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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

RESOURCE PACKAGE FOR ENSURING ACCESS TO HEALTH CARE OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS IN THE EUROPEAN UNION (EU) COUNTRIES

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Table of contents

User's guide

- The present document aims at supporting individual EU Member States in defining the fundamental elements that ought to be present in the development of a resource package for ensuring access to health care of refugees, asylum seekers and other migrants in the European Union countries. This resource package aims to support the multiple national, regional and local stakeholders involved in the response to the health needs of refugees, asylum seekers and other migrants who are part of the recent influx into the European Union.

- This resource package is primarily addressed to the national or subnational health authorities responsible for defining an operational strategy harnessing the contributions of different actors to the provision of accessible health care and the implementation of specific strategies and measures addressing the barriers to access to quality health care for these migrant populations. It is also intended for the different governmental and non-governmental actors as well as international and civil society organizations who participate in the national and local efforts directed at responding to the health needs of these vulnerable populations.

- Flexibility in the application of this resource package is highly recommended. Any governmental authority can select the parts that are relevant for their country/context and customise it to develop or strengthen their context-specific strategy to improve access to health care for refugees and asylum seekers.

- The context in which health professionals and managers operate is different from one country to the other and so is the situation for migrants. Information on available measures and tools contained in this resource package should be integrated in the national and local means of communications and established network of cooperation.

- Therefore the resource package proposed in this document is to be seen as a support tool for the development and dissemination of a resource tool at country/regional/local level, depending on its level of implementation.

- This resource package was developed and presented at the SH-CAPAC workshop on 16th and 17th June 2016 in Reggio Emilia, Italy and has since integrated the recommendations from the meeting and been adjusted to the new circumstances of the migrant flows. A first draft was discussed at the SH-CAPAC meeting on April 6th 2016 in Trnava, Slovakia. Further amendments may be needed in the future. Revisions will be made publicly available on http://www.easp.es/sh-capac/.

1 Why do we need to address the particular barriers faced by asylum seekers

For migrants, barriers to accessing healthcare represent a complex picture. It has long been recognised that newly arriving migrants may face special health risks and frequently do not receive the care they need. There are also important access problems faced by people living in temporary reception centres and by irregular migrants in general. Moreover, there are many challenges for providing healthcare to these vulnerable groups. These include: complex legislative requirements for obtaining permanent status, lack of knowledge about available services; language and cultural barriers, administrative and bureaucratic factors, and mistrust of health providers, particularly for those fearing detection.

Norredam et al. (2006) argue that a wide range of pre- and post-migration risk factors contribute to increasing the vulnerability of asylum seekers, particularly in their access to healthcare. Pre-migration factors include torture and refugee trauma, while post-migration factors may include detention, length of asylum procedure, language barriers, and lack of knowledge about the new healthcare system. As with other categories of migrants, these factors often interact with a component of deprivation in the host country. Asylum seekers also frequently experience social exclusion. A common aspect is that in most countries asylum seekers are entitled only to basic treatment for acute diseases. Current regulations in some countries impose severe limitations on the entitlement of asylum seekers to healthcare services under public programmes. A consequence is that changes in immigration policies may have a negative impact on access to healthcare.

2 The aim of this Resource Package

The present document is aimed at supporting EU Member States to address barriers to access to health care and to ensure continuity of care for refugees, asylum seekers and other migrants 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 will be achieved through the development of a resource package based on available evidence and expertise involving health and social authorities, IOs and NGOs active in the field. The objectives of the resource package are to:

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

Three areas of interventions are particularly relevant: the first priority is to improve information and communication in critical settings of reception, by strengthening information methods and tools addressed at refugees and using interpreters and other mediation professionals, such as community health educators, link workers, and intercultural mediators. Secondly, it is important to improve the flow of information between different levels of reception centres, as well as between transition countries/regions and countries /regions of destination. Finally, there is a need to improve the knowledge and skills of interdisciplinary teams and sectors at various level (national/regional/local) in developing integrated strategies and interventions to ensure access to health care for refugees, asylum seekers and other migrants. This goal will be achieved by the identification and later implementation of evidence based strategies and dissemination that are sustainable and suitable at local level.

3 Setting the scene

Despite the heterogeneity of trajectories, asylum seekers face a common challenge regarding health issues. Because of their particular life trajectories, they are more at-risk of facing health risks during the migration process but also after reaching their final destination. The recent asylum crisis faced by the European Union and its neighbouring countries such as Turkey highlights new challenges in providing health care for asylum seekers. Countries have been affected differently, depending on whether they are arrival, transit or destination countries. Yet despite the differential exposure, the situation has proved similar: asylum seekers faced barriers to access adequate health services.

Some of the barriers have already been identified. At the macro level, it concerns legal barriers, complex administrative procedures and financial aspects. At the organisational or service-level, it implies unavailability of the services, insufficient coverage of the health needs, lack of responsiveness of the services, i.e. lack of training of health care professionals or the lack of adaptation to the specific needs of asylum seekers, as well as lack of reachability. At an individual level, asylum seekers may face linguistic or cultural barriers, fear and mistrust of official services or may experience lack of health literacy, preventing them from accessing quality health care. If the barriers have been identified, solutions are scant. However, a number of strategies to overcome barriers have been identified, although others need to be developed. To cope with linguistic and cultural barriers, interpreting, (inter)cultural mediation or community health worker services have been developed in several countries. Moreover, specific health promotion programs, targeted training for health care professionals, rapid screening systems, are examples of good practices for improving access to health care.

However, the recent crisis has increased exponentially the number of asylum seekers in health services. The profile of asylum seekers has also changed – we are now also confronted with unaccompanied minors, families, pregnant women and elders – bringing specific health needs and new challenges. The migration routes, through the Mediterranean Sea or through the Balkans, impact the health of the candidates to asylum. In some countries, no health care is provided before entering the official system of asylum applications. For those entering the system, access may still be impeded by various obstacles. The politics of redistribution of asylum seekers across the European Union may also bring asylum seekers to settings where the local health care system – and the health professionals - are not ready to face specific health problems such as PTSD, sexual violence or tropical diseases such as malaria. The recent crisis has also highlighted the difficulties of coordination between immigration services and public health departments, between NGOs and local authorities that also affected negatively the access to health care for asylum seekers.

In order to gather updated information on the new challenges for health professional and services related to the current refugee crisis and to identify gaps between barriers and solutions, firstly, a series of interviews and focus groups were carried out in 10 EU countries; secondly, a literature search was conducted in the international literature and in the grey literature published between 2008 and 2016.

4 Qualitative study: interviews and focus groups

Between February and March 2016 20 semi-structured interviews were carried out in The Netherlands (4), in UK (10), and in Austria (6). In the same period 10 focus groups were conducted in Belgium (2); in Greece (2),

in Spain (2), in Italy (1), in Slovenia (1), in Hungary (1), and in Denmark (1)[1]. Countries were chosen on the basis of their role in the migration journey of asylum seekers: arrival, transit and destination.

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 during the arrival, transit and destination phases.
- To collect existing measures and tools that health services have put in place to deal with the challenges described (see Annex Ib).
- 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 (see Annex Ic).

The interviews and focus groups were addressed to professionals working in center for refugees/AS, working in health services where asylum seekers go for health care during the asylum seeking process.
The analysis of the interviews and focus group results were summarized below. These results provided clear indications on what should be included in a resource package addressing the barriers to access health care services and informed the search strategy of our literature review.

4.1 Summary results of the qualitative study

Challenges related to the current refugee crisis for care professionals and managers

1. *Administrative issues related to the legal status of the asylum-seeker/refugee:*
    - Different (and complex) procedures depending on the status of the asylum-seeker.
    - Long waiting times for recognised refugees to receive full health care coverage.
    - Those who are refused the refugee status and failed asylum seekers become UDMs.
    - Providers have poor knowledge and different interpretation of legislation.
    - Administrative procedures and legal limitations put a strain on the care delivery process.
2. *Linguistic and cultural barriers:*
    - Care is provided on the basis of poor communication.
    - Lack (or insufficient) of interpreters and intercultural mediators.
    - Utilisation of non professional interpreters.
    - Longer times in treatment, minimal medical information, difficult to explain symptoms, poor understanding of current treatment…
    - Linguistic barriers make it difficult to handle cultural barriers (women's health, mental health,..).
3. *Lack of information for health care providers and difficulties to ensure continuity of care*
    - Lack of health records (at arrival, transit, destination).
    - Absence of exchange of information between countries, and within one country.
    - Different databases may not be connected and difficult to access.
    - In transit countries AS may stop the treatment to be able to continue the journey with compatriots.

[1] Interviews and focus groups were conducted/oraganised by experts/researchers of the 10 countries selected: Jeanine Suurmond and Vinny Mak (The Netherlands); Nazmy k. Villarroel Williams (UK); Allan Krasnik (Denmark); Ursula Trummer and Sonja Novak Zezula (Austria); Hans Verrept (Belgium); Elisabeth Ioannidi and Anna Maina (Greece); Ainhoa Rodríguez García de Cortazar, and Jaime Jiménez Pernett (Spain, Malaga); Marta Escobar Ballesta and Rocío Valero Calle (Spain, Seville); Benedetta Riboldi and Anna Ciannameo (Italy), Simona Jazbinšek and Uršula Lipovec Čebron (Slovenia); István Szilárd and Erika Marek (Hungary).

4. *Lack of information for asylum seekers and refugees*
    - Lack of information on their right to health care.
    - Lack of knowledge on available services and how to navigate the health system.
5. *Organisation, quality and coordination of medical services*
    - Lack of organisation may result in chaos and little collaboration between the different care providers.
    - Lack of supplementary health care services overburden staff (physically and emotionally) and lead to complains from national patients.
    - Health care may be of uneven quality.
    - Poor management of the refugee crisis leads to overcrowding certain hospitals.
    - Specialist care may be hard to reach.
    - Health care system (inappropriately) consulted for social problems.

Challenges related to specific phases of the asylum process

1. *Arrival phase*
    - Healthcare professionals may have to intervene on site.
    - Information on refugee's right to access health care not always provided.
    - Primary care is provided mainly by international NGOs.
    - Chronic diseases or mental disorders and migrants' personal plans are not taken into account.
2. *Transit phase*
    - Personal medical files (e.g. on vaccination status) are rarely available.
    - NGO's provide primary health care services on site during the transit phase.
    - Focus is on acute health issues and communicable diseases.
    - Treatment of chronic diseases (e.g. cancer, aids-HIV, diabetes…) is often inadequate.
    - Time is one of the main challenges when it comes to asylum seekers in transit to access care.
3. *Destination phase*
    - Registration procedures are long (the time taken to process applications have an impact on access to care).
    - At this stage, refugees will lose much of the assistance they received in previous phases.
    - Insufficient knowledge of the health care system.
    - Linguistic and cultural barriers / limited culture competence of many care providers.
    - Limited health literacy makes it hard to navigate the complex health care system.

Challenges related to specific health situations

1. *Sexual and reproductive care.*
2. *Mental health care.*
3. *Children and adolescents care.*
4. *Victims of violence care.*

Please note that this is only a summarized description of the results of the qualitative study; a full description is available in Annex I

5 Systematic literature review

On the base of the results of the interviews and focus groups a literature review was conducted to systematically collect, summarize and critically appraise the available evidence and grey literature on access to health care services for asylum seekers and refugees. The search query was: *"What are the current barriers and solutions related to access to health services for asylum seekers and refugees in OCDE countries?"* A search strategy was developed and adapted for each database we searched, including: CINHAL, Embase, Medline, Scopus, the Cochrane Database and CAIRN (Annex II). In addition, further studies were retrieved from reference listing of relevant articles and consultation with experts in the field. Grey literature was examined manually for migrant health-related topics including policy frameworks. Studies were included in the review if they were published in journals from January 2008 to July 2016; papers written in English, French, Italian, Spanish and Dutch were included.

5.1 Summary results of the systematic review

The most frequent barrier to access health care services concerns language and cultural aspects. Besides the communication skills and the language knowledge, it involves also the socio-educational aspects and the lack of health literacy. Organization-quality of care and legislative, bureaucratic, administrative and financial issues have been reported by frequency as the second and the third barriers respectively. In some studies, affordability was the barrier to access health care services, although most of the studies were concerned with administrative and bureaucratic barriers. Information and continuity of care for refugees and asylum seekers was defined as the provision of clear and comprehensible information about the care provided and the services they may need. Whereas, information and continuity of care for care providers included the transfer of information related to the follow-up of the patient between providers and the access to relevant up-to-date information for care providers. The less frequent barrier observed concerned the coordination between services.

Most of the solutions concerned the organization and quality of care followed by solutions regarding linguistic and cultural aspects. Other solutions were found, by order of frequency, to improve coordination between services, information and continuity of care for refugees and asylum seekers, legislative, bureaucratic and administrative issues and information and continuity of care for care providers.

Please note that this is only a summarized description of the Systematic Review; for further information or detailed methodology -based on the PRISMA statement- and Results refer to Annex II, Annex III.

6 Guidance on addressing barriers to access to health care services

In this section a guidance based on the results of the interviews, focus groups and literature review is presented. Information and opinions collected during the workshop of experts held in Reggio Emilia on 16th-17th June 2016 are also conveyed in the guidance. Information to support Member States to address barriers in the access to health care for refugees and asylum seekers have been grouped in two categories. The first category provides evidence on the general barriers and solutions to address health care: legislative, administrative and bureaucratic barriers; linguistic and sociocultural barriers; organisational barriers and difficulties to ensure equitable quality of care; lack of coordination between services; lack of information for health providers and difficulties to ensure continuity of care; lack of information and education for refugees and asylum seekers. The second category provides evidence on barriers and solutions concerning specific

areas of health care: mental health care, sexual and reproductive care, children and adolescents care, and victim of violence care.

6.1 Legislative, administrative, financial and bureaucratic barriers

The problem

Beyond the health care system, wider legal and policy frameworks govern asylum and influence access to health care and who is responsible for care. Where refugees are legally recognized and adequate health services exist, the legal status of an individual is the most important factor determining access to health care. However, access to appropriate healthcare across EU is very varied and is overwhelmingly shaped by legal frameworks and the regulation of the migration process, which in turn lead to a number of administrative procedures that have to be respected to guarantee access to care. Refugees are formally owed protection, including access to health services, from their first country of registration for asylum. In practice, however, administrative barriers and the time taken to process documents and applications increase the frequency of situations where refugees have no effective health care coverage (Bradby, Humphris, Newall, & Phillimore, 2015). At any one time an individual may be lodging an application, awaiting a decision, awaiting an appeal, or may have been refused asylum (Taylor, 2009). As a consequence, legal entitlement does not guarantee access to health care and social insurance-based systems are particularly problematic for asylum seekers and refugees, since registration is more complex than in tax-funded systems (Bradby et al., 2015).

Evidence on the barrier

Legal status has been identified by our literature review and focus group results as the single most important factor directly impacting access to health and social services (Bradby et al., 2015; Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Mei Lan et al., 2015). A major problem in sourcing evidence is related to the wide variation in the definition and identification of refugees and asylum seekers used throughout Europe. What is meant by asylum seeker and refugee shifts, and the changing meanings have important implications to the access to health care. Two groups of migrants are particularly at risk: those individuals situated between legal positions who find themselves in the transitioning process from an asylum seeker to a refugee; and those "failed asylum seekers", who are awaiting deportation or who have appealed the decision and have made a fresh claim.

Affordability is a second important barrier to accessing health care for those who have not obtained full protection. Inability to pay for medical consultation, pharmaceuticals, transportation to appointments and other health-related costs, including contraception, have been highlighted as major barriers to accessing health care (Hadgkiss & Renzaho, 2014). Even for those who have gained full protection, the effect of poverty and scarce economic resources on broader health concerns was reported in some studies, highlighting that for new refugees health *per se* may not be felt as an immediate priority (McKeary & Newbold, 2010).

The delivery of health care services to asylum-seekers and refugees is seriously hampered by the complexity of administrative procedures that have to be executed to guarantee access to care. Different procedures have to be followed depending on the status of the asylum-seeker: as long as she/he has not been registered as an asylum-seeker (e.g. because she/he does not intend to stay in the country she/he is in at that moment) is considered to be an undocumented migrant. This implies that specific rules apply, which differ from one member state to another, which in turn leads to a number of administrative procedures that have to be respected to guarantee access to care.

Even for those who have refugee status, administrative and bureaucratic procedures continue to hamper access health care. Administrative procedures – such as a waiting period imposed by health insurance organizations – may lead to the person being without health insurance for a relatively long period, rendering access to care difficult because of financial thresholds. Complexity and the lengthy forms required to obtain exemption fees, unfamiliar procedures, such as contacting GP surgeries to make appointments, have also been identified as barriers to health services even for those with refugee status (Joels, 2008). For example, difficulties accessing health and social care could simply stem from not having a stable home address, in some countries without an address, persons without asylum are denied health care and treatment since residential information is required for GP registration (Mei Lan et al., 2015).

Furthermore, in some countries access to secondary care is only free available in case of an emergency, if treatment is life-saving or immediately necessary (Bradby et al., 2015; Joels, 2008). Therefore, people who have been refused asylum or are awaiting recognition may be left at an impasse with no right to treatment and no means to pay (e.g.: asylum seekers that are accommodated in centres for asylum seekers, refugees in arrival centres, people placed in detention centres awaiting deportation or in the process of identification, migrants with permission to stay who are released from detention centres because they cannot be deported and undocumented migrants). All the above listed groups of migrants/refugees may be excluded from the regular system of health care coverage and may only be entitled to emergency health care.

Nevertheless, the interpretation of emergency health care can be quite arbitrary, since the extent of services provided is often based on the individual decision of the health care worker treating the patient. There is insufficient knowledge among medical doctors, nurses and social workers of the different administrative statutes of refugees and asylum seekers and what the relevant health care rights actually are. As a result, patients may not receive the care to which they are entitled. Furthermore, it has emerged that these rules may be unclear and in some countries change frequently. When legal and administrative procedures are not respected, this may have far reaching consequences for the health care institution, which may not receive reimbursement from the state for the services delivered.

Finally, lack of knowledge of entitlement to health care services and information of available services are important barriers also for those who have been awarded refugee status and are entitled to primary and secondary care (Joels, 2008). Fear of detection or deportation may discourage access to health services for those refugees who do not or cannot declare themselves to the statutory authority, as in the case of migrants who are unable to claim asylum and, therefore, are not entitled to health care(Bradby et al., 2015).

Measures to address barriers

UNHCR suggests (UNHCR - United Nations High Commissioner for Refugees, 2011) that the most effective way to improve access to services is the removal of legal restrictions and of any discriminatory directives or practices that impede access to health. The first step to improve the situation is the creation of a consistent, shared labelling system for asylum seekers and refugees in all European countries, as this will simplify progress on ensuring access to appropriate and equitable health care for this group (Bradby et al., 2015).

At a local level it is important to promote an effective legal environment, health managers need to analyse the relevant laws and directives in their country, and work out the practical implementation of these laws in terms of health service access and provision. Furthermore, the full costs that refugees pay for health services should be analysed including costs of transport, consultations, investigations and medications including long term

prescriptions for chronic diseases. On the base of this analysis health managers and decision makers should examine and decide upon the various financing options needed to support refugees who have to pay user fees for primary and emergency services, and for specialised care (UNHCR - United Nations High Commissioner for Refugees, 2011).

Other important measures are to make health professionals aware of legislation affecting people seeking asylum and to prepare them to ensure appropriate health care is provided for all those seeking asylum. On the side of the refugees, proactive and facilitative programmes should be developed with the aim of informing people seeking asylum of their healthcare entitlements.

Successful example

Responsibility for administrative, interpreting, and financing issues taken from health care staff by management
(Austria)
Service/department in charge of the measure
Hospital directors / hospital management / outpatient department
Description of the measure
In Vienna, during the 2015/16, refugee movement, many children were treated at the outpatient department of the St Anna Kinderspital. Many of them had not yet applied for, nor received asylum seeker status. They could not, therefore, present a health card, which in Austria would entitle them to access public health services. In these particular cases, staff members were permitted to deviate from the defined administrative procedures. The hospital directors set a rule that "the patient comes first". If the patient could not show the right documents/health card, staff should copy whatever documents were available and treat the patient. Interpreting services were available. Subsequent to treatment, financial issues were dealt with by the management. In order to provide medicine for these patients, a "refugee pharmacy depot" was implemented, providing around 25 drugs for the most common infantile health problems. Documentation of drug provision was done with a simple list to avoid additional bureaucracy.
Expected outcomes
To create a working situation for medical and nursery staff where they are not hindered in their medical work by bureaucratic issues
Achieved outcomes
Achieved outcomes: refugee children without asylum seeker status were able to receive medical treatment and could be provided with drugs. Medical and nursery staff could provide professional treatment without being responsible for additional administrative procedures. Treating these vulnerable patients was seen as a joint challenge.
Resources needed for implementation
management decision, adapted administrative procedures

Source: *Interview and focus groups report*

References to know more:

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6.2 Linguistic and socio-cultural barriers

The problem

Linguistic and cultural barriers are systematically identified as one of the major challenges related to the refugee crisis. These barriers lead to communication problems that have adverse effects on the quality of care and patient health outcomes. For example, during the phase of admission and diagnosis clinical interviews may be misleading and only minimal medical information may be obtained. If adequate language support is not available, it is difficult to establish the patient's native language and identity; patients have difficulty describing symptoms and understanding diagnosis and health conditions. During treatment language discordance and cultural differences may lead to lack of trust on the part of patients towards physicians and patients may feel that the provider does not care; patients may have poor understanding of current treatment or follow up care, and it is difficult to obtain informed consent for therapeutic measures. In the same way the absence of language support at the moment of discharge may lead to having discharge instructions given in writing but in the local language, inappropriate linkage to health and social services in the community for the management of chronic illness or health behaviours. For example, in one Greek focus group the case was presented of a child with a brain tumour and the impossibility of explaining this to the father. As long-term treatment may impede asylum seekers from continuing their journey to the country in which they would like to settle, without adequate communication parents may decide to take their sick children with them.

Evidence on the barrier

Lack of interpretation and translation services is identified as a significant determinant of access to and utilisation of healthcare for the refugee population (Asgary & Segar, 2011; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Newbold, Cho, & McKeary, 2013; Szajna & Ward, 2015). In many Member States no, or insufficient professional interpreters or intercultural mediators are available. In practice interpreting / intercultural mediation is often carried out by NGO members, volunteers, other refugees or professionals who have not been trained in this domain. Many problems related to this situation are being reported.

In general, lack of adequate language support complicates the provider-patient encounter, generating fewer empathic responses, decreased rapport, less patient satisfaction, and increased medical error (Asgary & Segar, 2011). In particular, poor communication and inability to overcome language barriers negatively affect both the quality of health assessment and the number of migrants attending the health assessment during the asylum seeking process (Jonzon, Lindkvist, & Johansson, 2015). There is evidence that refugees experience

significant difficulties in making clinical appointments because of their low proficiency in the host-country language (Cheng, Vasi, Wahidi, & Russell, 2015; Clark, Gilbert, Rao, & Kerr, 2014). Furthermore, refugee patients tend to fail to attend follow up visits and revert to A&E services. Comprehension of written instructions for follow-up healthcare services and informed consent forms to be signed, are also identified as significant barriers and deterrents to accessing healthcare services by refugees and healthcare providers (Cheng, Drillich, & Schattner, 2015; Szajna & Ward, 2015). Importantly, language is also a barrier to the use of prevention services. A great deal of research has shown that migrant women have fewer mammograms, screening and pap tests (Saadi, Bond, & Percac-Lima, 2012).

The impossibility of resolving linguistic barriers makes it extremely difficult to handle socio-cultural barriers that may further impede the care delivery process. Patients coming from Syria and Iraq, for example, may sometimes vehemently refuse to be treated, or have their spouses treated, by a care provider of the other sex. This is worse if care providers have received insufficient training in cultural competence and may be completely unfamiliar with patients coming from the Middle East.

Although services do provide professional interpreters at times, their number is too limited and care providers rely mainly on family members and friends as interpreters (MacFarlane et al., 2009). Many studies show that language barriers are more complex than mere issues of interpretation and include recognition of literacy levels when refugees lack the necessary vocabulary to describe their conditions, complicating diagnoses, follow-up care and instructions (McKeary & Newbold, 2010). Concerns about accuracy and confidentiality emerge if an informal interpreter from the community is used as an interpreter (Cheng, Drillich, et al., 2015).

Finally, gender concordance, trusting relationships, and using the same person to interpret at each visit is presented as a beneficial in patient-provider communication (Bischoff, Hudelson, & Bovier, 2008).

Evidence on solutions

Since linguistic and socio-cultural barriers lead to communication barriers and as these are among the biggest obstacles in providing comprehensive and quality health care to refugees, the introduction of a large number of professional interpreters as well as intercultural mediators in EU health care systems is necessary[2]. The provision of practical support for refugee patients to register, make appointments and attend services by engaging interpreters to ensure clear explanations about unfamiliar clinical processes and treatments has proved to be effective in improving access (Bradby, Humphris, Newall, & Phillimore, 2015).

Language competence alone is not considered sufficient to facilitate effective clinical communication across language/cultural barriers. Hence the recommendation is to work with professional interpreters/mediators who have acquired both the necessary communication skills and knowledge as well as the vocabulary needed to work in the medical sector as part of their training. However the successful employment of interpreters and/or intercultural mediators is inseparable from the development of a culturally competent health care system.

[2] The domain of medical interpreting and intercultural mediation in health is fraught with inconclusive discussions of what the role of different types of 'intermediaries' (interpreters, intercultural mediators, patient navigators, etc.) ought to be. Accepted roles range from that of a 'translation machine' to that of a co-therapist' who is also providing interpretation with somewhere in the middle the 'intercultural mediator'. He/she provides linguistic interpretation, acts as culture broker, helps patients and care providers take up their respective roles, support the development of trustful patient-provider relationship, helps patients navigate the system, and may take up an advocacy role. For a detailed discussion see: (Beltran-Avery, 2001; Bot & Verrept, 2013; Tipton & Furmanek, 2016; Verrept, 2012). It should be pointed out that in many projects, e.g. in the US, medical interpreters act as culture brokers and as advocates.

McKeary and Newbold argue that from a system perspective, the solution must be addressed at a policy/governmental level by acknowledging that accepting refugees must be simultaneously recognised with healthcare budget (McKeary & Newbold, 2010).

There are different models for implementing interpreting services (e.g.: face-to-face and telephone/video remote interpreting, etc.), intercultural mediation and specific tools to facilitate medical consultations (e.g.: anamnestic questionnaires to gather the medical history of the patient; multilingual posters to aid migrants to explain their symptoms and health needs). Translation tools should not be focused only on health care but should also include administrative procedures in general.

Different options on how the services of professional interpreters and cultural mediators could be obtained depend on the characteristics of the health service and its language needs (Wollscheid, Menzies Munthe-Kaas, Hammerstrøm, & Noonan, 2015):

- In-house interpreters / intercultural mediators could be hired as regular staff where the need for a particular language is high or when a single staff interpreter could be qualified to work with several foreign language patient groups.
- Co-operation with external interpreting services implies that interpreters/mediators are hired as hourly, on-call employees or as independent contractors. This is most useful where demand for a particular language is intermittent or infrequent, or when a health care organisation has fewer common language groups in its service area.
- One particular strategy is the establishment of community-based interpreting/mediation as a shared resource for various health care organisations.

The difference between interpreting and intercultural mediation lies in the – generally - wider role of the intercultural mediator in comparison with that of the interpreter. Both are involved in interpreting, and both may – in some programs/countries, but not in others – in addition act as culture brokers, facilitators, patient navigators and advocates (Tipton, R. & Furmanek, O., 2016). In the absence of a recognised professional profile in many countries, the terms interpreter and intercultural mediator may encompass a variety of tasks that differ, even within the confines of one country, from one program/institution to another. In intercultural mediation programs, the emphasis tends to be more explicitly placed on serving as liaisons between patients and providers, the enhancement of mutual understanding taking into account socio-cultural differences and the reduction or prevention of conflicts. Advocacy, as far as we are aware, is attributed to the intercultural mediator[3], be it at an individual and/or group level. This is not the case in certain interpreter programs. Furthermore, intercultural mediators assist health care organisations in the process of rendering the services offered more responsive to the needs of a linguistically and culturally diverse population. Finally, they may have one-on-one and group meetings with patients and care-providers alike to help them interact as effectively and efficiently as possible. Finally, conflict mediation is part of the task description of intercultural mediators in some programs.[4]

[3] There are many synonymous terms for this role, including "Link workers" in Scotland; "Community health educators" in the UK; "Aides medico-psychologique" or "Auxiliaires de vie sociale" in France; "Agentes de salud" in Spain; "Agenti di salute" and "Operatori di strada" in Italy; "Zorgconsulenten" in the Netherlands and "Health mediators" in Eastern European Countries.

[4] For an overview of the roles of intercultural mediators – and for the development of a training program in case a such program does not exist in your country/region – see the website of the TIME-project (www.mediation-time.eu). The TIME project (Erasmus+) had as its aim to define the different types of intercultural mediation, the identification of good practices, the development of a professional profile and a training program. The intellectual outputs hereof can be downloaded from the website.

Successful example

Video-remote intercultural mediation (VRIM) in Belgium
(Brussels, Belgium)
Service/department in charge of the measure
Intercultural mediation and policy support unit (FPS Health, Safety of the food chain and Environment) and RIZIV (national health insurance institution)
Description of the measure
The intercultural mediation service in Belgium was introduced in 1991 and at the beginning it was organized solely with the on-site presence of mediators in health care institutions. The increasing diversity of the immigrant population made it clear that this approach lacked the flexibility needed today. Therefore, it was decided to create and an additional service involving the use of video-conference technology.
Expected outcomes
To reduce the negative effects of the linguistic, socio-cultural and ethnic barriers on the accessibility and quality of health care.
Achieved outcomes
This measure makes it possible to provide intercultural mediation in over 20 languages in more than 100 health care institutions in a cost-effective and flexible way. Preliminary evaluations have indicated that the VRIM is a valuable and necessary addition to the provision of on-site intercultural mediation services, which remain the preferred – but often unavailable and unaffordable – option of care providers, patients and mediators alike. VRIM limits the role of the mediator as he/she is not present on-site). In particular elderly care providers sometimes feel ill-at-ease with video-conferencing technology and are reluctant to rely on it. It seems to be important to stimulate and train care providers to use VRIM and to work closely with ICT-departments of health care services to avoid technical issues. Finally, intercultural mediators have to be trained to be able to provide high quality services using video-conference technology.
Resources needed for implementation
Funding for the mediators, a coordinating team, training for mediators and care providers, an awareness-raising and promotion campaign, good internet access, the necessary hardware and software. A well-developed soft and hard policy that guarantees that no patient data will become public.
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Source: *Interviews and focus groups report*

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6.3 Organisational barriers and obstacles to accessing health care services of equitable quality

The problem

Access to health care for refugees and asylum seekers is not limited to the problem of acute provision at initial reception but also involves mainstream service provision. Some health care is specifically provided in detention or reception centres, nevertheless, refugees and asylum seekers are also accessing care from the same clinics as the general population; consequently, adapting mainstream health care services is crucial. As previously explained, access to health care varies across Europe in terms of legal entitlement and formal access regulations (Bradby, Humphris, Newall, & Phillimore, 2016). Even where entitlement is established for formally resettled refugees, and regulations permit access, further impediments exist in terms of the organization of health care.

Most services tend to evolve reactively rather than proactively, adapting to the perceived or expressed needs of the population. As numbers of asylum seekers and refugees in a given area are difficult to predict, it is very hard for service providers to anticipate what needs may emerge in the near future (Bradby, Humphris, Newall, & Phillimore, 2015). Limited availability of services, difficulties in accessing general practice and an increased

reliance on accident and emergency services for non-emergency treatment are often reported, even though almost all refugees are registered with a general practitioner. There is also evidence of late booking, poor antenatal care and poor pregnancy outcomes plus high rates of mental health problems. It is, therefore, necessary to improve access to primary care.

