized in Reggio Emilia, Italy on June 16th and 17th 2016. The title of the workshop was**: Improving access to health care and capacity building in Member States under particular migratory pressure.**

The list of participants of the workshop is attached (annex 1).

The Objectives of the workshop were the following:

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1. Support Member States in promoting and ensuring access of the refugee, asylum seekers and other migrants populations to health care and public health interventions through the development and dissemination of a resource package to reorient local strategies and plans.
2. Build national capacity through training of trainers in affected countries who can implement training activities for health workers, so they can develop intercultural competences and have a clear understanding of a migrant sensitive health care delivery model, respecting human rights and dignity.

A draft *Resource Package for Ensuring Access to Health Care of Refugees, Asylum Seekers and Other Migrants in the European Union Countries*, developed as part of the Work Package 4, was used as the background document for discussions with representatives of nine target Member States.

The document identifies a series of barriers for accessing health care, and formulates recommendations to overcome those barriers. *The Resource Package* is based on a large number of interviews and focus groups, conducted in several target countries. A very valuable feedback was received in the Reggio Emilia meeting, which had the participation of representatives of nine target Member States, and is being incorporated into the final version of the *Resource Package*.

A draft SH-CAPAC Training Strategy was circulated and discussed in this combined WP4 and WP5 workshop. The strategy contains proposed training activities to develop refugee/migrant-sensitive health services by training health managers and health professionals. It also includes a draft structure of the on-line training program that will be offered by the SH-CAPAC project. The rich feedback derived from the consultation held during the workshop has been used to revise the draft Training Strategy and develop the online training course, which have been incorporated into the deliverable 5.1 of the SH-CAPAC project.

In the following paragraphs a detailed account of the deliberations held during the first two days of the workshop is presented as well as the salient conclusions of the working groups and plenary sessions.

2 16th June 2016

The first day of the workshop had the dual aim of presenting the state of the art of the Resource Package (RP), and obtaining relevant inputs from all participants to enrich and improve the final version of the document The Reggio Emilia team presented the results of the focus groups and interviews conducted in ten EU countries regarding the main barriers and possible solutions to access health care services for migrants and the effective measures implemented to address such barriers. During the work-group sessions and discussions, participants

discussed the gaps in accessing health care, the implementation of effective measures to address such barriers, and possible formats and strategies for the implementation and dissemination of the resource package.

2.1 Introduction to the first day of the workshop, and welcome to AUSL Reggio Emilia

On behalf of AUSL Reggio Emilia Dr Cristina Marchesi welcomed the participants to the town and the University of Reggio Emilia. Subsequently, Dr Antonio Chiarenza illustrated the programme and explained the objectives of the two-day workshop. He pointed out that the purpose of the meeting was not only to present the state of the art of the resource package but also to elicit participants' comments and suggestions to improve its final version. Therefore, the main aim of the workshop was not only about disseminating the project outputs but it represented an opportunity to engage experts to enrich the resource package itself. Afterwards, Olga Leralta introduced the objectives of the second-day programme, regarding the training strategy designed by the Andalusian School of Public Health (EASP).

2.2 Objectives and status of SH-CAPAC Project. Linkages with the current situation of the influx of refugees, asylum seekers and migrants to Europe

Prof Dr López Acuña gave an overview of the premises for the extraordinary call for proposal under the umbrella of EU's Health Programme (2014-2020). He emphasized that this and other projects funded under the umbrella of this particular call are directed to MSs, to improve the capacity of those countries under particular migratory pressure, to respond to health related challenges, and are not aimed at direct provision of services to these vulnerable groups.

Prof Dr Daniel López Acuña presented the variations in the migratory trajectories, showing the different stages (arrival, transit and destination) and the grey zones for migrants and countries. The legal status of those people is usually precarious: they are considered "irregular or undocumented migrants" until they apply for asylum, but their presence is likely to become again irregular if they move to another country. The application of the Article 31 of the Geneva Convention (1951) in fact, varies greatly between countries.

The evolution of asylum applications into the European Union shows that the number of "third country nationals found to present" arose from 431.000 people in 2013 to 1.3 million in 2015.

There is a link between categories of countries and legal status of migrants. The most affected arrival country is Greece, where most of the migrants try to travel northward but many of them remain, resulting in an increased number of asylum seekers and irregular migrants. Transit countries like Greece, Croatia, Slovenia, Austria and other non-EU countries like Macedonia, are characterised by a large influx and outflow at the same time. They are under great, but temporary pressure. Only first aid forms of health care might be provided. Traditional destination countries such as Sweden, Germany, UK, Belgium and the Netherland, tend to have a long history of granting asylum. At the moment, most of the reception centres and accommodation facilities of those destinations have reached and exceed their capacity. Those countries are familiar with the typical migrants' health needs but they are unable to meet them because of legal restrictions, poor accessibility and linguistic and cultural barriers. New destination countries like Spain, Portugal and many European Eastern countries, are facing the problem of scaling-up provisions while acquiring new skills and resources.

The health needs experienced by people during the migratory trajectory call for an intersectional approach in each phase and it is considered an issue of public health importance. Migrants' deteriorated purchasing power might lead to malnutrition; gaps in the national information and disease surveillance systems might increase

the risk of vaccine preventable diseases; sexual violence and trauma represent a specific reason itself to ask for asylum; reproductive, child and geriatric care are needed. Humanitarian interventions should go with regular comprehensive health care and public health interventions provided by countries' health systems, avoiding separated or dedicated services for migrants.

Subsequently, Prof Dr Daniel López Acuña introduced the nature of SH-CAPAC and its main elements to improve competences in MSs. The Project has predominantly a regional approach, based on MSs engagement, convening countries' representatives and other actors in workshops and discussions to get input and refine tools. Its main objectives are: coordination, engaging multiple stakeholders at different levels; population based needs-assessment, and the production of a specific guide; planning public health and health system interventions, including relevant tools to diagnosis and treatment; promoting and ensuring access to health care services; training front-line professionals and managers not only on intercultural aspects but also about public health and health system interventions. López Acuña stressed the importance of coordinated efforts between governments, NGOs, the European Commission, IOM, and UN Agencies to create synergies and connections, while avoiding isolation. The project's has a Health Systems approach that involves intercultural considerations, coordination of multiple stakeholders, continuity of care, centrality of access health care services, relevance of entitlements and integrated services. The members of the Consortium and the target countries have been presented, as well as beneficiaries. SH-CAPAC is one-year project that consists of different steps from developing framework and tools, to regional trainings and dissemination workshops, and technical assistance with country missions; the first one to take place in Bulgaria for coordination support, within two weeks.

The project started on January 2016 with a mapping of the responses to emerging migrants health needs in targeted countries to formulate "country profiles" that have been validated by countries' authorities and will be soon available on the project's website.

