D5.1: Report on models of community health and social care and best practices

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1	ASTIKI MIKERDOSKOPIKI ETAIREIA PROLIPSIS	Prolepsis	Greece
2	OXFAM ITALIA ONLUS	OXFAM ITALIA	Italy
3	ETHNO-MEDIZINISCHES ZENTRUM EV	EMZ	Germany
4	NATIONAL CENTER OF INFECTIOUS AND PARASITIC DISEASES	NCIPD	Bulgaria
5	ETHNIKO KAI KAPODISTRIAKO PANEPISTIMIO ATHINON	UoA	Greece
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The Mig-HealthCare project

Since the Middle East crisis broke in 2011 Europe has seen increased flows of migrants and refugees arriving mainly at the Mediterranean shores. This is not though the first time Europe has experienced the influx of large migrant/refugee flows. Immigration to Europe has a long history; Europe has always been a destination continent for people seeking refuge from war, poverty and natural disasters. Many can argue that in a way most European citizens have a migrant background and migrant origins. Especially Western European countries experienced a high growth in immigration after World War II. In particular MS of the EU-15 have sizeable immigrant populations, both of European and non-European origin. The fall of the Soviet Union in the later part of the past century brought new waves of migrants to Western Europe. This time it also bought waves of migrants to previously traditional emigration countries such as Greece, Italy and Spain.

The current refugee/migrant crisis has once again put Europe in a "reactive mode" as recently stated by Carlos Moedas, the European Commissioner for Research, Science and Innovation during the International Conference on Understanding and Tackling the Migration Challenge (4-5 February 2016, Brussels).

The good news is that Europe does have long experience in the integration of migrants and refugees. Over the last years the European Commission has focused efforts on tackling issues related to migration and has financed a plethora of related programs. The evidence on effectiveness exists – it needs to be assessed under the prism of new developments and put to the test. Action is urgent given also Europe's dark past in anti-migrant negative attitudes which are rising across Europe exacerbated by the adverse economic situation in many MS. European countries have a unique opportunity to put past and current experience to practice promoting the integration of refugees and migrants so as to "live up to European values of democracy, peace and respect of human rights" as put in the words of Carlos Moedas.

Health and social care for migrants and refugees in Europe

Migrants, asylum seekers and irregular migrants are, compared to the general population, at a higher risk of poverty and social exclusion. Research has indicated that in many cases these vulnerable groups do not receive appropriate health and social care that best meets their needs (Stanciole & Huber, 2009).

Anderson Stanciole (WHO, Switzerland) during a policy seminar on the barriers to Healthcare Services for Migrants organized by the European Health Management Association highlighted the fact that migrants are not a homogeneous group and face very different barriers when accessing health services. Additionally, it is clear that different MS have very different circumstances when it comes to how health and social care for migrants is organized. Hence

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the “one size fit all” approach is not going to respond to the very complex and urgent situation.

Nevertheless, there are common barriers among different migrant groups when accessing health and social services which mostly have to do with lack of knowledge about available services; language differences; and varying cultural attitudes to health and health/social care.

Numerous EU projects have been implemented in the last years with the objective of mapping existing health services for migrants and refugees and looking into their improvement through recommendations and action plans. Research and projects point to significant differences between the MS in terms of service provision while recommendations and action plans often oversee country specific circumstances (i.e. the economic recession). Some areas are widely unknown. For example we will explore what is available for mental health, dental health, services for minor surgical operations and services related to obstetrics and gynecology among migrants/refugees.

Work package 5 focuses on the development of a comprehensive roadmap for the implementation of effective community based healthcare models for migrants and refugees. It has the following objectives:

1. Review approaches, programs, national and regional initiatives in relation to social and health care for vulnerable migrants including preventive health and health promotion
2. Assess best practices and tools (implemented actions) of community – based health care models serving vulnerable migrants.
3. Indicate requirements and prerequisites and include concrete steps to action taking into consideration the different legal, organisational and institutional environments in Europe
4. Design informative material for migrant/refugees including lists of existing health and social care structures. Translation in the main migrant/refugee languages. Assess the feasibility of EU MS to implement community based care systems
5. Development of an algorithm-based guideline (hard copies, mobile and computer based) that will serve as a guidance for involved professionals on how to offer individualized assistance to migrants/refugees
6. Train health and social care service providers

Mig-HealthCare is collaborating with the MyHealth project in order to provide a comprehensive map of: (1) health care services (2) projects/initiatives (3) tools providing health related services to vulnerable immigrants and refugees as well as mapping of related legislation. The projects initiatives identified for the mapping task have informed the progress of work in WP5 – Task 5.1.

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The contents of this report

The present report addresses the 2 first objectives 1) the review and 2) the assessment of social and healthcare activities towards refugees/migrants. To identify best practices and effective tools, we used a specific comprehensive methodology of searching into four different broad work streams. **First**, a systematic review in the international, academic, peer-reviewed literature was performed to create an overview of models and interventions per specific focus area. Reported best practices and successful interventions were extracted and critically reviewed among the body of published peer-reviewed literature based on methodological rigor and theoretical underpinnings. **Second**, consortium partners were asked to provide local, regional and national documentation reporting on models, tools and best practices for community-healthcare and social care for migrants and refugees in their respective countries and/or languages. **Third**, a body of grey literature on the topic was assembled as reported by experts in the field of migrant and refugee health looking into a variety of possible sources. **Fourth**, a new, additional element was added, that of exploratory conversations with healthcare workers at various sites and locations hosting and serving migrants and refugees to identify bottom-up, hands on practice-based tools and approaches from people working in the field of refugee/migrant health. All sources of information were qualitatively and semi-quantitatively reviewed based on evaluation tools using criteria that apply to the area of our research.

The following questions were used to guide and form search strategies in the different sources described above:

1. What models for community-based healthcare and social care exist that specifically target migrants and refugees?
2. Which of these models have been reported to be effective (self-reported versus evidence-based conclusions)?
3. What are the core elements of successful models?
4. What are examples of successful and unsuccessful models, approaches, tools or interventions?
5. What challenges and lessons learned have been described?
6. Do noted experiences of third countries who have received mass influx of migrants and refugees in recent years (e.g., Lebanon, Turkey, Jordan) exist?
7. What are the lessons learned from community healthcare delivery to minorities such as Roma populations, misplaced minorities, religious minorities in the European Union (EU)?

In this report, we employed a fairly broad conception of “healthcare” and “social care” to cover different types of healthcare services, from mental health needs of adolescents to non-communicable diseases in elderly migrants.

We are aware of the controversy surrounding the terms community, *community based-healthcare* and *community health*. The terms may be employed for different types of activities and different countries may use the terms in different ways. Nevertheless, we believe meaningful results can be obtained from a review of publications explicitly addressing

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community-based models and interventions. For reasons of standardization, we used specific terminology to standardize the search for *best practice*, *community* and *community health/healthcare*.

Best practice is "a relevant policy or intervention implemented in a real life setting and which has been favorably assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes. Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, intersectorality and participation of stakeholders". **(**Criteria to select best practices in health promotion and chronic disease prevention and management in Europe https://ec.europa.eu/health/sites/health/files/major_chronic_diseases/docs/sgpp_bestpracticescriteria_en.pdf)

"***Community Health*** refers to the health status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their health" (McKenzie et al., 2005).

Community is defined as "a group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them" (Green and Ottoson, 1999).

Community-based care / community-based services / programmes defined as "the blend of health and social services provided to an individual or family in his/her place of residence for the purpose of promoting, maintaining or restoring health or minimizing the effects of illness and disability. These services are usually designed to help older people remain independent and in their own homes. They can include senior centres, transportation, delivered meals or congregate meals sites, visiting nurses or home health aides, adult day care and homemaker services".(A glossary of terms for community health care and services for older persons (http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf)

Migrant and *refugees* are terms that are often used interchangeably, but they are defined by the UN as follows (https://refugeesmigrants.un.org/definitions) :

Refugees are "persons who are outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection. The refugee definition can be found in the 1951 Convention and regional refugee instruments, as well as UNHCR's Statute".

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Migrants “While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more”.

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PART A: Systematic Literature Review of Tools and Best Practices in published peer-reviewed literature for Community-Based Healthcare for Vulnerable Migrants and Refugees

Riza E, Kalkman S

INTRODUCTION

Working towards the Agenda 2030 of Sustainable Health Development, to provide health for migrants and refugees worldwide form a group with specific vulnerabilities one of them being the fact they encounter substantial barriers to healthcare in their new home countries (http://www.who.int/migrants/about/framework_refugees-migrants.pdf). These barriers lead to inequitable access to healthcare as a fundamental human right. In recent years, many migrants have come to Europe voluntarily to improve their financial and job status, others forcibly due to armed conflict and persecution. As the refugee/migrant movement still unfolds, the future trend is that many of these people will make Europe their new home. In order to reduce and prevent health inequalities among migrants and refugees in Europe, local healthcare systems will need to adapt to the specific needs of this population. There is evidence that integration into existing healthcare systems is promoted through tailored services at the level of local communities (https://ec.europa.eu/migrant-integration/index.cfm?action=media.download&uuid=A37B8410-C20A-C37A-495762D3B9205FF9). However, information on how to effectively develop and run community-based healthcare models for migrants and refugees is scattered.

To identify requirements, prerequisites and concrete steps to design and implement community-based healthcare models serving migrants and refugees, we performed a comprehensive scoping review including a systematic search of the international, peer-reviewed literature. This systematic review aimed to answer the following question: *What are effective community-based healthcare models and interventions for vulnerable migrants and refugees*? Hereto, we first searched and mapped the different models that are reported worldwide in the academic literature, along with their characteristics and core elements, and reported outcomes. Second, we critically analyzed to what extent effectiveness can be reasonably argued for regarding each of the models and interventions. Third, based on our critical analysis we created a shortlist of potential best practices and tools. Our findings will provide policy-makers and health services researchers working with migrant and refugee populations concrete steps to successfully develop strategies to address health in equalities and foster integration at the level of local communities in Europe.

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METHODS

Search and selection

A systematic search was performed for articles published in the English language in three scientific literature databases (EMBASE, Scopus and PubMed) in March 2018 using synonyms of [migrant/immigrant/refugee/asylum-seeker] AND [healthcare] AND [community-based] AND [model]. Papers were eligible for data extraction if they provided a comprehensive description of a community-based model for healthcare delivery to migrants, immigrants, refugees, asylum-seekers or other relevant minorities. Eligibility was not restricted to models and interventions for specific groups of migrants and refugees. We included all ages, ethnicities and migrants of any status. Explicit mentioning of *vulnerability* was not required for inclusion, because all migrants and refugees are considered inherently vulnerable.

Also, we employed a fairly broad conception of *healthcare* to deliberately cover different types of healthcare services and refugee/migrant population subgroups, such as adolescents, mothers, chronic patients and migrants. The reason for this was to create a shortlist of potential best practices and tools covering the whole range of community-based health services to provide a broad base of information to policy-makers, researchers and funders who work in this area. All publications that proposed, discussed or formally assessed a community-based model or intervention were included for analysis. Abstracts and conference proceedings were excluded from formal analysis as an in-depth critical review was not possible to the same extent as it is for full text publications. However, having reviewed some abstracts and conference proceedings, we have strong reasons to believe that many interventions delivered as pilot studies have not been published as full text papers, despite the fact that they provide valuable insights into potentially effective community-based interventions. We also excluded publications that only reported on health needs, barriers and challenges to healthcare access among migrants and refugees which did not contain the element of specific practices and tools.