Moreover, unequal geographical distribution of facilities, and the lack of transportation and outreach interventions create further barriers to access health care for refugees and asylum seekers who often live in accommodation in areas of existing deprivation. Due to their condition of social isolation they inherit the same social determinants of ill-health as the native population yet with additional barriers to care. (Taylor, 2009)

Evidence on the barrier

Lack of migrant-friendly/sensitive health systems is the single most important factor impacting on access to health services and quality of care for refugees and asylum seekers. With no structural preparation in handling the diverse needs of refugee populations, the health sector faces important challenges that can represent real problems for service organisation and delivery. Unless new information strategies and language support services are set up, the quality of services adapted to the new needs, and innovative action and policies incorporated into regular management procedures, the very organisation of service delivery may become a further barrier to accessibility for refugees and asylum seekers. Failed adaptation of health systems creates a number of organisational dysfunctions, for example, unmet health needs tend to converge in emergency departments; unmet language needs tend to slow procedures down, and the uncoordinated adaptation of services to specific needs creates uncertainties for staff, managers and the health care setting alike.

The complex network of health and social services may seem impenetrable to recent refugees and asylum seekers (Asgary & Segar, 2011) and the availability of these services effectively out of reach. Barriers in accessing the health system often result in missed medical provider appointments and increased reliance on hospital emergency departments (Reavy, K., et al., 2012). This is also influenced by migrants' previous knowledge and experience of health systems most of which were characterised by a lack of GPs and direct access to hospital-based specialists. O'Donnell, C.A., et al. 2008).

Social and cultural isolation also emerged as significant barriers to health care for refugees and asylum seekers who live in deprived areas and lack transportation to attend medical practise. This is even more difficult for refugees with physical or mental disabilities, for the elderly and families with young children. (Cheng, Vasi, Wahidi, & Russell, 2015).

The infrequent use of specialised services or therapies by asylum seekers and refugees are also reported in the literature and confirms inaccessibility. Impediments to access are described both in terms of the organization (and geographical distribution) of health services and the wider context beyond the medical system. Obstacles in accessing specialists services may also derive from certain features of the asylum process and the management of refugees, for example an active dispersal policy may relocate refugees and asylum seekers to places where appropriate services have not been developed (Bradby et al., 2015).

These organisational barriers are connected with that of affordability, as it is widely recognized that high costs are the major factor preventing access to speciality care but also for continuity of care and preventive care that are largely unknown and unavailable to asylum seekers (Asgary & Segar, 2011). For instance, access to dental care, ophthalmology, orthopaedics, physiotherapy is sometimes hampered by the fact that in some countries the state only reimburses certain fixed amounts through the national health insurance system for

asylum seekers. As a result, specialists may refuse to treat asylum seekers, or are reluctant to accept new clients who not only bring complex health needs, but linguistic challenges and complex insurance coverage (McKeary & Newbold, 2010).

Time and communication emerged as significant factors impacting on access to health services and quality of care (Bennett, S. and J. Scammell, 2014). Long waiting lists, complex appointment referral systems, cultural insensitivity, and visiting different care providers were also reported as negative experience for refugee patients by both EU and US studies (Asgary & Segar, 2011) (Razavi, M.F., et al., 2011). For example, one study showed that due to organizational factors affecting follow-up, referral and specialist care, only a limited number of the refugees included in the study received treatment for latent tuberculosis and with a long time delay (Harstad, I., et al., 2010).

Measures to address the barrier

Adopting a "whole organisational approach" able to implement a comprehensive process of change and adaptation of services to appropriately respond to the needs of migrants and other vulnerable groups, has proved to be a successful strategy. This strategy requires management support and policy development in the organisation in order to enhance the capacity of the health providers, managers and administrators to address the health issues associated with refugee and asylum seekers, and to deliver quality health care services in a comprehensive, coordinated, and equitable fashion. It also entails the development of a diversity responsiveness assessment framework for measuring and monitoring service performance in order to improve accessibility, utilisation and quality of health care for refugees and asylum seekers (e.g.: Equity standards in health care; CLAS standards).

Within this framework, health care organisations need to develop specific policies and programmes that address priorities for the care of refugees and asylum seekers, adapt processes and services in the organisation and promote effective participation of the community especially the civil society.

For example, access to health care services for asylum seekers and refugees can be promoted by outreach services and free transport to and from appointments or thanks to the coordination between appointment and transport needs. A clinical model for prenatal and paediatric refugee patients has shown to be successful due to the role of C.A.R.E. (Culturally Appropriate Resources and Education) Clinic Health Advisor that was developed in conjunction with the organization (Reavy, K., et al., 2012).

Another example is the co-location of different health services such as general practice, pathology, pharmacy, counselling services, etc. in order to reduce difficulties associated with travelling to multiple sites. (Cheng, Vasi, et al., 2015). The implementation of drop-in primary health care units based in hospitals, the adoption of extended clinic opening hours or modification of timetables could be other solutions to create increased opportunities for refugees to be able to access to services and to reach them in time; moreover, telemedicine systems could facilitate the access to healthcare services overcoming geographical barrier and addressing people otherwise hard to reach due to physical and organizational problems (Berthold et al., 2014). One successful Australian model reported in the literature is the Primary Care Amplification Model (PCAM) which, has been showed, offers a flexible, yet robust framework to facilitate the delivery of continuous, coordinated and comprehensive care to migrant patients. (Kay, M, 2010).

Having a community engagement strategy in the health care organisation is a key factor to bridge the gap between community and health care services, this strategy makes it possible to identify and prioritise refugees'

health needs, and define and implement solutions in a mutually acceptable way (Cheng, Wahidi, Vasi, & Samuel, 2015). Furthermore, to combat logistical concerns and organisational barriers, health care organisations must work closely with their patients' resettlement agencies and other social services to ensure that patients have access to the resources necessary to achieve optimal health outcomes (Szajna & Ward, 2015).

The existence of a clear organisational policy setting out how interpretation and cultural mediation services are provided will ensure effective access and utilisation of services. This means implementing written policy on interpretation, translation, intercultural mediation and communication support; a patients' language identification system; guidelines for staff in organising interpreters or communication support; the possibility to use a gender-concordant interpreter defined criteria for interpreting quality and interpreting codes of conduct (Bischoff, Hudelson, & Bovier, 2008; Hudelson, Dominice Dao, & Durieux-Paillard, 2013).

Finally, the development of a comprehensive training programme for staff at all levels should be embedded in the strategic training plan of the organisation. Training should include best practice guidance on how to deal with particular vulnerable groups (e.g. mental health disorders, unaccompanied minors, victims of torture and sexual violence, women with genital mutilation, etc.) including support for the implementation of a referral system for such patients (Asgary & Segar, 2011), as well as the provision of human rights education and support for administrative and health staff (Scott, 2014).

Successful example

Migrant-Friendly health care in the Local Health Authority of Reggio Emilia: a whole organisational approach
(Reggio Emilia, Italy)
Responsibility
Research and Innovation Department of the LHA of Reggio Emilia
Description
Since 2005 an overall strategy to ensure equity of access and treatment for migrants has been established at the central level of the organisation. The strategy comprises the following main areas of interventions and is coordinated by a multidisciplinary team:
Ensure the right to health care through a dedicated service for UDMs and people at risk of exclusion because of lack of legal status *(migrants in irregular situation, asylum seekers, and failed asylum seeker).*
Improve accessibility to health services through a coordinated language support service available for all professionals and patients *(addressing linguistic and communication barriers).*
Improve service utilization through the provision of information on health and health services *(providing information on how to navigate the system; improve Health literacy).*
Ensure quality of care and responsiveness to migrant's health needs through systematic training embedded in the organisational training plan *(staff training programmes).*
Foster organisational change and improvements through the assessment of quality/equity of health care services. *(HPH-TF MFH standards of equity in health care)*
Promote involvement and participation of users and community through the establishment of partnerships and networks in the community. *(Partnerships, networking with other services, out-reach interventions, formal agreements and protocols)*
Promote research to achieve change through the participation at research projects and networks at local as well as international level *(COST Actions; EU funded projects; National/Regional funded projects)*

Achieved outcomes

Improved integration of the migrants population in the health care system. Reduced inequities in health care and contributed to reduce health inequalities.

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6.4 Lack of information for health providers and obstacles to ensuring continuity of care

The problem

Asylum-seekers often arrive in both transit and destination countries without any health records. Care providers, therefore, lack reliable information on the illness and treatment history of patients. For example, absence of information on the vaccination status of children is one problem that is systematically reported; no health records are available and, due to language barriers, it is impossible to obtain information from the parents. Patients often move from one country to another during their asylum-seeking process, and even when they are settling in a country, they may move from one place to another as countries may have policies to distribute refugees over their whole territory. In countries of transit, in particular, asylum-seekers may leave the hospital or interrupt treatment – against the care provider's advice – in order to continue their journey with their compatriots.

The high mobility of asylum seekers coupled with the fact that information is not exchanged between different levels of care services, as well as between countries/regions, make it impossible to ensure appropriate care and continuity of care. Furthermore, since many health professionals work in very poorly organized settings,

they need to obtain information not only on the health situation of asylum seekers but also on services and resources available and administrative/legislative issues. Lack of coordination between multiple providers and health and social services, as well as the lack of specific training for all stakeholders worsen the situation and make it difficult to share information and to ensure continuity of care for asylum seekers and refugees.

Evidence of the barriers

A first important barrier is the absence of a coordinated unified database that would make it possible for health providers to access patients' medical records (Taylor, 2009). Health providers argue that ideally, information on patients (both personal documents and medical records) should "travel" with the patients, but this is not the case. Health care professionals participating in the focus groups reported that no adequate systems for the exchange of medical information between member states exist. They pointed out that there is no exchange of clinical data even within one country when patients move from one place to another, or between different health care settings (e.g. from a medical service in a refugee camp to a GP); this situation may exacerbate the loss of highly relevant information on the illness and treatment history of patients. Even in countries where computerized medical data systems do exist, different databases may not be connected and thus unavailable for consultation by care providers. Consequently care is often partial and fragmented.

Care providers working in reception centres and primary care need to gain information on the organization and access to specialised health care services such as mental health care, sexual and reproductive care, victims of violence care. They also stressed the importance of receiving specific training and guidelines on how to deal with particular vulnerable groups (e.g. persons with mental health problems, unaccompanied minors, victims of torture and sexual violence, women with genital mutilation, etc.).

They highlighted the need to be informed on available services and resources from other sectors (e.g.: housing, schooling, etc.) and to be involved in existing emergency plans to improve the health care response and access to health care for asylum seekers, including support for the implementation of a referral system for such patients. A tool for facilitating the collaboration between care providers would be the mapping of the different stakeholders acting in the field (international organizations, NGOs, national/regional health services, governmental agencies, etc.) and the creation of platforms for sharing the workload and expertise between and within countries.

It is also important that care providers have full knowledge of current legislation concerning refugees and asylum seekers, and the impact of different immigration status' on accessibility to healthcare services and the relevant administration processes (e.g. reimbursement/exemption of health care costs, etc.), as well as knowledge on laws concerning personal data protection, the universal right to health care and international treaties. Almost all interviewees and focus group participants highlighted the importance of training for health professionals, managers and administrative staff. The implementation of training courses on cultural competence is urgently needed in particular in those countries mostly affected by massive arrivals (e.g.: Greece) and those countries that are relatively new to immigration influxes, e.g.: Hungary, Slovenia.

The need to improve care providers competence is also highlighted in the literature review. A study (Ross, Harding, Seal, & Duncan, 2016) investigating healthcare professionals' views regarding improvements that could be made with migrants found that although most respondents reported that they were confident with immigration terminology, not all of them were aware that refugees have the right to full access to health care. According to WHO, care providers lack of knowledge on migrants related-health problems reflects an inability to manage the different health issues, including: communicable diseases, inherited conditions, chronic

diseases, nutritional deficiencies, and the effects of displacement, trauma, torture, or sexual abuse (Odunukan et al., 2015). Furthermore health professionals need to be trained to improve their cultural competence in providing care to very diverse populations. For these reasons further education on care providers is needed to overcome these barriers to health care.

Measures to address the barriers

In order to effectively provide care for refugees and asylum seekers care providers need to access relevant information. To this purpose the establishment of an information system has been envisaged, that would be able to monitor migrants entering in the health care system. Participants in the focus groups suggested that some kind of European or national cohesive IT system should be created to enable the storage of relevant medical information about asylum seeker and refugees. Migrants transit rapidly through countries and for files to be transferred with them may take many months. Therefore participants suggested a sort of passport or digital ID card that can be used to easily access medical information.

One study (Joels, 2008) reported that in UK the problem of poor communication between port health control units and local health authorities during assessments on point of entry in the country was addressed by introducing patient-held records for people seeking asylum. The study showed that the introduction of patient-held records helped to improve continuity of services and to standardise assessment. However, it seems that Patient-Held-Records is not necessarily the panacea to improve continuity of care. The results of a more recent study (Schoevers, 2011) conducted in The Netherlands show that the use of the Patient-Held Records was low, because it was not felt to be a solution by undocumented women and general practitioners.

Results from the literature highlight the need for coordination among service providers in order to reduce the complexity and overload of information and enable a more targeted exchange of information, thus ensuring continuity of care (Qayyum, Thompson, Kennan, & Lloyd, 2014). Coordination of care (Joshi et al., 2013) should involve: i) care planning, ii) informal communication between workers or services, iii) team meetings, case conferences, interagency meetings, iv) shared assessments and records v) coordination with non-health services including language services (interpreters, translated health information) formal settlement services, torture and trauma services and vi) referral pathways and inter-service agreements (Joshi et al., 2013).
Implementing additional support and training regarding refugee health needs on health-care workers could increase knowledge and confidence, reducing barriers to health care and improving quality of care. The improvement of staff skills could be achieved by increasing education on refugee and asylum seeker groups through training, education sessions and production of practical materials outlining available services and support (Ross et al., 2016). This is in line with the WHO report (Bradby, Humphris, Newman, & Phillimore, 2015), the main goal being to implement actions focused on staff expertise: the provision of interpreters; enhanced cultural competency training and enhanced inter-sectoral working.

Training and continuing education should be available to all health professionals and others who interact with migrants, including reception staff, managers, social workers, border guards, and detention facility staff. Specific trainings, during the course of undergraduate health professions education as well as in post-degree continuing education – as for instance cultural competence training programme for medical students - is emerging as a critical component to ensure migrant needs (Odunukan et al., 2015). The cultural competence (Nazzal, Forghany, Charis Geevarughese, Mahmoodi, & Wong, 2014) of care providers encompass' skills, development of knowledge, attitudes. Improving cultural competence would, on the one hand, enable providers to work in multi-cultural situations, while, on the other, increasing the continuum of care with migrants' services utilization and reducing the number of migrants dropping out of care.

In providing cultural competency training it is important to take into account the limits of this approach if its implementation is to be based on the assumption that culture can be reduced to a technical skill in which health staff can be trained in order to develop the relevant expertise. Research and experience in health care (Chiarenza, 2012) show that simplistic representations of culture and the mere description of cultural differences are by definition stereotypical and may not reflect the uniqueness of the individual. Therefore, no simple knowledge-based training in which providers are taught the customs and values of particular ethnic minority groups can prepare professionals to adequately respond to refugees' needs. There is no "one way" to treat any migrant, given the enormous intra-group diversity within these broad classifications.

In conclusion, the exchange of best practices, with concrete examples of successful strategies in European contexts on how to address problems/barriers to access health services or to gain financial support for migrant healthcare in different countries is recommended as an effective measure to improve the situation.

Successful examples

SH-CAPAC WP5 Training activities to develop refugee/migrant-sensitive health services by training health managers and health professionals

Granada, Spain

Service/department in charge of the measure

Escuela Andaluza de Salud Pública, Granada

Description of the measure

Online training course, that is part of the SH-CAPAC project "Supporting Health Coordination, Assessments, Planning, Access To Health Care And Capacity Building In Member States Under Particular Migratory Pressure" funded by the European Union's Health Programme (2014-2020).

The training contents have been selected and compiled in three tracks to meet the needs of the different participant profiles: *health Managers:* 15 units; *health Professionals:* 18 units; *administrative Staff:* 12 units. The training is delivered in an online format in English. Each unit has a balanced mix of theoretical and practical contents, focusing on theoretical presentations; problem based learning (case studies); experiential and analytic self-reflection.

Interactive online activities and group exercises complement the information provided. Additionally, participatory discussion sessions will be organised. During the course, trainees can post a message on the specific forum available for each Unit/Module and will receive feedback or answers to the questions from tutors.

Expected outcomes

Carry out comprehensive public health and health systems assessments of the impact of the migratory pressures and identify the response needed by the national health systems.

Implement tools for addressing the health needs of refugees, asylum seekers and other migrants,

Recognise available resources to improve access to health care and public health interventions for refugees, asylum seekers and other migrants in their territories and health systems, and

Increase competences to provide migrant sensitive health care.

Resources needed for implementation

Access to internet.

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6.5 Lack of information and continuity of care for refugees and asylum seekers

The problem

Migrants often lack the necessary information relating to access and to how hospitals and clinical services operate as well as relating to health issues generally in the specific local context. It is well known that low level of patient knowledge and information has adverse effects on effective utilisation of health services, patient adherence to the care process, self-management of health and access to care. Specific challenges for migrants include difficulties in navigating the health system, understanding explanations of treatments and ensuring fully informed consent, taking an active role in the care process, and accessing health education, health promotion and disease prevention programmes. On one hand, migrants experience difficulties in understanding points of access to the local health system and to managing health-related information; on the other the delivery of health care services may not be adapted to migrants' preferences and health providers may have a limited understanding of migrants' situation and health literacy needs.

Evidence on the barrier

The major issue identified by the relevant literature is the lack of knowledge on health resources and available services.(Fang, Sixsmith, Lawthom, Mountian, & Shahrin, 2015; Grant, Mayhew, Mota, Klein, & Kazanjian, 2015; Hadgkiss & Renzaho, 2014; Oktem, Akalin, & Gelgec Bakacak, 2016; Qayyum, Thompson, Kennan, & Lloyd, 2014; Simonnot, Chauvin, & Vuillermoz, 2016; Swe & Ross, 2010; Tastsoglou, Abidi, Brigham, & Lange, 2014; Torun et al., 2016; Wahoush, 2009). Refugees are not familiar (Swe & Ross, 2010) with healthcare systems and services as well as with the western appointment system.

Problems identified are the lack of provision of health service information upon arrival in the country, poor understanding of primary health care and referral pathways, and logistical difficulties in accessing services, including specialist services, dental care and preventative health services. (Hadgkiss & Renzaho, 2014; Swe &

Ross, 2010) Lack of information on how to access and navigate services are fuelled by language barriers, cultural factors, unfamiliarity with local places, as well as by a lack of confidence in using public transportation.

Information has a central role in health care and continuity of care for migrants, however it remains a delicate and complex challenge. For migrants, access to the health care system in general, and to health information in particular, is more difficult than for native residents (Norredam, 2011). Most of them rely on familiar, personal and neighbourhood networks they trust to acquire and understand health-related information, rather than on institutional sources which are often too complex to be understood. (O'Donnell, Higgins, Chauhan, & Mullen, 2008).

Educational resources and information programmes only partially reach people from migrant groups. This is often due to a lack of affordable second language courses for adults, creating a barrier for refugee migrants who wish to improve their literacy skills. New migrants lacking basic literacy skills, experience particular difficulty in becoming sufficiently health literate to seek and make sense of relevant health information and to navigate the needed services within the context of the EU health systems.

Language and cultural barriers may hinder refugees' access and utilisation not only of the health care services themselves, but also of health information available to them. Barriers to accessing written material are widely reported and the written information is perceived as insensitive to the cultural, linguistic and literacy needs of diverse communities. Translations of leaflets and educational materials do not help migrant patients who have limited literacy skills. Similarly, the use of interpreters to improve communication with low language proficiency patients may not be effective if the interpreter simply repeats complicated jargon-filled sentences to the patient.

Refugees find the information context complex and difficult to understand with the means they have, this limits information acquisition and thus participation in the care process, health promotion programmes and preventive health care services (Kreps, 2008; Qayyum et al., 2014). Numerous studies state, for example, that interventions aimed at increasing access to cancer screening, mental health services, diabetes education, smoking cessation, HIV programmes and child immunisation were less successful for migrant populations (Show, 2009; Simich, 2010). If health literacy, intercultural competence, diversity sensitivity and language assistance are not integrated, the services made available by health care providers may well prove to be unresponsive to refugees and other migrants.

Measures to address the barrier

It is fundamental, especially upon arrival in the receiving country, to provide refugees with health education, including information on how the health system works, if they have the rights to access health care, how to navigate health services and illness prevention with screening and vaccinations (Lee, Sulaiman-Hill, & Thompson, 2013). Evidence suggests possible interventions to ensure migrants are informed of health services to allow them to assume control over decisions and actions on their own health. Service providers need a range of strategies for the dissemination of information to migrants; these strategies may include provision of language-appropriate and migrant sensitive written material, the use of cultural mediators and/or community health educators to facilitate health promotion and education programmes (Lee et al., 2013). Empowering migrants through health literacy means making it possible for migrants to understand and use healthcare information to make appropriate health decisions.

Here follows a list of strategies to overcome this barrier preventing migrants from accessing health care. Each strategy that can be implemented consists of two components: the type of interventions and the communication channel used to reach migrants.

❖ *Type of intervention*

- *Environmental interventions*: effective interventions include the use of patient navigators, translated signage or pictograms, interpreters. Providing signage in migrants' languages would not only help refugee patients to find their way around the health system but also create a sense of belonging and inclusiveness.(Kickbusch I, 2013)
- *Educational and informational interventions*: to ensure information is accessible, comprehensible and useful for migrant/refugee patients, it is important to involve members of the target groups in the process of production and implementation of information material. While use of plain language is important in conveying messages, other means of communication such as images, pictures, graphic illustrations, audio and videos need to be considered in the production of materials (Kickbusch I, 2013). These interventions are part of the culturally informed care approach proposed by WHO for improving the health of migrants (Odunukan et al., 2015).
- *Specific health literacy strategies*. Engaging migrant users and communities in the planning, implementing and evaluating of educational and informational interventions, capitalising on all resources. (e.g. use of community health educators, link workers, intercultural mediators).
- *Health care provider training* can improve communication by taking into account simplified messaging and cultural sensitivity. Health providers should elicit information about health literacy and language proficiency that may affect people's ability to undertake health care.
- *Networking and intersectoral interventions:* health care services also need to form alliances with stakeholder organisations such as pharmacies, social work departments, schools, law enforcement and immigration, and voluntary organisations, to work towards the common goal of providing adequate information and support throughout the asylum seeking process (Kickbusch I, 2013).

❖ *Communication channels*

Several useful communication channels that may be used to reach migrants have been indicated by the literature review:

- *Information seminars/talks*

Information sessions, seminar presentations or talks in their own language, so this is familiar, possibly with an interactive approach in order to allow migrants to ask questions if necessary (Lee et al., 2013; O'Donnell et al., 2008).

- *Written materials*

Migrants perceive provisions of written material brochures, pamphlets and local community newspapers, as a good source of information. Articles should be multilingual, short and easy to understand. (Lee et al., 2013; O'Donnell et al., 2008).

- *Web-based information*

Social network websites have become popular among migrants to keep in touch with friends and family overseas. Many migrants also use computers as learning aids and an information source: computer technology contributes to disseminating information and to enhancing literacy (Lee et al., 2013). Television, videos, and other new media channels are considered as sources of information, especially for migrants with literacy barriers (Lee et al., 2013; O'Donnell et al., 2008).

- *Local networks*

For migrants, personal contacts at a local level are very useful to have health related-information: relationships, friends and social surroundings are very important for exchanging and gathering health information (O'Donnell et al., 2008). Early connections for migrant families and refugee with "secondary networks" - as for instance: national, ethno-specific, social and religious community groups - are very relevant for the dissemination of health information (O'Donnell et al., 2008). These small and informal networks are also essential to reach migrants at the urban quarter-level; they include neighbourhood based and stakeholder based networks.

Successful examples

A refugee relocation system: relocation of migrants from Italy and Greece to Malta as part of the European Solidarity

Service/department in charge of the measure

This measure is being implemented by the Migrant Health Liaison Office within the Primary Health Care Department, Malta.

Description of the measure

The Migrant Health Liaison Office delivers the programme to migrants who are relocated to Malta from Italy and Greece. Arrangements are made with the reception centre staff on receiving information about the migrants' arrivals from the Ministry of Home Affairs and Security. The programme is delivered in the reception centres since the newly relocated asylum seekers will not be familiar with the transport system and the location of towns and villages on the island. Furthermore, transport expenses may deter migrants from attending the programme.

Information is delivered in the form of a presentation and discussion and topics include: Culture Shock, an introduction of the health system in Malta, how to access healthcare services, entitlement, what services are available and where, availability of treatment, availability of medicines (over the counter medicine) and safe use of medicines, awareness of illegal practices, how to be responsible for your own health, health and safety issues, infectious diseases, how to prevent transmission of infections.

Expected outcomes

An understanding of the health system in Malta.
Appropriate use of healthcare services.
Having a reference point in the case of health concerns.
Familiarisation with the group to plan and continue with further health education sessions.
Providing a space for discussion to overcome barriers in future planning.

Achieved outcomes

Migrants have an understanding of the health care system and know where to ask for further information. They are given information about their entitlement to health care and the sense that their situation is being acknowledged.

Resources needed for implementation

A Training Centre in **all** reception centres with equipped with IT items and other logistics: projector, laptop, internet, stationery, flip charts, chairs, water dispenser, first aid items both for learning and in case of an emergency, etc.

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6.6 Lack of coordination between services

The problem

In many countries where a lot of care is provided by volunteers or by international NGO's, the quality of care may be not so high. Most of the international focus groups participants reported that the inappropriate response of the authorities and the presence of different actors in combination with a lack of organization and coordination produce a chaotic setting that has very bad consequences. Refugees receive differing and confused information about health care services so that they can't understand how to behave within such a complicated system. This is connected with the issue of lack of information for refugees but also with the problem of the circulation of information and health data between different institutions at different levels. Poor management of the refugee crisis in health care and lack of coordination between the different health providers, cause overcrowding in hospitals that could be avoided with better organization. This situation may also lead to care providers working with refugees suffering from burnout syndrome and compassion fatigue (see organisational barrier if there is repetition).

Evidence on the barrier

Many studies indicate that limitations in providing health care to patients is a result of chaotic organization and a lack of cooperation and integration between different agencies (Governmental and NGO); in certain countries a specific actor for coordinating this activity is not even identified. The abundance and variety of service providers can, in itself, cause problems as the complex relationships between organisations can lead to confusion for refugees. (Qayyum, Thompson, Kennan, & Lloyd, 2014).

Lack of cooperation between health care providers can also lead to dysfunctions and confusion in service delivery. Focus group participants mentioned that there are a large number of different health professionals and volunteers working in health care services. The variety of random workers with different professions, backgrounds, work attitudes, knowledge and skills (the majority with no previous training in the field of migration and health) also creates great challenge to health care coordination. In this situation, where there are new health care workers on the spot every day, consistent team work is almost impossible, the working process was reported to be harder to organize, and having control over it was felt to be unimaginable. The current gap in coordination between different care providers not only creates confusion in the division of roles, but also produces a waste of human and financial resources (IOM - International Organisation for Migration, 2015b).

Lack of collaboration between social and health services hinders the identification of effective solutions to improve the living conditions and health of the refugees. Refugees were reported to rely on health care services to solve a number of problems that are clearly situated in the social domain. Issues of housing and administrative problems are often presented to health care providers as they seem to be the single point of contact with the host society.

Lack of policy coordination is another important challenge because it is strictly linked with the possibility to access to health care (Ignacio Correa-Velez*1, 2005): in many cases there is no coordination model in place that defines roles and responsibilities of the major stakeholders in taking care of refugees. This is also a very complex issue because there are multiple elements to coordination: participants, coordination structures, budgeting and money flows, and information.

Lack of coordination between different sectors (legal, employment, shelter, water and sanitation, health, social and education sectors...) is a consequence of the previous point and it causes difficulties in implementing inter-sectorial interventions that are more efficient and can reduce the waste of resources. For example, various obstacles to more active cooperation between public health and law enforcement authorities result in back and forth transfer of responsibilities without much getting done. At the same time local hospitals are unable to keep up with demand as they are in fact the only officially sanctioned health care service available to migrants. Doctors reported difficulties in obtaining accurate and timely medical information on migrants from NGO and others previous care providers (IOM - International Organisation for Migration, 2015a).

Measures to address the barrier

Both research and experience in the field highlight that a partnership with a wide range of actors, especially government, UN and international agencies, non-governmental organisations, academic institutions and the private sector is necessary to ensure the availability of quality public health services for refugees.(UNHCR - United Nations High Commissioner for Refugees, 2011) Since coordination of care between multiple providers and services has the aim of achieving improved quality of care for patients, the first step is to improve formal access and ensure entitlement to access to services for all groups of migrants throughout the different phases of the migration trajectory in a common and coherent way.

An integrated approach to policy development, planning and to the delivery of services is an effective solution to improve coordination of services both between agencies and vertically throughout the various levels of government (Feldman, 2006). This coordination begins at the planning stages of service delivery, in particular, there is a need for structured coordination of health and social welfare services for the resettlement of refugees in regional and rural areas (Duncan, 2007). One study (McDonald, Gifford, Webster, Wiseman, & Casey, 2008) recommends the development of a 'well-planned, well-integrated and well-resourced' approach which aims at long-term sustainability of refugee communities. A factor that is critical for success is the establishment of a coordinating agency, for instance local government as a lead coordinating agency (Qayyum et al., 2014).

Shared and horizontal protocols involving multiple sectors and levels ensure coordination and quality of care (IOM - International Organisation for Migration, 2015a). This measure makes it possible to define specific agency roles and responsibilities during the entire reception process. For example, close coordination between education and training services and employment services, and between refugee health and community services, along with "well-defined referral pathways can yield multiple beneficial results, including cost savings" (McDonald et al., 2008).

The creation of a network for the exchange of information and good practice between all structures and services working with migrants improves the collaboration between health care workers of different agencies. The first step is to be aware of all other actors involved in providing care to refugees, for example by maintaining a shared list of all health care providers, as volunteers keep changing and doctors do not know the people in the different NGO's. A clear and defined communication strategy is also important to be able to connect all actors and engage them on the same mission (UNHCR - United Nations High Commissioner for Refugees, 2011)

Standardised inter-institutional operational procedures are another important measure that would ensure that health provision for migrants is incorporated into general health system planning and strategy documents at a local level (Norredam, 2016). They constitute a set of step-by-step instructions that define the roles, responsibilities, guiding principles and procedures to help organizations and workers carry out routine

operations: this measure aims to improve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply to industry regulations.

"Technical round-tables" are another facilitating factor to create and maintain coordination and to share experiences and good practice. The exchange of information and data between different actors is a focal point to ensure coordination and continuity of care. Migrant refugees need to be involved in these discussions in order to involve migrants in the identification of barriers and solutions with the aim of better coordinating actions. Intercultural mediators or other mediating professionals, such as community health educators, could have an important role in facilitating the discussion.

The existence of an intersectorial strategy is a key factor to guarantee coordination between sectors and actors involved in providing health care to refugees (Norredam, 2016). Moreover the development of a coordinated system of care could also mean improving communication between the different levels involved, between different institutions and between different structures and stakeholders.

Additional measures to favour coordination could be informal communication between workers or services, team meetings, case conferences with multidisciplinary team, interagency meetings, shared assessments and records, round tables with non-health services including language services (interpreters, translated health information), formal settlement services, torture and trauma services, referral pathways and inter-service agreements (Joshi et al., 2013).