Finally, Daniel López Acuña presented the structure of coordination mechanisms and the expected changes to occur at the end of the Project. He announced the next SH-CAPAC meeting, that will take place on 15-16th September in Granada and that will be followed by the dissemination of the products in the second semester.

2.3 Aims and development of WP4: improving access to health care for refugees and asylum seekers

Dr A. Chiarenza presented the "Resource Package" (RP): its objectives, contents and process development. It was explained that the main aim of the RP is to support EU Member States to address barriers to access to health care and to ensure continuity of care of refugees, asylum seekers along the whole migration journey, from arrival to transit areas of reception, to regions/countries of destinations. This action aims to ensure emergency as well as routine treatment by facilitating access to mainstream services, to primary care services and ancillary services addressing specific refugees, asylum seekers and other migrants' needs. It also aims to ensure the entitlement to health care for failed asylum seekers. These aims are achieved through the development of a resource package based on available evidence and expertise involving health and social service authorities, IOs and NGOs active in the field.

The specific objectives of the resource package are:

- To provide evidence on the new challenges for health service related to the current refugee crisis;
- To provide a framework and outline steps for improving access to health care for refugees, asylum seekers and other migrants; and
- To provide evidenced tools and measures and other resources that can support MSs addressing formal and informal barriers that hinder or limit the access to health care for refugees and asylum seekers

In order to gather information on the new challenges and solutions for health services related to the current refugee crisis a series of interviews and focus groups have been conducted in ten EU countries between February and March 2016: Austria, Belgium, Italy, Spain, Greece, Hungary, Slovenia, Netherland, UK and Denmark. The focus groups and interviews had three main objectives:

- To identify the new challenges that refugees and health professionals are facing in relation to the current crisis and how the situation of asylum seekers impact on the accessibility of health care in the phase of arrival, transit and destination.
- To collect existing measures and tools that health services have put in place to deal with the challenges described.
- To collect opinions and views from potential users on what a resource package should contain and look like to support their practice as health professionals and managers.

The interviews and focus groups were addressed to care professionals and managers working in centres for refugees/AS and/or in mainstream health services (primary care, hospitals, health promotion/prevention centres). The analysis of the interviews and focus groups results were summarized in brief country reports that provided an overview of the problems, solutions and needs of health professionals and health managers when providing health care and organizing service delivery for asylum seekers and refugees. These results provided clear indications on what should be in a resource package addressing the barriers to access health care services.

Finally, Dr Chiarenza presented the final draft of the RP, describing its content, format and dissemination strategy. The first part of the RP contains a description of the main barriers to access to health care for refugees and asylum seekers and the possible solutions to overcome or to reduce them; the second part contains information on how effective strategies should be developed and implemented, including a directory of best practices; finally the third part of the RP contains indications to disseminate the RP at local level, including tips for integrating the RP into the national and local means of communications.

2.4 Plenary discussion

Prof David Ingleby brought the attention of the audience on the issue of the legal entitlements of different target groups (e.g.: irregular migrants are only entitled to access emergency care) which undermine their possibility to receive health care. He turned to the audience with some questions like: are the health systems relaxing themselves? What are the rules about interpreting? Which are the elements of advocacy present in the resource package? How does it handle the legal status/framework? He finally stressed the need to find an agreement on the interpretation of "emergency care", particularly between health care providers. Subsequently Dr Antonio Chiarenza emphasized three aspects that will be addressed in the resource package: the necessary changes in the administrative procedures, the information for migrants and staff on the rights to health care, and the advocacy actions to drive national governments. Finally, Prof Dr Daniel Lopez Acuña

stressed the relevance of advocacy and the fact the legal framework that characterizes periods of regular migration cannot apply anymore in this situation of big influx; MSs should understand the state of exception, and relax the interpretation of the legislation.

2.5 Results of the focus group conducted in 10 EU countries: new challenges that the refugees and health professionals are facing in relation to the current crisis

Hans Verrept, Head of the Intercultural Mediation and Policy Support Unit, Psychosocial care, DG Health Care - Federal Service of Health, Food Chain Safety and Environment of Belgium, presented the result of the focus groups conducted in 10 EU countries. In this stream of work the WP4 team used existing networks of experts to conduct the focus groups that allowed getting the results in only two months. The aim of the resource package is to provide evidence, tools, measures, and resources to reduce barriers, and to improve access to health care for asylum seekers and refugees. Focus groups have been organised in ten EU countries (Austria, Belgium, Denmark, Greece, Hungary, Italy, Slovenia, Spain, The Netherland and UK) in February and March 2016. The results of the focus group sessions' analysis suggest four major categories of barriers to access health care services for migrants:

- Administrative issues related to the legal status of asylum-seekers/ refugees: depending on the legal status, the entitlements and accessibility change between country and during the administrative procedures; for example in Belgium, mental health services are free for charge for asylum seekers, but refugees have to pay for the same services. There is not a sensitive response, health and social services may be insufficiently familiar with the procedures required to guarantee access.
- Linguistic and cultural barriers: there is a lack of professional interpreters and intercultural mediator's services, and even more challenges for groups coming from Afghanistan or other Arabic Middle East regions (e.g. Syria and Iraq). Cultural competence is poorly developed among health care providers, particularly in countries that are new for receiving migrants; different medical cultures may cause tension in health care delivery.
- Lack of health records – continuity of care: there is no data for vaccination status for example. In general migrants tend to do not seek health care during their journey because they are willing to reach their desired destination as soon as possible, and so 'moving' impedes the provision of integrated/extensive care.
- Organization, quality, and coordination of medical services: care providers might be reluctant to see asylum seekers because of administrative complexity. It can emerge a competition with indigenous patients if many services are not available for the local population. The increased overcrowding may generate burnout and fatigue among health care providers. Moreover the health care systems are consulted for social problems and specialists may be hard to reach. The recognition of uncommon diseases represents another issue.

Each phase of the migratory route (arrival, transit, and destination) has its peculiar challenges. At the arrival stage for example, the duration of registration procedures, the lack of health literacy, the use of emergency services for chronic / social / mental health problems represent the major issues. In the transit phase, it's often delivered an incomplete treatment and there is no track of it; there are no means for prevention, health promotion and psychosocial interventions. Finally, in destination countries the most frequent problems are related to the legal status. The recognition of refugee status may result in the (partial) loss of assistance. There are also specific health situations that pose particular challenges: sexual and reproductive health care, mental health, children and unaccompanied minors, and victims of violence, are the most common.