Papers reporting on methods for participatory community-based health research, healthcare models strictly for rural or low-resources areas and papers on models to engage migrants in clinical research were all excluded. We did not set limits for publication date, but since we envision our work to be of particular relevance to the present refugee crisis in Europe, we divided our search in pre and post 2012 publication date in an effort to aggregate data on the recent situation (following the Syrian armed conflict of 2011). Publications dated before 2012, we reasoned that may have been published with respect to, for example, the United States and Australia, in years predating the current European influx of migrants and refugees from Africa and the Middle East.

Data extraction and analysis

Of all articles included for final analysis, data was extracted on the following variables: (1) full citation; (2) year of publication; (3) type of study/paper; (4) country of implementation; (4) target population; (5) type of care/health needs; (6) model/intervention (key words); (7) basic characteristics of the model/intervention; (8) best practices; (9) lessons learned; (10)

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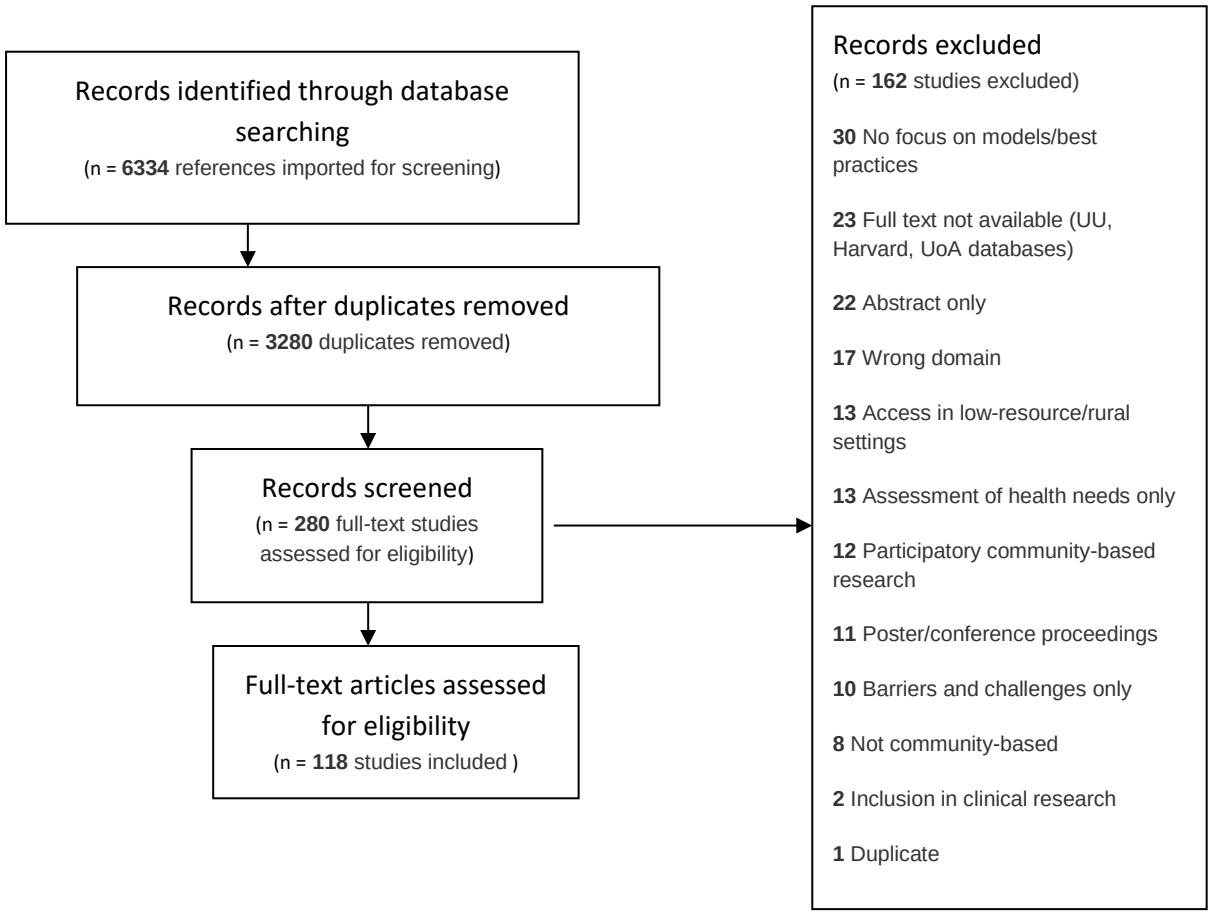
challenges and limitations. For the critical appraisal we also extracted data on: (11) mode of evaluation (study design); (12) duration of evaluation (follow-up); (13) study sample (if applicable); (14) theoretical underpinnings (see Appendix 1). Variables for data extraction were established by means of an iterative process, indicating a going back-and-forth between records and database.

To facilitate analysis, publications were grouped by indication/disease area through an iterative process, and subsequently categorized as models or interventions for health promotion/education, prevention or disease management. At the aggregate level, we critically assessed the various models and interventions on presumed effectiveness based on the level of evidence provided.

RESULTS

From our literature database search, we retrieved 3054 unique records. Screening of titles and abstracts narrowed full text screening down to 280 publications. Based on the predefined inclusion and exclusion criteria, a total of 118 publications remained for data extraction. Abstracts and conference proceedings were screened but not included in the review. A full overview of reasons for exclusion can be found in the flowchart below.

PRISMA Flow Diagram for MIGHEALTHCARE



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In order to facilitate the graphical presentation and interpretation of the results, the findings are presented by aggregated category in 5 separate tables. Each table contains information on each and every intervention identified through the literature search which helped assess the quality of the reported interventions taking into account standard research methodology criteria, namely location of implementation, population description, type of study, description of model/ intervention and reported outcomes.

Overall study characteristics

Out of 118 records, 53 (44.9%) discussed mental health (Table 1), 36 (30.5.4%) general health services (Table 2), 13 (11.0%) non-communicable diseases (excluding mental health) (Table 3), 9 (7.9%) primary healthcare (Table 4) and 7 (6.2%) women's, maternal and child health (Table 5). Countries or regions of implementation included: 67/119 (56.3%) North America (United States and Canada), 28/119 (23.5%) Europe, 9/119 (7.6%) Australia and New Zealand, 5/119 (4.2%) the Middle East, 2/119 (1.7%) Asia and 1/119 (<1%) Latin America. Populations targeted included *migrants*, *immigrants*, *refugees*, *asylum-seekers*, *and racial and ethnic minorities* as defined by the respective authors. Some publications further specified the target population as constituting women, children, adolescents or families, elderly patients, trauma- or torture-exposed individuals, seasonal/farm workers, or individuals with a low-income. Study designs included mostly mixed methods (use of quantitative and qualitative data), qualitative research (interviews and focus groups, surveys and less frequently experimental designs (controlled, randomized or pre-posttest designs). Most experimental studies were labeled as pilot studies. Community aspects were framed as either interventions implemented in the migrant community or as models or programmes that rely on the engagement of different community stakeholders (such as universities, schools and different community health services). The vast majority of studies were published between 2006 and 2018 (89.1%). In the following, we distinguish between single interventions and complex interventions. By *complex interventions* we mean activities (models or programmes) that contain a number of component parts (interventions) with the potential for interactions between them which, when applied to the intended target population, produce a range of possible and variable outcomes. Due to their nature, the effectiveness of complex interventions is more difficult to substantiate.

Mental health

Single interventions developed for community-based mental health services for migrant and refugees predominantly pertain to training of (future) healthcare workers and cultural brokering (Table 1). Training programmes strongly focus on cross-cultural understanding and competency of healthcare workers (1-3). Some programmes pair student training (psychology or nursing students) with actual delivery of healthcare services to fulfill the dual goal of addressing the health needs of an underserved migrant population and stimulating competency among future healthcare workers to work with migrants and refugees (4, 5). In terms of *cultural brokering* (6) we identified the use of community peers (7-11), bilingual gatekeepers (12) and ethnic matching of therapists and patient (13, 14) as proposed strategies to overcome access barriers arising from cultural differences. Complex interventions to promote community mental health constitute school-based programmes to

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screen (and sometimes also treat) children and adolescents from migrants and refugee communities for mental health problems (6, 15-19), mental health promotion in community day centers (20, 21) and by community organizations (22, 23) and various other community-based mental health services (24-31). Tools identified were screening tools for psychosocial risk assessment (10, 32, 33).

Core elements of the identified interventions and models were: partnering with members from the target communities (e.g., employing staff and volunteers from communities) (34, 35), community mobilization to stimulate outreach (23, 36, 37), bridging cultural differences and language barriers through culturally and linguistically sensitive approaches (4, 35, 37-43), education and training of health service providers on the needs of the target population (3, 30, 44), providing information on mental health (awareness raising) (36, 45), availability of information in relevant languages (34), advocacy (46, 47), facilitating better integration (42), responsiveness, coordination and planning of different health and social services (2, 44, 45, 48, 49), establishing a sense of belonging, community and trust (8, 48, 50), and promoting empowerment and cultural competency (9, 51, 52). Other issues that were considered relevant to secure success were funding to secure sustainability of the programmes (48) and community-based participatory research (37).

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Table 1. Study characteristics for records on community-based mental health services for migrants and refugees.

No.	Authors (year)	Location (country) of implementation	Population	Type of study (*n*)	Model/intervention	Outcome definition	Reported ouctome
1	Ahmad et al (2012)	North America (Canada)	Afghan refugees	Randomized study and survey (pilot)	**Computer-assisted psychosocial risk assessment**	User intention to see a psychosocial counselor (primary outcome) and user acceptance of the tool and visit satisfaction (secondary outcomes)	72% of intervention group reported intention to visit a psychosocial counselor, compared to 46% in usual care group. Participants in the intervention group agreed with the benefits of the tool, both groups were alike in patient satisfaction.
2	Areán et al (2008)	North America (USA)	Elderly minorities	Secondary analysis of data from a randomized trial	**Integrated primary care versus community mental health services**	Service use and mental health outcomes at baseline, 3 months and 6 months post-randomization	While providing services in primary care results in better access to and use of these services, accessing these services is not enough for assuring adequate clinical outcomes.
3	Bäärnhielm et al (2015)	Europe (Sweden)	Refugees	Mixed methods	**Locally organized cross-cultural training for mental healthcare workers**	Change in participants' perceived knowledge and barriers to "do a good job" before and after the course; and participants' perceived barriers and success factors in encountering mental illness among refugees before and after the course	After training, participants reported that the hindering effect of lack of knowledge on their work decreased significantly. Focus groups indicated that after training, participants shifted from emphasizing communication barriers towards empathy with refugees with mental ill-health.
4	Beehler et al (2012)	North America (USA)	Traumatized immigrant children and adolescents	Effectiveness study	**School-based mental health program offering an array of clinical and coordinating services to all students**	Improvement of client functioning and PTSD symptoms as a result of 7 separate service elements	Greater quantities of CBT and supportive therapy increased functioning, while greater quantities of coordinating services decreased symptoms of PTSD. TF-CBT services were associated with both improved functioning and PTSD symptoms, although TF-CBT was implemented with fidelity to the overall comprehensive service model rather than the structured intervention model.