Successful example

Technical roundtable
(Seville, Spain)
Service/department in charge of the measure
Directorate General for the Coordination of Migratory Policies.
Description of the measure
Establishment of a technical roundtable composed of healthcare counselling centres together with social organizations working with refugees.
Expected outcomes
To identify actors involved in a possible massive reception, specifically targeting healthcare services
Achieved outcomes
The measure was promoted by the organization and supported by the management. There is no shared opinion between the Ministries on the need to rely on the specialized organizations. Refugees' healthcare overlaps with other migrant's healthcare, and there appears to be some reluctance to take refugee issues fully on board.
Resources needed for implementation
Maximum involvement is stressed**.**

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7 Guidance on addressing barriers to access to specific health care services

7.1 Barriers to accessing appropriate mental health services

The problem

Focus group participants working in arrival camps reported that they meet a huge number of refugees with mental health problems in need of psychosocial assistance and support. Rates of post-traumatic stress disorder, anxiety and depression in these groups are especially high. This is due to the situation and traumatic experiences they encountered before and during their journey, for example, many females seeking asylum from war-torn countries have been raped. Wider problems also include concerns about confidentiality, racism and xenophobia. To make it worse, repressive police and army actions (unexpected replacement of people, officers carrying weapons, police helicopter flights etc.) further stimulate re-traumatization among refugees, which resulted in the need for many interventions of health care workers and volunteers that could be have been avoided.

Furthermore, extended asylum procedures, particularly when involving detention or the threat of detention or deportation often lead to psychiatric disorders. Literature shows that fear of jeopardizing an asylum application and social taboos can inhibit the disclosure of psychological symptoms. Even where permission to remain is granted, general stressors in the post-migration environment linked to social determinants of health, such as poverty, violence and threats, racism, acculturation stress and loss of family and friends, can damage health. In particular, structural features, such as insecure asylum status, financial difficulties and discrimination affect children and unaccompanied refugee minors (Bradby, Humphris, Newall, & Phillimore, 2015).

In spite of all this, it has been reported that there are no appropriate professionals (psychologists, psychiatrists, therapists etc.) in arrival camps who can adequately address refugees' needs. When there are, however, these professionals are not always able to perform their activities due to a repressive police approach, which is at the forefront of work organization in arrival camps. As a result many people waiting to get medical help do not actually need it, but are in extremely hard circumstances only looking for support, human contact, information, food, water or dry clothes and shoes.

Similarly, there is no adequate care addressing the mental health needs of asylum seekers that are transferred to the asylum centre. Special care, including psychotherapeutic care, can in some countries be covered, but only within a limited range to so-called vulnerable persons with special needs (disabled people, the elderly,

pregnant women, single parents with minor children, victims of trafficking, persons with mental health problems and victims of rape, torture or other serious forms of psychological, physical and sexual violence) and on condition that a special commission approves it. Despite the fact that there are psychologists employed in some centres for asylum seekers, there are no generally accessible specialist therapies for traumatized refugees. They may be able to access them only if a general practitioner writes them a referral, which is conditioned by many barriers (long waiting periods, lack of translators/intercultural mediators, lack of cultural competent specialists etc.).

Evidence on the barrier

The available literature suggests that one of the main themes in the delivery of mental care to refugees is communication (Jensen, Norredam, Priebe, & Krasnik, 2013). Language especially in the context of mental health represents one of the main barriers: emotions, fears and feelings are more difficult to explain compared to other types of clinical symptomatology particularly when the language is lacking. This theme includes considerations related to the use of interpreters, but also that communication with patients entails more than simply speaking the same language.

From a linguistic and cultural point of view, mental diseases represent a taboo for many communities and cause stigma and humiliation; in some contexts it's not even clear what mental health care involves, and there are different perceptions about the meaning of mental diseases. The stigma of mental illness within many refugee communities may provide a barrier to seeking mental health services, as in some cultures, mental illness is considered a taboo topic and is not openly discussed (Ellis, Miller, Baldwin, & Abdi, 2011).

Cultural factors have been reported as potential barriers in mental health service provision, many studies have shown that not being able to recognize mental health problems acts as a significant barrier to accessing mental health resources and lead to underutilization of mental health services. Cultural dissonance between refugee patients and service providers, for example, may create a barrier to access mental health services. Medical practitioners may be perceived as inflexible and insensitive to patients' needs, rushing through the consultation, thus preventing the development of trust and a rapport between doctor and patient (Thomson, Chaze, George, & Guruge, 2015; Wohler & Dantas, 2016).

The organization of mental health care interventions suffers because of the lack of knowledge concerning referral options, difficulties with transport, rigid appointment systems, lengthy waiting lists and delays before accessing specialists represent a common hindrance to accessing these services (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Wohler & Dantas, 2016).

Mental health service systems and refugee resettlement services typically are delivered by different agencies and with relatively little connection. Limited continuity of care and fragmented service delivery are identified as barriers to engagement: referrals to mental health services were seen as problematic and this reflects in the drop out ratio from care. Patients with psychological problems are often bounced between inpatient and outpatient services, but the lack of coordination in referral systems causes interruptions in care. In addition to this, refugee clients may not understand why they have been referred to a specialist service (Colucci et al., 2015). Lack of flexibility and responsiveness in the system, transfer of information between units, detachment between the patient and treatment initiatives, and coordination with social services is reflected in discontinuity of care.(Jensen, Johansen, Kastrup, Krasnik, & Norredam, 2014)

Measures to address the barrier

The negotiation of a shared understanding of the concepts of mental health, illness, and treatment has emerged as being essential in various studies. For this reason, clinicians should work with the patient, his/her family, and intercultural mediators to develop a shared understanding of the present difficulty and the meaning of symptoms (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014). Some authors (Colucci et al., 2015; Ellis et al., 2011) observed that partnerships between mental health service providers, communities, and religious organisations can open pathways to mental health care, and improved service relationships between physical and mental health services has also been found to be important.

Research suggests the need for linguistically and culturally sensitive services and this means changes in the training of practitioners, practitioner behaviours as well as changes in service delivery (Thomson et al., 2015). Mental health workers should be trained in cultural and language competency, with a more sensitive approach in order to be able to reach migrant perspective. Providers of mental health to migrants require cross-cultural communication skills to work with culturally different immigrants across age groups and considering migration experiences (Thomson et al., 2015). Alternative approaches to traditional mental health services, such as the employment of a strength based narrative methodology, being youth-friendly, approachable, non-judgemental, respectful, and compassionate and taking an "informal" approach have proved to successfully overcome barriers due to perceived stigma and lack of knowledge about what is on offer (Colucci et al., 2015).

Working with interpreters and cultural mediators is necessary to be able to offer mental services, however, problems may arise when these professionals belong to the same ethnic or cultural group, as patients may be particularly concerned about confidentiality (Ellis et al., 2011; Thomson et al., 2015). Therefore, in selecting interpreters, mental health professionals should consider gender, age, dialect, and cultural factors such as dynamics between different ethnic groups. Asking migrants for their preferences for interpreter use at the outset and considering the need for professionally qualified interpreters and defining interpreter confidentiality are key elements to ensure trust and confidentiality, especially in the context of mental health.(Colucci et al., 2015).

In order to reduce organisational barriers, literature and experience suggest that mental health services should be accessible by public transport, preferably be discreet and "out of sight", user-friendly environments, including drop-in and outreach services. Furthermore a flexible approach to appointments is indicated to be successful with new migrants who have difficulty understanding boundaries and systems in formal settings (Colucci et al., 2015). Other authors have suggested the involvement of intercultural mediators, advocates, or brokers to ensure appropriate referrals and access. Similarly effective are strategies aimed at taking services out of the clinic to places that people are familiar and comfortable with, and that do not carry the stigma of mental health settings (Hughes, 2014). Locating services within service systems that are trusted and highly accessed by refugee families and youth, such as schools, is a powerful approach to diminishing the stigma associated with mental health services (Ellis et al., 2011).

An integrated approach to mental health service delivery has been suggested by multiple authors arguing that mental health services should build direct relationships with refugee communities and the wider social service system, including settlement programs (Colucci et al., 2015). Strengthening the collaboration and co-ordination between different services by disseminating information on services both to the marginalised groups themselves and to health care practitioners in the area has also proved to be successful (Priebe et al., 2012). Establishing partnership between mental health services, local schools and refugee serving agencies and marketing clinical services, for example, has proved to be an effective strategy to overcome the numerous

access barriers. Finally, by creating a system-wide, collaborative, integrated model that recognises and addresses critical clinical and economic aspects in the delivery of services, high quality, evidence-based care can be made available to groups susceptible to the burdens of mental illness(Grazier, 2008).

Successful example

Psychological intervention guide for direct assistance to migrants and refugees
(Seville, Spain)
Service/department in charge of the measure
University of Sevilla**;** University Complutense of Madrid; Psychologist of the World organization; Official College of Psychologist in Spain
Description of the measure
A guide was created to illustrate psychological issues present in migratory processes by involving health providers and different institutions.
Expected outcomes
To contribute through a psychological perspective to the current humanitarian crisis.
Achieved outcomes
It was introduced during the current year, thus it has not yet been evaluated.
Available at: https://www.ucm.es/data/cont/docs/315-2016-06-02-g.refugiados_PDF.pdf

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7.2 Barriers to accessing appropriate sexual and reproductive health services

The problem

Access to sexual and reproductive care depends on the regulations of the single country. Migrants face different legislative and bureaucratic barriers to accessing sexual and reproductive health services. In some countries they are entitled only to emergency care. There might be limitations regarding sex and age or pregnancy status, etc., while in other contexts undocumented migrants cannot access health care at all. In addition there is a general lack of knowledge among health-care workers, who ignore the legal framework and the respective entitlements.

A group of experts gathered in the workshop conducted in the LHU of Reggio Emilia agreed that there are many issues surrounding sensitive topics: abortion for instance is free in certain countries, in others it requires parents' permission, and based on the political context it may become an illegal service, for which physicians may even incur in some kind of punishment. Decentralization of regulations 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 free fertility care. There is a huge debate as to whether the latter should be considered as an essential service or not. On linguistic and cultural barriers, the group of experts mentioned the lack of cultural mediators in hospitals and no specific academic curricula for mediators.

Evidence on the barrier

Limited access to sexual health services and reproductive services, such as cervical and breast cancer screening, antenatal, delivery and postnatal care, abortion, limited knowledge about contraception, sexual health or sexually transmitted infections, acceptance of fertility services, as well as lack of recognition of post-natal depression are among the major issues experienced by migrant women identified in the systematic literature review.

A recent review (Keygnaert I et al., 2016) identified affordability as the major barrier to access maternal health-care. The exclusion of migrants from legal frameworks often means that these populations can only access health care services if they have the financial means to do so. The situation regarding financial costs for maternal health care varies among European countries; in certain countries child delivery in a hospital can be very expensive.

The legislative barrier is a second important barrier hindering access to sex and reproductive care for refugee women. Research shows that lack of legal documentation creates barriers to access family planning programmes, leading to delayed prenatal care (Keygnaert I et al., 2016). From the health-care workers side, the lack of information on legal issues reflects on difficulties in determining what level of service they can provide to each migrant.

Linguistic and socio-cultural barriers have been reported as having a negative impact on the quality of women's health care. Suboptimal care is often associated to miscommunication, lack of professional interpreters (Yelland et al., 2016), and limited knowledge and information on sex and reproductive care (Keygnaert I et al., 2016). In sexual and reproductive care the interweaving of language and socio-cultural factors is more evident, different understandings of the body parts, as well as the gender role, could become issues in childbirth and parenting. For instance, most migrant women are resistant to common gynaecological and

obstetrical care practices and prefer to give birth at home with the assistance of family and they can have misconceptions on the western/conventional clinical approach in managing pregnancy and delivery. One study indicated (Brown, Carroll, Fogarty, & Holt, 2010) that Somali women may have aversion to caesarean section, because of fear of death and resistance to other obstetrical interventions. Last but not least, pregnancies in migrant women have frequent complications, among these diabetes mellitus, hypertension, infectious diseases (HIV, Hepatitis B) as well as the lack of immunization coverage for relevant infections in pregnancy (Correa-Velez & Ryan, 2012).

In general, lack of information and familiarity with the health system (Tobin, Murphy-Lawless, & Beck, 2014) hamper access to sexual and reproductive care (Riggs et al., 2012). Migrant women do not know how to navigate the health system and are often unaware of their rights and of the available services, in addition they have limited access to transportation, lack of confidence in speaking in the language of the arrival country and making phone bookings for clinical appointments (Riggs et al., 2012). Not only refugee and asylum seeking women lack knowledge of sexual and reproductive services, they may also not have had health education regarding the importance of such services (Sudbury & Robinson, 2016).

A study conducted by United Nations High Commissioner for Refugees (UNHCR) and the Women's Refugee Commission shows that awareness of family planning methods and the use of contraceptives is very low among refugee women. Furthermore, the literature identifies a significant lack of knowledge regarding cervical cancer and screening practices. For example only few participants included in one study (Haworth, Margalit, Ross, Nepal, & Soliman, 2014) reported ever hearing of a Pap test and ever having one. Similar findings have been retrieved for breast cancer screening in migrants (Percac-Lima, Ashburner, Bond, Oo, & Atlas, 2013; Percac-Lima, Milosavljevic, Oo, Marable, & Bond, 2012).

Regarding organizational barriers, expert participants at the Reggio Emilia workshop reported that problems arise when there is a lack of concordance between the gender of the health care provider and the patient, and when there is a lack of coordination between services, between health services and NGOs and community services. For instance, experts agreed that lack of collaboration between services may hinder access to health care when there is a lack of dialogue between mental health services and sexual reproductive health departments, as well as the lack of collaboration between public and private health care providers and the lack of communication with social and education sectors.

Measures to address the barrier

Scientific evidence is abundant on migrant sexual and reproductive health-related issues, but it is scant in providing solutions. In the literature few studies specifically focus on possible interventions and although efforts in high-income countries to increase access to appropriate sexual and reproductive health care services are reported, not enough changes have been observed over time. (Yelland, Riggs, Small, & Brown, 2015).

A synthesis report (Bradby, Humphris, Newall, & Phillimore, 2015) indicates that provision of full health coverage for all pregnant women and for children regardless of immigration status is the first important step to ensure equal access to health care. Secondly, it is indispensable to ensure accurate information on available maternal health services and rights to access them. Strategies such as promoting and investing in family planning can be effective ways to improve migrant women's health and prevent unintended pregnancies (Keygnaert I et al., 2016). The recommendations developed by United Nations High Commissioner for Refugees and the Women's Refugee Commission, stress the importance on the one hand, of promoting global advocacy to ensure a full range of family planning methods, including emergency contraception are available

in settings of displacement, and, on the other hand, of enhancing information and acceptance of family planning methods among refugee women (UNHCR - United Nations High Commissioner for Refugees, 2011). It is also important that all relevant information and education around sexual and reproductive care should take into account the socio-cultural dimension of migrants and their relevant health literacy needs (Keygnaert, Vettenburg, Roelens, & Temmerman, 2014).

Tailored community based services delivered in primary care setting involving MDs, cultural mediators, health educators, midwifes and other health care workers at the community level would enhance the possibility of building a relationship with caregivers and would offer women greater continuity of care (Tobin et al., 2014). Direct access to midwife care within the community for women who are asylum seekers and refugees is indicated as a key strategy which helps to identify women earlier, reduce non-attendance rates and build partnerships in care (Briscoe & Lavender, 2009). Midwife counselling in providing information, education and care plays a vital role both for women and new-borns (Briscoe & Lavender, 2009; Sudbury & Robinson, 2016). Furthermore, the implementation of community midwifery teams in UK proved to be successful in responding to refugee women's complex health and social needs by multidisciplinary working, establishing links with emergency care, sexual health, NGOs, and housing associations (Sudbury & Robinson, 2016).

Most research strongly supports the need to provide "culturally competent" care. This requires specific training, service adaptation and guidelines for health care providers (Haith-Cooper & Bradshaw, 2013). It also implies involving migrants and their communities in service planning and development, and facilitating interactions between service users and health professionals.

The use of intercultural mediators, or similar intermediaries, such as community health educators and link workers, has proved to be very useful in helping migrant women to navigate the system, understand health information and effectively utilise the available services (Yelland et al., 2016). Some countries implemented university courses for mediators focusing on sexual and reproductive health (e.g. Female Genital Mutilation). In the context of maternity care a potential solution included community and language-specific groups of pregnancy care combining antenatal services with support provided by multi-professional health care workers and qualified interpreters (Yelland et al., 2015).

Educational aids as well as the provision of language support should be delivered with a culturally sensitive approach in order to improve migrant maternal and sexual health and to respect their social, psychological and cultural backgrounds respectively (Keygnaert I et al., 2016). The need to provide for effective health education/promotion and preventive programmes to migrant communities has also been stressed by experts participating in the workshop in Reggio Emilia. To this purpose the role of community health educators was emphasised in providing information and education activities at the community level, and connecting migrants with health services.

The health network approach, and the organisation of mothers' groups for social contact and information exchange proved to be successful to overcoming access barriers (Goosen, van Oostrum, & Essink-Bot, 2010). The provision of information material in several languages on maternal issues - induction of labour, epidural analgesia, caesarean section and breastfeeding - as well as the availability of trained interpreters are considered essential (Tobin et al., 2014).

Finally, further research to support migrant women's needs and experiences are necessary to fill the knowledge gaps on reproductive health as well as problems related to pre- and postnatal care in addition to migration issues (Balaam et al., 2013).

Successful example

ZANZU: MY BODY IN WORDS AND IMMAGES

Country of development

Belgium and Germany

Service/department in charge of the measure

Zanzu is created by Sensoa, the Flemish Expertise Centre for Sexual Health, and BZgA (Bundeszentrale für gesundheitliche Aufklärung), the German Federal Centre for Health Education.

Description of the measure

Zanzu is a website that helps both professionals and patients to communicate in their own/different language(s) through translation about sexuality, their body, health, relationships, legal information… The website is a support tool and provides tips for talking about sexuality in a multicultural context.
It has been developed in 12 different languages

Expected outcomes

To overcame linguistic barriers and to help patients in their relationship with health professionals.
To increase the level of information and knowledge of patients.

Resources needed for implementation

IT support and technical skills

Available at: http://www.zanzu.be/en

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7.3 Barriers to accessing appropriate health services for children and adolescents

The problem

Refugee children and adolescents are one of the most vulnerable groups in Europe, some of them have fled persecution or war, and others have run away from poverty and destitution. There are also those who are victims of trafficking. For these reasons, mental health conditions such as post-traumatic stress disorder (PTSD), anxiety and depression are frequent (Woodland, Burgner, Paxton, & Zwi, 2010). Among them, unaccompanied refugee children and adolescents are particularly at risk. They live not only in a relatively difficult situation as minor refugees staying in another country, but also face other risks due to the absence of their parents, such as traumatic experiences, exploitation or abuse (Derluyn & Broekaert, 2008).

In EU asylum seeking children have a right to equal access to healthcare under the same conditions as children residing in the Member State where the application for international protection is lodged (Abbing, 2011). However, those who are separated from their families and have no - or only temporary – residence permits are at risk of becoming undocumented children. These children can be minors arriving in Europe to be reunited with their family but not falling under the official family reunification schemes; those who entered with one or more relatives irregularly; or children born in Europe but whose parents are undocumented. They can also include minors who are sent by their families to Europe in search of better conditions or who have run away, and are therefore alone, but who prefer to keep outside the reception circuits for unaccompanied minors and are invisible to social services. As stated in PICUM's report (PICUM - Platform for International Cooperation on Undocumented Migrants, 2008) undocumented children encounter enormous difficulties in accessing a high standard of health care, in terms of bureaucratic impediments, lack of adequate information and the fear of being caught.

Evidence on the barrier

The research highlights the need to prioritize support for children and adolescents health needs, in particular those related to mental health following traumatic experiences, such as forced migration. Service-related barriers, low priority on mental health, poor mental-health knowledge, stigma, as well as several social and

cultural factors have been observed as barriers (Erminia Colucci, Szwarc, Minas, Paxton, & Guerra, 2014). Furthermore there is little information available on barriers and facilitators to mental service for adolescents. One study identified 8 key themes: "concepts of mental health, illness, and treatment; service accessibility; trust; working with interpreters; engaging family and community; the style and approach of mental health providers; advocacy; and continuity of care."(E. Colucci, Minas, Szwarc, Guerra, & Paxton, 2015).

As regards legal aspects, age has important consequences for young asylum seekers: in particular, it influences access to health care, to education and determines the possibility for family reunification if under 18 years. Many international and national policies for asylum seekers and refugees grant young people under the age of 18 more protection and support (Chiumento, Nelki, Dutton, & Hughes, 2011). Where the age determination of unaccompanied asylum seekers involves medical examinations[5], human rights play an important role. Lack of common practices as regards age determination conflicts with the principle of providing equal access to protection throughout the European Union (Abbing, 2011).

Methods for assessing the age of unaccompanied children and asylum seekers - without official documents proving age – are different across Europe, they include in most countries an interview and visual evaluation, while in other cases medical examinations - radiographs of skeleton and or teeth, anthropometric measurement and sexual development measurement – are performed (Hjern, Brendler-Lindqvist, & Norredam, 2012).

In one study (Human Rights Council, 2010) the Office of the United Nations High Commissioner for Human Rights (OHCHR) highlights that the legal status of migrant parents may affect access to health care by migrant children, particularly if their parents are in an irregular situation and are, therefore, reluctant to seek health care for fear of their immigration status being detected. A particular area of concern is when such children are unable to access to vaccinations in a timely manner.

Lack of information on the rights to health care is a barrier for refugee children as well as adult migrants. Parents often are not aware of their children's right to access free health care or free education. Refugee children can have interrupted education and this reflects on language transitions affecting their development, learning and socialization. Finally, formal and informal barriers affecting access to health care for all migrants also impact on refugee children and adolescents' care. Thus, the inability to navigate the health system, perceived high cost, negative prior experiences with providers, no interpreter support, no means of transport and insurance problems as barriers to care for mothers looking after an ill child have been experienced by refugee children (Wahoush, 2009).

Measures to address the barrier

In literature, several interventions to overcome these barriers are described, including effective health promotion programs and prevention strategies, communities and NGOs engagements, as well as information and education of health-care workers on refugee children and adolescent health-related issues. NGOs often assume an important role in ensuring that the refugee community benefits from services and in filling the gaps, which cannot be covered by government. Furthermore, NGOs collaborate with the health and social

[5] The medical examinations consist of anthropometric methods, including measurement of the puberty development or radiological examinations, dentition, non dominant hand and wrist (most commonly applied), the medial ends of both collarbones (less usual).

services to inform refugees on how to access and navigate services, to organise language courses for women and children, to provide interpretation services and arrange psychological support for women and children (Sandliki, Torun, Karaaslan, & Acar, 2016).

The available literature supports the need for implementation of effective health promotion interventions, including: community participatory and focus groups, participation of refugee nurses, peer educators, health education sessions and reorienting of health and family services. For instance, possible solutions applied in the field of dental care have been identified: intensive health promotion and education campaigns on parents through ethnic media and social networks to encourage utilisation of a new clinical service for refugee children in a targeted group of refugees from Sub-Saharan Africa resulted in significant changes in parental knowledge, attitudes and beliefs on infectious diseases after attending the clinic, including decreased stigma around tuberculosis and more knowledge on immunizations (Sheikh & MacIntyre, 2009).

Also the provision of information for both refugee children and staff plays a central role. In one Swiss hospital a "migrant kit" (Ratnam, Crisinel, & Simeoni, 2016) was proposed for residents and staff in outpatient and inpatient units, it included material regarding asylum seekers' itineraries in the country, social support available, medical guidelines, tools for community interpreters, etc. The tools proposed in this kit contributed on one hand to a more equal access to migrant children's healthcare in Switzerland, and on the other it assured more tailored care for each child (Ratnam et al., 2016).

Although research on interventions facilitating communication between migrant children, youth or families with minority language background and services is scant, a recent review (Wollscheid, Menzies Munthe-Kaas, Hammerstrøm, & Noonan, 2015) on this topic found that the use of interpretation services (in-person interpreter, telephone interpreter, ad hoc-interpreter) or bilingual personnel have a positive effect in facilitating communication (Wollscheid et al., 2015). In conclusion the main implication of these studies is the demonstration of how enhancing refugee children, adolescents and parents experience and knowledge can reflect with improvement in their quality of care.

Successful example

Child and adolescent psychotherapy
(London, UK)
Service/department in charge of the measure
Refugee Therapy Centre
Description of the measure
The Centre provide psychotherapy and associated treatments to people who have been tortured, giving priority to children. The Centre receives referrals for children and young people from schools, colleges, refugee community organisations, social services and health professionals. In order to meet the needs of children, two booklets, "Information for Parents" and "Information for teachers" were provided, on the belief that if children and families are helped early enough, much needless emotional suffering and difficulty in later life may be prevented.
Professionals working at the Centre address the needs of the individual child, working through past experiences, providing support to tackle current difficulties and rebuilding confidence and self-esteem which helps children to make a positive contribution to their new environment. A psychodynamic or psychoanalytic approach in assessment and treatment is used primarily.
Expected outcomes
To offer children to insight into their problems and to provide them with a space for their own sense-making,

helping them to verbalise feelings which they may have feared or suppressed through aggressive or harmful behaviour, working through their experiences in a safe and supportive environment.
To support children and their families to tackle this experience and to prepare themselves to psychological consequences.

Achieved outcomes

Enabling children to understand their experiences and feelings helps to relieve their distress and enables them to make positive changes. The Centre focuses on the need to contextualize projects and to give greater attention to ethnographic needs. This assures greater resilience and sustainability and closer and social and cultural adaptation for the community that we set out self to serve.
Working with families and communities in an effort to restore social structures and a sense of normality is a key factor of this experience.
Need to have access to in-depth information about refugees children's cultural environment, the nature of trauma they have endured and family dynamic is an important issue to carry on.

Available at: http://www.refugeetherapy.org.uk/

Other resources

https://refugeportal.wordpress.com/best-practice-guidelines/

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7.4 Barriers to accessing appropriate health services for the victims of violence

The problem

A refugee's experience of trauma and displacement may present challenges to clinicians who are unfamiliar with refugee trauma and its clinical consequences. (Crosby, S. 2013). Refugees are often exposed to physical, mental and emotional torture in their native countries and a large number of women and children face violence and mental or sexual abuse during the migration travel. Post-traumatic stress disorders and major depression are the most common psychiatric conditions in refugee populations. Torture and other forms of violence continue to have a psychological impact on the lives of refugees in their host countries and are critical factors hindering access to appropriate health and social care (Alayarian, 2009).

Sexual and gender-based violence (SGBV) is also a significant problem among refugee populations. Although the majority of people who experience SGBV are women, boys and men are also targets. Reports of sexual violence against women are now emerging from Syria. Sexual and gender-based violence has important consequences such as genital injuries, sexually transmitted infections and HIV infection, unwanted pregnancy, forced abortion, infertility and long-lasting mental illness (Keygnaert I et al., 2016). Not only has SGBV significant clinical consequences, it may also trigger social stigma and even ostracization of women from families and/or communities.

Evidence on the barrier

In general, torture and SGBV survivors are often reluctant to seek treatment because they fear social stigmatisation, discrimination and further social isolation by community/family members. As a consequence, victims of violence may communicate a range of nonspecific health problems in order to avoid disclosing information about their actual experience.

Cultural and language barriers may also impact upon the individual and prevent them from discussing their needs. For this reason, clinical encounters are often complicated by inadequate communication between health provider and patient. Telling torture history is very difficult and painful for victims, explaining personal details and recalling the abuse is even more difficult if the listener does not share the patient's language. Furthermore, cultural differences, such as different ways of understanding mental illness and healthcare systems, increase communication barriers (Crosby, 2013).

For the issues described above, one of the most important barriers to access to health care services for torture victims is the lack of trust between clinician and patient. Due to the refugee's perception of discrimination based on legal status, the common refugee fear of being arrested or deported on the basis of his/her past experiences or personal information, lack of trust is an obstacle to obtaining adequate knowledge of the refugee's history and sufficient data in order to detect physical and psychological symptoms related to past traumatic experiences during the primary care visit (Alayarian, 2009).

Obstacles to establishing a trustworthy rapport, language and cultural barriers, emphasise the need to provide care for this particularly vulnerable group with appropriately trained staff. In most cases, neither health practitioners nor cultural mediators and interpreters are trained to talk about violence. Health providers often operate without specific knowledge or validated tools for the evaluation of psychological symptoms and mental

disorders (Asgary & Smith, 2013). Moreover, for psychologists, it is difficult to conduct therapy with a victim of violence through an interpreter who may not be sensitive to the issues of torture and sexual abuse. (Asgary & Smith, 2013).

The lack of coordination between health services, NGOs and local authorities and the lack of a formal network impede the development of effective interventions and the possibility to ensure global treatment for torture victims. One barrier to the effectiveness of resources identified is the absence of specific measures that meet the needs of women victims of violence, such as rapid processing of work and residence permits. The additional difficulties faced by some migrant women, such as lack of social support or economic resources, imply greater obstacles to their empowerment through access to employment and housing. (Briones-Vozmediano, La Parra, & Vives-Cases, 2015).

Finally, the lack of legal frameworks preventing sexual violence and clarifying migrant women's legal status often creates barriers to seeking help and health care. The absence of legal context often puts migrant women at risk of further exploitation and abuse when seeking help in the aftermath of sexual victimization and inhibits their access to health care (Keygnaert I et al., 2016). Furthermore, lack of entitlement and clinical documentation prevent health professionals from effectively utilising information from previous psychological and physical evaluations, thus jeopardizing the success of primary care.(Briones-Vozmediano et al., 2015).

Measures to address the barrier

Since the experience of sexual violence or torture often leads to social stigma and prevents survivors from seeking help from routine mental health services, it is vital that an integrated and sensitive approach is developed, that incorporates mental health services in primary care clinics or in community based-services (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). Developing an integrated, sensitive approach to mental health care that considers the interrelationship of individual, family and community and the interconnection of physical, psychological and social problems has proved to be an effective strategy to ensure adequate care for this vulnerable group (Crosby, 2013).

Staff with specific competences is fundamental to respond to the needs of survivors of torture and sexual violence in an appropriate and sensitive manner (Hassan et al., 2016). To this end it is necessary to train a new breed of practitioners who are competent and sensitive and have the skills needed to deal with significant, emotionally draining situations, especially when taking care of underserved and marginalized populations without social support (Asgary & Smith, 2013).

To maximize the quality of the clinical encounter and to minimize the risk of errors, bilingual clinicians or qualified interpreters should be familiar with international guidelines on providing care to victims of violence and should be aware of the cultural impact of violence on patients' communities and the risks related to disclosure. To this end the Istanbul Protocol of the United Nations is an excellent tool that can help health providers recognize and treat cases of torture or institutional violence (Akar, Arbel, Benninga, Dia, & Steiner-Birmanns, 2014).

When using interpreters or cultural mediators it is important to ensure the person in need of support trusts the interpreter and is happy to talk to them, and to make sure whether the language, dialect, gender, religion and region that the interpreter is from are all appropriate. Even when all these criteria are met, it is important to check that the client does not know the interpreter. The use of phone interpreting when sensitive topics are to be discussed should be considered.

Provision of care and services to victims of violence is also a socio-economic and political issue, calling for government attention in approving structured laws which increase provision of services and resources (Briones-Vozmediano et al., 2015), including access to housing, financial assistance, help in finding employment, free legal assistance, advice and support for social integration (Briones-Vozmediano et al., 2015). A facilitating factor is the establishment of a comprehensive and systematic approach to collaboration with social and advocacy organizations, in order to address the multiple ethical and professional concerns in providing sound medical, social and legal services. At the social health level it is vital to create institutional support through government agencies and local health institutions (Asgary & Smith, 2013).