2.6 Results of the focus group conducted in 10 EU countries: existing measures and solutions to address barriers in the access of health care

Antonio Chiarenza made a presentation on the existing measures and solutions to address barriers in the access to health care identified in the focus groups conducted in ten EU countries. A number of measures that are currently in place in the countries involved in the focus groups could be potentially helpful in addressing the needs of asylum seekers and improving their situation. First, it is important to enlarge the health care services made available to asylum seekers. Some countries currently offer only acute treatments. However, this should be expanded to encompass more healthcare services, particularly mental health services, in view of the pressing healthcare needs of asylum seekers. Second, it is necessary to reduce the complexity of the legislative framework and administrative procedures in order to ensure entitlements to health care (acute and chronic) for those in the process of applying for refugee status, those waiting for a decision on appeal and failed asylum seekers. Third, it is fundamental to ensure the availability and quality of language and communication support services including the use of interpreters, intercultural mediators and/or Community Health Educators. Fourth, culturally sensitive training aimed at improving the coping skills of asylum seekers is required to improve health and deal with the health deterioration and mental health problems frequently observed after arrival. This should take into account the interaction between physical and mental health symptoms.

Finally, it is necessary to consider the impact of policies of relocation, in particular, it is important to provide support to healthcare providers for asylum seekers who are in transit; this might require, for instance, that patient information is appropriately recorded and made available to the new provider. Focus group results suggest developing an information system and tools in order to ensure the effective flow of information regarding health situation, psychosocial condition and individual and family migration project between different levels of reception centres and between transition and destination countries/regions.

2.7 Plenary discussion

The presentation of the results of the Focus Groups was followed by a brief plenary discussion where participants introduced their opinions and the major barriers to access health care from their experience. General comments arose about the composition of the focus groups itself: the balance between civil society and NGOs, versus governmental health professionals' participation. The audience highlighted the fundamental role of NGOs that often fill institutional gaps, and receive patients who are afraid to use mainstream services. Due to their position, NGO's should be targeted by training strategies and the advocacy mandate of civil society should be reinforced. Managers, who are in general reluctant to participate in "social" training, should be involved as well as migrants-sensitive policy makers. Bureaucratic procedures for asylum seekers were mentioned with regard to the long time that they usually take, leaving people without the documentation required to enter the health system for a while. The lack of transports that impede access in many settings was also cited. Participants reported that some problems occur when health care providers are asked to answer problems that are not directly related to health, like public transports, housing, etc. The risk to create a positive discrimination in such contexts where the health provision is scarce (and mainly provided by NGOs) even for the local population was a debated element. Asylum seekers and refugees do not need sophisticated and dedicated health care services, rather they need to have facilitated access to existing local health services. In conclusion, participants stressed the importance of translating the final version of the resource package in different languages to increase its utilisation.

2.8 Working Group session "Mapping the gaps on accessing health care"

The participants were divided over four tables and they discussed the major barriers to access to health care services in four specific areas.

Table 1: Accessing mental health care

The working group consisted of David Ingleby, Simone Goosen, Jan Van De Velde, Daniel Lopez-Acuña, Ainhoa Ruiz, Federica Zamatto, Mohamed Sabri, Marta Escobar. Janne Sorensen was the facilitator and Simone Goosen was the note-taker.

The group's goal was to identify and discuss the existing barriers to access mental health care services.

Table 2: Accessing sexual and reproductive health care

The working group consisted of Charlotte Solver-Rehling, Ewa Dobrogowska-Schlebusch, Julia Kadin Funge, Tona Lizana Alcazo, Rossano Fornaciari. Ines Keygnaert was the facilitator and Sara Barragan Montes was the note-taker.

The group's goal was to identify and discuss the existing barriers to access sexual and reproductive health care services.

Table 3: Accessing child health

The working group consisted of Lotte De Schrijver, Amalia Tzikou , Ineke Van Eechoud, , Riitta-Liisa Kolehmainen-Aitken, Olga Leralta. Jeanine Suurmond was the facilitator and Marika Podda Connor was the note-taker.

The group's goal was to identify and discuss existing barriers to access to health care services for children.

Table 4: Accessing health care for chronic diseases

The working group consisted of Erika Marek, Lies Verlinden, Ana Correira, Sonja Novak Zezula, Jacqueline Mulders, Hans Verrept, Iain Aitken. Andrej Kallay was the facilitator and Ilaria Dall'Asta was the note-taker.

The group's goal was to identify and discuss existing barriers to access to health care services in the chronic disease care area.

Plenary wrap-up

Hans Verrept coordinated the plenary wrap-up and the discussion about results of working groups.

Table 1: Accessing mental health care

Simone Goosen reported the summary of Table 1 group session. Participants agreed that in terms of legislative barriers, access to mental health care varies depending on the different services provided in each phase (arrival, transition and destination), and the administrative process. The European Union should endorse minimum standards for mental health care service delivery. From the linguistic and cultural point of view, mental diseases represent a taboo for many communities and might cause stigma and humiliation; in some contexts it's not even clear what is mental health care, and there are different perceptions about the meaning of mental diseases. Depending on the situation it should be considered an individual versus group-approach, and specific attention should be given to the respect of privacy, particularly while using interpreting and cultural mediation services; moreover the engagement of religious persons may help to deal with cultural matters. The

organization of mental health care interventions suffers because of the lack of knowledge on referral options and long waiting lists that represent a common hindrance to access such services. In general there is scarce collaboration between actors involved, but few exceptions exist: in the Netherland for example, the health insurance company supports a 'bridge function' through different levels of care, from primary health to hospitals. The continuity of care and the information flow within and between countries are limited because of the shortage of transports and medical record systems. To conclude, participants stated that mental health care should be considered as a public health priority rather than an option or a luxury good.

Table 2: Accessing sexual and reproductive care

Sara Barragan Montes reported the results of Table 2 discussion. About Legislative /bureaucratic barriers she mentioned that it depends on the country's regulation, migrants face different legislative and bureaucratic barriers to access sexual and reproductive health services. In some regions they are entitled only to emergency care, there might be limitations regarding sex and age or pregnancy status, etc. There are some other countries where undocumented migrants cannot access health care at all. In addition there is a general lack of knowledge among desk professionals, who ignore the legal framework and the respective entitlements. Participants agreed there are many issues about sensitive topics: abortion for instance is for free in some countries, in some others it requires parents' permission, and based on the political context it may become an illegal service, for which physicians may even incur in kind of punishment. Decentralization of regulation within countries was mentioned as another barrier, as well as the loss of continuity of care during the different phases of the asylum seeking process, and the lack of public treatment for fertility care. There is a huge debate as to whether the latter should be considered as an emergency intervention or not. About Linguistic and cultural barriers, the group have mentioned that there is a lack of cultural mediators in the hospitals and none specific academic curricula to prepare them**.** Some countries implemented parallel trainings, a part of university's courses, even specific for sexual and reproductive health for cultural mediators (e.g. Female Genital Mutilation). The relevance of engaging community leaders in this domain remains uncertain.

About organizational barriers, participants reported that there is an imbalance in health care staff's gender and that NGOs and volunteers' association may create parallel structures, for instance in Greece they have different cultural-based approaches and they tend to provide migrants with different information regarding sexual and reproductive health. There is often a lack of coordination between them and the national health system and a lack of health educators in the communities who should be integrated into the national health care systems.