5	Behnia (2003)	North America (Canada)	Refugees with torture experience from Bosnia, Cambodia, El Salvador, Iran and Somalia	Qualitative study (interviews)	**Formal mental health services versus community peer groups**	Respondents' experiences with formal mental health services versus community peer groups	Participants were satisfied with community peer groups and expressed strong support for their establishment. Participants favored the establishment of a support group formed solely by survivors of war and torture.
6	Bhattacharyya & Benbow (2013)	Europe (UK)	Black and minority ethnic elders (BME)	Literature review	**Innovative mental health services for BME**	Published examples of innovative services and key learning points and implications for clinical practice and policy	(1) Key commissioning issues: forward planning for continuing funding and mainstreaming versus specialist services. (2) Key provider management issues: employing staff from the communities of interest, partnership, and removing language barriers. (3) Key provider service issues: education for service provider staff on the needs of BME elders, making available information in relevant languages, building on carers' and users' experiences, and addressing the needs of both groups.
7	Birman et al (2008)	North America (USA)	Refugee children	Description of service delivery model and assessment of participant improvement over time as a function of services	**Community-based mental health program**	A) Characteristics of children and families served (e.g., history of trauma, demographics); (B) Patterns of service delivery (e.g., providers, types of services, etc.); and (C) Improvement over time of mental health of children and adolescents receiving services	Results showed that participants improved, but that the improvement was not related to dosage of services.
8	Brar-Josan (2017)	North America (Canada)	Refugees	Qualitative case study	**Cultural brokers**	Work description of educational cultural brokers providing services to refugee youth in school settings	(1) Facilitating cultural integration and sense of belonging, (2) bridging to settlement services, (3) supportive counselling, (4) facilitating referrals to mental health practitioners, (5) educating about mental health, (6) providing contextual information and cultural interpretation

9	Chase & Rousseau (2018)	North America (Canada)	Refugees	Ethnographic study	**Community Day Center**	Experiences and perceptions of users of a Community Day Center for asylum seekers in Montreal	The Day Center shows significant promise as an innovative early stage mental health intervention for precarious status migrants
10	Chen et al (2014)	North America (Canada)	Racialized immigrants, refugees and non-status people with HIV/AIDS (IRN-PHAs)	Community-based participatory research (mixed methods)	**No specific intervention assessed**	Suggestions for service improvements	A three-pronged approach involving IRN-PHA empowerment, anti-stigma and cultural competence promotion, and greater service integration is proposed for improving IRN-PHAs' mental health service experience.
11	Chiumento et al (2011)	Europe (UK)	Refugee and asylum-seeking children	Qualitative study (interviews)	**Multiagency model for community health services**	Refugee statistics and mental health policy imperatives that advocate multi-agency working	Refugee children are more likely and prefer to access a school-based mental health service than a clinic. Links between schools and mental health services facilitate mutual understanding of different agencies working in the interests of all children and, using outcome measures and quotes, the evidence indicates that the service achieved its aim of improving refugee children's mental health.
12	Choi (2017)	Asia (Korea)	Immigrant women	Pre-post test design (with non-equivalent control group)	**Mental health improvement program using bilingual gatekeepers**	Mental health literacy (questionnaire), acculturative stress (scale) and mental health (questionnaire)	The program was effective in improving mental health and mental health literacy scores as well as reducing the degree of acculturative stress.
13	Dura-Vila et al (2013)	Europe (UK)	Refugees	Questionnaires	**Community-based mental health service**	Past adversities and current circumstances, referral problems, service utilization and treatment outcomes using the Strengths and Difficulties Questionnaire (SDQ)	Community-based mental health services for young refugees appeared effective - significant improvement was found in SDQ scores for the sub-group (n = 24) who took up the treatments offered.
14	Ellis et al (2013)	North America (USA)	Refugees	Longitudinal outcomes assessment	**School-based model for prevention, resilience building and early intervention**	War Trauma Screening Scale, Adolescent Post-War Adversities Scale-Somali version, UCLA PTSD Reaction Index for DSM-IV (Revision	Students across all tiers of the program demonstrated improvements in mental health and resources. Resource hardships were significantly associated with symptoms of PTSD over time, and the stabilization of

						1), and the Depression Self-Rating Scale	resource hardships coincided with significant improvements in symptoms of depression and PTSD for the top tier of participants.
15	Fernando (2005)	Europe (UK)	Black and minority ethnic (BME) communities	Description of models and lessons learned	**Projects within statutory mental health services and in the non-governmental ('voluntary') sector**	Overview of the attempts that have been made in England to develop mental health services that address needs of BME communities	A significant part of changing statutory sector mental health practice must be concerned with changing the clinical practice of psychiatry towards adopting a multicultural approach – both in terms of how mental health assessments are carried out and the scope of what goes for therapy.
16	Fondacaro et al (2014)	North America (USA)	Refugees	Description of the model and survey data	**Training program for psychology students ("Connecting Cultures")**	Students' satisfaction and knowledge gained (twice-yearly)	93% of students reported they were satisfied with the training they received from the program and 96% reported their involvement in the program trainings had increased their knowledge related to working with refugees.
17	Gionakis & Stylianidis	Europe (Greece)	Migrants	Description of model and challenges	**Community Day Center**		
18	Goodkind et al (2014)	North America (USA)	African refugees	Multimethod, within-group longitudinal pilot study	**Community-based advocacy and learning intervention with refugees and undergraduate students**	Exploration of individual- and group-level trajectories, individual characteristics that predict the form and/or amount of change, and examination of mechanisms or processes of change as delineated by the authors' conceptual model of the intervention	The intervention was found to be feasible, acceptable, and appropriate for African refugees. Growth trajectory analysis revealed significant decreases in participants' psychological distress and increases in quality of life, and also provided preliminary evidence of intervention mechanisms of change through the detection of mediating relationships whereby increased quality of life was mediated by increases in enculturation, English proficiency, and social support. Qualitative data helped to support and explain the quantitative data.

19	Hamilton et al (2014)	North America (USA)	Low-income minority children and families	Mixed methods	**Community-based mental health services**		
20	Harris & Maxwell (2007)	Europe (UK)	Refugees and asylum seekers	Qualitative study (interviews)	**Community-health services provided by one mental health worker**	Community suggestions for interventions and components of a new model for care	Community suggestions: counselling, awareness raising, activities/keeping busy, traditional healers/traditional community or religious leaders. Components of model: community mobilization, raising awareness, networking and liaison, individual clinical work.
21	Hess et al (2014)	North America (USA)	Refugees (and students)	Qualitative study (interviews)	**Social change model with refugees and students**	Experiences of refugees and student working with the model	Participation in the project constituted a transformative learning experience through which refugees and students came to new understandings of the relationship between social inequities and well-being.
22	Holden et al (2014)	North America (USA)	Ethnic minorities	Review paper	**Culturally centered integrated care model (combination of the patient-centered medical home model and cultural competency training)**	None	The model addresses the complex and multiple levels within the health care system—from the individual level, which includes provider and patient factors, to the system level, which includes practice culture and system functionality issues. It is the authors' intention that the proposed model will be useful for health practitioners, contribute to the reduction of mental health disparities, and promote better mental health and well-being for ethnic minority individuals, families, and communities.
23	Im & Rosenberg (2016)	North America (USA)	Bhutanese refugees	Qualitative study	**Peer-led community health workshop (CHW)**	Impact in the Bhutanese refugee community	Data revealed the improvement in health promotion outcomes and health practice, as well as perceived emotional health. The results also showed that the peer-led CHW provided a platform of community building and participation, while

							increasing a sense of community, sense of belonging and unity.
24	Kaltman et al (2011)	North America (USA)	Low-income immigrants	Description of model	**Collaborative mental health care program implemented in a network of primary care clinics that serve the uninsured**	None	The program has demonstrated that it is possible to implement a cost-efficient and evidence-based treatment model. Although adaptations and flexibility in the model were essential, the key components of traditional collaborative care were preserved.
25	Kaltman et al (2016)	North America (USA)	Low-income, trauma-exposed Latina immigrants	Mixed methods (pilot)	**Mental health intervention for primary care clinics that serve the uninsured**	Experience of trauma-exposed Latina immigrants with depression and/or posttraumatic stress disorder (PTSD) in an open pilot trial of the intervention	Results indicated that the intervention was feasible, acceptable, and safe
26	Khawaja & Stein (2016)	Australia & New Zealand (Australia)	Asylum-seekers	Qualitative studies	**Strategies identified by healthcare workers to deliver culturally effective services**	Professionals' perceptions of psychosocial issues faced by asylum-seekers, the challenges of providing culturally effective services to this group, and how these services can be improved	The findings indicated that participants perceived that clients experienced psychological, health, and cultural difficulties. The stress and uncertainty around visa applications emerged as the most severe factor impacting asylum seekers' mental health. Working effectively with interpreters and culturally adapting assessment and treatment for these clients emerged as effective strategies. Gathering information in a conversational way and using clients' different cultural explanatory models were methods used to identify and address mental health issues, rather than using formal measures. Interventions were eclectic and holistic, and reflected treatments that were appropriate for the clients' cultural backgrounds.
27	Kieft et al (2008)	Europe (The Netherlands)	Asylum-seekers	Description and discussion of model	**Informal paraprofessional support systems (by**	None	This community approach is considered to be applicable and relevant within an asylum seekers'

					trained peer asylum-seekers and refugees)		centre, as it incorporates an additional easy-access level of psychosocial care and social agency, which seemed to empower participants and help prevent psychosocial problems from becoming more severe.
28	Knipscheer & Kieber (2004)	Europe (The Netherlands)	Mediterranean migrants	Qualitative study	**Ethnic matching in the therapist-patient dyad in community mental healthcare**	Effects of ethnic matching on treatment satisfaction	The majority of the respondents did not value ethnic matching as important; clinical competence and compassion were considered to be more relevant than ethnic background. An ethnically dissimilar therapist treated the majority of the outpatients. Outpatients treated by a native Dutch therapist reported similar satisfaction with the services provided as those treated by an ethnically similar therapist.
29	Koehn et al (2014)	North America (Canada)	Older Punjabi immigrants	Mixed methods	**Mental health promotion by community organizations**	If and how community organizations offer services that promote mental health and well-being (guided by three overarching social and economic determinants of mental health: social inclusion (SI), freedom from violence and discrimination, and access to economic resources and participation)	All three mental health determinants were identified as important by service providers and seniors, with SI as the most important. Family dynamics (shaped by migration and sponsorship status) influence all three determinants and can promote or diminish mental well-being. Service providers assert that more outreach and sustainable funding are needed to reach the majority of potential beneficiaries unable to participate in community programmes. Information on mental well-being of seniors should be targeted at both seniors and their families.
30	Law (2007)	North America (USA)	Ethnic and racial minorities	Evaluation and discussion	**Assertive Community Treatment (ACT) and the role of the Clinical Director**	Role of the clinical director	The clinical director has an administrative role, a direct service role and a clinical collaboration role within ACT. The role of clinical director demands specialized clinical,

							administrative, advocacy, and evaluative skills.
31	Lee et al (2008)	North America (USA)	Korean immigrants	Review paper	**Community partnership between religious and mental health services**	Potential benefits and opportunities	By working with the Korean clergy, a small voluntary organization such as the Association of Korean American (KA) Psychiatrists could provide invaluable assistance in removing the barriers to mental health services for KAs.
32	Llosa et al (2017)	Middle East (Lebanon)	Refugees	Secondary analysis of interview data	**Psychosocial risk assessment by lay individuals in a refugee camp**	Household informant and individual level interviews using a Vignettes of Local Terms and Concepts for mental disorders (VOLTAC), individual and household informant portions of the field-test version of the WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS) and the WHO Self Reporting Questionnaire (SRQ-20)	Results suggest that a two phase, screen-confirm approach is likely a useful strategy to detect incapacitating mental disorders in humanitarian contexts where mental health specialists are scarce, and that in the context of a multi-step screen confirm mechanism, the household informant portion of field-test version of the WASSS may be an efficient screening tool to identify adults in greatest need for mental health care in humanitarian settings.
33	Misra et al (2006)	Europe (UK)	Asylum-seekers and refugees	Qualitative study (interviews)	**Model for mental health service provision**	Experiences of professionals who treat asylum-seekers and refugees, and of those responsible for the planning, management and delivery of mental health services to this group; and key lessons from the development of a model for service provision	Main issued faced were: increased demands placed on the time and resources of already stretched mental health services, language and cultural barriers, the difficulties in working through interpreters in delivering therapy, and the need for longer consultation time. Asylum seekers and refugees were felt to seek health professionals' help with matters that were outside the professionals' remit. Key lessons include the need for better information on asylum seekers and refugees and making use of appropriately trained health professionals from this group to help