Successful example

Caring for trafficked persons **(Borland & Zimmerman, 2012a, 2012b)**

"Caring for trafficked persons-Guidance for health providers "(Borland & Zimmerman, 2012a) are recommendations developed in 2009 by the International Organization for Migration (IOM) and London School for Hygiene and Tropical Medicine (LSHTM) in order to help health providers who may now or in the future provide direct health care services for individuals who have been trafficked. They are designed to accommodate varying degrees of contact with and involvement in the care and referral of people who have been trafficked.

In particular, the document aims to target: GPs, primary care providers, private and public health providers, emergency room staff, health centre staff, such as receptionists or technical staff, clinicians, outreach care providers in fields such as sexual health or refugee/migrant health, mental health care professionals, e.g. psychologists or psychiatrists.

The guidance document presents: background information on human trafficking, current knowledge on the health risks and consequences of trafficking and guiding principles in the care of trafficked persons.

Also 17 action sheets covering the following general areas are provided:

• Tools for the patient encounter, such as trauma-informed care and culturally and linguistically responsive care;
• Approaches to various aspects of medical care, such as comprehensive health assessment, acute care, communicable diseases, and sexual and reproductive health;
• Strategies for referral, security and case file management, and coordination with law enforcement.

Facilitator's guide (Borland & Zimmerman, 2012b)

The IOM and LSHTM in 2012 in a second step also developed a facilitator's guide and accompanying materials for individuals who wish to carry out training for health providers. The training is designed for all types and levels of health providers (e.g. nurses, medical technicians, doctors, counsellors, etc.), particularly those actively providing services.

The Facilitator's Guide contains basic information for the facilitator on how to prepare before the training takes place and information to facilitate Training on Caring for Trafficked Persons Core.

These guidance documents provide:

- An overview of the session including: objectives and timetable;
- Facilitator notes giving detailed instructions on how to facilitate each part of the session, including activities;
- PowerPoint slides;
- Hand-outs related to the session.

In conclusion, health care providers can play an important role in assisting and treating individuals who may have suffered unspeakable and repeated abuse and the guide (Borland & Zimmerman, 2012a, 2012b) provides a practical approach - to be adapted to the local context - to address trafficked persons health-related problems.

The full training package is also available online at the IOM Bookstore (http://publications.iom.int/bookstore) and at the LSHTM website (http://genderviolence.lshtm.ac.uk/category/reports/).

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8 Concluding remarks

The results of the focus groups, interviews and literature review clearly show that a resource package containing tools and measures to improve access to health care for refugees and asylum seeker should be adapted at national/local level. The context in which health professionals and managers operate is different from one country to the other and so is the situation for migrants. Information on available measures and resources useful to support the access to health care should be integrated in the national and local means of communications and established network of cooperation. Therefore the resource package proposed in this document is to be seen as a support tool for the development and dissemination of measures at country/regional/local level, depending on its level of implementation. Furthermore, national governments should allocate funds to improve the support to people already working with asylum seekers and to develop plans to improve integration in society of asylum seekers.

ANNEX I

DETAILED RESULTS OF THE QUALITATIVE STUDY

ANNEX Ia

Challenges related to the current refugee crisis

Administrative issues related to the legal status of the asylum-seeker/refugee

In some member states, the main obstacle is the legislation that limits access to health care for many categories of migrants and refugees only to emergency care (e.g. asylum seekers that are accommodated in centres for asylum seekers, refugees in arrival centres, people placed in detention centres waiting for deportation or in the process of identification, migrants with permission to stay who are released from detention centres because they cannot be deported and undocumented migrants). All the above listed groups of migrants/refugees may be excluded from the regular system of health care coverage and may only be entitled to emergency health care as defined in the International Protection Act. In spite of that, the interpretation of emergency health care can be quite arbitrary, since the extent of provided services is often based on the individual decision of the health care worker treating the patient. As previously stated, lack of knowledge of the different statuses and their implications for health care as arbitrary decisions taken by care providers and public social welfare services may have a major impact on the accessibility of health care. E.g. in Spain many incorrect responses regarding health care coverage and access have been given to asylum seekers in healthcare centres.

Many participants to the focus groups pointed out that the delivery of health care services to asylum-seekers, refugees and undocumented migrants is seriously hampered by the complexity of administrative procedures that have to be executed to guarantee access to care. Different procedures have to be followed depending on the status of the asylum-seeker: as long as she/he has not been registered as an asylum-seeker (e.g. because she/he does not intend to stay in the country she/he is in at that moment) is considered to be an undocumented migrant. This implies that specific rules apply, which differ from one member state to another, which in turn leads to a number of administrative procedures that have to be respected to guarantee access to care. Countries such as Slovenia and Hungary notice that almost no asylum-seekers apply for asylum there.

If migrants register as asylum-seekers, their access to care is – in most countries – guaranteed. In some, they may even be eligible for reimbursed types of care – such as non-residential mental health care – that is not reimbursed for national citizens, including non-indigenous ones, (this is e.g. the case in Belgium). Once a person has been granted refugee status, she/he tends to have the same rights to health care as the national citizens of the country involved. However, administrative procedures – such as a waiting period imposed by health insurance organizations – may lead to the person being without health insurance for a relatively long period, rendering access to care difficult because of financial thresholds. Asylum-seekers who have been refused refugee status become undocumented migrants, which will limit their access to health care services and will entail a lot of red tape for health care services that want to deliver care.

Member states point out that legislation on the delivery of care for different types of asylum-seekers/refugees leads to a lot of extra strain and work for care providers. In addition, care providers are often insufficiently familiar with the applicable rules and regulations. There is not enough knowledge among medical doctors, nurses and social workers of the different administrative statutes of refugees and asylum seekers and what their health care rights actually are. As a result, patients may not receive the care they are entitled to. It is further pointed out that these rules may be unclear and in some countries change frequently. Institutions outside the health care system may be involved in granting access to health care services such as public social welfare centres. They may have the final say in health care reimbursement matters e.g. in Belgium. These issues are of particular relevance to undocumented migrants.

Some institutions and individual care providers seem to act arbitrarily and the existing legislation is interpreted differently. Individual views of care providers on the presence of asylum-seekers or migrants in society, often influenced by the media and political discourse, may have an important impact on the accessibility of the health care system for migrants. Information on the different legal statuses of migrants and their impact on access to health care is – in different countries – not readily available for care providers and is inefficiently spread to health care managers and care providers alike. In particular, care providers argue that administrative procedures and legal limitations to the different types of care an individual patient may be entitled to, also put a strain on the care delivery process itself. They may have to explain why certain types of treatment cannot be given or certain drugs cannot be prescribed. When legal and administrative procedures are not respected, this may have far reaching consequences for the health care institution, which may not receive reimbursement from the state for the services delivered.

Language and cultural barriers

Linguistic and cultural barriers are systematically identified as among the major challenges related to the refugee crisis. In many Member States no or insufficient professional interpreters or intercultural mediators are available. In practice interpreting/intercultural mediation is often carried out by NGO members (e.g. in Greece), volunteers, other refugees or professionals) who have not been trained in this domain (e.g. psychologists, educators). Many problems related to this situation are being reported. Care often has to be provided on the basis of poor communication. Providing care without interpreters/intercultural mediators takes up a lot of time which leads to long waiting times for the other patients. Diagnoses and the necessity of possibly extended treatment cannot be adequately communicated. In one Greek focus group the case was presented of a child with a brain tumour and the impossibility of explaining this to the father. As long-term treatment may impede the asylum seekers possibility to continue their journey to the country in which they would like to settle, without adequate communication parents may decide to take their sick children with them. Certain diagnostic tools – e.g. psychological tests for traumatized children or children with emotional problems – cannot be used, making the work of psychologists very difficult or even impossible.

Rare are the member states where care providers have institutionalized the availability of intercultural mediators or interpreters. Even where this is the case, as it is in Belgium, the number of mediators / interpreters is too limited and care providers may be insufficiently aware of the possibility to call them in. Some care providers – in particular in mental health services – refuse to work with interpreters / intercultural mediators. It proves to be difficult to make care providers rely systematically on professional intercultural mediators / interpreters. This is the case for 'on site' intercultural mediators / interpreters and even more for remote intercultural mediators or interpreters who intervene by phone or with the aid of videoconference technology. The impossibility of resolving linguistic barriers makes it extremely difficult to handle cultural barriers that may further impede the care delivery process. Care providers have received insufficient training in cultural competence and may be completely unfamiliar with patients coming from the Middle East. There also seems to be a need to share information on cultural issues acquired by care providers. The lack of cultural competence seems to be most problematic in mental health care, making it difficult to provide adequate care for refugees with mental health problems such as PTSD.

As some patients coming from Syria and Iraq, for example, may sometimes vehemently refuse to be treated (or have their spouses) treated by a care provider of the other sex, it may be important to have a sufficiently high number of female providers present. This is particularly relevant for the gynaecology department. Rescuers in Lesvos reported that in some cases they cannot provide first aid to drowning women as their

men do not permit the rescuers if they are male to untie some of the women' clothes. Such cultural issues cause problems for their work. Due to cultural reasons, patients may be unwilling to discuss issues that lie at the heart of their mental health problems. Differences between the medical culture of countries such as Syria/Iraq lead to conflicts with MD's. Antibiotics, for example, can easily be obtained in Syria. And pharmacists have a role that is very similar to that of MD's working in primary care in (Europe) Belgium. There is a lack of quality information for workers on new healthcare pathways and on the existing possibilities in the region where people can be directed. There also is a lack of quality information for asylum seekers/refugees on how to navigate the health care system.

Lack of information and difficulties to ensure continuity of care

Asylum-seekers often arrive, whether in the arrival, transit or settlement phase, without any health records. The identity given by patients may not be real. Care providers often do not have reliable information on the illness and treatment history of the patient. Absence of information on the vaccination status of children is a problem that is systematically reported. In some countries refugee children coming from Africa and Afghanistan were systematically vaccinated as providers knew that many –if not most- of them had not been vaccinated. Children coming from Syria – where the health care system used to function well – are also vaccinated, although this may not be necessary. This is because no health records are available and, due to language barriers, it is impossible to obtain information from the parents. Patients often move from one country to another during their asylum-seeking process. Even when they are settling in a country, they may move from one place to another, as countries may have policies to distribute refugees over their whole territory. Moving makes it difficult for care providers to set up extensive treatments.

No adequate systems for the exchange of medical information between member states exist. Even within one country, moving from one place to another, or from one type of health care institution to another (e.g. from a medical service in a refugee camp to a regular GP), may entail the loss of highly relevant information on the illness and treatment history of the patient. In countries where computerized medical data systems exist, different databases may not be connected and impossible for care providers to consult. As a result, partial and fragmented care is often provided and the right to health (care) not fully guaranteed. Ideally, information on patients (documents, medical records, clinical background, treatment,…) should 'travel' with the patients. This is not the case. Information is patchy and patients cannot be looked after comprehensively with the risk of errors being made and inadequate care being provided. In particular, in countries of transit (e.g. mainland Greece), asylum-seekers may leave the hospital or stop the treatment – against the care provider's advice - to be able to continue their journey with their compatriots. This may also be the case for children. It is often impossible to trace these patients as they may have registered using different names and because no address or phone number is known.

Organization, quality and coordination of health care services

In countries where a lot of care is provided by volunteers or by international NGO's (reported by Hungary and Slovenia) the quality of care may be of very uneven quality. In Slovenia, for example Hungarian care providers worked in mobile hospital units that were very well equipped and had sufficient supplies of medicines. Other patients had to be treated in muddy conditions in the open. The presence of different NGO's and groups of volunteers, combined with a lack of organization, may result in chaotic and inadequate collaboration between the different care providers. Complex administrative procedures related to the provision of medical care to refugees leads to extra costs for health care institutions that are not taken into

account by the funding authorities. As in most countries no supplementary health care services are organized, capacity problems arise. This situation may affect the services available for the indigenous population. Indigenous patients are reported to complain about the presence of refugees in health care institutions which leads to longer waiting times.

MD's point out that refugees may only need minor forms of treatment and will delay care delivery to indigenous patients who are really in need of emergency care. This seems to be particularly the case on the island of Lesvos where very high numbers of refugees arrive. In Slovenia, it was reported that the inappropriate response of the authorities and the chaotic conditions daily covered by different media together with the lack of knowledge about other cultures strengthened two concerns among the people: that refugees can spread contagious diseases and that they pose a serious security threat. These sometimes even prevented health care workers who wanted to help refugees to do so, since they faced a lack of support or even strong opposition from their families or employers in case of working in arrival centres.

Poor management of the refugee crisis in health care is said to lead to overcrowding of certain hospitals. Burn-out syndrome and compassion fatigue are being observed in care providers working with refugees. They report that they feel emotionally burdened when they meet refugees 'they cannot help as much as they would like to'. Refugees are also reported to rely on health care services to solve a number of problems that are clearly situated in the social domain. Issues of housing and administrative problems are often presented to health care providers as they seem to be the single (positive?) point of contact with the host society. Health care institutions in some countries argue that there is a lack of collaboration between social and health services to improve the living conditions and health of the refugees. It is pointed out that care providers should be alert to recognize diseases that are uncommon in the receiving countries but may be so in the refugees' countries of origin. In Belgium some private hospitals do not want to treat refugees and asylum seekers because of the risk of non-payment and administrative burden. This leads to unacceptable situations such as a pregnant woman about to give birth being quickly transferred to a public hospital by ambulance. Access to specialized care (for instance dental care, ophthalmology, orthopedics, physiotherapy) is sometimes hampered by the fact that care providers are allowed to set their own fees: the state only reimburses amounts fixed by the national health insurance system for asylum seekers. As a result, specialists may refuse to treat them.

Challenges related to specific phases of the asylum process

A person's administrative status seriously affects her/his rights and access to health care services in member states. This may be related to the phase of the asylum-seeking process the person is at in a certain country. E.g. they may avoid registering as an asylum seeker in countries they do not wish to settle in, and this in turn may affect their access to health care.

Arrival phase

Usually, all asylum seekers entering a member state are entitled to emergency health care free of charge. During the arrival phase, healthcare professionals may have to intervene on site, as asylum seekers may not manage to find the health practitioner's office. Proper information on their right on access to health care/ health assistance should already be provided at that stage. Unfortunately this is often not the case. Sometimes bureaucratic registration procedures take about 6 months – during this time span, refugees are

not health insured. They may not yet have a social security number, which may have an impact on accessibility of certain types of prescribed drugs.

During the arrival phase, Doctors of the World and Doctors without Borders along with other NGO's from different countries provide primary health care services in a number of member states. The emergency cases end up at hospitals. In countries where large numbers of asylum seekers arrive (at the time of the Focus Groups (FG) in particular in Lesvos/Greece), this may be problematic because of the high number of patients to be seen. Because of the increase in number of asylum seekers arriving in Slovenia, migrants were being accommodated in additional units, where in contrast to the main ones, there were no nurses or doctors present there. As a result, asylum seekers who may need psychosocial support, or medicines for treatment of chronic conditions often visit emergency units of health care centres. This increases bias and prejudice towards the migrant population, since they are regarded to be undisciplined patients who are exploiting and misusing emergency units for problems that are not urgent. Because of limited time in this phase, 'emergency' care with absolutely no integration of care is provided. It is impossible to get a complete clinical picture. Often chronic diseases or mental disorders and immigrants' personal plans are not taken into account.

Transit phase

Registered asylum seekers are entitled to primary health care free of charge. Because of the lack of information, in the transit phase/ at the transit areas health care professionals may have to go on site in order to treat asylum seekers in transit arriving in their country, as they may not be able to find their way in the health care system. The asylum seekers who live in camps get healthcare in the camp. In many member states NGO's provide primary health care services on site during the transit phase. If the health problem is considered serious, the migrant/refugee is taken to the hospital but they may not complete their treatment as they want to continue their trip to Northern Europe.

Personal medical files (e.g. on vaccination status) are rarely available. So in every new health institution, all of the relevant information needs to be collected again. This is a waste of time and dangerous in urgent situations. As a result, treatment of chronic diseases (e.g. cancer, aids-HIV, diabetes,…) is often inadequate. Refugees Reception Centres are facing a double problem. On the one hand, the flow of information among professionals from the different centres is incomplete and often late and on the other hand, they have noticed that refugees do not always understand the doctor or care provider. There is little chance of implementing prevention and promotion programs offered by the public health system. The focus is on acute health issues and communicable diseases.

No psychological counselling to help refugees deal with the traumatic experiences of the exodus is available or it is very difficult to receive. Time is one of the main challenges when it comes to asylum seekers in transit to access and be assisted by healthcare services. More specifically, pregnant women are urged to take specific tests that assess their and their babies' health. Taking into account the waiting times and protocols of our system, the access to these services (e.g., gynaecological consultations, ultrasounds, and analytics) is very complicated. The same challenge exists for urgent psychological assistance and mental healthcare. The information reported by people who are in transit may be confusing. For example, they state that they intend to stay for a month but may leave two days later.

Destination phase

Once an asylum-seeker has been granted refugee status, he has the same entitlements to care as all legal residents. In some countries, this may imply that types of services that were provided free of charge before the recognition, will have to be paid for by the refugee. This is e.g. the case for non-residential mental health care services in Belgium and leads to financial barriers. At this stage, the refugee will lose much of the assistance she/ he may have received during the previous phases (e.g. to make use of social and health care services). Insufficient knowledge of the health care system and cultural differences often hamper access to health care. Now, she/he will be expected to make use of mainstream health care services unaided. This will in many cases be problematic as the refugee's limited knowledge of health services are organised makes it hard for them to navigate the bureaucratic and complex health care system. Language and cultural barriers described above negatively affect access and quality of health care services also at this stage. The effects of these barriers are aggravated by the limited cultural competence of many care providers. The lack of understandable information for refugees on the organization of social and health care services further complicates their access to help they may need.

Specific health situations in which specific challenges arise

Mental health care

Regarding the difficult situations and traumatic experiences many refugees encountered before and on their journey, focus group participants working in arrival camps meet many refugees with mental health problems in need of psychosocial assistance and support. A woman from Syria said that her village was completely destroyed. She said that there were a lot of dead bodies in the streets and hygienic conditions deteriorated. In addition, they were running out of food. They could not feed their animals, so dogs started eating the dead and after that attacked the people who were alive. Refugees were not living in normal situations and are in need of mental health care.

Repressive police and army actions (unexpected displacements of people without informing them, officers carrying weapons, police helicopter flights etc.) furthermore stimulated re-traumatization among refugees, which resulted in many interventions of health care workers and volunteers that could be preventable. In spite of all that, there were no appropriate professionals (psychologists, psychiatrists, therapists etc.) in arrival camps who could adequately address refugees' needs. If they were, however, they were not always able to perform their activities due to the repressive police approach, which was at the forefront of work organization in arrival camps. As a result many people waiting to get medical help did not actually need it, but were in extremely hard circumstances only looking for a support, human contact, information, food, water or dry clothes and shoes.

Similarly, there is no adequate care addressing mental health needs of asylum seekers that are transferred to the asylum centre. Special care, including psychotherapeutic one, can in some countries be covered, but only in limited range to so-called vulnerable persons with special needs (disabled people, elderly, pregnant women, single parents with minor children, victims of trafficking, persons with mental health problems and victims of rape, torture or other serious forms of psychological, physical and sexual violence) and on condition that a special commission approves it. Despite the fact that there are psychologists employed in some centres for asylum seekers, there are no generally accessible specialist therapies for traumatized

refugees. They may only be able to access them only if a general practitioner writes them a referral which is connected to many barriers (long waiting periods, lack of translators/intercultural mediators, lack of cultural competent specialists etc.). There are some NGO's such as 'Freedom from torture' offering mental health care for refugees but the waiting lists are too long. An additional difficulty during the psychological treatment is associated with the differentiation of psychosomatic symptoms arising from post-traumatic stress disorder from physical illnesses. It's complicated to discriminate between physical, psychological and social issues in this population.

Sexual and reproductive health

The follow-up of the relatively large number of pregnant women in arrival camps seems to be a major problem. Participants' experiences with them are the eloquent proof of how conditions in arrival camps influence the refugees' health and trigger the problems instead of preventing them. In Spain e.g., many pregnant women had cramps and doctors mistook them for labour contractions. They were taken to the maternity hospital and examined by ultrasound, but the cramps appeared to be a consequence of the women lying on the cold floor. In the UK prenatal care can be charged for. There is a payment plan in order to help migrants pay it back. Some pregnant women are only registered in the health service system at a late stage in their pregnancy. Mothers with babies need to be redirected to the available support services.

Refugee children and adolescents care

According to state regulation in Spain minors should receive specific protection due to their high vulnerability. To ensure that they are minors a "bone age assessment" is necessary, which could have a large margin of error, making it difficult to determine their real age. Since this bone age study can be a source of anxiety and it isn't reliable at all, it is considered necessary to look for new complementary ways of establishing migrant's age.

Victims of violence care

In Spain the implementation of the Istanbul Protocol as a way to prove that individuals had suffered torture is a challenge due to the high cost (2.000€ - 3.000€) of the expert report. The cost is not covered by public service, so social organizations must paid for it. High rates of violence against women and sexual violence are reported for asylum seeking women. There is some evidence that young men are also at risk for sexual abuse.

ANNEX Ib

List of measures to address barriers in health care collected through the focus groups

1. Measures to address legislative, administrative and bureaucratic factors

The obstacles registered in this issue are about the complexity of administrative procedures that have to be executed to guarantee access to care and that are very different depending on the status of the asylum-seeker. In particular there is not enough knowledge on the different administrative statutes and the health care rights are among medical doctors, nurses and social workers and there are different kind of interpretation of the existing legislation.

Educate the doctors on the different types of legal status and asylum procedures
(Brussels, Belgium)
Service/department in charge of the measure
MEDIMMIGRANT (NGO) and FEDASIL (Federal Agency for Asylum Seekers).
Description of the measure
Information session on the different types of legal status, their impact on access to health care and the required administrative procedures. The information can also be consulted on the internet. Moreover, Med immigrant provides information via a helpline.
Expected outcomes
Time-saving and better understanding of the situation and the current legislation. Better access to healthcare. Doctors are more willing to help asylum seekers and refugees.
Resource needed for implementation
Ideally, funding to hire staff to inform care providers.

Voucher for one free consultation for undocumented / uninsured patients
(Brussels, Belgium)
Service/department in charge of the measure
This strategy was implemented by the social service in one hospital.
Description of the measure
Every patient has the right to one free consultation without any administrative or financial barriers. During this consultation, the physician will decide whether medical care is urgent or can be delayed. If necessary, administrative strategies will be developed to guarantee access to health care.
Expected outcomes
The goal was to guarantee easy initial access to health care, as well as to remind (undocumented/uninsured) patients of their rights and to remind doctors that health care is a human right.
Resources needed for implementation
Commitment from the management of the health care institution, political decision for implementation in the country.

Sensitization strategy aimed at administrative and healthcare staff of healthcare centres.
Service/department in charge of the measure
Technicians from the CAR in Seville (in collaboration to the Andalusian School of Public Health)
Description of the measure
To sensitize administrative and healthcare staff of healthcare centres in order to increase their knowledge and empathy skill so to offer a better assistance to users.
Expected outcomes
Increase the knowledge and empathy of the target population.

Achieved outcomes:
The organization disposed personal and material resources. Difficulties were found when trying to reach all collectives (e.g., problems with schedules, shifts, permits, etc.).
Resource needed for implementation
Better dissemination means that allow developing better sensitization campaigns.

Mediation and accompanying program
(Seville, Spain)
Service/department in charge of the measure
Sociocultural mediator
Description of the measure
To reduce accessibility barriers in regard to administrative procedures through mediation and accompanying activities.
Expected outcomes
Reduction of difficulties in the access to administrative procedures.
Achieved outcomes
Difficulties were found in the personal characteristics of the administrative staff working in the registration windows.
Resource needed for implementation
If there were more people working in mediation, results would be better.

Responsibility for administrative, interpreting, and financing issues taken from health care staff by management
(Austria)
Service/department in charge of the measure
Hospital directors / hospital management
Description of the measure
In Salzburg, the contact point interpreting services and intercultural care has taken over the responsibility to organize transport of refugees and asylum seekers after out patient treatment in St Anna Kinderspital, hospital directors have told staff: the patient comes first. If the patient can't show the right. documents/health card, copy as many documents as available and treat him/her. Management will organize financial issues. A "refugee pharmacy depot" was implemented, providing 25 most common drugs for minor health problems; documentation is done with a list, no additional bureaucracy; target group those refugees who have not yet applied for or received status of asylum seeker.
Expected outcomes
To create a working situation for medical staff where they are not hindered by bureaucratic issues
Achieved outcomes
Achieved outcomes supported by already developed system
Resources needed for implementation
Technical infrastructure, contract with interpreting agency
Availability of the measure
http://www.videodolmetschen.com/en/about-us.html

2. Measures to address language and cultural barriers

The most important obstacles about this issue is that no or insufficient professional interpreters or intercultural mediators are available in health services, and this means long waiting times and not adequate communication of diagnoses and the necessity of treatment. Moreover care providers have received insufficient training in cultural competence and some of them refuse to work with interpreters / intercultural mediators.

Video-remote intercultural mediation (VRIM) in Belgium
(Brussels, Belgium)
Service/department in charge of the measure
Intercultural mediation and policy support unit (FPS Health, Safety of the food chain and Environment) and RIZIV (national health insurance institution)
Description of the measure
The intercultural mediation service in Belgium was introduced in 1991 and at the beginning it was organized solely with the on-site presence of mediators in health care institutions. The increasing diversity of the immigrant population made it clear that this approach lacked the flexibility needed today. Therefore, it was decided to create and an additional service involving the use of video-conference technology.
Expected outcomes
To reduce the negative effects of the linguistic, socio-cultural and ethnic barriers on the accessibility and quality of health care.
Achieved outcomes:
This measure makes it possible to provide intercultural mediation in over 20 languages in more than 100 health care institutions in a cost-effective and flexible way. Preliminary evaluations have indicated that the VRIM is a valuable and necessary addition to the provision of on-site intercultural mediation services, which remain the preferred – but often unavailable and unaffordable – option of care providers, patients and mediators alike. VRIM limits the role of the mediator as he/she is not present on-site). In particular elderly care providers sometimes feel ill-at-ease with video-conferencing technology and are reluctant to rely on it. It seems to be important to stimulate and train care providers to use VRIM and to work closely with ICT-departments of health care services to avoid technical issues. Finally, intercultural mediators have to be trained to be able to provide high quality services using video-conference technology.
Resources needed for implementation
Funding for the mediators, a coordinating team, training for mediators and care providers, an awareness-raising and promotion campaign, good internet access, the necessary hardware and software. A well-developed soft and hard policy that guarantees that no patient data will become public.
Contact: Hans Verrept, hans.verrept@gezondheid.belgie.be

Face-to face-interpreting
(Austria)
Service/department in charge of the measure
Contact point interpreting services and intercultural care
Description of the measure
Already implemented employed interpreters were also provided outside core working times
Expected outcomes
To facilitate communication

Achieved outcomes
Achieved outcomes supported by already existing interpreter pool and search for Arabic interpretersat a very early stage (early 2015)
Resources needed for implementation
Coordinator, budget, training for staff

Telephone-interpreting
(Austria)
Service/department in charge of the measure
Depends on organization; e.g. contact point interpreting services and intercultural care; hospital director
Description of the measure
Telephone interpreting agency in Salzburg 24hours/day available; following the initiative of the hospital, the agency now offers Farsi/Dari instead of Spanish
Expected outcomes
To facilitate communication
Achieved outcomes
Achieved outcomes supported by already developed system
Resources needed for implementation
Technical infrastructure, contract with interpreting agency
Availability of the measure
http://www.videodolmetschen.com/en/about-us.html

Video interpreting agency contracted
(Austria)
Service/department in charge of the measure
Depends on organization; e.g. contact point interpreting services and intercultural care; hospital director
Description of the measure
Video interpreting covers all languages necessary for health care providers in case of a rare dialect: information on availability interpreter within 15 minutes
Expected outcomes
To facilitate communication
Achieved outcomes
Achieved outcomes supported by already developed system
Resources needed for implementation
Technical infrastructure, contract with interpreting agency
Availability of the measure
http://www.videodolmetschen.com/en/about-us.html

3. Measures to address continuity of care and lack of information

Care providers often do not have reliable information on the illness and treatment history of the patient because no adequate systems for the exchange of medical information between member states exist: the result is often a partial and fragmented care provided and the right to health (care) not fully guaranteed.

Extensive intake at arrival. A process where the nurse consults extensively with the patients shortly after arrival
(Amsterdam, Netherlands)
Service/department in charge of the measure
This measure was implemented by the Coa.
Description of the measure
During this extensive intake the nurse collects all relevant medical data. This medical data can be about current health problems or their health history. When patients require immediate care the nurse refers the patients to the appropriate healthcare provider. The Coa expected that the quality of care around and for asylum seekers and refugees would improve when the information of their current and previous health is available. Additionally, the refugees and asylum seekers do not require to first see a GP before they can be referred to the appropriate healthcare provider.
Expected outcomes
To collect all relevant medical data.
Achieved outcomes
The implementation of this measure was successful. Due to the entire healthcare around and for asylum seekers and refugees being based and organized around this intake. Therefore, it is recommended that other organizations would adapt this extensive intake.
Resources needed for implementation
To successfully implement this measure the extensive intake has to be part of the arrival process. This extensive intake is done nationally in the Netherlands. Therefore, it would be a suggestion towards other Member States in this project.

SIRIA PROGRAMME
Malaga, Spain
Description of the measure
Inter-centre information system on health data and social report of refugees. Completed in first reception centres, in the Spanish case, Centres for Temporary Stay of Migrants, and it may then be consulted and completed throughout the whole transit.
Service/department in charge of the measure
Reception centres (no access from public health system centres)
Expected outcomes of the measure
Follow-up
Achieved outcomes
Partially

4. Measures to address organisational barriers to health service delivery

Hospitals have limited resources and no supplementary health care services have been organized, so capacity problems seem to occur. This situation may affect the services available for the indigenous population.

Migrant-Friendly health care in the Local Health Authority of Reggio Emilia: a whole organisational approach
(Reggio Emilia, Italy)
Responsibility
Research and Innovation Department of the LHA of Reggio Emilia
Description
Since 2005 an overall strategy to ensure equity of access and treatment for migrants has been established at the central level of the organisation. The strategy comprises the following main areas of interventions and are coordinated by a multidisciplinary team.
Ensure the right to health care through a dedicated service for UDMs and people at risk of exclusion because of lack of legal status *(irregular migrants, asylum seekers, and failed asylum seeker).*
Improve accessibility to health services through a coordinated language support service available for all professionals and patients *(addressing linguistic and communication barriers).*
Improve service utilization through the provision of information on health and health services *(providing information on how to navigate the system; improve Health literacy).*
Ensure quality of care and responsiveness to migrant's health needs through systematic training embedded in the organisational training plan *(staff training programmes).*
Foster organisational change and improvements through the assessment of quality/equity of health care services *(HPH-TF MFH standards of equity in health care).*
Promote involvement and participation of users and community through the establishment of partnerships and networks in the community *(partnerships, networking with other services, out-reach interventions, formal agreements and protocols).*
Promote research to achieve change through the participation at research projects and networks at local as well as international level *(COST Actions; EU funded projects; National/Regional funded projects).*
Achieved outcomes
Improved integration of the migrants population in the health care system. Reduced inequities in health care and contributed to reduce health inequalities.
Contact: Antonio Chiarenza - Research and Innovation – AUSL Reggio Emilia – Antonio.chiarenza@ausl.re.it

Camp for asylum seekers in Bicske
Budapest, Hungary)
Service/department in charge of the measure
The government
Description of the measure
Government (Office of Immigration and Nationality) established and run camp in Bicske where asylum seekers get access to healthcare services.
Expected outcomes
The expected outcomes were that the asylum seekers who registered themselves received basic/ primary healthcare services that are entitled to them after registration. In case of need they were referred to secondary health care assistance as well.