Then about lack of collaboration between services, the most important issues reported are the lack of dialogue between mental health services and sexual reproductive health departments (as well as with fertility care services), the lack of collaboration between health clinics and private health care providers and the lack of communication with social and education sectors. The lack of policy coordination is another important challenge as well as the importance of inter-sectorial interventions. These aspects are strictly linked with the lack of information and continuity of care: the group reported that many NGOs and volunteers lack sustainable funding and that medical doctors lack knowledge about the legislation. So there is a risk of misinterpretation of the meaning of "emergency care". To conclude participants stated that about lack of information for migrants, in some countries like Poland, NGOs deliver health education/promotion and preventive activities delivered amongst migrant's communities.

Table 3: Accessing child care

Marika Podda Connor reported the results of Table 3 discussion. She mentioned the two major aspects of the legislative, administrative and bureaucratic barriers: the universal entitlement that is not always guaranteed

to all children up to 18 years and the legislative and regulation changes amongst Member States that take long time. Concerning linguistic and cultural barriers, participants reported that families are often limited in their autonomy to make choices about their children's health. Another matter is about those refugees who do not seek health care when they feel sick, because they prefer to continue the journey to their country of destination. Certain cultures consider mental health disorders as a taboo, and some families do not agree to diagnose such problems. Parents might doubt the confidentiality while using interpreters and cultural mediators. Family planning and contraception are also considered culturally sensitive topics and participants agreed that sexual and reproductive health (including family violence) should be provided, particularly to adolescents. They also mentioned cultural competence as an important skill to be strengthened amid health professionals. There are other elements, not directly linked to health, that are relevant for children like playing, having fun, school and education, etc. Hence it is necessary to connect health, social and other sectors involved in children's assistance and to reflect on the perceptions that migrant children have about local kids and vice versa. Regarding organizational barriers in health service delivery, there is often a lack of health care providers in the camps and in general they have limited knowledge/information about children's entitlements (the same occurs between administrative staff). It results in the necessity to transfer children and their families to other locations. There is scarce information available for parents as well, regarding the existent procedures to access the health system, so they tend to bring their children directly to emergency departments. It becomes even more complex to provide health care services for children when families are on moving, it is difficult to schedule activities through different countries and guarantee continuity of care, even in terms of prevention (vaccination coverage).

Table 4: Accessing chronic disease care

For table 4 the rapporteur was Dr Iain Aitken. He put the attention on our "electronic era", in which every information flow into different electronic systems. The first big gap in the access to chronic disease care is that there is not a universal electronic system for the management of refugees personal electronic files (with every personal and medical information). It's important to bear in mind that some conditions are communicable and chronic at the same time (e.g. HIV and Hepatitis) and that there is a group of chronic complains (e.g. back-pain, headache). From the legislative perspective the interpretation of "emergency care" by healthcare providers is an issue: who decide what is emergency?

In terms of culture we have to pay attention on the cross cultural interpretation of chronic disease: in every culture there are different interpretation of symptoms, different medical culture, different expectations and often different healthcare organisation system in the chronic disease management.

The gender of provider is another issue link to the culture: also in emergency situations for female patients could be important to have a female doctor. Often there's a problematic relationship between providers and migrants and a negative providers' attitude link to the frustration due to misunderstanding situations and due to a sense of inadequacy.

Regarding organisation the discussion was about the bad relations between NGOs and Governments due to the different interests and goals and the little collaboration between them at local level.
In terms of information there are two kind of issues. Problems during the transition from one country to another: in the origin country a person who was independent in managing his/her health condition (e.g. hypertension), in the new country might lose this capacity due to different protocols, drugs and medical indications; problems during the transition from one legal status to another (e.g. from asylum seeker to national health system) because the changes of rights and duties.

2.9 Effective measures and solutions to address barriers to health care

1) Addressing language and communication barriers: Intercultural mediation service in Emilia-Romagna and Belgium

Ilaria Dall'Asta introduced the Linguistic and Cultural Mediation (LCM) service in the Local Health Authority of Reggio Emilia (AUSL of Reggio Emilia). The service is a part of migrant friendly and cultural competent health care organisation strategy. The goal of the strategy is to ensure equality of access to all citizens (Amsterdam Declaration, MFH-2005). To reach this goal is necessary to overcome issues in clinical communication, the main measures to do it are the improvement of patient information and education, the improvement of health staff intercultural competence and the creation of linguistic and cultural mediation service. In 1998 to respond to the urgent needs of undocumented migrants was create a specific service "Centro per la salute della famiglia straniera" in which 6/7 linguistic and cultural mediators worked as free-lancers, in 2004 was piloted a coordinated LCM service in the emergency and mother-child care in one hospital of the AUSL of Reggio Emilia and from 2006 onward the LCM service was implemented in all 6 hospitals and 6 health districts of the province of Reggio Emilia. Today the LCM service is coordinated by the Research & Innovation department of the AUSL of Reggio Emilia and is run by a social cooperative. There is a qualitative and quantitative monitoring system to evaluate and re-organize the service on the basis of health staff and citizen's needs. The LCM service provides 6 different types of interventions: On-site presence in hospitals, on-site presence in primary care services, weekly scheduled presence, urgent presence, telephone intervention and written translations. Then Ilaria Dall'Asta explained briefly the national refugees' management system in Italy and presented how the LCM interventions are used for the local management of refugees. During the whole health care pathway (first meeting, medical tests, specialist examinations and so on) a LC mediator is available to accompany the refugee along the care process. Moreover, specific education and information sessions are organised for refugees, during these courses a social educators and a LC mediator are present. Finally, Ilaria Dall'Asta explained that appropriate training programmes are organised to improve the quality of LCM service, however she pointed out some challenges need to be addressed, such as the recognition of the professional role of LC mediators in health care and the integrate LCM interventions in the daily health staff work.

Hans Verrept introduced the video-remote intercultural mediation (via videoconference) system used in Belgium. The intercultural mediation service in Belgium was introduced in 1991 and at the beginning it was organized with the on-site presence of mediators in 47 hospitals, but after a first evaluation some limitations of this system were identified (lack of flexibility, limited local offer), so it was decided to implement a video-remote intercultural mediation service. This new system permits the availability of the most important languages (Arabic, Russian, Turkish) without appointment and other 20 languages available (but mediators have to be booked in advance). This service is organized with automatic booking of mediators by staff and same mediators are available for all centres that are connected to the network (70 hospitals, refugee centres, primary care centres, NGO's). At the beginning there were hindering factors in the implementation of the service such as the limited role of the mediators (not present on-site and perceived as less interactive) and as a consequence the preference among care providers, patients and mediators for on-site interventions. To improve video-remote intercultural mediation will be useful to work on staff reluctance to work with the system and to avoid technical issues.