							in the planning and provision of mental health services.
34	Moore et al (2007)	North America (USA)	Racial and ethnic minorities	Description of an intervention concept	**Integration of a quality improvement model with an evidence-based approach to planning Continuing Medical Education (CME)**	None	The authors anticipate that this project will help medical education researchers understand not only how to help physicians recognize and treat depression in ethnic and racial minority patients, but also to understand how to assist CME providers in changing their practice behaviors to incorporate a more effective approach to helping physicians provide the best possible care to their patients.
35	Murray et al (2010)	North America (USA)	Refugees	Literature review	**Various mental health interventions**	Review of refugee research, examination of empirical evaluations of therapeutic interventions in resettlement contexts, and recommendations for best practices and future directions in resettlement countries.	The resettlement interventions found to be most effective typically target culturally homogeneous client samples and demonstrate moderate to large outcome effects on aspects of traumatic stress and anxiety reduction. Further evaluations of the array of psychotherapeutic, psychosocial, pharmacological, and other therapeutic approaches, including psychoeducational and community-based interventions that facilitate personal and community growth and change, are encouraged.
36	Nadeau et al (2005)	North America (Canada)	Immigrants and refugees	Description of model	**Transcultural child psychiatry service**	Aspects necessary to engage migrant and refugee families in making use of needed mental health services for their children	Aspects identified: Modifications in obtaining access to care; Issues of communication (i.e., the use of interpreters); Addressing cultural differences in understanding and responding to a child's difficulties; recognizing the plasticity of culture; Collaboration with colleagues in hospitals and with professionals in the community.

37	Nadeau et al (2017)	North America (Canada)	Migrant youth and their parents	Qualitative study	**Collaborative model for delivery of youth mental health (YMH) services**	Aspects relevant to establishing an optimal care setting for collaborative YMH services for migrant families	(1) Providing an equilibrium between communication, collaboration and privacy/confidentiality, (2) special attention to ensuring the continuity of care and the creation of a welcoming environment where trusting relationships can develop, (3) the inclusion of family intervention, and (4) the provision of collaborative decision-making pathways to care, addressing interprofessional and interinstitutional collaboration as well as cultural differences in explanatory models and values.
38	Nakkash et al (2011)	Middle East (Lebanon)	Palestinian refugee children	Process evaluation	**Community-based mental health promotion intervention**		
39	Nazzal et al (2014)	North America (USA)	Refugees	Description of model	**Community-oriented prevention and early intervention model**	Challenges and benefits	This innovative, community-oriented prevention and early intervention model has a variety of benefits for newly arrived refugee groups, as it incorporates specific, culturally congruent interventions that can be helpful to preventing or mitigating mental health issues in refugee populations. Challenges were encountered from the community members themselves (fear of stigma) and in program administration and implementation.
40	Polcher & Calloway (2016)	North America (USA)	Newly arrived refugee	Pilot project	**Early mental health screening tool for newly resettled adult refugees at a community health center**	Number screened, follow-up referral and treatment requests	51/178 (28.6%) adult refugees screened positive for risk of emotional distress with. Follow-up with a primary care provider was completed with 30 (59%) of those who screened positive. Half (15) requested mental health treatment. Although there are challenges to implementing a standardized mental health screening for refugees, this pilot reiterates the

							need for standardized mental health screening of refugees.
41	Price et al (2012)	North America (USA)	Immigrants and refugees (youth and families)	Discussion of model	**Culturally responsive trauma-focused mental health services within school settings**	Successes and barriers	Making cultural adaptations to identified trauma interventions that were consistent with community priorities, cultural norms, and values resulted in more accessible programs and greater engagement in treatment services.
42	Priebe et al (2012)	Europe	Socially marginalized groups (including refugees, asylum-seekers and irregular migrants)	Qualitative study	**Good practices in mental healthcare**	Good practices according to experts in 15 European countries	4 components of good practice were identified across all six groups: a) establishing outreach programmes to identify and engage with individuals with mental disorders; b) facilitating access to services that provide different aspects of health care, including mental health care, and thus reducing the need for further referrals; c) strengthening the collaboration and co-ordination between different services; and d) disseminating information on services both to marginalised groups and to practitioners in the area.
43	Sijbrandij et al (2017)	Europe and the Middle East	Syrian refugees	Review	**Scalable psychological interventions for people living in communities affected by adversity**	Provision of (1) an evidence-based rationale for the use of the scalable Problem Management + oriented programmes being adapted for Syrian refugees; and (2) information on the newly launched STRENGTHS programme for adapting, testing and scaling up of PM+ in various modalities in both neighbouring and European countries hosting Syrian refugees.	With the large-scale implementation of the PM+ programmes, the STRENGTHS programme aims to strengthen responsiveness of national and local health care systems affected by the Syrian refugee crisis and to significantly reduce the burden of disease among vulnerable people such as Syrian refugees affected by war and displacement. STRENGTHS also aims to provide insights and recommendations on effective implementation mechanisms to respond more rapidly to the needs of other contemporary and future populations affected by conflict.

44	Small et al (2016)	North America (USA)	Resettled refugees	Quasi-experimental study (pre-post design with random assignment to treatment arms)	**Comparison of three different treatment modalities: treatment as usual (TAU), home-based counseling (HBC), and a community-based psycho-educational group (CPG)**	Effects on posttraumatic stress symptoms, depression, anxiety, somatization, and social support	Results indicate merit in each of the treatment modalities, with varying efficacy across intervention according to mental health symptoms. In general, however, participants in HBC and CPG demonstrated greater overall improvement in mental health outcomes than participants receiving TAU.
45	Snowden et al (2006)	North America (USA)	Racial and ethnic minorities	Questionnaires	**Strategies for reaching minority communities and overcoming barriers to treatment-seeking**	In multivariate analysis, strategies were linked to ethnic-specific penetration rates in California's Medicaid Program calculated as measures of access	Undertaking outreach activities was associated with greater access for Latinos and Native Americans. For Asian Americans, hiring bilingual or bicultural staff was associated with greater access but having a bilingual or bicultural receptionist was associated with lesser access. For all minority groups as well as for Whites, the overall supply of mental health practitioners in the county was strongly associated with greater access.
46	Stein et al (2002)	North America (USA)	Traumatized immigrant children	Discussion of opportunities and challenges	**Collaborative research model for school-based mental health services**	Potential, challenges and limitations	The partnership provides a framework that is useful in overcoming many of the challenges faced in conducting school-based mental health research. The framework guided the overall program development, facilitated priority-setting and helped to assign important roles to different stakeholders. Challenges were time constraints and stakeholder engagement.
47	Sturm et al (2017)	Europe (France)	Migrants (children and families)	Description of model with case study	**Intercultural consultation at a medical and psychological healthcare service**	Principles of intercultural consultation, therapeutic and mediation techniques used, and integration of the work into the global service provision of the medical and	Still too early to evaluate the outcome of the innovations introduced in terms of clinical improvement. A future study could focus on determining if the integration of the consultation into the services at the facility actually enhances therapeutic alliance with

						psychological healthcare service	children and families. On a more general level, authors identify the need to link research on culturally competent service provision to research on outcomes and quality of therapeutic alliances established between professionals, children and families.
48	Tran et al (2014)	North America (USA)	Latina immigrants	Pre-post design for evaluating effectiveness/impact	**A pilot *promotora* intervention offering coping skills training**	Mental health outcomes of *compañeras*	*Compañeras* improved on the following outcomes: depressive symptoms, attitudes of depression treatment, perceived and acculturative stress, perceived social support, and positive coping responses.
49	Tse et al (2010)	Australia & New Zealand (New Zealand)	Chinese migrants	Qualitative study	**Strengths model as a recovery intervention**	Service/model user experience	Service user participants regarded the strengths model as helpful in assisting their settlement and integration into the host society. Practitioners were confronted by the following three challenges in applying the model with Chinese migrants: passive role played by service users, difficulties in understanding the concept of strengths, and service users with complex needs.
50	Tyrer & Fazel (2014)	Not specified	Refugee and asylum-seeking children	Literature review	**School and community-based interventions**	Efficacy of a school or community-based mental health intervention for refugee or asylum-seeking children	Findings suggest that interventions delivered within the school setting can be successful in helping children overcome difficulties associated with forced migration.
51	Weine (2011)	North America (USA)	Refugee families	Description of intervention development template	**A preventive intervention development cycle**	None	Preventive mental health interventions should meet the needs of refugee families, including: Feasibility, Acceptability, Culturally Tailored, Multilevel, Time Focused, Prosaicness, Effectiveness, and Adaptability. These 8 characteristics can be addressed through incorporating innovative mental

							health services research strategies, including: resilience framework, community collaboration, mixed methods with focused ethnography, and the comprehensive dynamic trial.
52	Williams & Thompson (2011)	Not specified	Refugees with conflict-related psychotrauma	Literature review	**Community-based mental healthcare services**	Effectiveness of community-based mental healthcare services and best practices	Articles consistently demonstrated the benefit of community-based mental health service in improving mental health outcomes. Themes of cultural awareness, language, setting, and post-migration stressors emerged across the articles. Studies also point to the gaps in research of a longitudinal nature and ones that deal with scattered populations post-migration. Additional interventions and evaluations are required to draw consistent and conclusive judgments on best practice in dealing with refugee mental health issues.
53	Xin et al (2011)	North America (USA)	Multiethnic adult refugees	Pilot intervention study (questionnaires)	**1-year service-oriented pilot intervention for mental health promotion in local communities**	Participation rate, number of persons screened for depression and referred to specialty care (primary outcome) and participant feedback (secondary outcome)	55 refugees participated in the program, 50% was screened for depression and 6 were referred for follow-up. Participants provided positive feedback for supporting the continuity and expansion of the intervention.

Health services

Community-based interventions and strategies to reduce health disparities in migrant and refugee communities predominantly focus on health promotion and access to care (Table 2). Single interventions described are telephone or electronic resources providing health information (53, 54), cultural brokering through volunteer community or ethnic ambassadors (55-61), and bilingual advocacy and interpretation services (62, 63). To stimulate the sense of community and adoption of a healthy dietary pattern, a community garden project was described (64). Complex interventions are community-academic partnerships (bringing faculty staff, students and refugees together) (65-70), community-based nursing initiatives performing outreach, assessment, care and referral (71-73), and home-based health services (74). In addition, programmes that target prevention (e.g., breastfeeding and sexual health) and services that provide care for the uninsured were mentioned (75).

Common elements of identified interventions and models were stewardship and responsibility of stakeholders in the field of healthcare delivery (76, 77), emphasis on sense of community, commitment and obligation of stakeholders (57, 76-78), community-based leadership and ownership of programmes (68, 79), social networking (79, 80), establishment of evidence-based guidelines (81, 82), minimizing discrimination (82), promoting understanding and human values (73, 83), use of targeted outreach strategies (84), community collaboration and advocacy (62, 78, 81, 83-86), raising awareness about health risks (75, 76, 85), culturally and linguistically sensitive approaches (58, 60, 62, 63, 75, 77, 78, 81, 84, 87), establishing trust between migrant population and service providers (66, 70, 73), training and education of service providers on the health needs of the community (66, 68, 70, 75, 80), ensuring availability of resources (75, 87) and sustainability of programmes (68, 81), monitoring of programme utilization and programme evaluation (68, 78, 82).

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Table 2. Study characteristics for records on community-based health services for migrants and refugees.