Achieved outcomes

More than 400 000 asylum seekers entered the European Union through Hungary, only around 170 000 of them registered themselves, but only 91 000 reached one of the camps. The problem was that most of them just passed through the country hindering their access to health services. Even if they reached one of the camps, it was common that they left before finishing the necessary therapy. However, a number of asylum seekers did access the healthcare system through this institution

Resources needed for implementation

Governmental action that supports asylum seekers in reaching the camp and increase the health care capacity of the in-camp services.

Availability of the measure

Decree 32/2007 (VI.27.) of the Hungarian Ministry of Health, on diseases with public health concerns related to those third country nationals who are staying in Hungary, and are having the right of free movement'

On-site healthcare service and pharmaceutical aid in transit zones

(Budapest, Hungary)

Service/department in charge of the measure

Association of Hungarian Primary Care Paediatricians, the Hungarian Baptist Aid and Mikszáth Pharmacy

Description of the measure

Association of Hungarian Primary Care Paediatricians, the Hungarian Baptist Aid and Mikszáth Pharmacy cooperated in providing on-site healthcare services for asylum seekers at the Western Railway Station. It started out with a call for volunteers by Migration Aid which is a volunteer civil initiative to help refugees arriving to Hungary reach their assigned refugee camps or travel onwards. At first, volunteer doctors went on the spot at the Railway Station to aid the asylum seekers in need. There was there neither any professional emergency aid organization, nor governmental organization. Later on, the above mentioned three organizations teamed up to improve the situation. First, they worked in tents, and as a last step they moved into two containers, one worked as an examination room, and one as a pharmacy.

Expected outcomes

To ensure basic healthcare services for those in need in a transit zone.

Achieved outcomes

They could provide satisfactory onsite health assistance and have received a very positive response and trust from the migrants and refugees.

Resources needed for implementation

Professional back up organization, governmental action, training for volunteers.

Psychiatric and psychological support

(Lesvos, Greece)

Service/department in charge of the measure

Psychiatrists and psychologists of the island

Description of the measure

The psychologists of the island meet and try to design certain exams necessary for their work

Expected outcomes

To have a common approach and procedure when they try to diagnose mental health problems

Achieved outcomes

At this stage they still work on this procedure

Psychological intervention guide for direct assistance to migrants and refugees

(Seville, Spain)

Service/department in charge of the measure

University of Sevilla**;** University Complutense of Madrid; Psychologist of the World organization; Official College of Psychologist in Spain

Description of the measure

A guide was created to illustrate psychological reactions present in migratory processes by involving health providers and different institutions.

Expected outcomes

To contribute through a psychological perspective to the current humanitarian crisis.

Achieved outcomes

It was introduced during the current year, thus it has not yet been evaluated.

Consultation at the GP practice outside of the asylum seeker centers

(Amsterdam, Netherlands)

Service/Department in charge of the measure

Local health system and asylum centres

Description of the measure

Instead of the GP doing consultation at the asylum seeker centres, the GP does consultation at their own practice.

Expected outcomes

The practice can provide better and more equipment and materials. Also the asylum seeker has to make some effort to get to the practice, causing the patient to consider their health instead of easily going to the GP.

Achieved outcomes

With this measure the asylum seeker has more confidence in the healthcare provided. Additionally, the GP has their full arrangement of equipment and materials available. The GP thinks that they are taken more seriously, since the care looks more professionally at a practice than at a asylum seeker centre.

Resources needed for implementation

The GP can implement this measure with the approval of the asylum centres.

Healthcare protocol for professional teams

(Seville, Spain)

Service/department in charge of the measure

Psychological care team of "CEPAIM Foundation"

Description of the measure

Some symptoms of secondary traumatization were identified in providers working with refugees and asylum seekers. The psychological care team is working on the development of a protocol to aid those providers.

Expected outcomes

To prevent symptoms related with secondary traumatization and "compassion fatigue" syndrome, which affects the occupational wellbeing of providers.

Achieved outcomes

At this stage they still work on the development of an intervention protocol.

Resources needed for implementation

A well trained professional team is required, as well as adequate facilities.

5. Measures to address lack of organization/collaboration between services

Moreover the presence of different NGO's and groups of volunteers in combination with a lack of organization may result in chaos and too little collaboration between the different care providers.
This increases bias and prejudice towards migrant population, since they are regarded to be undisciplined patients who are exploiting and misusing emergency units for problems that are not urgent.

Warehouse
(Lesvos, Greece)
Service/department in charge of the measure
The NGO MDM has reported this practice.
Description of the measure
They referred to the well organised warehouse the MDM have with all sorts of clothing which is divided into different sizes. Thus, when the refugees arrive and they are wet they can provide all different clothing and shoes in few seconds as they are easily accessible according to the size of the person
Expected outcomes
To provide warm clothes to people who arrive completely wet with hypothermia
Achieved outcomes
They consider it very helpful
Resources needed for implementation
Clothing from volunteers

Shelter charity association
(Budapest, Hungary)
Service/department in charge of the measure
Shelter Charity Association
Description of the measure
Doctors at Shelter Charity Association also received a number of asylum seekers 20-50 cases each day, and they offered primary health services for them in the shelters.
Expected outcomes
To aid those in need to get necessary health assistance.
Achieved outcomes
As more medicine and bandages would have been necessary as it was available. Governmental support and organization would be a way to ensure better services.
Resources needed for implementation
Governmental support in organization and providing materials and assets
Availability of the measure
Available on Hungarian only
http://www.oltalom.hu/rovat.php?id=47&lang=hu&mid=90

Dialogue with the local public social welfare centres
(Brussels, Belgium)
Service/department in charge of the measure
Social services
Description of the measure
Regular concertation (agreement) with the local public social welfare centre on access to health for specific

patients and patient groups. Better communication and dialogue could improve the collaboration between public social welfare centres and hospitals.

Expected outcomes

Access to and reimbursement of health care services

Achieved outcomes

In a number of cases the granted access created a precedent and improved access for the patient group in question.

Resources needed for implementation

An open attitude and a social worker prepared to make the time for dialogue.

List of all health care providers in the island

(Lesvos, Greece)

Service/department in charge of the measure

The General Secretariat of Eastern Aegean islands is trying to identify the different NGO's that provide health care to migrants and refugees in order to have a picture of who is doing what.

Description of the measure

They need a list of all health care providers in the island, as volunteers keep changing and doctors do not know the people in the different NGO's

Expected outcomes

Better collaboration and coordination between all the different health care providers.

Siria programme

(Malaga, Spain)

Service/department in charge of the measure

Reception centres (no access from public health system centres)

Description of the measure

Inter-centre information system on health data and social report of refugees. Completed in first reception centres, in the Spanish case, Centres for Temporary Stay of Migrants, and it may then be consulted and completed throughout the whole transit.

Expected outcomes

Follow-up

Achieved outcomes

Partially.

Multidisciplinary group for the assistance of asylum seeking families

(Seville, Spain)

Service/department in charge of the measure

Coordination of the program "Reception" of CEPAIM Foundation

Description of the measure

Creation of a multidisciplinary team that assist refugee and asylum seeking families in diverse areas (e.g., psychologist, social worker, lawyer, labour counsellor).

Achieved outcomes

We are working on it. There is a barrier in the great amount of existing information that results in disinformation.

Resources needed for implementation

More mediators in all fields; the figure of a healthcare practitioner; training in Arab and intercultural competence.

Coordination with the healthcare services of the area
(Seville, Spain)
Service/department in charge of the measure
Director of the association "Onna Adoratrices"
Description of the measure
The objective of this measure was the approach and contact with healthcare services in the area (e.g., healthcare centre, hospitals) through social workers. Activities carried out were several meetings and visits so that social workers could know our resources and the reality faced by the women we assist.
Expected outcomes
To be assisted when we had to face healthcare problems with the women we work for.
Achieved outcomes
Social workers led us to new cases referred by the healthcare system. Objectives were accomplished through direct contact with healthcare services and posing our difficulties in healthcare to them. Something that hinder this measure was the staff rotation in healthcare services.
Resources needed for implementation
Resources to offer sensitization and training to healthcare providers.

Technical roundtable
(Seville, Spain)
Service/department in charge of the measure
Directorate General for the Coordination of Migratory Policies.
Description of the measure
Establishment of a technical roundtable composed of healthcare counselling centres together with social organizations working with refugees.
Expected outcomes
To identify actors involved in a possible massive reception, specifically targeting healthcare services
Achieved outcomes
The measure was promoted by the organization and supported by the President. There is no homogeneous opinion between the Ministries on the need to rely on the specialized organizations. Refugees' healthcare overlaps with other migrant's healthcare, and there appears to be some reluctance. The lack of financial resources since 2010 is inducing an "avoidant attitude".
Resources needed for implementation
The maximum involvement is stressed**.**

Cooperation between Slovenian NGO Filantropija and Doctors of the world
(Slovenia)
Service/department in charge of the measure
Slovenian NGO Filantropija and Doctors of the World
Description of the measure
Despite the numerous persons around Slovenia who participated in health care provision for refugees, the help of different international teams was of a great value. Successful cooperation between Slovenian NGO Filantropija and Doctors of the world resulted in a mobile unit, working at two different arrival centres for refugees. The same model of a mobile unit that is going to work in all units of the centre for asylum seekers is now being established with the aim of providing more comprehensive health care (including psychosocial care) for refugees accommodated there.

AGREEMENT WITH RED CROSS AND UNHCR REGARDING THE ACCOMPANIMENT AND PROTECTION OF REFUGEES DURING TRANSIT

(Málaga, Spain)

Description of the measure

There is already a protocol (based on the protocol that was drafted for the reception of Bosnian refugees), waiting to be put in place.

Service/department in charge of the measure

Malaga Health District

Migration flows' research

(Seville, Spain)

Service/department in charge of the measure

Directorate General of the Civil Guard.

Description of the measure

Migration Flows' analysis and study. To detect smuggling networks. To detect any inconvenience at reception contexts. To detect border protection systems.

Regular meetings (every 3-4 months) between social cooperative managers and healthcare authority workers (healthcare and administrative workers)

Responsibility

Local Health Authority

Expected outcomes

Pathways should be established for access to basic services and administrative practices should be simplified.

Achieved outcomes

The organisation of doctor's appointments and clinical check-ups was a success (this success was supported both by the network of departmental services and the professional experience of the workers involved, including LC mediators).

The administrative problem of limited/missing urgent documents has still not been resolved (the police headquarters does not send GP renewal documents within tight deadlines) and our administration reluctantly accepts "alternative" documents from those indicated by law.

Resources needed for implementation

On the administrative side, the allocation of a GP and NHS registration renewal need to be simplified. On the healthcare side, there needs to be greater sharing with the other healthcare facilities in the ER Region.

Transmission of reception healthcare data to GPs

(Reggio Emilia, Italy)

Responsibility

Local Health Authority and Foreign family health centre (CSFS), AUSL Reggio Emilia

Expected outcomes

After an initial period of guaranteed access to basic services at the Centre for Foreigners (dedicated to temporary resident foreigners) lasting a few months, people should be able to register with the NHS and choose a GP; the data (files) from the first doctor's appointments are sent to ensure continuous assistance and healthcare.

Achieved outcomes

The results were not always achieved; firstly, not all GPs were aware of the first reception procedure that took place in clinics at the Centre for Foreigners (assessing essential parameters, migration background,

vaccinations, etc); another obstacle to achieving the goals of continuous assistance is the changing opening hours and also the unavailability of LC mediation.

6. Measures to improve information and education

The lack of understandable information for refugees on the organization of social and health care services further complicates their access to help they may need. This will in many cases be problematic as the refugee's limited health literacy makes it hard for him to navigate the complex health care system. Information barriers are exacerbated by people who pass through and only stay in the region for a short period of time. Also care providers have received insufficient training in cultural competence and may be completely unfamiliar with patients coming from the Middle East.

ZANZU: MY BODY IN WORDS AND IMMAGES

Country of development

Belgium and Germany

Service/department in charge of the measure

Zanzu is created by Sensoa, the Flemish Expertise Centre for Sexual Health, and BZgA (Bundeszentrale für gesundheitliche Aufklärung), the German Federal Centre for Health Education.

Description of the measure

Zanzu is a website that helps both professionals and patients to communicate in their own/different language(s) through translation about sexuality, their body, health, relationships, legal information… The website is a support tool and provides tips for talking about sexuality in a multicultural context.
It has been developed in 12 different languages

Expected outcomes

To overcame linguistic barriers and to help patients in their relationship with health professionals.
To increase the level of information and knowledge of patients.

Resources needed for implementation

IT support and technical skills

Available at

http://www.zanzu.be/en

Training for refugees on the health care system in Belgium

(Brussels, Belgium)

Service/department in charge of the measure

Regional authorities who are in charge of integration course

Description of the measure

Trainings on health literacy, preventive health care (vaccination, sexual health, ….), health promotion, accessibility of health care. This training is part of the so-called 'integration courses' newly arrived migrants have to attend.

Expected outcomes

Reduction of health care costs, more prevention.

Achieved outcomes

We don't know whether this goal has been achieved.

Resources needed for implementation

Funding to organize training.

Response of medical faculties and Faculty for Health Sciences
(Slovenia)
Service/department in charge of the measure
Faculty for Health Sciences
Description of the measure
Medical faculties and Faculty for Health Sciences that organised groups of students enrolled in courses such as first aid and emergency aid that helped in the arrival camps, where they learned about the situation and gained many working experiences in the field of their study. Moreover, students also organized on their own and offered their help in health care units in arrival camps. As a result, they did not just gain important professional experience, but sometimes also lost many prejudices and stereotypes.

Supervision and training programme for reception and healthcare workers at the Fanon Centre
(Reggio Emilia, Italy)
Responsibility
The work has been jointly planned between the Sprar project (Municipality of RE and Coop. Dimora d'Abramo) and the Local Health Authority. It has been financed with Sprar reception project funds, for which the Municipality is the responsible body, and Coop. Dimora is the managing body.
Description
The supervision/training took the following format:
1) SUPERVISION MEETINGS in small specific groups (15 participants at most), focusing on the supervision of cases involving asylum seekers and beneficiaries of international protection. These meetings were scheduled over 18 months (from January 2013 to June 2014).
The working group was formed of service representatives/workers who were already working, under various capacities (social, healthcare, etc), with the SPRAR project in managing regional integration programmes for beneficiaries.
2) SEMINARS FOR A WIDER AUDIENCE with the goal of raising awareness and engaging/informing regional agencies on the issue of international protection.
Expected outcomes
The acquisition of more knowledge on cultural and historical aspects of refugees' backgrounds and an understanding of relational and psychological dynamics to develop greater expertise in handling the situation; discussion among workers on their views of their work and the meaning they give to what they do in order to form, over time, a multidisciplinary, wide-ranging group (from public, healthcare and private social institutions) that can begin to develop a common view of work and the goals set through collaboration.
Achieved outcomes
For the most part, yes, even though there could have perhaps been more involvement from other services from the outset.
Resources needed for implementation
A more shared approach to planning with other regional subjects; training/supervision alternating between meetings and moments for reflection/exercises online could also be considered (through shared platforms).

Information for small groups of female refugees from Sub-Saharan Africa
(Reggio Emilia, Italy)
Responsibility
Volunteer obstetrician and gynaecologist.
The Nigerian English-speaking intercultural mediator was present.

Description

The work was carried out in collaboration with associations/cooperatives that handle the reception of female refugees, mainly from Sub-Saharan Africa.

The information was primarily aimed at healthcare education, STD prevention, contraception and understanding services, with particular reference to the area of WOMEN'S HEALTH.

Expected outcomes

Easier access to services among female refugees who come to the Reggio Emilia region. Support for women in the programme on protecting their own health and preventing unwanted pregnancies.

Achieved outcomes

It is rather complicated to assess whether all the objectives have been achieved in terms of quantity, but we noticed that:

The size of the small group in which you could present yourself and say something about yourself in an atmosphere of respect and willingness to listen helped bring out any needs and individual requests.

Feeling that people are listening to you adds recognition of your dignity, having a positive influence on self-awareness and on individual choices.

Access to services is made easier safe in the knowledge that you will meet people you already know.

It was possible to organise 2 successive meetings a few months apart for a small group of about 10 women. We think this helped form an atmosphere of greater exchange, improved the level of trust and let us elaborate certain content in a more personalised way.

Resources needed for implementation

The available time of the staff involved needs to be acknowledged; a mediator should be present and the programme should be shared with the agency that handles the reception of refugees.

Mothers workshop: empowerment of women in regard to maternal and child health

(Seville, Spain)

Service/department in charge of the measure

Psychologist of Sevilla Acoge Foundation.

Description of the measure

Development of biweekly workshops to work and talk about issues related to health, education, relationships between parents and children, cultural conflicts (e.g., parents from other countries, minors born in Spain). This kind of group is based on participation and cooperation among participants which have been very useful not only in relation to the objectives of the workshop (i.e., usefulness for people) but also for the parallel activities developed in our organization.

Expected outcomes

To foster the participation of women whose children are being assisted by other programs of the foundation. To create a support group based on trust and respect where women can share their experiences related to health, children's education and problem solving through resources offered by the group. To assist to participants' demands adapting the agenda of the meetings to their requests, recurring to other professionals when necessary.

Achieved outcomes

Identification of needs by the staff and the people assisted by the reinsertion itinerary. Identification of additional needs and the referral of users to other professionals. The constancy in the attendance to workshops and the high number of participants are reasons to think of positive results, besides the positive evaluation of participants. The lack of available resources were the main inconvenience (e.g., people who could not attend to workshops because they could not afford the transport to get to the organization). This workshop has served to incorporate new female users to our services as well as to complete the follow-up of our members who attend to other activities.

Resources needed for implementation
More resources to deepen in a more integral assistance and to make more people benefit from it.

Inform about the right to free healthcare for migrants in the Andalusian region
(Seville, Spain)
Service/department in charge of the measure
Association for the Defence of Public Health / Somos Migrantes Platform.
Description of the measure
To request a meeting with de Directorate General for Social Affairs to explain that the regional instruction was not disseminated after the RD16/2012. To counterattack the media campaign on denial of rights to healthcare by visiting the communities to properly inform about this right.
Expected outcomes
To make the positioning of the Andalusian Public Health System known, which ensures free healthcare for migrants and refugees.
Achieved outcomes
The expected results have been achieved. However, public employees' political position was a disadvantage because of the disagreement with this health right perspective.
Resources needed for implementation
The most effective method could be Press releases.

Briefing on tuberculosis, its treatment and diagnostic methodology
(Seville, Spain)
Service/department in charge of the measure
Nuria Rojas, responsible for CEAR's social services area.
Description of the measure
A briefing on Tuberculosis was organized at Virgen Macarena Hospital (Infectious Disease Area). Different organizations working with socially vulnerable people were invited. The briefing emerges as a result of some difficulties in primary health care, for example, the different assessments depending on the "mantoux test" medical evaluation.
Expected outcomes
To established a unique and consensual criteria for diagnosing.
Achieved outcomes
CEAR requests health care organizations and professionals to assist and organize the briefing. An informative circular was sent to other healthcare centres by the Infectious Disease Area. The problem still exists.
Resources needed for implementation
It requires substantial time to get the first positive outcomes.

Health literacy courses
(Austria)
Service/department in charge of the measure
Human resource management**;** Academy of the hospital trust**;** Nursing schools
Description of the measure
Providing information on health, lifestyle, health care system
Expected outcomes
staff members are able to empathize with refugees and asylum seekers
Availability of the measure:
http://www.bpb.de/lernen/formate/planspiele/65586/planspiele-detailseite?planspiel_id=56

Planspiele
(Austria)
Service/department in charge of the measure
Human resource management**;** Academy of the hospital trust**;** Nursing schools
Description of the measure
Experimental planning games
Expected outcomes
Staff members are able to empathize with refugees and asylum seekers
Availability of the measure
http://www.bpb.de/lernen/formate/planspiele/65586/planspiele-detailseite?planspiel_id=56

Giving refugees a map of the healthcare services available in the region (map of the city of Reggio Emilia) during their first doctor's appointment. The map is handed out and explained in the waiting room together with the mediator.
(Reggio Emilia, Italy)
Responsibility
Foreign family health centre (CSFS), AUSL Reggio Emilia
Expected outcomes
"Basic" understanding and orientation of the healthcare organisation in the city.
Achieved outcomes
We believe the outcomes were positive; the tool should be improved and integrated with a street map of the city (use of public services). The main support still comes from the cooperative instructors.
Resources needed for implementation
On the administrative side, the allocation of a GP and NHS registration renewal need to be simplified. On the healthcare side, there needs to be greater sharing with the other healthcare facilities in the ER Region

ANNEX Ic

Development and dissemination of the resource package

Format of a resource package

Participants to the focus groups and interviews proposed various formats for a resource package. It seems that the best solution is a country-specific format that fits with national and local settings, and existing communication strategies. Face-to-face interventions, training sessions and workshops have been identified as more effective rather than other mediated tools such as brochures, websites, etc. Conversely for some of the participants, online courses –even as part of mandatory training- would be similarly efficient to improve some specific communicative and educational skills. Booklets and leaflets, as well as other paper materials that are easy to disseminate and immediately accessible (with no need to use Internet) might be useful for those health care professionals who are unfamiliar with the Web.

Focus groups' participants have also identified others relevant instruments like: presentations, booklets, brochures, resource briefcase, protocols with decision trees, interactive blogs, websites, intranet, help-lines, learning management systems, tutorial videos, forums for sharing different expertise and connecting professionals with different skills, mobile application for professionals, national and international workshops, and symposiums hold by key stakeholders on regular basis.

The resource package should be aimed to train rather than educate and it should be more experiential than informational. Indeed the general objective should be to raise awareness and to provide participants with skills and capacities to react and answer to real situations, instead of saturate them with theories and concepts. It is recommended to conduct the training in healthcare centers, communities, and social organizations, creating learning communities in healthcare centers, or organizing focus groups. These must be common spaces for a two-way-training where all stakeholders can participate. It is also recommend the collaboration with experts and professionals from other contexts.

It has been highlighted that a relevant training course should be part of the emergency preparation programs. Moreover it should be provided not only to professionals already involved in migrants' assistance, since it could be important for all the health care managers, administrative staff, social workers and other different stakeholders. Courses should be offered during office hours so they do not imply extra working time or conflicts with family life. Furthermore they should be continuous due to the high mobility of providers who work in health care and social organizations (e.g., transfers).

Finally, it has been emphasized that whatever format will be selected, the resource package should be short, simple, cheap and easy to access.

Professionals targeted by the resource package

Participants of the focus groups identified different actors to whom submit the resource package in order to maximize its impact. Almost everybody agreed that the resource package should target all the health care workers, administrative staffs, managers, representatives of humanitarian and faith-based organizations, civil society, volunteers, and academia. In the short term front line professionals who are already working with migrants would immediately benefit of new sources because they are willing to improve their daily practice; while in the long term health care managers and many more experts may take advantage of the resource package, and supervise its implementation. Moreover, at organizational level, interpreters, intercultural mediators and social workers should be targeted as well since they act as spokesman of users, they maintain

a continue contact with migrants and administrative staff, and they are also members of multidisciplinary team.

Migrant-sensitive policymakers and national governmental institutions are key entities to take the discourse at political level, promote the dissemination and ensure the adoption of the resource package. At community level it is valuable to take into account all members and actors of communities, different civil and social movements. The contributions from different perspectives are needed, since barriers to access the health care by migrants depend on heterogeneous factors and challenges. Indeed a culturally competent health care workforce will help to improve access, and quality health care outcomes while contributing to the elimination of health disparities.

The dissemination strategy for the resource package

Concerning the most effective strategies to disseminate the resource package, the respondents of the focus groups argued that it would be useful to count on providers from different backgrounds to act at many levels (e.g. policy, organizational and community levels) and settings (e.g., health and social sector, universities, counselling, etc.). They also asserted that the resource package should be selectively and geographically disseminated, even through existing networks of people who work in that field. At policy level, it would be useful to include the resource package among the existent training programs, current healthcare plans, existing national websites and communication strategies. It could be disseminated through the Ministry of Health, national and local health professional organizations, national schools of public health, universities, NGOs during team meetings or board meetings. As mentioned previously, health professionals interviewed considered the political discourse a powerful tool to promote this package. The creation of a specific and up-dated platform will help the follow-up, in addition to the participation in forums and the elaboration of reports.

Furthermore the cooperation between different faculties (e.g. Ethnology and Cultural Anthropology, Medicine, Health Sciences, Education, etc.) is considered relevant since students' opinions and experiences could have a wider social influence. The resource package should be included in undergraduate and postgraduate trainings for health professionals. At community level, neighbourhoods' community action centres and community health roundtables may play a crucial role.

The main strategy to inform the widest audience however is to make use of the media (mainstream and social), involving public figures to raise awareness and sensitize citizens to look at this vulnerable population as human beings having the right to be integrated in our society. The media have the biggest impact on the public opinion, and they are seeing as an essential channel to transfer information and knowledge. Someone argued that it might be helpful to show short video-clips through hospitals TV-screens to inform patients and care-providers. Mobile units have been also mentioned as they may contribute to disseminate the resource package. Finally respondents stressed that the resource package should be economically accessible to everybody at all levels. Such inter-sectorial and integrated approach could therefore encourage the diffusion of information, the creation of alliances and synergies, the sharing of planning, the exchange of good practices.

ANNEX II

Detailed description of methods and results of the systematic literature review

Methods

Research question and objectives

On the base of the results of the interviews and focus groups a literature review was conducted to systematically collect, summarize and critically appraise the available evidence and grey literature on access to health care services for asylum seekers and refugees.

This literature review was conducted as a part of a larger research project aiming at developing a resource package to support Member States when facing afflux of refugees and asylum seekers.

What this study aims is to identity existing gaps between barriers and solutions in accessing health services for asylum seekers and refugees in the current context of the migration crisis in OCDE countries. To achieve this objective, a literature search was conducted in the international literature and in the grey literature.

The research question was: *"What are the current barriers and solutions related to access to health services for asylum seekers and refugees in OCDE countries?"*

More specifically, this review had 4 objectives: 1) to identify current barriers for asylum seekers and refugees in accessing health services, 2) to identify evidence-based solutions and best practices that aim to improve access to health services for asylum seekers and refugees, 3) to add evidence to the outcomes of the focus-groups conducted in the SH CAPAC project, and 4) to identity existing gaps between barriers and solutions in accessing health services for asylum seekers and refugees.

Search strategy and data extraction

The overall design of this research is a systematic international literature review of the scientific and grey literature related to the access to health care services for asylum seekers and refugees.

The search strategy initially designed for the PubMed database was then adapted to the other databases searched. Truncated search terms and Thesaurus were used to increase the sensitivity. The search equation was based on the PICO (Participants, Interventions, Comparisons and Outcomes) method.

- Population: Refugees /asylum seekers/unaccompanied minors/unaccompanied children/ undocumented /irregular migrants (e.g. asylum seekers waiting for official permit of asylum). Studies involving only migrants, labour, immigrants, emigrants, ethnic minorities, internally displaced populations were excluded.
- Intervention: Health Services Accessibility + barriers or solutions

A search strategy was developed and adapted for each database we searched, including: CINHAL, Embase, Medline, Scopus, the Cochrane Database and CAIRN.

Studies were included in the review if they were published in journals from January 2008 to July 2016; papers written in English, French, Italian, Spanish and Dutch were included. Letter to the Editor, Comments, book reviews or Editorials were excluded. All other types of study design were included. Studies conducted in Asia, Africa and South America were also excluded.

In addition, further studies were retrieved from reference listing of relevant articles and consultation with experts in the field. Grey literature was examined manually for migrant health-related topics including policy frameworks. The following websites were searched for additional resources: International Red Cross, Doctors of the World, Doctors without Borders, Caritas international, Oxfam, WHO, WHO Europe Region, IOM, UNHRC and the European Union. Abstract books of the last EUPHA conferences (Granada 2014, Milano 2015, Oslo 2016) were also searched. A hand search was also conducted in the existing databases of the AUSL Reggio Emilia. When necessary, requests were sent to the authors of relevant studies in order to get access to the papers or additional data. The data extraction was based on the criteria developed by the NHS Centre for Reviews and Dissemination (CRD)[a]. Citations and abstracts were stocked in an Endnote library. Standardised review forms were used to retrieve the following data: 1) general information on the study; 2) data on the study population; 3) health care provision; 4) health care settings; 5) barriers preventing access to health care services; and 6) solutions to improve access to health care.

Study selection

Three reviewers carried out the review process (MD, BR and CQ). Each reviewer first checked the title and the abstract based on the inclusion and exclusion criteria.

The topic of the paper should concern the description of the barriers related to access and/or the development and test of the interventions aiming at decreasing access barriers for asylum seekers and/or refugees. Studies focusing on epidemiological aspects (e.g. if a study describes disparities in prevalence or in health care consumption but without explaining why the differences occur or without trying to solve it, the study should not be included), studies focusing on integration aspects without any reference to health care accessibility (e.g. studies reporting integration classes or adaptation of the educational system to better integrate refugees) and studies presenting research methods, instrument development, theoretical models without application were excluded.

Each abstract was coded as Accepted, Rejected and To discuss. "To discuss" abstracts were discussed between the three reviewers and final decision for acceptance was made by consensus. If necessary, the full text of the article was reviewed before acceptance.

Classification of the interventions

The three reviewers classified the interventions according to the barriers and/or solutions regarding access to health care services. Divergent coding was discussed and the final decision on the classification of the interventions was made by consensus.

The barriers and the solutions were based on previous studies on access to health care. A barrier was defined as an obstacle to access health care. A solution was defined as a possible intervention to enable access to health services. Two main categories were structured: *General barriers concerning access to healthcare services* and *Barriers concerning access to specific healthcare services.*

Articles focusing on specific barriers and solutions (i.e.: mental health, violence and torture...) have been classified in the category *Barriers concerning access to specific healthcare services*, while papers focusing on general barriers (i.e.: Legislative, Linguistic and cultural barriers...) have been included in *General barriers concerning access to healthcare services* category.

[a] CRD - NHS Centre for Reviews and Dissemination - (2001) Report Number 4 (2nd ed.), Undertaking Systematic Reviews of Research on Effectiveness. York: CRD.

Each main category has been structured and examined in subgroups as follows:

General barriers concerning access to healthcare services

- Legislative, administrative, financial and bureaucratic barriers
- Linguistic and cultural barriers
- Organisational barriers and obstacles to accessing health care services of equitable quality
- Lack of information for health providers and obstacles to ensuring continuity of care
- Lack of information and education for refugees and asylum seekers
- Lack of coordination between services

Barriers concerning access to specific healthcare services

- Barriers to accessing appropriate mental health care services
- Barriers to accessing appropriate sexual and reproductive health care services
- Barriers to accessing appropriate health care services for children and adolescents
- Barriers to accessing appropriate health care services for victims of violence

Among each main category - *General barriers concerning access to healthcare services* or *Barriers concerning access to specific healthcare services* - a same study could be classified in more subgroups within the same major category (i.e.: - a same study could be classified in barriers to accessing appropriate health care services in mental health and children/adolescents both subgroups).

Results

After reviewing 2316 references, 252 papers have been included in the final database for analysis (Figure 1). Among the 252 papers included 132 have been classified in the category *General barriers concerning access to healthcare services and* 120 *in Barriers concerning access to specific healthcare services one.*

Characteristics of the studies included in the review

Year of publication

Publication dates (Figure 2) range from 2008 (n=21) to 2016 (n=27); most of the papers were published in 2015 (n=40). From 2008 to 2015 - excluding 2016 as only the first semester has been considered in the analyses - an increasing trend of publications on barriers and solutions related to access to health services for asylum seekers and refugees over time has been identified.