2) Addressing information barriers: Refugee Humanitarian Crisis: A Rapid Response from the College of Psychology at University of Seville

Marta Escobar Ballesta from CESPYD at the University of Seville made a presentation on addressing information barriers. When this crisis started to reach its peak in the summer-autumn of 2015, in which more than a half million of people crossed the Mediterranean Sea. CESPYD, the centre of community research and action at University of Seville, already had a wide experience working with migrant and refugee populations. At that time, CESPYD was working at national level in a research project called PROCOMDI that aimed to improve the responsiveness and accessibility to health services of these groups living in border contexts. To manage the new crisis the first step was mobilization the University Community, this process started with a meeting with the Dean's office of the College of Psychology. So after that, it was established a working group to respond to this humanitarian crisis which also worked as a support platform for associations working with migrants and refugees. The result was the capitalisation on the available resources and the commitment of the group in undertaking the following actions.

Firstly, the College of Psychology at University of Seville, in its commitment towards social justice, was proclaimed as Save Haven for migrants and refugees. With this statement the University Community denounce the inaction of governments and institutions, the abandonment of the displaced people, and the inhumane treatment of those who try to enter our borders to survive. In this sense, the College of Psychology commits to guarantee the training of professionals, and future professionals; to meet the needs of displaced populations, ensuring sensitive care services to their cultural patterns and specific conditions; to lead research and educational programs that provide society with scientific resources to combat inequities, empower communities and provide care for victims of war and greed; and to advocate for the support platform for associations.

The second action was to promote an international call for research and advocacy response to the Global Refugee Crisis. This initiative was promoted under the 27th Division of the American Psychological Association, the Society for Community Research and Action, renown community psychologists from University of Illinois at Chicago in the US, The American University in Cairo in Egypt, Universidad de Valparaíso in Chile, Doğuş University in Turkey, University of Salento in Italy and University of Porto in Portugal. The members of this initiative agreed that it is necessary to request to cities' mayors to welcome refugees into their communities and denounce those who sabotage the resettlement since they are breeding racist and xenophobic attitudes among the local populations; to write local newspapers denouncing anti-immigrant and anti-Muslim rhetoric and voicing support for refugees; denounce hate speech, particularly if it incites hatred or violence against a particular immigrant group; to contact state and local representatives to express concern about hate speech; encourage community leaders and service providers to meet the needs of refugee populations, ensuring culturally responsive services and care; raise awareness in the university community about initiatives and evidence-based interventions that promote refugees' psychosocial well-being and that take advantage of their strengths, preserve their cultural legacy and reconstruct their communities; to promote coalitions among multiple stakeholders at multiple levels and between different sectors to contribute to a Global Approach on Migration and Mobility.

The collaboration between the Psychology Association in Madrid, the University Psychology Clinic at Universidad Complutense de Madrid and the College of Psychology at University of Seville promoted the development of a guide for psychosocial intervention with migrants and refugees population. This guide entails an urgent and shared attempt to systematize good practices in psychology that are applicable to this current challenge. The content is divided in two main areas: The area of psychological assistance aims to provide

psychologists with the available knowledge on the most common reactions experiences by displaced people, as well as the tools, guidelines and therapeutic skills to address them. The area related to social and community intervention specially directed at preventing racism and xenophobia. It provides social actions that should be implemented at multiple levels (political level, public service level, personal level, etc.).

In conclusion, Marta Escobar Ballesta presented some lessons learned that could be drawn from this initiatives: the responses need to be based on denouncing the violation of HHRR; the acknowledgement that health crisis among refugees are not only caused by wars in their countries of origin but also due to the abandonment of the institutions during the journey and arrival at EU borders; the need to assume proactive attitudes and actions such as mobilization processes. Finally, there is a need to adapt practices and training programs to situations that require immediate responses with the available resources; and the need to reinforce resources investment for University, research, training as well as to welcome refugee scholars and students.

3) Addressing legislative and administrative barriers: Voucher for one free consultation for uninsured patients

Ineke Van Eechoud from the Department of Patient Support: Social Work and Diversity & Intercultural Mediation, University Hospital Ghent, Belgium explained that the voucher scheme was implemented in response to a change of the Belgium system that occurred two years ago. Originally it was introduced as one free consultation per person for undocumented migrants, but in practice, such benefit was later extended to all uninsured and indigent patients. In Belgium undocumented migrants cannot be enclosed in the mutual health care, therefore they are not covered by the legal Belgian health insurance scheme. The Royal Decree of 1996 that embraces dispositions about "urgent medical aid–entitlements", states that undocumented migrants can access to health care if the grade of urgency has been previously proved by registered medical doctors. Thanks to an interdisciplinary approach of social workers and administrative staff, migrants who apply for the voucher may have different guarantees to obtain it. The Urgent Medical Aid encompasses preventive and curative health care (and it is different from Emergency Medical Assistance which applies for everyone) and it is delivered by the Public Social Welfare Centres; the latter are built on the principles of territoriality and social empathy, and define the entitlements on individual basis. The voucher scheme has been implemented to promote qualitative, accessible and affordable medical care, and to face the uncertainty of cost-recovery for new undocumented migrants. The responsibility of this system is up to the Department of Patient Support and Administration, University Hospital of Ghent and it has been realized in partnership with three departments of Patient Support & Administration (Patient Support, Patient Billing, Reporting and Registering),teams of medical doctors, Public Social Welfare Centres, and with the Auxiliary Sickness & Invalidity Insurance Fund. As a result the voucher scheme guarantees the first quality medical consultation per each new undocumented migrant without any cost for the patients.

In terms of difficulties in implementation, Voucher is not only delivered to undocumented migrant patients) and there is also an ethical balancing about how to identify undocumented migrants / uninsured patients.

4) Addressing organisational barriers: Health Intake practices for asylum seekers in Netherland

Simone Goosen and Jeanine Suurmond introduced her presentation showing the context of asylum seekers in her country, The Netherland. The influx re-started to quickly grow up in the last two years after the pick in the 2000. The "Health Intake practices for asylum seekers" is a measure that embraces the two dimensions of curative care and public health, respectively managed by insurance companies and GGD GHOR – Nederland, a national organization contracted by the Central Agency for asylum seekers. Curative care consists of general practices and other integrated services provided by contracted care professionals: hospitals, midwives, dentists, and mental health care. From the public health perspective, community health services are guaranteed by GGD GHOR at each phase: arrival, reception centres and community level. At the arrival (mainly in the first two days) migrants are screened for TB with chest X-Ray (last year, in front of evidence based data, it has been decided not to offer screening for all the Syrian refugees anymore because of the great number of arrivals). What they do as well is asking migrants to fulfil a health questionnaire on the computers available in the arrival areas, to be uploaded in a digital medical system; this approach enables health professionals to find out acute medical issues. Medical doctors in collaboration with officers of the Immigration Department interview migrants to check if they fit for the procedures by the legal point of view. During their stay in the reception centres (up to 6 weeks), asylum seekers are entitled to youth health services for children under nineteen years old, nurse and medical intake, check of the vaccination status, GP-midwives, and the risk-group continues the investigation for TB even until the third phase at community level (up to two years).The strategy attempts to guarantee a continuum of care between the second and third level. There have been many challenges in the implementation, because of the different elements to keep up together, like hiring new staff, to maintain good quality services. Funding and service negotiation issues with the Government, represented other challenges for policy; they wanted to be sure that after screening infectious diseases they had the capability to treat such patients with particular attention for children. The Central Agency for asylum seeker monitors the services provided by both, public health organization and curative services. The health inspectorate is very helpful as well, because it could bring money for quality services. Simone Goosen concluded her presentation by saying that there is a need for high collaboration between different stakeholders to make this effective measure replicable in different contexts.