No.	Authors (year)	Location (country) of implementation	Population	Study design (*n*)	Model/intervention	Outcome definition	Reported outcome
1	Aluko (2007)	North America (USA)	Racial and ethnic minorities	Description of model	**Community-coalition to reduce health disparities through educational empowerment**	None	The model effectively raised the level of awareness of the social responsibility of the healthcare delivery system to hold itself accountable in the provision of equity in healthcare. This community model brings together all stakeholders in the healthcare delivery and consumer equation, around a common goal of communal stewardship, emphasizing community and corporate obligation and responsibility.
2	Barenfeld et al (2015)	Europe (Sweden)	Elderly migrants from Finland or the Balkan Peninsula in Sweden	Qualitative study	**Group-based health promotion programme (HPP) developed in a researcher-community partnership**	Participants' experiences and content implemented in the programme	Participants and personnel jointly helped raise awareness. The participants experienced three key processes that could open doors to awareness: enabling community, providing opportunities to understand and be understood, and confirming human values and abilities. Depending on how the HPP content and design are being shaped by the group, the key processes could both inhibit or encourage opening doors to awareness.
3	Barenfeld et al (2017)	Europe (Sweden)	Elderly migrants from Finland or the Balkan Peninsula in Sweden	Qualitative study	**Programme of person-centred group meetings and one individual home visit to prolong independence in daily activities**	Participants' everyday experiences of using health-promoting messages exchanged during the programme	Participants experienced how using health-promoting messages was a dynamic process of how to make decisions on taking action to satisfy health-related needs of oneself or others immediately or deferring action. Five sub-processes were identified: gaining inner strength, meeting challenges in available resources, being attentive to what is worth knowing, approaching health

							risks, and identifying opportunities to advocate for others.
4	Blair (2012)	North America (USA)	South Asian elderly immigrants	Qualitative study	**Volunteer ambassadors from ethnic and faith communities to perform information and referral services for elders**	Roles of ambassadors as community health workers (CHWs) for immigrants undergoing late-life acculturation	Ambassadors worked in polygonal relationships with elder clients and elders' children, rather than simply working in dyads with elder clients themselves. This polygonal framework integrated intra-familial and extra-familial acculturative dynamics into a single relational model. Within these relationships, CHWs exhibited hybridity of social roles, integrating familial and professional attributes, but fully achieving neither familial nor professional status.
5	Brown & Barton (1992)	North America (USA)	Migrant farm workers	Description of program evolvement over time	**Collaborative effort between a health services agency and a baccalaureate nursing program**	None	After almost 10 years of cooperation, the commitment to the endeavor on the part of both agencies remains strong as the benefits to each continue to increase. The ultimate beneficiaries, however, are the migrant families receiving care and the students providing care.
6	Connor et al (2007)	North America (USA)	Migrant farm worker families	Description of model development and proceedings	**Community-partnership model to increase delivery of general health services (by students and faculty members)**	None	Students and faculty members gained a deeper appreciation of the health and social issues that migrant farm worker families face by providing health care services in the places where migrant families live, work, and are educated. Although the model is not unique, it is significant because of its sustained history, interdisciplinary collaboration among community and academic partners, mutual trust and connections among the partners, and the way the program is tailored to meet the needs of the population served.

7	Cook & Wills (2012)	Europe (UK)	Marginalized urban communities	Qualitative study	**Lay health trainers targeting harder-to-reach people from their communities, offering one-to-one support for healthy lifestyle changes**	Experiences and approaches adopted by health trainers in engaging with marginalized communities	Tensions were reported between the lay identity of health trainers and their adoption of a formalized role. Health trainers emphasized their similarities but underestimated their often-significant differences to their communities. Health trainers based in community or voluntary groups found engagement easier than those based in primary care, and saw engagement as an end in itself, through its creation of opportunities for health. Lay workers are not necessarily part of the marginalized communities they are expected to engage, while their ability to do so is compromised by the professional culture of the NHS and its approach to community engagement.
8	Cortinois et al (2012)	North America (Canada)	Recent immigrants	Mixed methods	**Telephone service for health information (Toronto's 2-1-1)**	Information on service users' characteristics and levels of user satisfaction	Results are mixed in terms of the phone service's support to immigrants. A significant percentage of users do not take full advantage of the service. The service could become the information "entry point" for recent immigrants if it was able to reach them early in the resettlement process.
9	De Paoli (2018)	Europe (Greece)	Syrian refugees	Observations and lessons learned	**Health service provision in refugee camps**	Lessons learned	For meaningful communication between patient and medical staff an interpreter is necessary. Transport of patients to and from hospitals can be achieved by handing out bus tickets and/or organizing a dedicated van service. Due to the need for access to medications for chronic diseases, early agreements with donors are required for NGOs to be able to purchase the medications.

10	Devillé et al (2011)	Europe (multiple)	Immigrants	Qualitative study (Delphi study)	**Good practices for healthcare for immigrants in Europe**	Views and values of professionals working in different health care contexts and in different European countries as to what constitutes good practice	Major principles of good practice: (1) easy and equal access to health care, (2) empowerment of migrants, (3) culturally sensitive health care services, (4) quality of care, (5) patient/health care provider communication, (6) respect towards migrants, (7) networking in and outside health services, (8) targeted outreach activities, and (9) availability of data about specificities in migrant health care and prevention.
11	Dutcher et al (2008)	North America (USA)	Refugees	Description of tool	**Electronic resource for culturally and linguistically appropriate health and medical information**	None	The tool is an important contribution to the refugee health care establishment, as well as to online health information more generally. The tool provides content in languages other than English and makes it available to the public and to the health care community. The collaborative process used to develop the tool, as well as the clear declaration of the source and the review for each item in the database, ensures a level of quality necessary for use in the health care environment.
12	Eggert et al (2015)	North America (USA)	Apartment-dwelling refugees	Mixed methods (pilot study)	**Community garden project to reduce health disparities**	Successful coalition formation, a community garden, reported satisfaction from all gardeners with increased vegetable intake, access to culturally meaningful foods, and evidence of increased community engagement	The opportunity for community health nurses to convene a coalition to affect positive health for refugees is demonstrated.
13	El Ansari et al (2009)	Europe (UK)	Black and ethnic minority communities	Qualitative study (Delphi study)	**Bilingual advocacy and interpretation services**	Advocate-, service- or client-related challenges that advocacy services face	Advocate-related challenges: status, esteem and remuneration of bilingual advocates in relation to other health professionals, as well as skills development, career progression,

							gender, capacity building and potential research contributions. Service-related challenges: workload, case mix, administration, commissioning processes/arrangements; entrepreneurial aspects of advocacy services; and mechanisms/potentials for cost recovery. Client-related challenges: continuity of advocacy; language requirements and advocacy needs of clients; and ways in which mobile populations influence planning and delivery of advocacy services for inner city hospitals.
14	Ferrera (2017)	North America (USA)	Refugee youth	Mixed methods	**Health promotion initiative that integrates principles of positive minority youth development**	Narratives of immigrant youth who have participated in the programme	Narratives underscore contributing contextual influences and pathways to conscientization, civic action, how programming can effectively facilitate positive minority youth development, as well as individual and community-level empowerment that leads to increased health literacy.
15	Flores (2009)	North America (USA)	Minority children	Description of interventions	**Three successful interventions that reduce healthcare disparities (increase breastfeeding rates, enhance HIV-preventive behaviors in adolescents and insure uninsured children)**	Common features of successful interventions	Pediatric health care disparities can be eliminated through targeted interventions. Achievement of this goal requires an intervention that is rigorous, evidence-based, and culturally and linguistically appropriate. The intervention must also include community collaboration, minimize attrition, adjust for potential confounders, and incorporate mechanisms for sustainability.
16	Gawde et al (2015)	Asia (India)	Migrants	Mixed methods (pilot study)	**Community-level partnership building to increase access to healthcare**	Process evaluation based on observations of different community stakeholders	Community-level interventions involved predominantly information, education, and communication activities for which pre-existing formal and informal social networks and community events were used. Although the intervention reached

							migrants living with families, single male migrants neither participated nor did the intervention reach them consistently. Contextual factors such as culture differences between migrants and native population and illegality in the nature of the settlement, resulting in the exclusion from services, were barriers.
17	Goodkind et al (2011)	North America (USA)	Refugees in urban areas	Mixed methods	**Community-based transdisciplinary mental health intervention that brings together refugees and undergraduate students**	Changes over time in individual psychological well-being and quality of life as well as changes in the community's responsiveness to the needs of newcomers	The project is in its fourth year and a total of 111 refugees and 81 undergraduate students have participated in the program. The team has managed to develop a preliminary body of evidence demonstrating the positive effects of the project. The primary concern is the short intervention period and the degree to which long-term, sustainable change can be achieved.
18	Hesselink et al (2009)	Europe (The Netherlands)	Ethnic minorities	Mixed methods	**Ethnic healthcare advisors**	Aspects of the role of ethnic healthcare advisors that can contribute to improving access to services	Healthcare advisors reached many ethnic minorities, provided information about the healthcare and welfare system, and referred them to services. Besides adapting the function to the local situation, some general aspects for success can be indicated: the ethnic background of the advisor should correspond to the main ethnic minority groups in the district, advisors need to conduct outreach work, there must be a well-organized back office to refer clients to, and there needs to be enough commitment among professionals of local health and welfare services.
19	Levine et al (1994)	North America (USA)	Underserved minority populations	Discussion paper	**Community-academic health center partnerships**	Characteristics of successful partnerships	Essential characteristics of successful partnership between academic health centers and neighboring underserved communities include community-

							based leadership and ownership of specific programs, training and utilization of indigenous community health workers, joint planning for a sequenced strategy of addressing various health problems, interdisciplinary community practice and training opportunities for students and faculty, built-in evaluation and broad community development and long-term maintenance of effective strategies.
20	Luque et al (2013)	North America (USA)	Migrant farm and seasonal workers	Literature review	**Practice models for community-academic partnerships**	Characteristics of models	Many of the partnership models were structured with the lead agency as either the academic partner or an Area Health Education Center. The academic partner was usually a nursing school, and less frequently a medical school. Other service partners frequently mentioned were federally-qualified Community Health Centers, Migrant Health Centers, and health departments.
21	Mason (2016)	Europe (Spain)	Irregular migrants	Description of strategy	**Community-based nursing approach to improve access to healthcare (linking social capital)**	None	The strategy can be implemented by nurses with limited financial and physical resources in small community settings frequented by irregular migrants to improve health care. The health and well-being of irregular migrants has an impact on community health. Nurses must be aware of and consider implementing novel strategies to ensure that all community members' healthcare needs, which are a basic human right, are addressed.
22	McBride et al (2016)	Australia & New Zealand (Australia)	Refugees and asylum-seekers	Mixed methods (pilot study)	**A nurse led initiative to improve healthcare**	Issues encountered by asylum-seekers and refugees within the hospital setting;	Throughout the pilot period, 946 patients were referred to the role, of which 99% received an assessment of physical, mental, and social health.