Country of study conduction

Ninety studies have been conducted in the North America continent. Ninety studies come from the European region, including Turkey and Balkans and 17 studies were considered as international. Studies in European countries have been conducted mostly in the United Kingdom (n=28) followed by Sweden and Switzerland (n=6 respectively), Ireland (n=5), Denmark (n=4), Greece (n=3). Other European countries as Belgium, Italy, Malta, Norway, Spain and The Netherlands accounted only for 2 articles each one. Countries with lower number of studies on the topic were: Bulgaria, Croatia, Finland, France, Germany, Macedonia, Serbia (n=1, each one). Among non-European studies, the countries were United States (n=61), Australia (n=44), Canada (n=29) and Israel (n=2).

Study design

Overall, the design of the studies was qualitative (n=147), 45 papers were literature reviews, either scoping reviews, either systematic reviews, 41 studies had a quantitative design and 19 studies had a mixed approach, with a qualitative and quantitative design.

Target groups of the studies/Participants included in the study

Table 1 presents the description of the target groups of the studies included in the literature review. All the studies aimed at improving directly or indirectly access to health care for ASR. Among the 252 studies, 81 involved both asylum seekers and health/social care professionals. Policymakers were directly involved in 20 studies. No relevant difference has been observed between general barriers concerning access to healthcare services and those on access to specific healthcare services one concerning the participants/target of the interventions included in the studies.

Comparing the legal status of the participants, studies concerned recognised refugees (n=120), asylum seekers (n=35) and asylum seekers and refugees (n=28). The 24 remaining studies involved mixed groups of refugees, asylum seekers, undocumented migrants and immigrants. Some studies had a specific interested in mixed groups living in socioeconomic deprivation.

Concerning the refugee groups, 173 studies aimed at involving all refugees / asylum seekers without attention to a specific country of origin. Among the studies targeting a specific ethno cultural group, the following countries and regions were found: sub-Saharan Africa (n=46), Myanmar-Vietnam-China-Korea (n=30), Middle East (n=19), Afghanistan & Pakistan (n=13), Latin & Central America (n=4), south Asia (n=3), Roma (n=1), Bosnia (n=1) and Kurdish (n=1). Women, including pregnant women, were the target group of 52 studies while men were specifically targeted in only 5 studies. Thirty studies were interested in adolescents and children, including 4 studies on unaccompanied minors.

Phase of the migration process

The majority of the studies were conducted at the destination phase - when the refugees are definitely resettled in their new country- both in general barriers concerning access to healthcare services (n=94) and in those on specific healthcare services (n=97) (Table 1). Thirteen studies specifically targeted the arrival phase, while 3 were focused in the transit phase. However, this distinction may be more theoretical than practical.

Health-care setting

In Table 1 are reported the Health-care setting cited by the studies, the most cited setting both in General barriers concerning access to healthcare services and those on specific healthcare services was the health-care system level (n=81, n=49 respectively), followed by the primary care service level (n= 57, in total). Also considering only studies focusing on possible solutions the health-care system level (n=130) and the primary care service level (n=49) were the mostly reported.

Current barriers and solutions related to access to health services for asylum seekers and refugees

Among the 252 papers included 132 have been classified in the category *General barriers concerning access to healthcare services and* 120 *in Barriers concerning access to specific healthcare services one.*

Overall 456 barriers and 350 solutions were identified. A same study could be repeated several times in each main category and in some papers were identified both barriers and solutions. It is worth noting that when a barrier was identified, the solution is not always reported or coincides with same barrier.

- *General barriers concerning access to healthcare services*

Studies that not reported a specific type of health care provision have been included in the category General barriers concerning access to healthcare services resulting in 132 papers (Figure 3).

The most frequent barrier to access health care services concerns language and cultural aspects (n=65). Besides the communication skills and the language knowledge, it involves also the socio-educational aspects and the lack of health literacy. This barrier also concerns the individual level and included specific barriers such as trust and reliability towards health professionals, satisfaction with health care. Some studies also identified cultural aspects that may prevent access to health care such as gender preferences, health beliefs and cultural norms. Language and cultural aspects were solved by the use of interpreters, intercultural mediators or community peers (n=45).

Legislative, bureaucratic, administrative and financial barriers were reported in 44 general barrier and 26 possible solutions. When the studies concerned refugees, legal barriers were not a barrier, while asylum seekers were more likely to experience such barriers. In some studies, affordability was the barrier to access health care services, although most of the studies were concerned with administrative and bureaucratic barriers.

It is relevant to point out that barriers and solutions showed similar figures in the subgroup related to information and continuity of care for care provider (n=20; n=18 respectively) and in the Organisation and quality of care subgroup (barriers n=47; solutions n=46). Lack of Organization and quality of care means the lack of transportation to access services, lack of availability of the needed services, lack of coverage of the needs of the patients and lack of responsiveness from the staff (e.g. lack of training and/or education of the staff), despite this most of the solutions in this category concerned the organization and quality of care (n=46).

Information and continuity of care for refugees and asylum seekers was defined as the provision of clear and comprehensible information to the ASR about the care provided and the services they may need. This was found in 36 barriers and 28 solutions.

In the coordination between services subgroup more solutions (n=30) than barriers (n=22) were retrieved. It included papers on the circulation of the information at the institutional level, the intersectoral collaboration and the coordination between: different health-care settings and the various actors involved in the care of ASR (NGOs, public authorities, law enforcement, social workers and health professionals).

The barrier less mentioned was related to information and continuity of care for care providers (n=20) and it included the transfer of information related to the follow-up of the patient between providers and the access to relevant up-to-date information for care providers.

- *Barriers concerning access to specific healthcare services*

Studies focusing on a specific type of health care provision (n=120) were included in the category *Barriers concerning access to specific healthcare services, the* distribution papers by each specific access to healthcare service is reported in Figure 4.

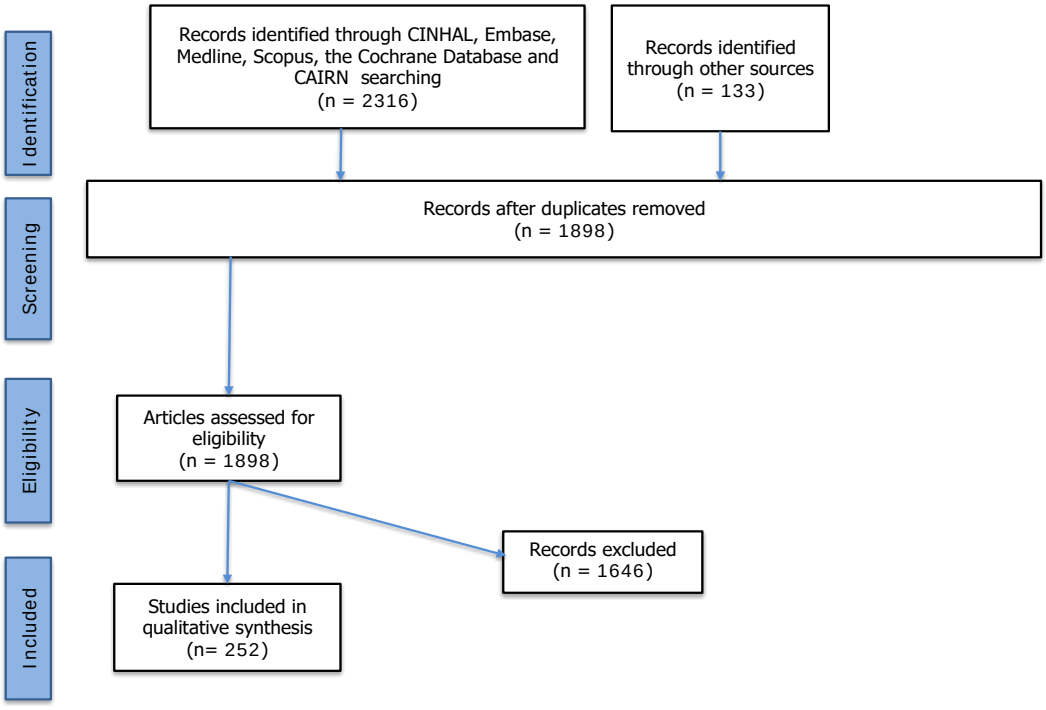
The most reported barriers concerned mental health and sexual and reproductive health (n=81; n=78 respectively). In the sexual and reproductive health subgroup the gap among barriers and solutions was relevant, while it was not the same for the children and violence and torture subgroups, reporting similar results between barriers and solutions (Figure 4).

Figure 5 reports the distribution of papers on access to specific healthcare services by barriers and solutions. Figures seem in line with those presented in the *General barriers concerning access to healthcare services* category: the barriers and solutions most frequently mentioned concerned language and cultural aspects (barriers n= 79; solutions n=38) and Organisation and quality of care (barriers n=58; solutions n=50), but compared to the *General barriers category* the differences among barriers and solutions in these subgroups were higher.

The Legislative, bureaucratic and administrative aspects and information and continuity of care for refugees and asylum seekers subgroups showed similar results in both solutions and barriers.

Unexpectedly - in this category - papers focusing on information and continuity of care for care providers were scant and the number of barriers and solutions coincided (n=5).

Figure 1: PRISMA Flow diagram of papers selected [b]



[b] *Sources: adapted from:* Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Figure 2: Distribution of publications over the time

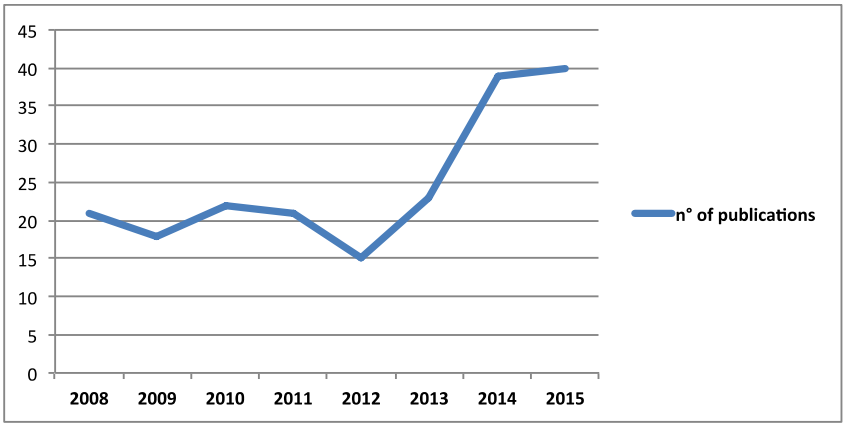


Table 1: Characteristics of the included studies on general barriers and solutions to access to healthcare services [c]

	GENERAL BARRIERS ON ACCESS TO HEALTHCARE SERVICES (n=132)	BARRIERS ON ACCESS TO SPECIFIC HEALTHCARE SERVICES (n=120)	TOTAL (n =252)
Health-care setting			
Health care system	81	49	130
Reception centre for asylum seekers/refugees	11	4	15
Primary care service/GP	30	27	57
Hospital service	3	8	11
Specialised services	5	9	14
Mental health services	0	24	24
Accident & emergency department	1	0	1
Other settings (school, community…)	6	10	16
Migration phases			
Arrival phase	9	4	13
Transit phase	3	0	3
Destination phase	94	97	191
All	15	7	22
Not specified	13	13	26
Participants included in the study			
Refugees and Health Providers	48	33	81
Refugees	63	66	129
Health Providers	22	29	51
Policymakers	11	9	20

[c] *Please note that a same study could focus on more than one type of Health-care setting, migrations phase and participant*

Figure 3: Distribution of papers on access to healthcare services by general barriers and solutions [d]

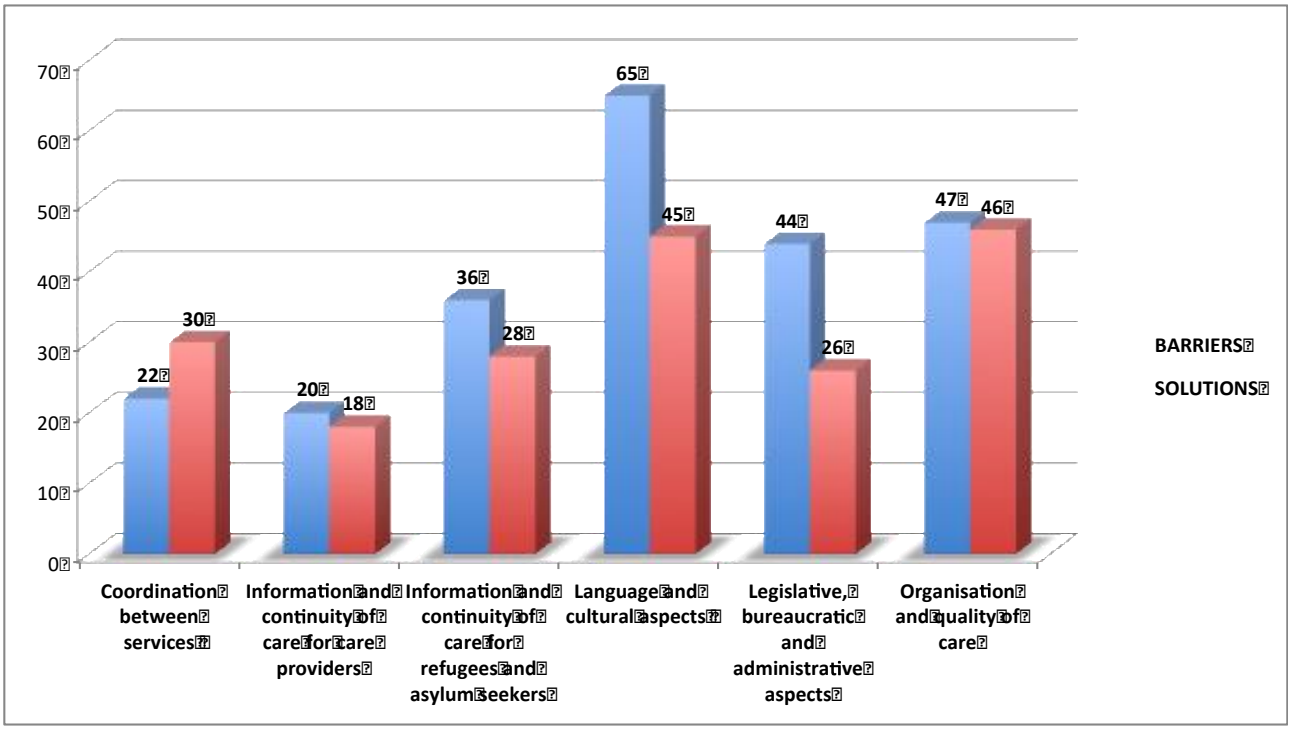
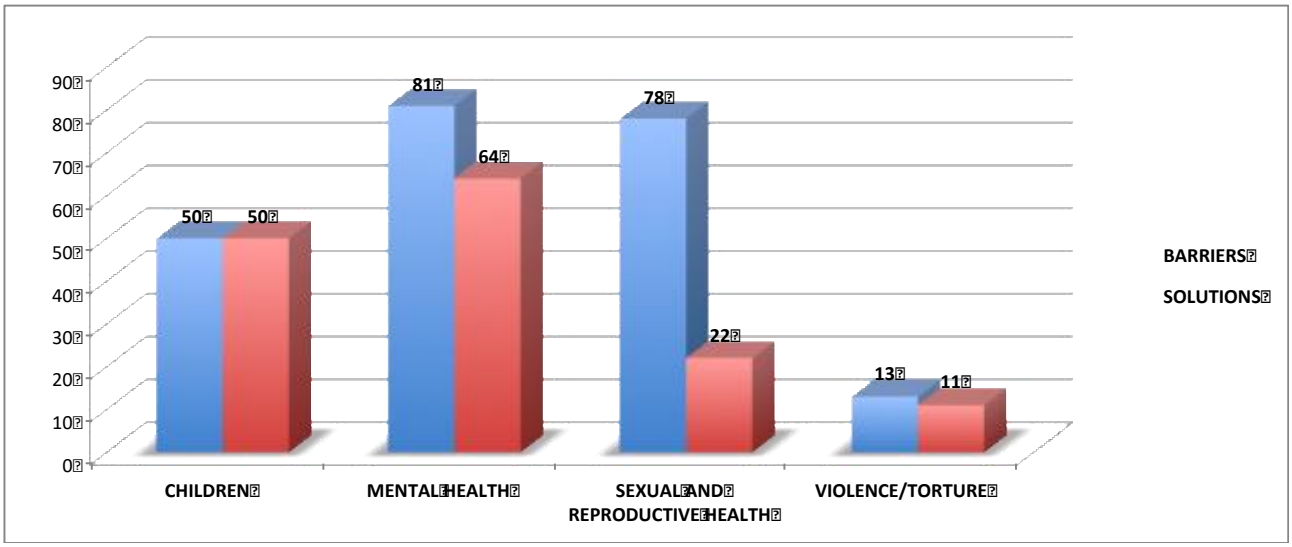
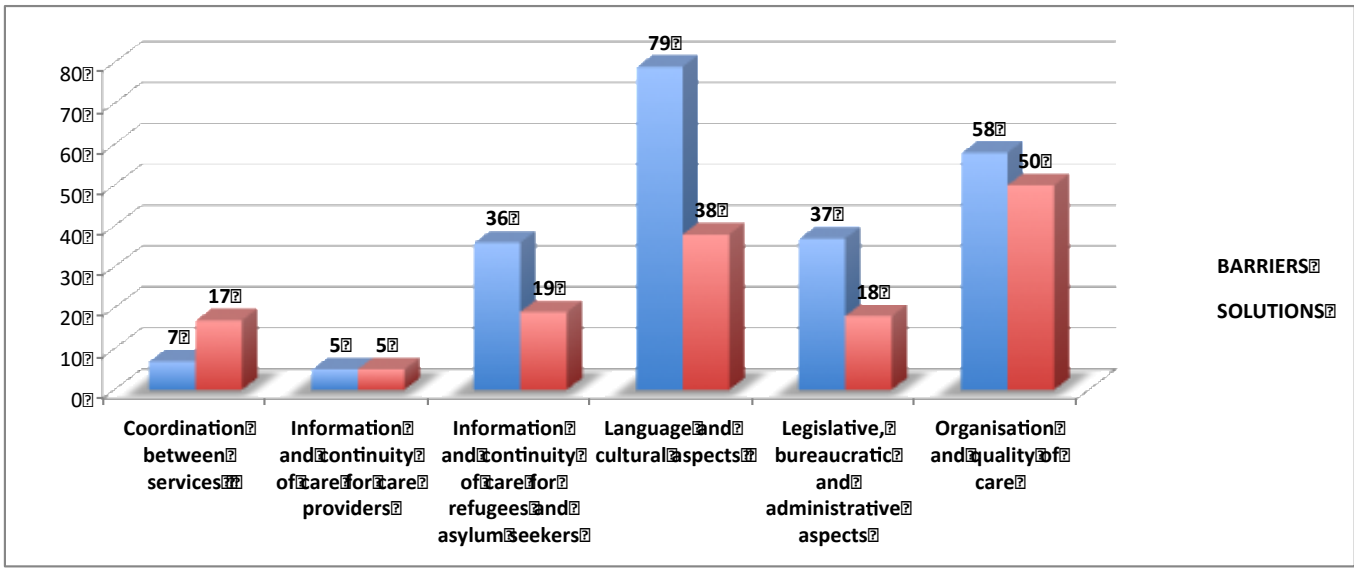


Figure 4: Distribution of papers by each specific access to healthcare service [d]



[d] *Please note that within the same main category due to overlap a same study may be cited several times*

Figure 5: Distribution of papers on access to specific healthcare services by barriers and solutions [d]



[d] *Please note that within the same main category due to overlap a same study may be cited several times*

ANNEX III

List of complete references included in the systematic review

FIRST AUTHOR AND TITLE OF THE ARTICLE	YEAR	COUNTRY	OBJECTIVE OF THE STUDY	STUDY POPULATION	METHODOLOGY
Abbing, H.D., ***Age determination of unaccompanied asylum seeking minors in the European Union: a health law perspective.***	2011	Europe	to create of EU best practice guidelines for age determination amongst unaccompanied asylum seeking minors.	Unaccompanied minors	qualitative
Ahmad, F., et al., ***A pilot with computer-assisted psychosocial risk-assessment for refugees.***	2012	Canada	to create interactive eHealth tools (multi-risk Computer-assisted Psychosocial Risk Assessment CaPRA) that could build bridges between medical and social care in a timely manner.	Afghan refugees	quantitative
Ahmed, A., et al., ***Experiences of immigrant new mothers with symptoms of depression.***	2008	Canada	to better understand immigrant new mothers with depressive symptoms (a) experiences and attributions of depressive symptoms, (b) their experiences with health care providers and support services, (c) factors that facilitated or hindered help seeking, (d) factors that aided recovery or (e) were associated with women continuing to experience symptoms of depression. to identify barriers and to offer suggestion for improvement.	refugees, asylum seeking, non-refugee, and immigrant women	qualitative
Akar, F.A., et al., ***The Istanbul protocol (manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment): implementation and education in Israel.***	2014	Israel	to standardize the implementation of rules concerning (domestic) violence against women, children and the elderly, the management of cases where patients have been subjected to violence while under the custody of legal enforcement agencies, or patients who have been victims of torture. To implement a manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment.	refugees and asylum seekers women, children and elders	qualitative
Al-Obaidi, A., et al., ***Incorporating Preliminary Mental Health Assessment in the Initial Healthcare for Refugees in New Jersey.***	2015	United States	to assess the feasibility of introducing a mental health screening tool into the initial health care assessment for refugees in New Jersey, US.	refugees	qualitative
Alayarian, A., ***Children, torture and psychological consequences.***	2009	United Kingdom	to provide clinical services, to influence policy and practice by searching for evidence and demonstrating solutions to improve the lives, homes and communities of children disadvantaged by torture and the services that support them and to provide some remedies to children of refugees who are suffering the consequence of trauma that they experienced and demonstrate good practice.	refugee children	qualitative
Anders, A.D.P. and J.N. Lester, ***Navigating authoritarian power in the United States: Families with refugee status and allegorical representation.***	2015	United States	to examine the cultivation of modern convictions in the elementary school and health care system, and the influence of such convictions at the intersection of authoritarian power.	Burundian refugees	qualitative

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Asgary, R. and C.L. Smith, **Ethical and professional considerations providing medical evaluation and care to refugee asylum seekers.**	2013	United States	to review ethical concerns in regard to accountability, the patient-physician relationship, and moral responsibilities to offer health care irrespective of patient legal status; competing professional responsibility toward society and the judiciary system; concerns about the consistency of asylum seekers' claims; ethical concerns surrounding involving trainees and researching within the evaluation setting; and the implication of broader societal views towards rights and social justice.	asylum seekers	literature review
Asgary, R. and N. Segar, ***Barriers to health care access among refugee asylum seekers.***	2011	United States	to portray the access to health care of asylum seekers.	asylum seekers	qualitative
Aspinall, P., ***Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospitals***	2014	United Kingdom	to provide a foundation for understanding the changes that might need to be brought about in the health and related systems to meet the needs of individuals living in an unequal society.	asylum seekers, undocumented migrants, refugees and migrants	literature review
Baarnhielm, S., C. Javo, and M.O. Mosko, ***Opening up mental health service delivery to cultural diversity: current situation, development and examples from three northern European countries.***	2013	Germany, Norway, Sweden	to analyse the barriers to mental health care access for refugees, migrants and minorities, and problems with quality of culturally sensitive care in the three countries.	refugees, migrants and minorities	literature review
Baarnhielm, S., et al., **Approaching the vulnerability of refugees: evaluation of cross-cultural psychiatric training of staff in mental health care and refugee reception in Sweden.**	2014	Sweden	to evaluate the outcomes of cross-cultural mental health training given to professionals in health care and refugee reception in Stockholm, Sweden.	health care professionals, refugee reception professionals	mixed approach
Baird, M.B., ***Well-being in refugee women experiencing cultural transition.***	2012	United States	to present a situation-specific theory of well-being in refugee women experiencing cultural transition.	South-Sudanese refugee women	qualitative
Balaam, M.C., et al., ***A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth.***	2013	INT	to synthesis the evidence related to migrant women's perceptions of their needs and experiences in relation to pregnancy and childbirth.	refugee and immigrant women	literature review
Balaam, M.C., et al., ***'We make them feel special': The experiences of voluntary sector workers supporting asylum seeking and refugee women during pregnancy and early motherhood.***	2016	United Kingdom	to explore the experiences of voluntary sector workers supporting asylum seeking and refugee women during pregnancy and early motherhood.	asylum seeking and refugee pregnant women	qualitative
Balachandra, S.K., et al., ***Family-centered maternity care for deaf refugees: the patient-centered medical home in action.***	2009	United States	to apply principles of the patient-centered medical home - PCMH to address an extremely challenging clinical situation: providing high-quality maternity care to a recently immigrated Vietnamese refugee couple lacking formal language skills.	Vietnamese refugee couples, deaf Vietnamese refugees	qualitative

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Bell, P. and E. Zech, ***Access to mental health for asylum seekers in the European union: An analysis of disparities between legal rights and reality.***	2009	Belgium	to explore some of the issues surrounding access to mental health care for asylum seekers, using Belgium as a case in point and to address the discrepancies that continue to exist between member states, notably policies on health care for refugees, and in particular mental healthcare.	asylum seekers	qualitative
Bellamy, K., et al., ***Access to medication and pharmacy services for resettled refugees: a systematic review.***	2015	NR	to review systematically the literature and synthesise findings of research that explored barriers and/or facilitators of access to medication and pharmacy services for resettled refugees.	refugees	literature review
Beltran-Avery PP. ***'The role of the health care interpreter'***, National Council on Intepreting in Health Care. 2011.	2011	United States	to explore the evolution of the role of the health care interpreter.	stakeholders	qualitative
Bennett, S. and J. Scammell, ***Midwives caring for asylum-seeking women: research findings.***	2014	United Kingdom	to explore the experiences of midwives caring for asylum seeking women.	asylum seeking women	qualitative
Berthold, S.M., et al., ***Comorbid mental and physical health and health access in Cambodian refugees in the US.***	2014	United States	to identify the relationship between mental and physical health problems and barriers to healthcare access in Cambodian refugee adults.	Cambodian refugees	quantitative
Bischoff , A., et al. ***Doctor – Patient Gender Concordance and Patient Satisfaction in Interpreter-Mediated Consultations: An Exploratory Study.***	2008	Switzerland	to explore the effect of doctor – patient gender concordance on satisfaction of foreign language – speaking patients in consultations with and without a professional interpreter.	refugees and immigrants	quantitative
Bischoff, A. and K. Denhaerynck, ***What do language barriers cost? An exploratory study among asylum seekers in Switzerland.***	2010	Switzerland	to investigate the association between language barriers and the costs of health care.	asylum seekers	quantitative
Bodenmann, P. and A.R. Green, ***Health disparities: Local realities and future challenges.***	2012	Switzerland	to describe the potential disparities taht vulnerable population face in order to explain their cause, and propose possible solutions.	asylum seekers, undocumented immigrants, marginalised Swiss natives and immigrant communities	qualitative
Bogenschutz, M., ***"We find a way": challenges and facilitators for health care access among immigrants and refugees with intellectual and developmental disabilities.***	2014	United States	to discover the particular challenges that immigrants with disabilities face when accessing health care, and the facilitating factors that assist them in this process.	disabled refugees and immigrants	qualitative
Boise, L., et al., ***African refugee and immigrant health needs: report from a community-based house meeting project.***	2013	United States	to gather data about the perceived health needs and barriers to health care Africans encounter, and lay the foundation for a program of action to guide APH's future work.	African refugees & immigrants	qualitative

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Borland, R. and C. Zimmerman, ***Caring for trafficked persons. Guidance for health professionals.***	2012	INT	to provide practical, non-clinical guidance to help concerned health providers understand the phenomenon of human trafficking, recognize some of the health problems associated with trafficking and consider safe and appropriate approaches to providing health care for trafficked persons. It outlines the health provider's role in providing care and describes some of the limitations of his or her responsibility to assist.	refugees and asylum seekers	mixed approach
Borland, R. and C. Zimmerman, ***Caring for trafficked persons. Training facilitator's guide.***	2012	INT	to present a facilitator's guide and accompanying materials for individuals who wish to carry out training for health providers.	refugees and asylum seekers	qualitative
Boynton, L., et al., ***The role of stigma and state in the mental health of Somalis.***	2010	United States	to present a case report of a 55-year-old Somali refugee suffering from depression and posttraumatic stress disorder.	Somali refugees	qualitative
Bradby H, Humphris R, Newman P, Phillimore J. ***Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region***. Health Evidence Network synthesis report. 2015	2015	INT	To review available evidence and examining which policies and interventions would work to improve accessibility and quality of health care delivery for asylum seekers and refugees.	health status for refugees and asylum seekers in the European Region	mixed approach
Bradby, H., et al.**Refugees and asylum seekers in the European Region - reviewing the research evidence.**	2016	Europe	to identify which policies and interventions work to improve health care access and delivery for asylum seekers and refugees in the European Region.	refugees and asylum seekers	literature review
Bradby, H., et al., ***Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region***	2015	INT	to synthesize research findings from a systematic review of available academic evidence and grey literature to address the following question: what policies and interventions work to improve health care access and delivery for asylum seekers and refugees in the European Region?	refugees and asylum seekers	literature review
Brandon Chen, Y.Y., et al., ***Improving access to mental health services for racialized immigrants, refugees, and non- status people living with HIV/AIDS.***	2015	Canada	to explore IRN- PHAs' (people living with HIV AIDS) mental health service- seeking behaviours, service utilization experiences, and give suggestions for service improvements.	refugees, immigrant, and non- status migrants	qualitative
Briones-Vozmediano, E., et al. ***Barriers and facilitators to effective coverage of Intimate Partner Violence services for immigrant women in Spain.***	2015	Spain	to explore service providers' perceptions in order to identify barriers and facilitators to effective coverage of Intimate Partner Violence (IPV) services for immigrant women in Spain, according to the different categories proposed in Tanahashi's model of effective coverage.	refugee and immigrant women	qualitative
Briscoe, L,. & Lavender, T. **Exploring maternity care for asylum seekers and refugees. .**	2009	United Kingdom	to explore and synthesize the experience of maternity care by female asylum seekers and refugees.	refugees and asylum seekers	qualitative

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Brolan, C.E., et al., ***Invisible populations: parallels between the health of people with intellectual disability and people of a refugee background.***	2011	Australia	to recognise the importance of health policy in leading affirmative action to ensure these populations become visible in the implementation of the National Primary Health Care Strategy.	refugees, humanitarian entrants and people with intellectual disability	qualitative
Brown, E., et al., ***"They get a C-section...they gonna die": Somali women's fears of obstetrical interventions in the United States.***	2010	United States	to explore sources of resistance to common prenatal and obstetrical interventions among 34 Somali resettled adult women in Rochester, New York.	Somali refugee women	qualitative
Burchill J. ***Safeguarding vulnerable families: work with refugees and asylum seekers.***	2011	United Kingdom	to explore the experiences of health visitors working with refugees and asylum seekers.	health visitors, refugee families	qualitative
Campbell, R., et al., ***A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada.***	2014	Canada	to examine the vulnerabilities of undocumented immigrant and contrast their experiences seeking healthcare with refugee claimants and permanent residents.	asylum seekers, undocumented migrants and migrants	qualitative
Charbonneau, C.J., et al. ***Exploring the views of and challenges experienced by dental hygienists practising in a multicultural society: A pilot study.***	2014	Canada	to explore the views of and challenges experienced by dental hygienists practising in a multicultural society.	refugees, new immigrants, Aboriginal people, and people of low economic status	qualitative
Chauvin, P., et al. ***Non access to vaccinations among migrant and ethnic minorities' children***: analysis from Doctors of the World International Network Observatory.	2016	Europe	to collect data on immunization among children and to identify barriers to immunization.	refugee children	qualitative
Chauvin, P., et al., ***Access to healthcare for people facing multiple vulnerabilities in health.***	2015	Europe	to describe the epidemiological situations of vulnerable migrant groups and their barriers when accessing health care services.	refugees and asylum seekers	qualitative
Cheng, I.H., A. et al. ***Refugee experiences of general practice in countries of resettlement: a literature review.***	2015	United Kingdom	to describe and analyse the literature on the experiences of refugees and asylum seekers using general practice services in countries of resettlement.	refugees and asylum seekers	literature review
Cheng, I.H., et al., ***Importance of community engagement in primary health care: the case of Afghan refugees.***	2015	Australia	to describe how the Afghan pre-migration experiences of primary health care can affect engagement with Australian primary care services, including the implications for Australian primary health care policy, planning and delivery.	Afghan refugees	qualitative
Cheng, I.H., et al., ***Rites of passage: improving refugee access to general practice services.***	2015	Australia	to analyse the factors influencing Afghan refugees' access to general practice.	Afghan refugees	qualitative