2.10 Working group session "Implementing effective measures to address access barriers"

The participants were divided over four tables and they discussed the implementation of effective measures to address access barriers in four different areas.

Table 1: Implementing/improving language support services

The working group consisted of Ineke Van Eechoud, Janne Sorensen, David Ingleby, Ainhoa Ruiz, Federica Zamatto, Mohamed Sabri. Hans Verrept was the facilitator and Jan Van De Velde was the note-taker. The group's goal was to identify and discuss the effective measures to improve language support services in order to address communication barriers to access health care services.

Table 2: Implementing/improving information and continuity of care strategies

The working group consisted of Marta Escobar, Charlotte Solver-Rehling, Ewa Dobrogowska-Schlebusch, Julia Kadin Funge, Tona Lizana Alcazo, Rossano Fornaciari. Ines Keygnaert was the facilitator and Sara Barragan Montes was the note-taker. The group's goal was to identify and discuss the effective measures to improve information and continuity of care strategies in order to address information barriers and improve access to health care services.

Table 3: Implementing/improving organisational development strategies

The working group consisted of Erika Marek, Jeanine Suurmond, Lotte De Schrijver, Amalia Tzikou , Marika Podda Connor, Riitta-Liisa Kolehmainen-Aitken, Olga Leralta. Simone Goosen was the facilitator and the note-taker. The group's goal was to identify and discuss the effective measures to improve organisational development strategies in order to address organisational barriers to access health care services.

Table 4: Implementing/improving health and social services coordination

The working group consisted of Andrej Kallay, Lies Verlinden, Ana Correira, Sonja Novak Zezula, Jacqueline Mulders, Iain Aitken. Daniel López-Acuña was the facilitator. The group's goal was to identify and discuss the effective measures to improve health and social services coordination in order to address management barriers to access health care services.

Plenary wrap-up

Daniel López-Acuña coordinated the plenary wrap-up and the discussion about results of working groups.

Table 1: Implementing/improving language support services

Jan Van De Velde presented the results for Table 1. Work-group participants highlighted the urgent need to train health professionals on how to use available resources (including HHRR - interpreters and intercultural mediators - and interpreting tools), and how to improve their communication and cultural skills. Progress in this domain has been done by many countries but it remains insufficient. Professional organisations of care providers should be aware of the issue and include the presence of interpreters and intercultural mediators experts within standard procedures, discouraging the use of alternative solutions (e.g. Google Translator or informal interpreters) that represent inadequate strategies to deal with linguistic and cultural barriers. Cultural mediators should be targeted as well by specific trainings to reinforce their capacity to generate and maintain users' trust. They need to be recognized as professionals with a specific deontology code, comprising the issue of professional secrecy. Interpreting and intercultural mediation services should be available 24/7; Governments should provide the necessary budget for their implementation and prioritize quality while purchasing such products (International standards are already available and could be included in the resource package). It would be relevant that the different project consortiums prepare a consensus document on the importance of establishing interpreting and cultural mediation services that may convert the present momentum on refugee crisis into concrete action. Finally the group stressed that the legislative framework should be adapted so as to create the right to have interpreting and cultural mediation services, for both providers and users.

Table 2: Implementing/improving information and continuity of care strategies

For table two the rapporteur was Ines Keygnaert who described the workgroup's talk about the main issues in terms of continuity of care and the suggestions to overcome them. The first one could be the use of tools already developed, (e.g. technologies, like mobile app or social networks), to share health information between and within countries (national – local level). It would be important to share tools across nations like health records and other resources (e.g. economic and human) and in the same way to create a network of health mediators across countries. The second one could be the mobilisation at community level among neighbourhood associations, local networks (not necessarily professional), etc. might be relevant to get information and improve continuity of health care. Another fundamental opportunity would be to increase migrants participation, putting at stake their knowledge and competences. The third one is the creation of multidisciplinary teams to promote an intersectorial approach integrated in the three different phases of arrival, transition and destination. In terms of action needed one important point is the political cooperation and

communication at different levels to better coordinate the situation across countries. Finally the variation of the legal status and relative entitlements was mentioned as an element of discontinuity of care.

Table 3: Implementing/improving organisational development strategies

Simone Goosen presented the results for Table 1. The group stressed the importance of strengthening coordination and communication between many different partners and stakeholders to overcome organizational barriers to access health care services. The primary intervention identified, was the implementation of a platform for sharing information efficiently, of which data would be uploaded based on a clear delineation of specific requirements (e.g. situational information: coast guard, groups of people arriving, health status, housing availability, resources needed and available, etc.). The overall objective would be to improve the communication between all the actors involved. Participants identified the Ministry of Migration (or other ministries whose role is to manage migration's issues in their countries e.g. Ministry of employment and home affair) as main responsible for the execution and supervision of this measure which should be extended to other countries. Concerning actions needed, participants mentioned the necessity to define clearly what information should be collected, to understand where human and other resources could be found, to start structuring an action plan. Finally, the group reported facilitating and hindering factors for the realisation of the platform to address access barriers: they identified the fact that health professionals are used to share information and they are willing to be connected between them and other sectors, as principal helping factor; while the sensitivity of the topic, the involvement of military forces and the link with regional levels, as factors that might hamper the implementation of the strategy.

Table 4: Implementing/improving health and social services coordination

For table 4 the rapporteur was Daniel López-Acuña. The theme of coordination between health and social services has an agenda in transformation and it's a very difficult challenge not only in the refugees and asylum seekers universe but, first of all, in the regular system. The discussion of the work group was about ten key elements to pay attention to overcome this barrier:

1. It would be very important to focus on vulnerable groups: children, disabled, prenatal, obstetrical, and geriatric care;
2. It would be extremely helpful to map available services (health and social) in specific geographical areas to inform better the users (normally the service map doesn't exist even for the regular citizens);
3. It would be very important to create interdisciplinary team, with health staff and social staff;
4. It would be good to try to introduce, particularly in the local level, logic of public management and integration (health and social interventions);
5. To foster more frequently consultations and dialogue between health and social providers in local services;
6. It would be important to educate beneficiaries on different routes to use services in a combined (social and health) way: multilingual etc. to navigate health and social services;
7. It would be important to undertake joint training for social and health professionals, especially at local level;
8. The important role of the municipal authority in being a facilitator at the local level;
9. The possibility of actively involve migrants, refugees and asylum seekers in the discussion of the framework for integration and also in the socialisation of information especially in the social media;
10. The final discussion was about the importance in expanding the role of linguistic and cultural mediators and making them brokers of the dialogue and interaction between the two systems: social and health. They better understand the logic of the population and the logic of the services.