						nature of the initiative; and key outputs	The initiative effectively provided clinical support, advocacy, education, referrals, and both formal and informal capacity building.
23	Miner et al (2017)	North America (USA)	"Older" adult refugees	Retrospective chart review	**Home healthcare (HCC) services**	Health outcomes using OASIS-C data	Participants' pain level, anxiety level, medication management, and activities of daily living management all significantly improved over the course of their HHC episode.
24	Mladovsky et al (2012)	Europe	Migrants	Review	**Health services**	Good practices	Governments should ensure that migrants are entitled to health services, that the services are appropriate to their needs and that data systems are in place to monitor utilisation and detect inequities. Health services should adopt a 'whole organisation approach', in which cultural competence is viewed as much as a task for organisations as for individuals. Health workers should take steps to overcome language, social and cultural barriers to care.
25	Pejic et al (2016)	North America (USA)	Somali refugees	Description of model including case example	**Community-based interventions and services through a preventive, family systems ecological framework**	Critical features of effective family support programs for refugee families	Peer group community support services that build upon shared cultural experiences may help decrease the stigma associated with accessing mental health services for many refugee families. A coalition of community partners and employing an ecological, public health framework to develop programming can lead to culturally relevant family based mental health support services that can more effectively address the significant challenges and social changes experienced by refugee families.
26	Pottie et al (2017)	Multiple countries (worldwide)	Migrants and communities affected by migration	Qualitative study (Delphi study)	**Policy approaches to improve health systems for populations affected by migration**	Policy approaches identified by leading migrant health experts from different countries	Participants identified the following key areas as priorities for policy development: health inequities, system discrimination, migrant related

							health data, disadvantaged migrant sub-groups, and considerations for disadvantaged non-migrant populations. Highly ranked items to improve health systems were: Health Equity Impact Assessment, evidence based guidelines, and the International Organization for Migration annual reports.
27	Priebe et al (2011)	Europe	Migrants	Qualitative study (interviews)	**Good practice in migrant healthcare**	Difficulties and good practice as identified by professionals delivering health services to migrants	Difficulties: language barriers, arranging care for migrants without health care coverage, social deprivation and traumatic experiences, lack of familiarity with the health care system, cultural differences, different understandings of illness and treatment, negative attitudes among staff and patients, and lack of access to medical history. Good practices: organisational flexibility with sufficient time and resources, good interpreting services, working with families and social services, cultural awareness of staff, educational programmes and information material for migrants, positive and stable relationships with staff, and clear guidelines on the care entitlements of different migrant groups.
28	Shaw-Taylor et al (2002)	North America (USA)	Racial and ethnic minorities	Discussion paper	**Culturally and linguistically competent health care delivery**	Recommended standards	The development of cultural and linguistic competence must be seen as good business practice for health care organizations in a community that is becoming increasingly diverse. Public health agencies must play an important role in gathering information on the community's racial, ethnic or cultural profile. These agencies must

							also play an important role in supporting the efforts of health care organizations as they develop training programs that will meet the health goals of the community.
29	Shommu et al (2016)	North America (USA and Canada)	Immigrants and ethnic minorities	Literature review	**Community navigators to help immigrant and ethnic minority groups overcome barriers to healthcare**	Summary of the literature	Navigators were identified to train and guide members of several ethnic communities for chronic disease prevention and management, to undertake cancer screening and to access primary healthcare. The studies reported substantial improvement in the immigrant and ethnic minority health outcomes in the United States. The single Canadian study also reported positive outcome of navigators among immigrant women.
30	Tumiel-Berhalter et al (2011)	North America (USA)	Racial and ethnic minorities	Mixed methods	**Community program with a participatory approach to improve the health of four underserved communities ("Good For The Neighborhood")**	Feedback from community partners and participants as to how to adopt the program to meet the needs of the community	The program has been sustained for over 3 years and has reached over 3,500 predominately minority individuals in four communities with 1/3 of participants engaging regularly in the program. The program has evolved in the four communities to meet specific needs. A "park and stay" approach in partnership with the community has led to a strong program that community partners and residents embrace. Community ownership and social networking, including word-of-mouth from residents is essential to establishing a successful program.
31	Verhagen et al (2013)	Europe (The Netherlands)	Elderly migrants	Protocol for quasi-experimental study (mixed methods, with control group)	**Ethnic community health workers (CHWs)**	Use of health care and social welfare facilities by the elderly (primary outcome) and quality of life and functional impairments (secondary outcomes)	None

32	Verhagen et al (2014)	Europe (The Netherlands)	Not specified	Literature review	**Ethnic community health workers (CHWs)**	Effectiveness of CHWs in improving the health and the delivery of health care services to ethnic minority older adults in Western countries	Indications exist that CHWs serve as a means of improving health care use and health behaviour and, to a lesser extent, health outcomes among ethnic minority older adults. Further research is required to draw more solid conclusions on the effectiveness of CHW interventions in this target group.
33	Weissman et al (2012)	North America (USA)	Refugees	Description of model	**Free, student-run community health initiatives for refugees**	None	Trusting, long-term relationships are important in working with vulnerable refugees. Continuous feedback, discussion, and needs assessment are crucial for provision of relevant, appropriate, and accessible services. Student-run health initiatives offer a powerful opportunity to address the medical needs of underserved populations, and to further clinical and humanistic learning for medical students. Working with refugee populations offers a unique experience in cross-cultural medicine, learning about pathology uncommon in the United States, and understanding systems-based practices.
34	Yang & Kagawa-Singer (2007)	North America (USA)	Racial and ethnic minorities	Description of model development	**Ethnicity-specific subsystems of care**	Historical reconstruction of the evolution of the ethnicity-specific health care infrastructure in the Chinese community of San Francisco (USA) and creation of an organizational development model for ethnicity-specific health care organizations and infrastructures	The four stages of the model include developing and recruiting a bicultural and bilingual health care workforce, structuring health care resources for maximum accessibility, expanding health care organizations, and integrating ethnicity-specific health care resources into the mainstream health care system
35	No authors listed (2015)	Australia (Victoria)	Refugees and asylum-seekers	Description of community care services	**Guidelines on the provision of community**	None	A set of guidelines on the aims of community care services for refugee

	Victorian Government				**services for refugees and asylum seekers**		and asylum seekers' health, partnerships and models of care
36	Philis-Tsimikas (2014)	North America (USA)	Immigrants	Primary health care intervention	**Community based programme for self management of diabetes**	Community based peer education model with cultural adaptation, teaching tips and suggested activities for immigrants	The key strategies for implementing community-based diabetes programmes include data collection and tracking system, staffing, training, health systems integration, local resource identification and ongoing communication among all parties.

Non-communicable diseases

Community-based strategies for management of non-communicable diseases pertained to cancer screening (88-92), diabetes mellitus (93-96, 118), cardiovascular disease prevention (97, 98) and other chronic diseases (99, 100) (Table 3). Tools to increase uptake of (mostly breast) cancer prevention measures were culturally tailored, narrative educational videos (88) and pictograph-enhanced instructions (90). Other measures included patient-centered strategies with one-on-one interactions and small group educational sessions (91, 92, 94). Diabetes management and cardiovascular disease prevention interventions were designed to include culturally tailored approaches and story-telling to fit the needs of patients from migrant and refugee communities (91-93, 95-97, 117).

Core elements of described interventions are culturally and linguistically sensitive education (91, 92, 97, 100), involvement and support of the migrant communities' infrastructures (98), awareness raising about health risks (89), outreach approaches through families and community peers (89, 93, 99), facilitating the 'community voice', intersectional collaboration, and securing sustainability through funding (89).

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Table 3. Study characteristics for records on community-based management of non-communicable diseases (NCDs) for migrants and refugees (excluding mental health).

No.	Authors (year)	Location (country) of implementation	Population	Study design (*n*)	Model/intervention	Outcome definition	Reported outcome
1	Ahmad et al (2013)	North America (Canada)	South Asian immigrant women	Qualitative study	**Strategies to increase breast cancer screening uptake**	Aspects relevant to increase uptake of breast cancer screening (mammography)	Three dominant themes were identified: (1) 'Target and Tailor' focused on awareness raising through multiple direct and indirect modes or approaches with underlying shared processes of involving men and the whole family, use of first language and learning from peers; (2) 'Enhancing Access to Services' included a focus on 'adding ancillary services' and 'reinforcement of existing services' including expansion to a one-stop model; and (3) 'Meta-Characteristics' centred on providing 'multi-pronged' approaches to reach the community, and 'sustainability' of initiatives by addressing structural barriers of adequate funding, healthcare provider mix, intersectoral collaboration and community voice.
2	Alzubaidi et al (2017)	Australia & New Zealand (Australia)	Arabic-speaking migrants	Qualitative study	**Model for diabetes self-management care**	Data to inform research design and recruitment for studies into a new model of diabetes self-management	Significant knowledge gaps and skills deficits in all self-management domains were evident. The provision of tailored self-management support was considered crucial. A strong preference was reported for face-to-face storytelling interactions over telephone- or internet-based interventions. Gender-specific group education and self-management support sessions delivered by Arabic-speaking diabetes health professionals, lay peers or social

							workers trained in diabetes self-management were highly regarded.
3	Bader et al (2006)	Europe (Austria)	Turkish immigrant women	Pre-post design (pilot study)	**Linguistically and culturally-sensitive cardiovascular disease (CVD) prevention program**	Blood pressure readings and questionnaire responses regarding awareness of main CVD risk factors, awareness of cholesterol level, awareness of blood pressure and awareness of blood glucose	The program reached female Turkish migrants and was effective in reducing their level of unawareness about CVD.
4	Choi (2012)	North America (USA)	Immigrant women	Qualitative study (pilot study)	**Pictograph-enhanced instructions for breast cancer prevention**	Clarity, comprehension and acceptability among community-residing immigrant women with low health literacy	Participants perceived that the drawings were engaging and enhanced clarity of the intended healthcare messages. The black and white simple line drawings were well received by participants of varying race and ethnicity.
5	Escriba-Aguir et al (2016)	Multiple	Ethnic minorities	Literature review	**Patient-targeted healthcare interventions to promote cancer screening programmes**	Rate of participation in cancer screening programmes	The results show that culturally adapted interventions appear to increase the rate of participation in cancer screening. The effectiveness of the interventions seems to be related to the use of small media, one-on-one interactions, small group education sessions, reminder strategies, and strategies for reducing structural barriers and out-of-pocket costs.
6	Lew et al (2017)	Latin America (Nicaragua)	Nicaraguan ethnic minorities	Mixed methods (pilot study)	**Nurse-led, interactive group sessions providing combined diabetes prevention and self-management education**	Preliminary efficacy was assessed with A1C, weight, and quality of life (QOL) measures at baseline, 3 months, and 6 months. An open-ended survey assessed intervention satisfaction.	The intervention was found to be acceptable. Study feasibility was good, with successful research capacitation and achievement of sampling goals.
7	Ornelas et al (2017)	North America (USA)	Refugee women	Pre-posttest study (pilot study)	**Culturally tailored, narrative educational videos to increase cervical cancer screening uptake**	Changes in cervical cancer knowledge and intentions to be screened, and satisfaction with the videos	Women were significantly more likely to report having heard of a test for cervical cancer and indicated significantly greater intentions to be screened after watching the video. Their knowledge about cervical cancer

							and screening also improved significantly, and they reported high levels of acceptability with the video. Our results suggest that the videos were acceptable to the target audiences and may be effective in increasing cervical cancer screening among refugee women.
8	Sethi et al (2017)	Middle East (Lebanon)	Syrian refugees	Description of model development	**Community-based program to deliver chronic disease care for refugees**	Participatory needs assessment and community surveys	A network was developed of 500 refugee outreach volunteers who are supported with training, supervision, and materials to facilitate health promotion and disease control for community members, target NCDs and other priority conditions, and make referrals to a primary health care center for subsidized care. This model demonstrates that volunteer refugee health workers can implement community-based primary health activities in a complex humanitarian emergency.
9	Shirazi et al (2015)	North America (USA)	Afghan immigrant women	Qualitative study (pilot study)	**Culturally-sensitive, faith-based education to promote breast cancer screening**	Recommendations following from results of interviews	(1) Training of "grass roots" bilingual members of the community in all aspects of the program including planning, design, implementation, and evaluation; (2) incorporation of male-specific educational sessions led by male health advisors; (3) use of narrative communication consistent with the Afghan oral culture where storytelling is used to relate information and cultural/religious values; and (4) inclusion of Islamic faith components that are inspirational and relevant to the lives of the women and their male gatekeepers (e.g., husbands, brothers) and that will influence these men to

							understand the women's needs and support them.
10	Siddaiah et al (2013)	North America (USA)	Latino immigrants	Pre-posttest design	**Community-based, culturally competent respiratory health screening and education**	Screening and referral rates	High positive screening rates for both men (64%) and women (61%) were found. Of the participants who screened positive and were advised to seek medical care, 52% did so. Community-based screenings provide an opportunity to access at-risk immigrant populations for health screening and education, and to facilitate referral and access to medical services.
11	Van de Vijver et al (2015)	Europe (The Netherlands)	Migrants	Literature review and roundtable with policy-makers and public health experts	**Community-based CVD prevention program**	Recommendations on how to use the model (originally developed for Africa) in high-income countries	The model can be contextualized to the local situation by adapting the key steps of the model to the local settings. The involvement and support of African communities' infrastructures and health care staff is crucial, and the most important enabler for successful implementation of the model in migrant communities in high-income countries. The impact of the adapted intervention can be measured through an implementation research approach including collection of costs from health care providers' perspective and health effects in the target population, similar to the study design for Nairobi.
12	Wieland et al (2017)	North America (USA)	Refugee and immigrant adults with type 2 diabetes (T2DM)	Pilot feasibility study (interviews)	**Linguistically and culturally tailored digital story-telling intervention for diabetes type 2 management**	Acceptability of the intervention, confidence and motivation about managing diabetes as a result of watching the video. HbA1C was assessed at baseline and up to six months follow-up.	Implementation of the intervention in primary care settings is feasible and resulted in self-rated improvement in psychosocial constructs that are associated with healthy T2DM self-management behaviors. There was some evidence of improvement in glycemic control.