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Chiumento, A., et al., ***School-based mental health service for refugee and asylum seeking children: multi-agency working, lessons for good practice.***	2011	United Kingdom	to describe the Haven Project: a school based Child and Adolescent Mental Health Service (CAMHS) for refugee children in Liverpool and to present a multiagency model for replication across community mental health services.	refugee children and adolescents	qualitative
Clark, A., et al., ***'Excuse me, do any of you ladies speak English?' Perspectives of refugee women living in South Australia: barriers to accessing primary health care and achieving the Quality Use of Medicines.***	2014	Australia	to identify the barriers to accessing primary health care services and explore medicine-related issues as experienced by refugee women in South Australia.	Sudanese, Burundese, Congolese, Burma, Afghan and Bhutanese refugee women	qualitative
Cobb, T.G., ***Strategies for providing cultural competent health care for Hmong Americans.***	2010	United States	to enumerate the barriers to providing health care to Hmong Americans and share strategies to respect Hmong culture when providing quality health care.	Hmong refugees	qualitative
Colucci, E., et al., ***In or out? Barriers and facilitators to refugee-background young people accessing mental health services.***	2015	Australia	to explores barriers and facilitators to engaging young people from refugee backgrounds with mental health services	youth refugees	qualitative
Colucci, E., et al., ***The utilisation of mental health services by children and young people from a refugee background: a systematic literature review.***	2014	NR	to summarize what is known about the use of mental-health services by children and young people of refugee background and to identify factors that may constitute impediments to service use as well as factors that may facilitate access to and engagement with services.	children and young refugees	literature review
Correa-Velez, I. and J. Ryan, ***Developing a best practice model of refugee maternity care.***	2012	Australia	to develop a best practice model of maternity care for women from refugee backgrounds at a major maternity hospital in Brisbane, Australia.	pregnant refugee women	mixed approach
Crosby, S.S., ***Primary care management of non-English-speaking refugees who have experienced trauma: a clinical review.***	2013	INT	to discuss the importance of and methods for obtaining refugee trauma histories, to recognize the psychological and physical manifestations of trauma characteristic of refugees, and to explore how cultural differences and limited English proficiency affect the refugee patient-clinician relationship and how to best use interpreters.	refugees	literature review
Degni, F.,et al. **Communication and Cultural Issues in Providing Reproductive Health Care to Immigrant Women: Health Care Providers' Experiences in Meeting Somali Women** Living in Finland.	2011	Finland	to explore physicians-nurses/midwives' communication when providing reproductive and maternity health care to Somali women in Finland.	Somali refugee women	qualitative
Derluyn, I. and E. Broekaert, ***Unaccompanied refugee children and adolescents: the glaring contrast between a legal and a psychological perspective.***	2008	Belgium	to show the 'psychological' perspective and the necessity of a strongly elaborated reception and care system for these children and adolescents in order to meet their specific situation and needs.	unaccompanied minors	qualitative
DeStephano, C.C., P.M. Flynn, and B.C. Brost, ***Somali prenatal education video use in a United States obstetric clinic: a formative evaluation of acceptability.***	2010	United States	to explore the acceptability of health education videos by Somali refugee women in a clinical setting.	Somali refugee women	qualitative

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Drummond, P.D., et al., ***Barriers to accessing health care services for West African refugee women living in Western Australia.***	2011	Australia	to survey help-seeking pathways and barriers to accessing health care services in 51 West African refugee women who had settled recently in Perth, and in 100 Australian women.	West African refugee women	quantitative
Duguet, A.M. and B. Bévière, ***Access to health care for illegal immigrants: A specific organisation in France.***	2011	France	to present the French system of social protection, the "Couverture médicale universelle" or CMU, which provides the same protection to asylum seekers and documented immigrants as to nationals, and the "Aide médicale d'état" or AME, that is open to every person who does not fulfil the legal conditions to obtain the CMU, such as illegal immigrants.	asylum seekers and documented immigrants	qualitative
Duke, P. and F. Brunger, ***The MUN Med Gateway Project: marrying medical education and social accountability.***	2015	Canada	to provide access to family physicians and continuity of care for newly arrived refugees; to provide opportunities for medical students to practise cross-cultural health care; and to mentor medical students in advocacy for underserved populations.	refugees	qualitative
Dutcher, G.A., et al. ***The Refugee Health Information Network: a source of multilingual and multicultural health information.***	2008	United States	to improve health services for refugees and asylums seekers. This is also a network designed to facilitate collaboration and sharing among state refugee health coordinators and clinics providing services to refugee and immigrant communities.	refugees and asylum seekers	qualitative
Ellis, B.H., et al., ***New directions in refugee youth mental health services: Overcoming barriers to engagement.***	2011	United States	to describe how Barriers like (a) distrust of authority and/or systems, (b) stigma of mental health services, (c) linguistic and cultural barriers, and (d) primacy and prioritization of resettlement stressors, may prevent refugee youth from receiving mental health services; To describe approaches to addressing them ; to describe of Supporting the Health of Immigrant Families and Adolescents (Project SHIFA), a program developed in collaboration with the Somali community in Boston, Massachusetts.	youth refugees	qualitative
Elwell, D., et al., ***Refugees in Denver and their perceptions of their health and health care.***	2014	United States	to assess the self-perceived health of and barriers to care for refugees in the Denver metro area in order to understand better the needs of this population	refugees	quantitative
Fang, DM & Baker, DL. **Barriers and Facilitators of Cervical Cancer Screening among Women of Hmong Origin.**	2013	United States	to explore the barriers and facilitators of cancer screening among women of Hmong origin.	Hmong refugee women	qualitative
Fang, M.L., et al., ***Experiencing 'pathologized presence and normalized absence'; Understanding health related experiences and access to health care among Iraqi and Somali asylum seekers, refugees and persons without legal status Health behavior, health promotion and society.***	2015	United Kingdom	to explore health and health care experiences of Somali and Iraqi asylum seekers, refugees and persons without legal status, highlighting 'minoritization' processes and the 'pathologization' of difference as analytical lenses to understand the multiple layers of oppression that contribute to health inequities.	Somali and Iraqi asylum seekers, refugees and persons without legal status,	qualitative

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Farokhi, M.R. et al. ***A student operated, faculty mentored dental clinic service experience at the University of Texas Health Science Center at San Antonio for the underserved refugee community: an interprofessional approach.***	2014	United States	to create the student-run San Antonio Refugee Health Clinic (SARHC), that serves the refugees by providing free health care/education while connecting them to San Antonio's primary health care system.	refugees	qualitative
Fatahi, N., et al., ***Experiences of Kurdish war-wounded refugees in communication with Swedish authorities through interpreter.***	2010	Sweden	to study experiences of war-wounded Kurdish refugees with respect to cross-cultural communication through interpreters	war-wounded Kurdish refugees	qualitative
Feldman, R., ***When maternity doesn't matter Dispersing pregnant women seeking asylum***	2013	United Kingdom	to investigate the health impact of dispersal and relocation on pregnant women and new mothers seeking asylum.	asylum seeking pregnant women	literature review
Flynn, A. and D. Flynn, ***'Give us the weapon to argue': eHealth and the Somali community of Manchester.***	2008	United Kingdom	to investigate the perceptions of a marginalised community, the Somali community in Manchester, UK, with regard to the possible benefits and disadvantages of eHealth as a means of providing patient healthcare information.	Somali refugees	qualitative
Furber, S., et al., ***A qualitative study on tobacco smoking and betel quid use among Burmese refugees in Australia.*** J Immigr Minor Health, 2013. **15**(6): p. 1133-6.	2013	Australia	to explore the beliefs and experiences of Burmese refugees in Wollongong on smoking to guide the development of smoking cessation interventions.	Burmese men refugees	qualitative
Furler, J., et al., ***Managing depression among ethnic communities: a qualitative study.*** Ann Fam Med, 2010. **8**(3): p. 231-6.	2010	Australia	to explores the complexities of this work through a study of how family physicians experience working with different ethnic minority communities in recognizing, understanding, and caring for patients with depression.	refugees and immigrant women	qualitative
Gagnon, A.J., et al., ***Do referrals work? Responses of childbearing newcomers to referrals for care.*** J Immigr Minor Health, 2010. **12**(4): p. 559-68	2010	Montreal	to explore the inhibitors and facilitators of migrant women for following through with referrals for care.	Refugee, asylum-seeker, and immigrant) women	qualitative
Gele AA, Torheim LE, Pettersen KS, Kumar B. ***Beyond Culture and Language: Access to Diabetes Preventive Health Services among Somali Women in Norw****ay.*	2015	Norway	to analyse the Access to Diabetes Preventive Health Services among Somali Women in Norway.	refugees and immigrants	qualitative
Geltman, P.L., et al., ***Health literacy, acculturation, and the use of preventive oral health care by Somali refugees living in massachusetts.*** J Immigr Minor Health, 2014. **16**(4): p. 622-30.	2014	USA	to investigate the impact of English health literacy and spoken proficiency and acculturation on preventive dental care use among Somali refugees in Massachusetts.	Somali refugees	quantitative
Geltman, P.L., et al., ***The impact of functional health literacy and acculturation on the oral health status of somali refugees living in Massachusetts.*** American Journal of Public Health, 2013. **103**(8): p. 1516-1523.	2013	USA	to assess the impact of health literacy and acculturation on oral health status of Somali refugees in Massachusetts.	Somali refugees	quantitative

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Gibbs, L., et al., ***An exploratory trial implementing a community-based child oral health promotion intervention for Australian families from refugee and migrant backgrounds: a protocol paper for Teeth Tales.*** BMJ Open, 2014. **4**(3): p. e004260	2014	Australia	to establish a model for child oral health promotion for culturally diverse communities in Australia.	Iraqi, Lebanese or Pakistani refugee families	quantitative
Ginieniewicz, J. and K. McKenzie, ***Mental health of Latin Americans in Canada: a literature review.*** Int J Soc Psychiatry, 2014. **60**(3): p. 263-73.	2014	Canada	to review the literature on the mental health of Latin American immigrants to Canada and identify possible barriers.	Central American refugees	literature review
Goosen, S., I.E. van Oostrum, and M.L. Essink-Bot, ***[Obstetric outcomes and expressed health needs of pregnant asylum seekers: a literature survey]***.	2010	The Netherlands	to analyse whether specific attention is needed for the improvement of health for pregnant asylum seekers by producing an overview of obstetric outcomes, risk factors and expressed health needs of asylum seekers.	asylum seekers	literature review
Graham, E.A., et al., ***Health services utilization by low-income limited English proficient adults.***	2008	United States	to evaluate the health care utilization of limited English proficiency (LEP) compared to English proficient (EP) adults with the same health insurance (Medicaid managed care) and full access to professional medical interpreters.	refugees and immigrants	quantitative
Grant, K.J., et al., ***The refugee experience of acquiring a family doctor.***	2015	Canada	to explore refugees' experiences of the barriers and facilitators involved in finding a regular family doctor.	Iranian, Afghan, Myanmar, Vietnamese, and Latino-american refugees	qualitative
Grazier, K.L., ***Integrating behavioral health care and primary care: Application of a clinical and economic model in culturally diverse communities.***	2008	United States	to integrate behavioural health care and primary care.	refugees, immigrants, and other groups vulnerable	qualitative
Grigg-Saito, D., et al., ***Building on the strengths of a Cambodian refugee community through community-based outreach.***	2008	United States	to eliminate health disparities in cardiovascular disease and diabetes.	Cambodian refugees	qualitative
Grigg-Saito, D., et al., ***Long-term development of a "whole community" best practice model to address health disparities in the Cambodian refugee and immigrant community of Lowell, Massachusetts.***	2010	United States	to overcame health disparities.	Cambodian refugees	quantitative
Gudeva Nikovska, D., et al. **Health services for migrants on the Balkan route - is Macedonia up to the challenge?**	2016	Macedonia	to assess current health situation in the 2 transit centers, identify health related activities in the project area, availability of health care services for the target populations and map actors involved in humanitarian and health assistance.	refugees	qualitative
Gurnah, K., et al., ***Lost in Translation: Reproductive Health Care Experiences of Somali Bantu Women in Hartford, Connecticut.***	2011	United States	to explore the reproductive health experiences of 1 such population-Somali Bantu women in Connecticut-to identify potential barriers to care experienced by marginalized populations	Somali Bantu refugee women	qualitative

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Hackett, J., et al., ***Evaluation of three population health capacity building projects delivered by videoconferencing in NSW.***	2009	United Kingdom	to evaluate three population health capacity building projects.	refugees	qualitative
Hadgkiss, E.J. and A.M.N. Renzaho, ***The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature.***	2014	Australia	to document physical health problems that asylum seekers experience on settlement in the community and to assess their utilisation of healthcare services and barriers to care, in an international context.	asylum seekers	literature review
Haith-Cooper, M. and G. Bradshaw, **Meeting the health and social care needs of pregnant asylum seekers;** midwifery students' perspectives: part 3; "the pregnant woman within the global context"; an inclusive model for midwifery education to address the needs of asylum seeking women in the UK.	2013	United Kingdom	to describe the conceptualisation and development of an inclusive educational model.	pregnant asylum-seeking women	literature review
Haley, H.L., et al., ***Primary prevention for resettled refugees from Burma: where to begin?***	2014	United States	to develop effective primary prevention initiatives to help recently arrived refugees retain some of their own healthy cultural habits and reduce the tendency to adopt detrimental ones	Burma refugees	qualitative
Harstad, I., et al., ***Screening and treatment of latent tuberculosis in a cohort of asylum seekers in Norway.***	2010	Norway	to assess follow-up of screening results at different healthcare levels in relation to demographics, screening results and organizational factors, and how this influenced treatment of latent tuberculosis.	asylum seekers	quantitative
Hassan, G., et al., ***Mental health and psychosocial wellbeing of Syrians affected by armed conflict.***	2016	NR	to provide information on cultural aspects of mental health and psychosocial wellbeing relevant to care and support for Syrians affected by the crisis.	Syrians refugees	literature review
Hauck, F.R., et al., ***Factors Influencing the Acculturation of Burmese, Bhutanese, and Iraqi Refugees Into American Society: Cross-Cultural Comparisons.***	2014	United States	to examine the factors influencing the acculturation of Burmese, Bhutanese, and Iraqi Refugees in the United States.	Burmese, Bhutanese, and Iraqi refugees	qualitative
Haworth, R.J., et al., ***Knowledge, attitudes, and practices for cervical cancer screening among the Bhutanese refugee community in Omaha, Nebraska.***	2014	United States	to investigate cervical cancer and screening knowledge and perceptions about the susceptibility and severity of cervical cancer and perceived benefits and barriers to screening.	Bhutanese refugee women	mixed approach
Helweg-Larsen, M. and L.M. Stancioff, ***Acculturation matters: risk perceptions of smoking among Bosnian refugees living in the United States.***	2008	United States	to investigate acculturation and risk perceptions of heart attack and lung cancer among a group of refugees.	Bosnian refugees	quantitative
Henley, J. and J. Robinson, ***Mental health issues among refugee children and adolescents.***	2011	Australia	to raise awareness of mental health issues for refugee children, empowering clinicians to engage effectively with this client group.	children and adolescents refugees	literature review

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Higginbottom, G.M., et al., ***"I have to do what I believe": Sudanese women's beliefs and resistance to hegemonic practices at home and during experiences of maternity care in Canada.***	2013	Canada	to analyse difficulties in difficulty in access to maternity care services.	Sudanese pregnant refugee women	qualitative
Hill, L., et al., ***Inter-professional learning to prepare medical and social work students for practice with refugees and asylum seekers.***	2009	United Kingdom	to describe the genesis and implementation of a series of innovative inter-professional workshops for medical and social work students, focussing specifically on marginalised groups.	refugees and asylum seekers	qualitative
Hjern, A., et al. ***Age assessment of young asylum seekers.***	2012	Europe	to describe the difficulties for age assessment of young asylum seekers.	young asylum seekers	qualitative
Hudelson, P.et al. **Quality in practice: integrating routine collection of patient language data into hospital practice**.	2013	Switzerland	to explore the feasibility and acceptability of a procedure for collecting patient language data at the first point of contact, prior to its hospital-wide implementation.	refugees	quantitative
Hughes, G., ***Finding a voice through 'The Tree of Life': a strength-based approach to mental health for refugee children and families in schools.***	2014	United Kingdom	to overcame the difficulties of access to traditional mental health services.	refugees families	qualitative
Iliadi, P., ***Refugee women in Greece: - a qualitative study of their attitudes and experience in antenatal care.***	2008	Greece	to examine whether refugee women, resettled in Greece, receive antenatal care and to explore possible factors that may influence their attitude towards maternal care.	refugee women	qualitative
Im, H. and R. Rosenberg, ***Building Social Capital Through a Peer-Led Community Health Workshop: A Pilot with the Bhutanese Refugee Community.***	2016	United States	to assess the impact of a pilot peer-led community health workshop (CHW) in the Bhutanese refugee community.	Bhutanese refugees	qualitative
Ingram, J., ***The health needs of the Somali community in Bristol.***	2009	United Kingdom	to identify the health needs of the Somali community in Bristol.	Somali refugees	qualitative
International Organization for Migration, ***International Migration, Health and Human Rights***	2013	INT	to devote particular attention to the most vulnerable categories of migrants and conceptualizes vulnerability as directly resulting from an inherent characteristic of the individual migrant or group (e.g. gender, age, disability, HIV status, lack of safety net and poor education) and as related to its fundamental structural causes (e.g. working and living conditions; lack of legal protection, including that in relation to the migrant's legal status in the host country; crime and conflict; language and cultural barriers; lack of formal and informal social protections offered during and after the migration process; and immigration detention).	asylum seekers, undocumented migrants, refugees and migrants	literature review

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Ioannidi, E. **First reception of refugees entering through the Aegean. The current situation in Greek islands.**	2015	Greece	to describe challenges in providing care and access to health care in Greek islands.	asylum seekers	qualitative
IOM, **Bulgaria**	2015	Bulgaria	to present the results of the assessment of migrant, occupational, and public health which took place in Bulgaria within the framework of the IOM Equi Health project.	refugees and asylum seekers	mixed approach
IOM, **Croatia**	2015	Croatia	to present the results of the assessment of migrant, occupational, and public health which took place in Croatia within the framework of the IOM Equi Health project.	refugees and asylum seekers	mixed approach
IOM, **Spain**	2015	Spain	to present the results of the assessment of migrant, occupational, and public health which took place in Spain within the framework of the IOM Equi Health project .	refugees and asylum seekers	mixed approach
IOM,**Greece**	2015	Greece	to present the results of the assessment of migrant, occupational, and public health which took place in Greece within the framework of the IOM Equi Health project.	refugees and asylum seekers	mixed approach
IOM,**Italy**	2015	Italy	to present the results of the assessment of migrant, occupational, and public health which took place in Italy within the framework of the IOM Equi Health project.	refugees and asylum seekers	mixed approach
IOM,**Malta**	2015	Malta	to present the results of the assessment of migrant, occupational, and public health which took place in Malta within the framework of the IOM Equi Health project.	refugees and asylum seekers	mixed approach
Jensen, N.K., et al., ***How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark.***	2013	Denmark	to investigate how general practitioners experience providing care to refugees with mental health problems.	refugees	qualitative
Jensen, N.K., et al., ***Patient experienced continuity of care in the psychiatric healthcare system—a study including immigrants, refugees and ethnic Danes.*** International	2014	Denmark	to investigate continuity of care in the psychiatric healthcare system from the perspective of patients, including vulnerable groups such as immigrants and refugees.	refugees and immigrants	qualitative
Joels, C., ***Impact of national policy on the health of people seeking asylum.***	2008	United Kingdom	to identify when in the process asylum seekers are entitled to free NHS care.	asylum seekers	qualitative

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Johnston, V., ***Australian asylum policies: have they violated the right to health of asylum seekers?***	2009	Australia	to critically examine these Australian asylum policies and assess the implications for public health practice.	asylum seekers	literature review
Jones, C. and A.E. Williamson, ***Volunteers working to support migrants in glasgow: A qualitative study.***	2014	United Kingdom	to explore the roles, motivations and experiences of volunteers who work to support asylum seekers (AS), refugees and refused asylum seekers (RAS) in Glasgow.	asylum seekers, refugees and rejected asylum seekers	qualitative
Jonzon, R., P. et al. ***A state of limbo--in transition between two contexts: Health assessments upon arrival in Sweden as perceived by former Eritrean asylum seekers.***	2015	Sweden	to explore and improve our understanding of how former asylum seekers from Eritrea perceived and experienced the health assessment during their asylum-seeking process.	Eritrean asylum seekers	qualitative
Joshi, C., et al., ***A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination.***	2013	NR	to identify the components of primary health care service delivery models for such populations which have been effective in improving access, quality and coordination of care.	refugees	literature review
Kaczorowski, J.A., et al., ***Adapting clinical services to accommodate needs of refugee populations.***	2011	United States	to describe our experiences with designing and adapting a variety of clinical services for youth and families with refugee status.	refugee families	qualitative
Kaluski, D.N., et al., ***Health insurance and accessibility to health services among Roma in settlements in Belgrade, Serbia - The journey from data to policy making.***	2015	Serbia	to assess the relationship between citizenship, residency and possession of health insurance cards, together with utilization of health services, among Roma residing in disadvantaged settlements in Belgrade.	Roma refugees	quantitative
Kandasamy, T., et al., ***Obstetric risks and outcomes of refugee women at a single centre in Toronto.***	2014	Canada	to determine the risk of adverse obstetric and perinatal outcomes among refugee women in Toronto.	refugee women	quantitative
Kay, M., C. Jackson, and C. Nicholson, ***Refugee health: a new model for delivering primary health care.***	2010	Australia	to describe the adaption of the Primary Care Amplification Model to enhance the delivery of health care to the refugee community.	refugees	qualitative
Kay, M., et al., ***Understanding quality use of medicines in refugee communities in Australian primary care: a qualitative study.***	2016	Australia	to identify strategies to support the quality use of medicines in refugee communities.	refugees	qualitative
Keygnaert I, Ivanova O, Guieu A, Van Parys A-S, Leye E, K. R. ***What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants?*** A review of the existing evidence in the WHO European Region. 2016.	2016	INT	To address the following question by way of a systematic review of available academic evidence and a critical interpretive synthesis of grey literature including policy frameworks: "What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of the existing evidence in the WHO European Region".	migrant women and children	mixed approach

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Keygnaert, I., et al., ***Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented*** migrants in Belgium and The Netherlands.	2014	Belgium and The Netherlands.	to explore how refugees, asylum seekers and undocumented migrants in Belgium and The Netherlands define sexual health, search for sexual health information and perceive sexual health determinants.	refugees, asylum seekers and undocumented migrants	qualitative
Kieft, B., et al., ***Paraprofessional counselling within asylum seekers' groups in the Netherlands: transferring an approach for a non-Western context to a*** European setting.	2008	The Netherlands	to increase access to basic psychosocial care to a target population that experiences difficulties in entering mental healthcare services, by a group of trained peer asylum seekers and refugees.	asylum seekers	qualitative
Kirmayer, L.J., et al., ***Common mental health problems in immigrants and refugees: general approach in primary care.***	2011	NR	to identify risk factors and strategies in the approach to mental health assessment and to prevention and treatment of common mental health problems for immigrants in primary care.	refugees and immigrants	literature review
Klinkenberg, E., et al., ***Migrant tuberculosis screening in the EU/EEA: yield, coverage and limitations.***	2009	Europe	to assess the effectiveness of tuberculosis (TB) screening methods and strategies in migrants in European Union/European Economic Area (including Switzerland) countries.	refugees, asylum seekers, immigrants	literature review
Kouli, E., et al., ***The institutional framework regarding the rights of immigrants for access to health services in the European Union.***	2014	Europe	to analyse the access rights of migrants to health services in European countries.	asylum seekers, undocumented migrants and migrants	literature review
Kowal, S.P., C.G. Jardine, and T.M. Bubela, ***"If they tell me to get it, I'll get it. If they don't...": Immunization decision-making processes of immigrant mothers.***	2015	Canada	to understand information-gathering and decision-making processes of immigrant mothers for scheduled childhood vaccines, vaccination during pregnancy, seasonal flu and pandemic vaccination.	Bhutanese, South Asian and Chinese refugee mothers	qualitative
Kreps GLS, L. . ***Meeting the health literacy needs of immigrants populations*****.**	2008	INT	To examine the challenges to communicating relevant information about health risks to vulnerable immigrant populations and to suggest specific communication strategies for effectively reaching and influencing these groups of people to reduce health disparities and promote public health.	immigrants	literature review
Kurth, E., et al., ***Reproductive health care for asylum-seeking women - a challenge for health professionals.***	2010	Switzerland	to identify reproductive health issues in a population of women seeking asylum in Switzerland, and to examine the care they received.	asylum seeking women	mixed approach
Lee, HY et al. **Mental health literacy in Hmong and Cambodian elderly refugees: a barrier to understanding, recognizing, and responding to depression.**	2010	United States	to explore mental health literacy, specifically focusing on depression, among Southeast Asian (SEA) elderly refugees.	Hmong refugee elders	qualitative
Lee, S.K., et al. ***Providing health information for culturally and linguistically diverse women: priorities and preferences of new migrants and refugees.***	2013	Australia	to identify priority about providing health information for culturally and linguistically diverse women.	refugees and immigrant women	mixed approach

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Lee, S.K., S.C. Thompson, and D. Amorin-Woods, ***One service, many voices: enhancing consumer participation in a primary health service for multicultural women.*** Quality in Primary Care, 2009. **17**(1): p. 63-69 7p.	2009	Australia	to establish an active consumer reference group to assist understanding and reducing the barriers to AOD services for a heterogeneous disadvantaged group that includes individuals from different cultural, language and educational background.	refugee and immigrant women	qualitative
Lindert, J., et al., **Mental health, health care utilisation of migrants in Europe.**	2008	Europe	to give an overview on (i) prevalence of mental disorders; suicide; alcohol and drug abuse; (ii) access to mental health and psychosocial care facilities of migrants in the European region, and (iii) utilisation of health and psychosocial institution of these migrants.	asylum seekers, undocumented migrants and migrants	literature review
Ludwig, B. and H. Reed, ***When you are here, you have high blood pressure": Liberian refugees' health and access to healthcare in Staten Island, NY.***	2016	United States	to examine health issues among Liberian refugees living in Staten Island and access potential barriers to accessing healthcare.	Liberian refugees	qualitative
MacFarlane, A., et al., ***Arranging and negotiating the use of informal interpreters in general practice consultations: experiences of refugees and asylum seekers in the west of Ireland.***	2009	Ireland	to compare use of professional interpreters and a trusted friend/family member.	refugees and asylum seekers	qualitative
MacFarlane, A., et al., ***Responses to language barriers in consultations with refugees and asylum seekers: a telephone survey of Irish general practitioners.***	2008	Ireland	to quantify the need for language assistance in general practice consultations and examines the experience of, and satisfaction with, methods of language assistance utilized.	refugees and asylum seekers	quantitative
Majumder, P., et al., ***'This doctor, I not trust him, I'm not safe': the perceptions of mental health and services by unaccompanied refugee adolescents.***	2015	United Kingdom	to appreciate the views and perceptions that unaccompanied minors hold about mental health and services.	unaccompanied minors	qualitative
Manchikanti P. T**he experiences of access to primary care by afghani refugees in south east melbourne: A reflection on the public health needs of ethnic minorities.**	2013	Australia	to identify the acceptability of primary care and its relevance towards primary care access for Afghani refugees in south east Melbourne.	Afghan refugees	qualitative
Mancuso, L., ***Overcoming health literacy barriers: a model for action.***	2011	United States	to overcome health literacy barriers.	Indonesian asylum seekers	literature review
Maroney, P.,et al. ***Experiences in occupational therapy with Afghan clients in Australia.***	2014	Australia	to identify data and themes in literature that shed light on the utilization of health services for refugees and host population.	Afghan refugees	qualitative
Matthews, A., et al. **How do asylum seeking and refugee women perceive and respond to preventive health care? Cervical Screening as a case study.**	2016	United Kingdom	to explore the facilitators and barriers to both accessing and providing cervical screening for ASR women within Glasgow.	refugees and asylum seekers	qualitative

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Matthews, A., et al. **Migration and the Media: the effect on healthcare access for asylum seekers and refugees.**	2016	United Kingdom	to explore how discourses in mainstream media affect asylum seeking/refugee women's and healthcare workers ideas of deservingness for healthcare.	asylum seeker and refugee women, primary healthcare staff	qualitative
Mayhew, M., et al., ***Facilitating refugees' access to family doctors.***	2015	Canada	to describe the patient level characteristics of government-assisted refugees (GARs) who had acquired family doctors after leaving specialized refugee clinics (RC).	refugees	quantitative
McCleary, J.S., Pet al. ***Connecting Refugees to Substance Use Treatment: A Qualitative Study.***	2016	United States	to explore factors that support and prevent refugees from connecting with chemical health treatment.	social service or public health professionals who work with refugees	qualitative
McDonald B, Gifford S, Webster K, Wiseman J, Casey S. ***Refugee resettlement in regional and rural Victoria: impacts and policy issues. Melbourne:*** Victorian Health Promotion Foundation.	2008	Australia	To increase understanding of the impacts of refugee regional and rural resettlement and relocation programs on the health and wellbeing of refugees; To increase understanding about the impacts of refugee regional and rural resettlement programs on regional communities; and to contribute to the development of policies and programs relevant to the resettlement of refugees in regional areas.	refugees	mixed approach
McKeary, M. and B. Newbold, ***Barriers to care: The challenges for Canadian refugees and their health care providers.***	2010	Canada	to explore the systemic barriers to health care access experienced by Canada's refugee populations.	refugees	qualitative
McKenzie, K., ***Issues and Options for Improving Services for Diverse Populations.***	2015	Canada	to outline the "Issues and Options" paper commissioned by the Mental Health Commission of Canada, which used a thorough literature review and a national consultation to develop a model for service development.	refugees, immigrants, ethnocultural, and racialized populations (IRER)	literature review
McMichael, C. and S. Gifford, ***"It is Good to Know Now…Before it's Too Late": Promoting sexual health literacy amongst resettled young people with refugee backgrounds.***	2009	Australia	to study the sexual health amongst recently arrived young people from refugee backgrounds in Melbourne, Australia.	Iraqi, Afghan, Burmese, Sudanese, Liberian, and Horn of Africa young refugees.	qualitative
McMurray, J., et al., ***Integrated primary care improves access to healthcare for newly arrived refugees in Canada.***	2014	Canada	to quantify the impact of a partnership between a dedicated health clinic for government assisted refugees (GARs), a local reception centre and community providers, on wait times and referrals.	refugees	quantitative
Médecins Sans Frontières, ***NOT CRIMINALS. Médecins Sans Frontières exposes conditions for undocument ed migrants an d as ylum seekers in Maltese* detention centres**	2009	Malta	to describe the provision of health careby Médecins Sans Frontières (MSF) started providing health care in Maltese detention centres for undocumented migrants and asylum seekers.	asylum seekers and undocumented migrants	quantitative