3 17th June 2016

3.1 Implementation and dissemination of the resource package: results of the FGs analysis, brainstorming on dissemination strategies of the resource package and networking

This session aimed at stimulating an open discussion on the best measures to implement and disseminate the resource package that might concern as well the progress of other project's products. Dr Antonio Chiarenza showed the results of the focus groups concerning the implementation and dissemination strategy of the resource package. The contents that emerged from the analysis include: Linguistic, communication and intercultural issues; training for staff at all levels; information for health professional and migrants, legislative and administrative issues; organization and continuity of care for quality services. The favourite format suggested by focus groups' participants was a face-to-face intervention (e.g. trainings, workshops), but many more options have been identified like online courses, paper materials, help-lines, tutorial videos, mobile app., etc. Participants selected as well the target population, indicating health care workers, administrative staff, managers, NGOs representatives, migrant-sensitive policymakers, communities, and others.

3.2 Plenary discussion

The inputs received from the focus groups' results was used to activate the discussion on the general issues of implementation and dissemination of the resource package and other project's products. During the debate it was mentioned that due to the fact that there are many EU-funded projects on health and migration at the moment it would be relevant to know who provides what, and to create links and a common platform. In terms of ownership the resource package, as the other products of the project, will be a public good in the public domain. There is a principle of duality beyond the idea of a resource package, denoted by two aspects: the provision of relevant tools to be used for all countries on the one hand, and costumer adaptation for best utilization on the other. The resource package will sustain different processes that will be adjusted in singular settings. It is clear that the product will be adaptable to different contexts but it won't generate fragmentation; the intention is to unify recommendations and best practices, avoiding atomization or country-specific means.

Concepts like sharing, socializing, tailoring, involvement, contribution, will characterize the dissemination's strategy; in addition, possible country missions will create a space for participation and training to integrate new resources with existing measures and mainstream systems. The resource package will be multipurpose and multi-format, it will look like a list of ingredients to be locally adjusted, rather than a recipe. Such product should target a multiplicity of audience, and shouldn't relay on one exclusive channel. International organizations may disseminate and push for the implementation of the resource package that will be integrated with regular activities at national and subnational level. The modality for its reproduction will be further discussed.

The audience of the Reggio Emilia workshop suggested different existing platforms to spread the tool (e.g. user-friendly project website, newsletters, conferences, etc.), as well as the importance of making this product available in different languages and in a good printout. Workshops, conferences, trainings for different target groups (including university medical education) would be appreciated to present the resource package. Participants stated that it is necessary to be very selective on how and what we want to communicate, starting with few key messages to attract users who want to learn more, having additional details. The allocation of funds should be discerning as well, because of the different needs of each country. In order to be selective, the assessment-guide (another project's product: WP2) might be used, focusing on the gaps that emerged

from such context analysis. The overcoming barriers in terms of public health practices finally, may return to the notion of "quality improvement" for which there is plenty of experience that might be taken into account to make the resource package more effective, and monitor its progress.

3.3 Activities to develop refugee/migrant-sensitive health services by training health managers and health professionals

Olga Leralta and Ainhoa Ruiz Azarola made respective presentation of the SH-CAPAC Training Strategy and the SH-CAPAC on line course that is being developed as part of the project. They also made reference to the upcoming workshop in Granada on September 15th and 16th for discussing the adaptation of the training strategy and training materials to the national and local contexts.

The following ideas were highlighted in the presentation and during the plennary discussions:

- Training courses for administrative staff may already exist in the EU, but the content in the current training proposal is innovative.
- Issues of language barriers and difficulties with the online format were highlighted as possible challenges.
- Instead of a strong emphasis on disease-content, the training should focus more on approaches to deal with these problems in this population.
- Need to address different audiences and train them together, including health managers.
- Improve organisational competences not only of individual professionals, but also involve actors in the community.
- Integration of different approaches: fostering intersectionality. This could be an innovative element in the SH-CAPAC training.
- Avoid overlapping and seek complementarity with other relevant EU training projects (EUR-HUMAN, healthefoundation.eu, online training on mental health and Syrian refugees, CARE project, etc.).

3.4 Working group session: "Identification of barriers and enablers for the training strategy"

Participants were divided into three groups to work on the following topics:

- Barriers and facilitators for the training strategy
- Gaps or unnecessary items in proposed content of the course
- Segment the audiences or combine them?

Working group 1

This group identified barriers and facilitators and opportunities to implement the training strategy. The conclusions reached were the following:

Barriers:

- General barrier to e-learning: lack of social contact, feeling of belonging to group, and emotional involvement.
- Peer to peer training methodology: finding peers needs organizational support.
- Medical doctors are difficult to involve.
- Poor/missing English language skills.

- Lack of long term planning of training programs at federal, regional and local levels.
- Training courses already existing in some countries.
- Multi-stakeholders approach: need to involve many decision makers.
- Find ways to disseminate/publicise the course.
- Monitoring of participation in online setting.
- Inadequate funding.
- Limited time available of target audiences (flexible approach to the contents concentrating on core aspects).
- Constantly changing situation (in Europe, in countries, at local level) so new updates and information required continuously. Allow for updates.
- Professionals exhibit a large spectrum of experience in working with migrants and refugees: experienced professionals, manager do not need and do not want the basis.
- Need for easy navigation.
- Missing motivation.
- Limited time.
    - Need of a system up-down.
    - Training is not a part of education of professionals.
    - Amount of hours for MD and administrative staff.
    - E-learning not suitable for everyone.
    - Get involvement of MD's.
    - Health literacy of participants.
    - Decision makers should be targeted to disseminate.

Facilitators and opportunities:

- Nurses will be interested, administrative staff will be happy, need it and see their need.
- Educational institutions are interested in dissemination.
- Integration into existing courses/workshops.
- Accreditation/provision of certificates.
- Identify the right person in every context. In Austria: quality and diversity managers in hospitals, in Slovakia health social workers may open the door to training.
- Flexible approach to contents: possibility to choose modules.
- Logistic of online course enables access to a greater number of participants.
- Different stakeholders involved in training may increase the possibilities to involve in the training.
- Cost-effectiveness of mediators, interpreters.
- Use of advocacy tools (videos).
- Preserve networks that are already "converted".
- Involve municipalities in disseminating.
- Involve political level offering indicators and synthesis of information.
- Design a module for policy makers/politicians.
- Allow for new updates and information.
- Refer to country specific and facilitate developing the local adaptation.
- Share through social media, add interviews with experienced/enthusiastic people that share how rewarding work with refugees is.
- Subtitles in local languages.
- Good example from other countries.
- Detection of motivated individuals.
- Part of policy.