13	Zeh et al (2012)	Multiple	Ethnic minorities groups (EMGs) with diabetes	Literature review	**Culturally-competent interventions and innovations for diabetes management**	Effectiveness of any specified diabetes health-related intervention to any EMG within a majority population with diabetes. Data were collected on all reported outcome measures.	Findings suggest that interventions tailored to EMGs by integrating the element of culture into that intervention, (cultural and religious beliefs including linguistic and literacy skills), produced a positive effect. This was consistent in most of the ten studies.

Primary healthcare

Primary healthcare services are considered an important community-based pathway to reduce access barriers to care among migrants and refugees (Table 4). Ways to strengthen this pathway include integrated care models that are dedicated to the health needs of migrants and refugees. Aspects that are considered relevant to successful interventions are engagement with the migrant community through partnerships (101, 102), stronger focus on ancillary services (103), interdisciplinary collaboration between public health and primary care institutions (104-106), culturally and linguistically trained interpreters (106, 107), use of evidence-based guidelines (106, 107), outreach activities by nurses (e.g., home visits) (108), training of staff in cultural competency (102, 109), health promotion education among the migrant community and advocacy (105, 109).

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Table 4. Study characteristics for records on community-based primary healthcare for migrants and refugees.

No.	Authors (year)	Location (country) of implementation	Population	Study design (*n*)	Model/intervention	Outcome definition	Reported outcome
1	Cheng et al (2012)	Australia & New Zealand (Australia)	Afghan refugees	Review based on international experiences, literature and expert opinion	**Policy implications of Afghan pre-migration experiences**	Effect and policy implications of Afghan pre-migration experiences of primary health care on engagement with Australian primary care services.	In Afghanistan, health care is predominantly provided through a community-based outreach approach, namely through community health workers residing in the local community. The Australian health care system requires client attendance at formal health service facilities. This difference contributes to service access and utilisation problems. Community engagement is essential to bridge the gap between the Afghan community and Australian primary health care services. This can be achieved through the health sector working to strengthen partnerships between Afghan individuals, communities and health services.
2	Feldman (2006)	Not specified	Refugees and asylum-seekers	Literature review	**Tripartite framework of gateway, core and ancillary services**	Primary care services are reviewed and presented in terms of a tripartite framework of gateway, core and ancillary services	The paper suggests that a lack of published evaluations and reports about interventions for refugees and asylum seekers constrains further policy development that could build on the strengths of such interventions. It also stresses the importance of ancillary services to successful mainstream provision.
3	Griswold et al (2018)	Not specified	Refugees	Review paper	**Primary health care interventions**	Effective interventions and approaches	Effective interventions in primary care include the appropriate use of culturally and linguistically trained interpreters for health care visits and use of evidence-based guidelines. Effective approaches for the delivery of preventive health and wellness services require community engagement and collaborations

							between public health and primary care. In order to provide optimal preventive and longitudinal screening services for refugees, policies and practice should be guided by unimpeded access to robust primary care systems.
4	Kim et al (2002)	North America (USA)	Korean immigrants	Report article	**Bilingual, culturally sensitive interdisciplinary primary health care project**	None	The project paired a bilingual advanced practice nurse with a bilingual community advocate to conduct a program emphasizing community outreach and health promotion and prevention. The project met the goals of individual collaborating partners and sustainability goals of the services beyond the funding period. Challenges relate to the degree to which employees embrace or reject the model.
5	Levin-Zamir et al (2011)	Middle East (Israel)	Ethiopian immigrants	Mixed methods	**Cross-cultural programme for promoting communication and health**	Effects of the programme on integration of Ethiopian immigrant liaisons in primary care as intercultural mediators; in-service training of clinical staff to increase cultural awareness and sensitivity; and health education community activities	Improvements were reported in: (1) clinic staff–patient relations; (2) availability and accessibility of health services, and health system navigation without increasing service expenditure; (3) perception of general well-being; and (4) self-care practice with regards to chronic conditions.
6	McElmurry et al (2013)	North America (USA)	Latino immigrants (urban areas)	Description of model	**Nurse-community health advocate team**	Description of (1) development and implementation of an urban outreach health program for Latino immigrants; (2) nurse-community-health advocate partnership roles in primary health care delivery, and (3) lessons learned from these	Major findings pertain to the project team's ability to address the health promotion needs of Latino immigrant families and to successfully incorporate CHAs in planning and implementing the program. CHAs were a "bridge" between health programs and the community, promoting cultural sensitivity. CHAs and nurses provided a range of

						activities over 7 years in urban community settings.	services including health education and promotion, outreach through home visits, assessment of family needs for referrals to appropriate resources, and follow-up support. The nurse-CHA team was an effective strategy for promoting Latino immigrant families' access to needed health care.
7	McMurray et al (2014)	North America (Canada)	Newly arrived refugees	Pre-posttest design	**Partnership between a dedicated health clinic for government assisted refugees, a local reception centre and community providers**	Wait times and referrals (outcomes for refugees arriving 18 months prior to the introduction of the clinic were compared with those of refugees arriving in the 18 months after the clinic was established)	The investigation revealed wait times to see a health care provider decreased by 30 % with the introduction of a dedicated refugee health clinic. The likelihood of refugees being referred to physician specialists decreased by 45 %, but those referred were more likely to require multiple referrals due to increasingly complex medical needs. Referrals to non-physician specialist health care providers nearly doubled following the availability of the clinic. The time-limited, but intense health needs of refugees require an integrated community-based primary healthcare intervention that includes dedicated health system navigators to support timely, more culturally appropriate care and successful integration.
8	Phillips et al (2017)	Australia & New Zealand (Australia)	Refugees and asylum-seekers	Mixed methods	**Approach to people-centred, integrated care within a refugee primary care service for counselling, medical care, community development and advocacy ("Companion House", CH)**	Community and staff experiences with the model	CH has created fluid links between teams, and encouraged open dialogue with client populations. There is a high level of networking between staff, much of it informal. This is underpinned by horizontal management and staff commitment to a shared mission and an ethos of mutual respect. The clinical teams are

							collectively oriented towards patients but not necessarily towards each other.
9	Pottie et al (2014)	North America (Canada)	Vulnerable migrants	Qualitative study (Delphi process)	**Innovative strategies to address the health concerns of vulnerable migrant populations**	Innovative strategies identified by healthcare professionals that could improve the delivery of primary health care for vulnerable migrants	The 3 most highly ranked practice strategies to address delivery challenges for migrants were language interpretation, comprehensive interdisciplinary care, and evidence-based guidelines. Training and mentorship for practitioners, intersectoral collaboration, and immigrant community engagement ranked fourth, fifth, and sixth, respectively, as strategies to address delivery challenges.

Maternal, women's and child health

To reduce maternal and child health inequalities among migrant communities, publically funded universal health services (110) and government-led approaches (111) are described (Table 5). A committed community and agency partnership through multiple mobilization strategies were considered successful for improving the health of pregnant women (112). Capacity building to maintain the interest of service providers and community members was essential for programme sustainability. In general, partnerships between the target community and the different local healthcare providers is recommended to identify the barriers faced by women and potential solutions for improving access to care (113). Intensive child health promotion and education campaigns using ethnic media and social networking was observed to positively affect parental awareness, knowledge and beliefs about infectious disease prevention in children (114).

For vulnerable populations such as prenatal and pediatric refugee patients, a Culturally Appropriate Resources and Education (C.A.R.E.) Clinic Health Advisor is recommended for specialty clinics (115). This type of health advisor facilitates communication, establishes the sense of community and helps patients navigate the healthcare system. To implement reproductive health services in humanitarian emergencies, facilitators are a pre-existing functioning health infrastructure, prior training in the particular type of service delivery, dedicated leadership and the availability of sufficient funding and resources (116).

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Table 5. Study characteristics for records on community-based maternal, women's and child health services for migrants and refugees.

No.	Authors (year)	Location (country) of implementation	Population	Study design (*n*)	Model/intervention	Outcome definition	Reported outcome
1	Bhagat et al (2002)	North America (Canada)	Immigrant Punjabi women	Description of model	**Community mobilization strategies to improve the health of pregnant women**	None	A committed community and agency partnership and multiple mobilization strategies were key to the successes that were achieved. There was a need for capacity building among interested service providers and community members so that the initiative could continue beyond the project stage.
2	Hutchins & Walch (1989)	North America (USA)	Immigrants and minority populations	Overview article	**Innovative government-led approaches to address special maternal and child health problems**	Brief project descriptions	Recent and current projects have taken innovative approaches to solving the special health problems of the minority populations. They range from a breastfeeding initiative in the Commonwealth of the Northern Mariana Islands to an area-wide genetic service program in the Virgin Islands.
3	Jackson et al (2001)	North America (USA)	Racial and ethnic minority women	Review paper	**Strategies to overcome barriers to women's care (by the National Centers of Excellence in Women's Health, COoEs)**	None	Early results suggest that the CoE serve a more diverse female population than more traditional models of care. They provide a conceptual framework for addressing barriers to care for minority women and can serve as sites to evaluate the effectiveness of alternative models of care. Of the many barriers encountered by minority women, those related to healthcare costs and cultural discordance are most prominent. Alliances and partnerships, such as those established between CoEs and minority community organizations, allow the dialogue

							necessary to identify and recommend solutions for barriers to care.
4	Krause et al (2015)	Middle East (Jordan)	Syrian refugees	Qualitative study	**Minimum Initial Services Package (MISP) for reproductive health (a standard of care in humanitarian emergencies)**	Status of MISP implementation for Syrian refugees in Jordan	Refugee women and adolescent girls perceived clinical services negatively and complained about the lack of basic necessities. MISP services and key elements to support implementation were largely in place. Pre-existing Jordanian health infrastructure, prior MISP trainings, dedicated leadership and available funding and supplies facilitated MISP implementation. The lack of a national protocol on clinical management of rape survivors hindered provision of these services, while communities' lack of information about the health benefits of the services as well as perceived cultural repercussions likely contributed to no recent service uptake from survivors.
5	Reavy et al (2012)	North America (USA)	Refugees	Mixed methods	**New clinic model for prenatal and pediatric refugee patients (in particular the role of the Culturally Appropriate Resources and Education (C.A.R.E.) Clinic Health Advisor)**	Differentiation of the role of C.A.R.E. Clinic Health Advisor from the certified medical interpreter and evaluation of the lived experiences of each role.	Themes emerging from qualitative data included communication, navigating the system and community. Chart reviews validated success of the clinic as evidenced by missed clinical appointments dropping from 25% to 2.5%, and childhood immunizations being sustained at 100% compliance through a baby's first year of life. This new clinic model and health advisor role are recommended for use with other vulnerable populations.
6	Sheikh & MacIntyre (2002)	Australia & New Zealand (Australia)	Refugee children and parents	Descriptive epidemiological study and survey	**Intensive child health promotion and education campaign using ethnic media and social network**	Rates of clinic attendance and parents' beliefs, attitudes and knowledge	Authors observed a significant change in parental knowledge, attitudes and beliefs about infectious diseases after attending the clinic, including decreased stigma around tuberculosis, more awareness of the seriousness of some infections, and increased

							awareness of the role of immunisation in prevention of infectious diseases. Authors consider targeted promotion of service to refugee parents effective.
7	Yelland et al (2015)	Australia & New Zealand (Australia)	Refugees	Protocol for a multi-phase, quasi-experimental study (interrupted time series design)	**Innovative programme of quality improvement and reform in publically funded universal health services that aims to address refugee maternal and child health inequalities**	Health service use and maternal and child health outcomes over a 3-year period of implementation. Process measures will examine refugee families' experiences of specific initiatives and service providers' views and experiences of innovation and change.	None