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Mei Lan, F., et al., ***Experiencing 'pathologized presence and normalized absence'; understanding health related experiences and access to health care among Iraqi and Somali asylum seekers, refugees and persons without legal status.***	2015	United Kingdom	to explore health and health care experiences of Somali and Iraqi asylum seekers, refugees and persons without legal status, highlighting 'minoritization' processes and the 'pathologization' of difference as analytical lenses to understand the multiple layers of oppression that contribute to health inequities.	asylum seekers, undocumented migrants and refugees.	qualitative
Merry, L.A., et al., ***Refugee claimant women and barriers to health and social services post-birth.***	2011	Canada	to gain greater understanding of the barriers these vulnerable migrant women face in accessing health and social services postpartum.	asylum seeking women	qualitative
Milosevic, D., I.H. Cheng, and M.M. Smith, ***The NSW refugee health service: Improving refugee access to primary care.***	2012	Australia	to describe the area of need, the innovative strategies that have been developed by specific organisations to address this need, and make recommendations to help GPs improve access to disadvantaged populations in their own communities.	refugees	qualitative
Mirdal, G.M., et al. ***Traumatized refugees, their therapists, and their interpreters: three perspectives on psychological treatment.***	2012	United States	to study how traumatized refugees, their therapists, and their interpreters perceive both curative and hindering factors in psychological therapy, thereby highlighting the mediators of change in a transcultural clinical setting.	refugees, therapists and interpreters	quantitative
Mirza, M. and A.W. Heinemann, ***Service needs and service gaps among refugees with disabilities resettled in the United States.***	2012	United States	to examine the adequacy of existing service systems in addressing the needs of refugees with disabilities resettled in the U.S.A.	disabled refugees	qualitative
Mirza, M., et al., ***Barriers to Healthcare Access Among Refugees with Disabilities and Chronic Health Conditions Resettled in the US Midwest.***	2014	United States	to explore the access to appropriate healthcare services of disabled refugees in order to identify service disparities and improve interventions.	disabled and chronically ill refugees	qualitative
Mitschke, DB, et al. **Uncovering Health and Wellness Needs of Recently Resettled Karen Refugees from Burma.**	2011	United States	to identify obstacles to acculturation long after initial resettlement of refugees.	Karen refugees	qualitative
Morris, M.D., et al., ***Healthcare barriers of refugees post-resettlement.***	2009	United States	to identify the health needs beyond a health assessment completed upon entry.	refugees	qualitative
Mucic, D., ***Transcultural telepsychiatry and its impact on patient satisfaction.***	2010	Denmark	to improve access to culturally appropriate care providers (i.e. culturally competent, bilingual clinicians) by the use of videoconferencing.	asylum seekers, refugees and migrants	quantitative
Murray, L., et al., ***The experiences of African women giving birth in Brisbane, Australia.***	2010	Australia	to uncover first-person descriptions of the birth experiences of African refugee women in Brisbane, Australia, and to explore the common themes that emerged from their experiences.	African refugee women	qualitative

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Museru, O.I., et al., ***Hepatitis B virus infection among refugees resettled in the U.S.: high prevalence and challenges in access to health care.***	2010	United States	to assess the epidemiology of HBV and entry into medical care in refugee communities resettled in the State of Georgia over a five-year period: 2003-2007.	refugees	quantitative
Nazzal, K.H., et al., ***An innovative community-oriented approach to prevention and early intervention with refugees in the United States.***	2014	United States	to present a community-oriented prevention and early intervention model that can be used with newly arrived refugees with limited English proficiency.	refugees	qualitative
Newbold, K.B., et al. ***Access to Health Care: The Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario.***	2013	Canada	to explore the accessibility of health services from the viewpoints of service providers, and refugee and refugee claimant women in Hamilton, Ontario.	refugee and aslum-seeking women	qualitative
Nicol, P., et al., ***Informing a culturally appropriate approach to oral health and dental care for pre-school refugee children: a community participatory study.***	2014	Australia	to provide a deeper understanding of the refugee experience related to early oral health by exploring pre-school refugee families (i) understanding of ECC and child oral health, (ii) experiences of accessing dental services and (iii) barriers and enablers for achieving improved oral health.	children in families of recently settled refugees	qualitative
Njeru, J.W., et al., ***Stories for change: development of a diabetes digital storytelling intervention for refugees and immigrants to Minnesota using qualitative methods.***	2015	United States	to develop a diabetes digital storytelling intervention with and for immigrant and refugee populations.	Somali and Latino immigrants and refugees	qualitative
Nkulu Kalengayi, F K. **Perspectives of asylum seekers and refugees on health assessment:"It is a requirement that benefits everyone"**	2014	Sweden	to explore asylum 'seekers perceptions and experiences of health assessment.	asylum seekers	qualitative
Norredam, M. **Migration and health: Organising access to EU health care systems for migrants.**	2016	Europe	to describe the formal and informal barriers related to access and to suggest solutions.	refugees and asylum seekers	qualitative
Norredam, M., ***Migrants' access to healthcare.***	2011	Denmark	to increase the understanding of migrants' access to healthcare by exploring two study aims: 1) Are there differences in migrants' access to healthcare compared to that of non-migrants? (substudy I and II); and 2) Why are there possible differences in migrants' access to healthcare compared to that of non-migrants? (substudy III and IV).	asylum seekers, undocumented migrants, refugees and migrants	quantitative
O'Donnell, C.A., et al., ***Asylum seekers' expectations of and trust in general practice: a qualitative study.***	2008	United Kingdom	to explore how migrants' previous knowledge and experience of health care influences their current expectations of health care in a system relying on clinical generalists performing a gatekeeping role.	asylum seekers	qualitative
O'Mahony, J. and T. Donnelly, ***Immigrant and refugee women's post-partum depression help-seeking experiences and access to care: a review and analysis of the literature.***	2010	NR	to analyse the literature about post-partum depression and the positive and negative factors, which may influence immigrant and refugee women's health seeking behaviour and decision making about post-partum care.	refugee and immigrant women	literature review

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O'Mahony, J.M. and T.T. Donnelly, ***How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences?***	2013	Canada	to explore how cultural, social, political, historical and economic factors intersect with race, gender and class to influence the ways in which immigrant and refugee women seek help to manage post-partum depression.	refugee and immigrant women	qualitative
O'Mara, B., ***Social media, digital video and health promotion in a culturally and linguistically diverse Australia.***	2013	Australia	to identify opportunities and challenges when using social media with communities from diverse cultural and linguistic backgrounds.	refugees, migrants and communities from diverse cultural and linguistic backgrounds	literature review
O'Reilly-de Brún, et al. **Involving migrants in the development of guidelines for communication in cross-cultural general practice consultations: a participatory learning and action research project**.	2016	Ireland	to involve migrants and other key stakeholders in a participatory dialogue to develop a guideline for enhancing communication in cross-cultural general practice consultations.	refugees and immigrants	qualitative
Odunukan, O.W., et al., ***Provider and interpreter preferences among Somali women in a primary care setting.***	2015	United States	to elucidate provider and interpreter preferences during clinical encounters according to gender and race among Somali women in the United States.	Somali refugee women	qualitative
Oktem, P., et al. **Migrant women's access to healthcare in Turkey.**	2016	Turkey	to address migrant and refugee women's access to healthcare in Turkey, which remained an under-researched topic, from a gender and human rights perspective.	refugees and immigrant women and key informants	qualitative
Okunseri, C., et al., ***Hmong adults self-rated oral health: a pilot study.***	2008	United States	to describe the self-related oral health, self-rated general health, and use of dental/physician services; and to identify the factors associated with self-related oral health among Hmong adults.	Hmong refugees	quantitative
Percac-Lima, S., et al., ***Decreasing disparities in breast cancer screening in refugee women using culturally tailored patient navigation.***	2013	United States	to evaluate whether a PN program for refugee women decreases disparities in breast cancer screening.	Somali, Arabic, or Serbo-Croatian (Bosnian) refugee women	qualitative
Percac-Lima, S., et al., ***Patient navigation to improve breast cancer screening in Bosnian refugees and immigrants.***	2012	United States	to report the outcomes of a breast cancer screening patient navigation program for refuge/immigrant women from Bosnia.	Bosnian refugee/immigrant women	quantitative
Pieper, H.O., et al. ***The impact of direct provision accommodation for asylum seekers on organisation and delivery of local primary care and social care services: A case study.***	2011	Ireland	to explore he impact of direct provision accommodation on organisation and delivery of local primary care and social care services in the community.	stakeholders	qualitative
Pimentel, VM & Eckardt, MJ. **More than interpreters needed: the specialized care of the immigrant pregnant patient.**	2014	NR	to provide an overview of the challenges and interventions to maximize health outcomes for the immigrant pregnant woman.	Immigrant pregnant women	qualitative

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Piwowarczyk, L., et al., ***Congolese and Somali beliefs about mental health services.***	2014	United States	to examine both concepts of mental illness in addition to attitudes and beliefs about treatment as well as potential barriers to accessing mental health services.	Congolese and Somali men and women	qualitative
Platform for International Cooperation on Undocumented Migrants. ***Undocumented Children in Europe: Invisible Victims of Immigration Restrictions***.	2008	Europe	to investigate the particular vulnerability that characterizes these children and analyse their specific needs and problems in various European countries.	asylum-seeking, refugee and migrant children	mixed approach
Posselt, M., et al., ***Merging perspectives: obstacles to recovery for youth from refugee backgrounds with comorbidity.***	2015	Australia	to identify challenges encountered by young people from refugee backgrounds with co-existing mental health (MH) and alcohol and other drug (AOD) problems (comorbidity) and sought to compare the perspectives of refugee youth and service providers in a metropolitan region of Adelaide, South Australia.	African, Afghan, Bhutanese, workers from MH, AOD and refugee support services	qualitative
Pottie, K., et al., ***Improving delivery of primary care for vulnerable migrants: Delphi consensus to prioritize innovative practice strategies.***	2014	Canada	to identify and prioritize innovative strategies to address the health concerns of vulnerable migrant populations.	primary care practitioners, including family physicians and nurse practitioners	qualitative
Poureslami, I., et al., ***Bridging immigrants and refugees with early childhood development services: partnership research in the development of an effective service model.*** .	2013	Canada	to assess the different meanings, understandings, and practices relating to early childhood development services, examine the ways in which behavioural, cultural, and institutional practices may influence early childhood development services access and use of services; and contribute to the development of a culturally competent definition, measure, and model for early childhood development services that is applicable to ethno-cultural communities.	Chinese, Korean, Iranian and Afghani refugees and immigrants, ECD service providers, community educators, and facilitators	qualitative
Power D & Pratt R. ***Karen refugees from Burma: focus group analysis***	2012	United States	to describe the health experiences of a recently arrived group of refugees, the Karen from Burma, in an American midwestern city.	Karen refugees	qualitative
Priebe, S., et al., ***Good practice in mental health care for socially marginalised groups in Europe: A qualitative study of expert views in 14 countries.***	2012	Europe	to explore the experiences and views of experts in 14 European countries regarding mental health care for six socially marginalised groups: long-term unemployed; street sex workers; homeless; refugees/asylum seekers; irregular migrants and members of the travelling communities.	refugees, asylum seekers, irregular migrants, long-term unemployed, street sex workers, homeless, and members of the travelling communities.	qualitative
Qayyum, M.A., et al., ***The provision and sharing of information between service providers and settling refugees.***	2014	Australia	to understand the provision and sharing of information between service providers and settling refugees while refugees transit to new living environments.	refugees and service providers from community and public sector organizations	qualitative
Rabiee, F., Smith, P. **Equity in Mental Health Service Provision for African Caribbean, Black African Refugees and Asylum Seekers.**	2016	United Kingdom	to examine understanding of mental health nd experience of accessing mental health services from the perspectives of black African and African Caribbean mental health service users and their carers.	African Caribbean, Black African refugees and asylum seekers	qualitative

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Ratnam, S., et al. **The "migrant kit": a new guide for migrant-friendly care in a Swiss paediatric hospital**	2016	Switzerland	to assess the guidelines (the "migrant kit") for residents and all staff in outpatient and inpatient units in a Swiss hospital.	health care professionals	quantitative
Razavi, M.F., et al., ***Experiences of the Swedish healthcare system: An interview study with refugees in need of long-term health care.*** Scandinavian Journal of Public Health, 2011. **39**(3): p. 319-325.	2011	Sweden	to examine the viewpoints of nine refugees in a county in Sweden, with a known chronic disease or functional impairment requiring long-term medical care, on their contacts with care providers regarding treatment and personal needs.	refugees	qualitative
Reavy, K., et al., ***A new clinic model for refugee health care: adaptation of cultural safety.***	2012	United States	to differentiate the role of C.A.R.E. Clinic Health Advisor from certified medical interpreter and to evaluate the lived experiences of each role.	refugees	qualitative
Rechel, B., et al. **Health system responses to the influx of refugees in Europe.**	2016	Europe	to present the results of a research project by the European Observatory on Health Systems and Policies and the World Health Organization Regional Office for Europe.	refugees	qualitative
Redwood-Campbell, L., et al., **Understanding the health of refugee women in host countries: lessons from the Kosovar re-settlement in Canada. Prehosp Disaster Med, 2008.** 23(4): p. 322-7.	2008	Canada	to describe the results of a self-administered survey regarding women's health issues and experiences with health services after the arrival of refugees and the sponsor group's experience related to women's health care.	refugee women	quantitative
Reichlin, R., et al. **Applying a Community-Based Participatory Research Approach to Improve Asylum-Seekers' Access to Healthcare in Israel.**	2016	Israel	to advocate inclusion in Israel's public healthcare system, and b) to address root causes of health inequities through facilitating participation of the asylum-seeking communities in political decision-making processes.	Eritrean asylum seekers, local activists and academics	qualitative
Rew, K.T., et al., ***Immigrant and refugee health: cross-cultural communication.***	2014	United States	to provide guidance for cross cultural communication.	refugees and immigrants	literature review
Reynolds, B. and J. White, ***Seeking asylum and motherhood: health and wellbeing needs.***	2010	United Kingdom	to investigate the health and wellbeing needs of pregnant asylum-seeking women and those with young babies living in initial accommodation centres.	pregnant asylum-seeking women, asylum seeking mothers	qualitative
Riggs, E., et al., ***'We are all scared for the baby': promoting access to dental services for refugee background women during pregnancy.***	2016	Australia	to describe Afghan and Sri Lankan women's knowledge and beliefs surrounding maternal oral health, barriers to accessing dental care during pregnancy, and to present the perspectives of maternity and dental service providers in relation to dental care for pregnant women.	Afghan & Sri Lankan refugees, dental staff including clinicians and administrative staff, and midwives.	qualitative
Riggs, E., et al., ***Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers.***	2012	Australia	to explore experiences of using maternal and child health services, from the perspective of families from refugee backgrounds and service providers.	Karen, Iraqi, Assyrian Chaldean, Lebanese, South Sudanese and Bhutanese refugees women, MCH nurses, other healthcare providers and bicultural workers.	qualitative

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Robinson, K., ***Supervision Found Wanting: Experiences of Health and Social Workers in Non-Government Organisations Working with Refugees and Asylum Seekers.***	2013	Australia/UK	to explores the role and function of supervision in social work with refugees and asylum seekers.	health and social workers	qualitative
Ross, L., et al. **Improving the management and care of refugees in Australian hospitals: a descriptive study.**	2016	Australia	to investigate healthcare provider perceptions of the impact of refugee patients at two public hospitals, one rural and one urban, in designated refugee resettlement areas.	refugees	quantitative
Rousseau, C. and J. Guzder, ***School-based prevention programs for refugee children.*** Child Adolesc Psychiatr Clin N Am, 2008. **17**(3): p. 533-49, viii.	2008	NR	to review existing school-based prevention programs.	refugee children	literature review
Russo, A., et al., ***A qualitative exploration of the emotional wellbeing and support needs of new mothers from Afghanistan living in Melbourne, Australia.*** BMC Pregnancy Childbirth, 2015. **15**: p. 197.	2015	Australia	to explored the experiences of Afghan women living in Melbourne throughout pregnancy, birth, and early motherhood, and gain insight into the aspects of their experiences that they perceive as positively and negatively impacting their emotional wellbeing.	Afghan refugee women	qualitative
Saadi, A., B. Bond, and S. Percac-Lima, ***Perspectives on preventive health care and barriers to breast cancer screening among Iraqi women refugees.*** J Immigr Minor Health, 2012. **14**(4): p. 633-9.	2012	United States	to assess the perspectives of Iraqi women refugees on preventive care and perceived barriers to breast cancer screening.	Iraqi refugee women	qualitative
Sandahl, H., et al., ***Policies of access to healthcare services for accompanied asylum-seeking children in the Nordic countries.*** Scand J Public Health, 2013. **41**(6): p. 630-6.	2013	Nordic countries	to compare policies of access to healthcare services, including physical examination and screening for mental health problems on arrival, for accompanied asylum-seeking children in the Nordic countries.	asylum seeking children	literature review
Sandhu, S., et al., ***Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries.*** Soc Psychiatry Psychiatr Epidemiol, 2013. **48**(1): p. 105-16.	2013	Europe	to explore professionals' experiences of delivering care to immigrants in districts densely populated with immigrants across Europe.	asylum seekers, undocumented migrants, refugees and migrants	qualitative
Sandikli, B. et al. **Role of NGOs in addressing the needs of Syrian refugees living in Istanbul**	2016	Turkey	to describe the role of NGOs in supporting migrants to access health care services.	Syrian refugee women, representatives of Syrian and Turkish NGOs, doctors and decision makers	qualitative
Schulz, T.R., et al., ***Improvements in patient care: videoconferencing to improve access to interpreters during clinical consultations for refugee and immigrant patients***	2015	Australia	to demonstrate the suitability of accessing interpreters via videoconference for medical consultations and to assess doctor and patient perceptions of this compared with either on-site or telephone interpreting.	refugee and immigrants	quantitative
Schulz, T.R., et al., ***Telehealth: experience of the first 120 consultations delivered from a new refugee telehealth clinic.*** Intern Med J, 2014. **44**(10): p. 981-5.	2014	Australia	to assess the demographic and disease profile of refugee patients attending a new tele-health clinic, to calculate the patient travel avoided, to examine technical challenges and assessed the performance of two videoconferencing solutions using different bandwidth and latencies.	refugees	quantitative

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Scott, P., ***Black African asylum seekers' experiences of health care access in an eastern German state.*** International Journal of Migration, Health and Social Care, 2014. **10**(3): p. 134-147.	2014	Germany	to examine how access to health care for (rejected) asylum seekers in an eastern German state is structured and experienced and to consider the implications for their human rights.	asylum seekers and rejected asylum seekers	qualitative
Seery, T., H. Boswell, and A. Lara, ***Caring for refugee children.*** Pediatrics in Review, 2015. **36**(8): p. 323-338.	2015	United States	to provide guidance to care for refugee children.	refugee children	literature review
Segala, D., et al. **Health education and HIV test offer in a population of refugees and asylum seekers: an experience in Ferrara area.**	2016	Italy	to improve HIV/AIDS-related knowledge within migrants, refugees and asylum seekers, to favour access to public health service and HIV/STDs test.	refugees and asylum seekers	quantitative
Sethi, B., ***Service delivery on rusty health care wheels: implications for visible minority women.*** J Evid Based Soc Work, 2013. **10**(5): p. 522-32.	2013	Canada	to demonstrate how immigrant/refugee women's access to health services is influenced by both immigration and health policies.	refugee and immigrant women	literature review
Sheikh, M. and C.R. MacIntyre, ***The impact of intensive health promotion to a targeted refugee population on utilisation of a new refugee paediatric clinic at the children's hospital at Westmead.*** Ethn Health, 2009. **14**(4): p. 393-405.	2009	Australia	to evaluate the impact of intensive promotion of a new health service to a targeted refugee population, recently resettled in Sydney, and the role of early social connection and membership of social group in promoting health service utilisation of refugees.	refugees	quantitative
Sheikh, M., et al., ***Equity and access: understanding emergency health service use by newly arrived refugees.*** Med J Aust, 2011. **195**(2): p. 74-6.	2011	Australia	to determine issues that affect newly resettled refugees in accessing an emergency department (ED).	Middle East and Africa refugees	quantitative
Show JS, et al. ***The role of culture in health literacy and chronic disease screening and management.***	2009	INT	to examine cultural influences on health literacy, cancer screening and chronic disease outcomes.	asylum-seekers, refugees and migrants	literature review
Simich L. ***Health literacy, immigrants and mental health.***	2010	Canada	to defines health literacy and its implications for immigrants in Canada.	refugees and migrants	literature review
Simonnot, N., et al. **Health and access to care for migrants facing multiple vulnerabilities in Europe.**	2016	INT	to collect data on health care and health care access for asylum seekers in Europe .	asylum seekers, undocumented migrants and migrants	quantitative
Sinha, S., S. Uppal, and A. Pryce, ***'I had to cry': exploring sexual health with young separated asylum seekers in East London.*** Diversity in Health & Social Care, 2008. **5**(2): p. 101-111 11p.	2008	United Kingdom	to explore sexual health and sexual exploitation for those young asylum seekers separated from parents.	unaccompanied minors	qualitative

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Spike, E.A., M.M. Smith, and M.F. Harris, ***Access to primary health care services by community-based asylum seekers.*** Med J Aust, 2011. **195**(4): p. 188-91.	2011	Australia	to determine whether community-based asylum seekers experience difficulty in gaining access to primary health care services, and to determine the impact of any difficulties described.	asylum seekers, health care practitioners and staff	qualitative
Sudbury, H. and A. Robinson, **Barriers to sexual and reproductive health care for refugee and asylum-seeking women.** British Journal of Midwifery, 2016. **24**(4): p. 275-281.	2016	United Kingdom	to examine barriers to sexual and reproductive health care for refugee and asylum-seeking women, exploring how issues can be addressed and ameliorated by midwives and the wider health-care team during pregnancy.	refugee and asylum-seeking women	literature review
Sullivan, C.H., ***Partnering with community agencies to provide nursing students with cultural awareness experiences and refugee health promotion access.*** J Nurs Educ, 2009. **48**(9): p. 519-22.	2009	United States	to describe a teaching-learning strategy emphasizing the community partnership between a baccalaureate school of nursing, an immigrant-refugee program, and a community literacy program in a rural state.	refugees	literature review
Swe, H.M. and M.W. Ross, ***Refugees from Myanmar and their health care needs in the US: A qualitative study at a refugee resettlement agency.*** International Journal of Migration, Health and Social Care, 2010. **6**(1): p. 15-25.	2010	United States	to look at the refugees' perspectives and identified the gaps in their understanding of the US health care system, health-seeking behaviours and challenges in using health care in the United States.	Myanmar refugees	quantitative
Szajna, A. and J. Ward, ***Access to health care by refugees: a dimensional analysis.*** Nurs Forum, 2015. **50**(2): p. 83-9.	2015	United States	to analyse access to healthcare services by the refugee population.	refugees	qualitative
Tastsoglou, E., et al., ***(En) gendering vulnerability: Immigrant service providers' perceptions of needs, policies, and practices related to gender and women refugee claimants in Atlantic Canada.*** Refuge, 2014. **30**(2): p. 67-78.	2014	Canada	to describe the experiences and perceptions of immigrant service providers in relation to gender and women refugee claimants.	refugee women	qualitative
Taylor, K., ***Asylum seekers, refugees, and the politics of access to health care: a UK perspective.***	2009	United Kingdom	to considers the wider ethical, moral, and political issues that may arise from the politics of access to health care.	asylum seekers	literature review
The World Health Organization. ***HEALTH OF MIGRANTS – THE WAY FORWARD***. Report of a global consultation.	2010	INT	This report includes a summary of the Global Consultation based on keynote addresses, presentations and debates, as well as a summary of the recommendations on future priorities and actions. It concludes with an outline for an operational framework based on the inputs from the consultation participants, and a "way forward" as formulated by the Organizers.	asylum-seekers, refugees and migrants	qualitative
Thomson, M.S., et al., ***Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations.*** Journal of Immigrant and Minority Health, 2015. **17**(6): p. 1895-1905.	2015	Canada	to review the relevant literature on immigrants' access to mental health services in Canada.	refugees and immigrants	literature review

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Tobin, C., J. Murphy-Lawless, and C.T. Beck, ***Childbirth in exile: asylum seeking women's experience of childbirth in Ireland.*** Midwifery, 2014. **30**(7): p. 831-8.	2014	Ireland	to gain insight into women's experiences of childbirth in Ireland while in the process of seeking asylum.	asylum seeking pregnant women	qualitative
Torres, S., et al., ***Improving health equity: The promising role of community health workers in Canada.*** Healthcare Policy, 2014. **10**(1): p. 73-85.	2014	Canada	to explore the challenges, successes and unrealized potential of community health workers in facilitating culturally responsive access to healthcare and other social services for new immigrants and refugees.	refugees and immigrants	qualitative
Torun, P., et al. **A health and health care needs assessment for the Syrian community living in Zeytinburnu district of Istanbul**	2016	Turkey	to assess the needs of urban refugees.	Syrian refugees	mixed approach
UNHCR, **Regional refugee and migrant response plan for Europe. Eastern Mediterranean and Wester Balkans route.**	2016	Turkey, Greece, Macedonia, Serbia, Croatia, Slovenia	to present a set of measures that will enable the humanitarian community to contribute to the protection of refugees and vulnerable migrants, as well as the human rights of all people involved.	refugees and asylum seekers	qualitative
United Nations High Commissioner for Refugees. ***Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas.***	2011	INT	To provide guidance for UNHCR country programmes to advocate for and facilitate access to (and when necessary provide and/or support) quality public health services for refugees equivalent to those available to the national population.	urban refugees	qualitative
United Nations High Commissioner for Refugees. ***Study of the Office of the United Nations High Commissioner for Human Rights on challenges and best practices in the implementation of the international framework for the protection of the rights of the child in the context of migration.***	2010	INT	To set out the specific standards and principles that informs the international framework of protection of the rights of the child in the context of migration.	asylum-seekers, refugees and migrants	literature review
Ussher, J.M., et al., ***Purity, Privacy and Procreation: Constructions and Experiences of Sexual and Reproductive Health in Assyrian and Karen Women Living in Australia.*** Sexuality and Culture, 2012. **16**(4): p. 467-485.	2012	Australia	to examine the constructions and experiences of reproductive and sexual health, and associated services, in Assyrian and Karen women who had arrived in Australia as refugees.	Assyrian and Karen refugee women	qualitative
Vanthuyne, K., et al., ***Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege?*** Social Science & Medicine, 2013. **93**: p. 78-85 8p.	2013	Canada	to explore the consequences of the cuts to healthcare coverage for refugee claimants, focusing on the perceptions of healthcare workers.	pregnant women and children asylum seekers	quantitative
Vermette, D., et al., ***Healthcare Access for Iraqi Refugee Children in Texas: Persistent Barriers, Potential Solutions, and Policy Implications.*** Journal of Immigrant & Minority Health, 2015. **17**(5): p. 1526-1536 11p.	2015	United States	to identify access barriers to healthcare and potential interventions to improve access for Iraqi refugee children.	Iraqi refugee children	qualitative

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Wagner, J., et al., ***Diabetes among refugee populations: what newly arriving refugees can learn from resettled Cambodians.*** Curr Diab Rep, 2015. **15**(8): p. 56.	2015	NR	to reviews rates of cardio metabolic disease and type 2 diabetes among refugees and highlights their unique risk factors including history of malnutrition, psychiatric disorders, psychiatric medications, lifestyle changes toward urbanization and industrialization, social isolation, and a poor profile on the social determinants of health.	refugees	literature review
Wahoush, E.O., ***Equitable health-care access: the experiences of refugee and refugee claimant mothers with an ill preschooler.*** Can J Nurs Res, 2009. **41**(3): p. 186-206.	2009	Canada	to explore the access to health services for preschool children in refugee or refugee claimant families living in Canada.	refugee and asylum-seeking children	mixed approach
Wangdahl, J., et al., ***Health literacy and refugees' experiences of the health examination for asylum seekers - a Swedish cross-sectional study.*** BMC Public Health, 2015. **15**: p. 1162.	2015	Sweden	to investigate refugees' experiences of communication during their health examination for asylum seekers and the usefulness of that examination, and whether health literacy is associated with those experiences.	asylum seekers	quantitative
Weine, S., et al., ***Evaluating a multiple-family group access intervention for refugees with PTSD.*** J Marital Fam Ther, 2008. **34**(2): p. 149-64.	2008	United States	to analyse the effects of a multiple-family group in increasing access to mental health services for refugees with posttraumatic stress disorder (PTSD).	Bosnian refugee families	quantitative
Wohler, Y. & Dantas, JA. **Barriers Accessing Mental Health Services Among Culturally and Linguistically Diverse (CALD) Immigrant Women in Australia: Policy Implications.**	2016	NR	to describe barriers that immigrant and refugee women from diverse ethnic backgrounds encounter in accessing mental healthcare in various settings.	refugee and immigrant women	literature review
Wojnar, D.M., ***Perinatal Experiences of Somali Couples in the United States.*** JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 2015. **44**(3): p. 358-369 12p.	2015	United States	to explore the perspectives of Somali couples on care and support received during the perinatal period in the United States.	Somali refugees	qualitative
Wollersheim, D., et al., ***Constant connections: piloting a mobile phone-based peer support program for Nuer (southern Sudanese) women.*** Aust J Prim Health, 2013. **19**(1): p. 7-13.	2013	Australia	to find out how to use mobile phone-based peer support to improve the psychosocial health of, and facilitate settlement in a group of Nuer refugee women.	refugee women	qualitative
Wollscheid, S., et al. **Effect of Interventions to Facilitate Communication Between Families or Single Young People with Minority Language Background and Public Services: A Systematic Review.**	2015	INT	to examine whether interventions to facilitate communication between public services, on the one hand, and minority language children and youth or families with an immigrant background, on the other, are effective.	children, young people and families with minority-language and immigrant backgrounds	literature review
Woodland ,L., et al**.Evaluation of a school screening programme for young people from refugee backgrounds.**	2016	Australia	To describe the development of the Optimising Health and Learning Program, guided by the only available published framework for the delivery of health services to newly arrived refugee children and report on the evaluation of the programme.	youth refugees	mixed approach
Woodland, L., et al., ***Health service delivery for newly arrived refugee children: a framework for good practice.*** J Paediatr Child Health, 2010. **46**(10): p. 560-7.	2010	Australia	to propose a framework for good practice to promote improved access, equity and quality of care in service delivery for newly arrived refugee children.	refugee children	literature review

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Xiao, L.D., et al. ***Perceived Challenges in Dementia Care by Vietnamese Family Caregivers and Care Workers in South Australia.***	2015	Australia	to explore the perceived challenges of dementia care from Vietnamese family caregivers and Vietnamese care workers.	Vietnamese refugee families, Vietnamese care workers	qualitative
Yelland, J., et al., ***Compromised communication: A qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care.*** BMJ Quality and Safety, 2016. **25**(4): p. e1.	2016	Australia	to explore Afghan women and men's experience of language support during pregnancy, labour and birth, and health professionals' experiences of communicating with clients of refugee background with low English proficiency.	Afghan refugees	qualitative
Yelland, J., et al., ***Maternity services are not meeting the needs of immigrant women of non-English speaking background: Results of two consecutive Australian population based studies.*** Midwifery, 2015. **31**(7): p. 664-670.	2015	Australia	to compare the views and experiences of immigrant women of non-English speaking background (NESB) giving birth in Victoria, Australia with those of women who were born in Australia.	refugee and immigrant women	quantitative
Yun, K., et al., ***Help-Seeking Behavior and Health Care Navigation by Bhutanese Refugees.*** Journal of Community Health, 2016. **41**(3): p. 526-534.	2016	United States	to document barriers to care, help-seeking behaviours, and the impact of a community-based patient navigation intervention on patient activation levels among Bhutanese refugees in the U.S.	Bhutanese refugees	quantitative