- Discussion about migration is a good start for training programmes.
- NGO's are open for training programmes.
- Connection with social services.
- Translations to local languages.
- Quality of course and importance of contents.
- General awareness of the importance of training.
- Looking for ambassadors nationally-locally: making use of existing networks.
- Segment the modules pending on target group (Module 4 not relevant for all profiles/Module 5 in some cases only briefly).
- Incorporate in curricula of care providers.
- Establish a diversity working group that unites number of universities in preparing contents.
- Incorporate training in continuous training for health professionals.
- Possibility for blended + face to face format.

Working group 2

- Lack of consensus on whether different audiences should or should not be combined in training.
- Different interests and expectations between health professionals and managers were highlighted as barriers and the different needs of the administrative staff.
- Need to differenciate profiles, criteria and definition of the audiences.
- Need to identify the key person in every organization.
- Create a confidence climate from the beginning of the course as a facilitator.
- The online format would be a barrier for some audiences.
- Differentiate contents pending on the profile, some common as e.g. cultural awareness.
- Specific health concerns are not to be central content.
- Names of units could be revised.
- The interests of managers and health professionals are very different, which makes it difficult to provide combined training.
- Group not convinced that administrative staff need all the proposed content.
- In training, asking what the daily main problems of the trainees are is what works best.
- Cultural competence is most important.
- A dynamic person to drive the training and networking is needed.
- Managers should have a course only for them.
- Personal contact is important in recruiting trainees.
- Health concerns should be less prominent in the training. The focus should be on what is specific for refugees, e.g. in mental health.
- Self-care of carers is also important.
- Consider starting training in separate professional groups, but bringing them together for the last two sessions.
- Define well the terms "health manager", "administrative staff" and "health professional."

Working group 3

The evaluation of the online modules developed by Mem-TP suggested to widen the spectrum of people and to include ethical dilemmas and deontological problems.

Target groups:

- ➔ Policy makers.
- ➔ NGOs at the borders at first line, especially new staff.

- ➔ Office of migration.
- ➔ Also researchers and lecturers at university/high schools teaching future healthcare providers working with migrants.
- ➔ Students.
- ➔ Professionals health system: whether health professionals providing care in facilities or the ones working in outreach: community health nurses, midwives, first line services in child health,…
- ➔ Admin staff in specific departments of health facilities, not only those in front-line units.

Barriers:

- ➔ Language issues.
- ➔ Duration:
  - Takes time to identify right people.
  - 30 hours is too long, too much, considered that some people are only allowed to take courses for a limited amount of hours per year.
  - 5 weeks in a row.
  - Asking permission can be a problem, given how time consuming it is.
- ➔ Clearance/permission of deans, directors to enrol into this course.
- ➔ Content:
  - Too much for some groups.
  - Overlap with existing training.
- ➔ Format:
  - Online training can be a barrier in itself.
  - How interactive will it be, who will be in charge of the forum during piloting and later on.
  - Selling it well, make it appealing: additional value is not clear yet.

Facilitators:

- ➔ Acceptability: EU accreditation + at national level Duration:
- ➔ Possibility to spread it over more months?
- ➔ Different tracks in the course: Trying to identify the key elements for personalisation of the course: different amount of hours for especific profile.
- ➔ Make visually clear what the pathways are.
- ➔ Format: lay-out ?website? app?
- ➔ Content:
  - Include migrants in evaluation of content.
  - In policy parts: make it possible to click to country-specific content so you do not have to learn about other EU countries if you do not want to.
  - Differentiate according to the three different phases of migration.
  - Provide information on legislation governing migrant rights, human rights and entitlements, more elements of ethics.

3.5 Plenary discussion

The salient points were the following ones:

- More reflection is needed on an interdisciplinary approach:?
- How feasible is it for administrative staff to do online training (in English?).
- It is important to assess the training needs before starting the training.

In connection with the training strategy, the content of the course and the audience for the Granada workshop these were some of the issues raised:

- Importance of defining the groups.
- Need for mapping the right audience.
- Assess possible barriers of the online format.
- Importance of addressing the different expectations, audiences and interests.
- Consider training contents as a resource package for training which can accommodate the needs of every country more than as an specific fixed course.

4 Next steps in the implementation of SH-CAPAC

Daniel López-Acuña shared information about future activities, country missions and dissemination strategies. He highlighted the following aspects:

- The first mission in connection with the *Resource Package,* coordinated with other aspects of the different work streams of the project (WP1, 2, 3 and 5) is being planned for the South Aegean Region in late August 2016. The second one will take place in the Region of Catalonia a month later.

- A 30 hour online training course to be run over a period of two months has been designed. The training materials are being developed and will be finalized by August 31, 2016. SH-CAPAC will coordinate with the training activities of other CHAFEA funded projects, especially EUR-HUMAN, to ensure complementarity of efforts.

- A workshop will be conducted in Granada, Spain, from September 15 to 16, 2016 to discuss the adaptation of the training materials and the training strategy to the national and regional situations in targeted Member States. A detailed report will be produced before the end of September 2016.

- The course will be in production in October and November for piloting the materials with participants from the target Member States. The targeted audience includes health managers, health practitioners and administrative staff. Arrangements are being made for identifying suitable candidates in the respective Member States.

- The training course evaluation will be conducted at the end of the online pilot training course. It will be concluded by December 15, 2016.

- It is important to note that the time period for implementing this project is too short. It has been necessary to compress in time tasks and activities that should have been implemented throughout a longer project period.

- A major challenge has been to engage Member States, particularly in light of constant changes in national and European policies in connection with the recent migratory influx, including the March 2016 EU Turkey agreement.

- A real challenge is to give continuity to the efforts and to keep the tools, instruments and training materials alive after December 2016. Member States need more time to get familiar with them. Action to support the implementation of what has been produced by SH-CAPAC and by the other four funded projects will need some continuity. In this regard, DG Sante and CHAFEA should consider the possibility

of a joint action in 2017, aimed at giving continuity to the work initiated during 2016 by the five funded initiatives.

- The CHAFEA's and DG SANTE's dissemination conference that is foreseen for March 2017 is of great importance. Starting discussions soon about the scope and purpose of the meeting is important.

Annex 1

List of participants

Co-funded by
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SH-CAPAC Reggio Emilia workshop JUNE 16-17 2016

"Improving access to health care and capacity building in Member States under particular migratory pressure"

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