Overall assessment of effectiveness

Following the assessment of publications included in this systematic search per category of intervention, Table 6 summarizes all findings in a graphic form to indicate the characteristics, outcomes including a further evaluation assessment.

Specifically, the evaluation criteria by which the publications were assessed went a bit further from the study design of the intervention, the size of the target population and the duration of follow-up. We noted elements of whether the intervention was successful, effective, and reproducible and whether the intervention was based on a specific behavioural theory or model.

Based on the presence of these criteria a ranking of the identified interventions was used which helped us prioritize the findings in order of scientific soundness/robustness. A marking scheme was devised with sub-categories in each criterion by which a total score for each intervention was achieved. The highest the score, the more scientifically robust was the described intervention.

In detail the scores for each criterion were:

- **Study design:** 0 = protocol, 1 = review/description (no data), 2 = qualitative or quantitative data, 3 = mixed methods, 4 = experimental study (randomized, controlled or pre-posttest design), 5 = literature review, p= pilot study
- **Sample size (number of participants):** 0 = none, 1 = <10, 2 = 10-20, 3 = 20-50, 4 = 51-100, 5 = > 100, 6 = > 1000
- **Duration of follow-up:** NA = not applicable, C= cross-sectional study, 1 = days, 2 = weeks, 3 = months, 4 = 1-5 years, 5 = > 5 years
- **Study population of Middle Eastern/ North African descent?** 1= no 2= yes
- **Theoretical underpinnings:** NA = not applicable, 1 = not present in publication, 2 = present in publication
- **Reproducible:** Not mentioned, 1=no, 2=yes
- **Ranking:** sum of scores of each variable

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Table 6. Level of evidence for the effectiveness of interventions and models for community-based healthcare for migrants and refugees.

No.	Authors (year)	Study design	Sample size (*n*)	Duration of follow-up	Middle eastern/ north African individuals included in target population?	Does article have reported outcomes/or advocate evidence-backed approach	Intervention	Theoretical underpinning	Reasonably reproducible	Ranking
1	Ahmad et al (2012)	4^{P}	2	3	2	**2**	eHealth tool	**N/A**	Not mentioned	**13**
2	Areán et al (2008)	2	5	3	1	**2**	Formal mental health services, community-based mental health services	**N/A**	Not mentioned	**13**
3	Bäärnhielm et al (2015)	3	4	C	2 *	**2**	Healthcare provider training	**N/A**	Not mentioned	**11**
4	Beehler et al (2012)	?	4	4	**2**	**2**	School-based mental health services	**2**	Not mentioned	**14**
5	Behnia (2003)	2	2	C	**2**	**2**	Community-based mental health services, formal mental health services, peer-led mental health workshops	**N/A**	Not mentioned	**8**
6	Bhattacharyya & Benbow (2013)	5	5	NA	**1**	**2**	No specific mental health intervention assessed	**N/A**	Not mentioned	**13**
7	Birman et al (2008)	1	3	NA	2	2	Community-based mental health services	**N/A**	Not mentioned	**12**
8	Brar-Josan (2017)	2	1	C	2	**1**	Informal supports to youth and families, and (2) formal supports in collaboration with	N/A	Not mentioned	**6**

							mental health practitioners			
9	Chase & Rousseau (2018)	2	3	C	**2**	**2**	Community-based mental health services	**N/A**	Not mentioned	**9**
10	Chen et al (2014)	3	2	C	**2**	**1**	No specific intervention assessed	**N/A**	Not mentioned	**8**
11	Chiumento et al (2011)	2	2	5	2	2	School-based mental health services	1	Not mentioned	14
12	Choi (2017)	4	3		1	2	Health literacy, informal mental health program	N/A	Not mentioned	**10**
13	Dura-Vila et al (2013)	2	4	?	2	2	Community-based mental health services	1	Not mentioned	**11**
14	Ellis et al (2013)	?	2	2	2	2	School-based mental health services	2 (Trauma systems therapy (TST), a phase based model of treatment, CBT)	Not mentioned	**10**
15	Fernando (2005)	1	NA	NA	2 (included African immigrants)	1	Formal mental health services	N/A	Not mentioned	**4**
16	Fondacaro et al (2014)	2	3	5	2	2	Healthcare provider training	2 (Acceptance and Commitment Therapy (ACT))	Not mentioned	**16**
17	Gionakis & Stylianidis	1	NA	NA	N/A	1	Community-based mental health services	N/A	Not mentioned	**2**
18	Goodkind et al (2014)	3	3	4	2	**2**	Community-based mental health services	**1**	Not mentioned	**15**
19	Hamilton et al (2014)	3	2	4	Unclear	**1**	Community-based mental health services	N/A	Not mentioned	**10**
20	Harris & Maxwell (2007)	2	3	4	2	**1**	Community-based mental health services	N/A	Not mentioned	**12**

21	Hess et al (2014)	2	4	3	2	**2**	Informal mental health program	N/A	Not mentioned	**13**
22	Holden et al (2014)	1	NA	NA	1	**1**	No specific intervention assessed	N/A	Not mentioned	**3**
23	Im & Rosenberg (2016)	2	2	3	2 (Bhutanese)	**2**	Peer-led mental health workshops	N/A	Not mentioned	**11**
24	Kaltman et al (2011)	1	5	5	1	**2**	Formal mental health services	2 (Collaborative care model)	Not mentioned	**16**
25	Kaltman et al (2016)	3[P]	2	5	1	**2**	Formal mental health services, group therapy sessions	2 (symptom reduction addressed through behavioral activation, a component of CBT for depression, group readiness addressed via motivational interviewing)	Not mentioned	**15**
26	Khawaja & Stein (2016)	2	1	3	unclear	**2**	Formal mental health services	2 (eclectic approach and adapted treatments to each individual, paradigms included components from cognitive, behavioural, interpersonal, narrative, existential, and schema therapies)	Not mentioned	**10**
27	Kieft et al (2008)	1	3	6	2	**2**	Peer-led mental health workshops	N/A	Not mentioned	**14**

28	Knipscheer & Kieber (2004)	2	4	C	2 (Turkish and Moroccan)	**2**	No specific intervention assessed	N/A	Not mentioned	**10**
29	Koehn et al (2014)	3	2	C	1	**2**	No specific intervention assessed	N/A	Not mentioned	**8**
30	Law (2007)	1	NA	NA	1	**1**	No specific intervention assessed	N/A	Not mentioned	**3**
31	Lee et al (2008)	1	NA	NA	1	**1**	Partnership in mental health services between community stakeholders	N/A	Not mentioned	**3**
32	Llosa et al (2017)	2	4	C	2	**2**	Mental health screening tool	N/A	Not mentioned	**10**
33	Misra et al (2006)	2	2	C	unclear	**2**	No specific intervention assessed	N/A	Not mentioned	**6**
34	Moore et al (2007)	1	NA	NA	2	**1**	Healthcare provider training	N/A	Not mentioned	**4**
35	Murray et al (2010)	5	5	NA	unclear	**2**	Community-based mental health services, formal mental health services	2 (studies employed methods of CBT, eye-movement desensitization and reprocessing (EMDR), pharmacotherapy, expressive, exposure, testimonial therapies)	Not mentioned	**14**
36	Nadeau et al (2005)	1	NA	NA	1 (Pakistani target population)	2	Formal mental health services	N/A	Not mentioned	**3**
37	Nadeau et al (2017)	2	2	3	1	2	Formal mental health services	1	Not mentioned	**11**
38	Nakkash et al (2011)	1	?	NA	2	N/A	Community-based mental health services	N/A	Not mentioned	**3**

39	Nazzal et al (2014)	1	NA	NA	1	2	Community-based mental health services	N/A	Not mentioned	**5**
40	Polcher & Calloway (2016)	?[P]	4	4	2	2	Mental health screening tool	N/A	Not mentioned	**12**
41	Price et al (2012)	1	NA	NA	2	2	School-based mental health services	2 (cognitive behavioral intervention for trauma in schools -CBITS)	Not mentioned	**7**
42	Priebe et al (2012)	2	4	C	1	2	No specific intervention assessed	1	Not mentioned	**10**
43	Sijbrandij et al (2017)	1	NA	NA	2	1	Group therapy sessions	2 (Narrative Exposure Therapy (NET), CBT, EMDR found to be most effective based on past studies) *this situation I found to be different than the other papers which through their own experience evaluated certain mental therapy techniques so I was not sure we could count it in the same way*	Not mentioned	**6**
44	Small et al (2016)	4	4	4	2	2	Group therapy sessions, formal mental health services, community-	2 (CBT)	Not mentioned	**18**

							based mental health services			
45	Snowden et al (2006)	2	3	4	1	2	No specific mental health intervention assessed	N/A	Not mentioned	**12**
46	Stein et al (2002)	1	NA	NA	1	2	School-based mental health services	2 (CBITS)	Not mentioned	**6**
47	Sturm et al (2017)	2	NA	4	1 (general)	1	???	N/A	Not mentioned	**8**
48	Tran et al (2014)	4	2	3	1	2	Informal mental health program	1	Not mentioned	**13**
49	Tse et al (2010)	2	2	C	1	2	???	N/A	Not mentioned	**7**
50	Tyrer & Fazel (2014)	5	5	NA	1 (general)	2	School-based mental health services, community-based mental health services	2 (CBT, trauma-focused CBT (TF-CBT), NET, EMDR, TST)	Not mentioned	**15**
51	Weine (2011)	1	NA	NA	1 (general)	1	School-based mental health services	N/A	Not mentioned	**3**
52	Williams & Thompson (2011)	5	5	NA	2	2	Community-based mental health services	2 (CBT)	Not mentioned	**16**
53	Xin et al (2011)	2^{P}	3	4	2	2	Mental health intervention program	N/A	Not mentioned	**13**
54	Aluko (2007)	1	NA	NA	1	1	Community-coalition to reduce health disparities through educational empowerment	N/A	Not mentioned	**3**
55	Barenfeld et al (2015)	2	2	4	1	2	Group-based health promotion programme (HPP) developed in a researcher-community partnership	N/A	Not mentioned	**11**
56	Barenfeld et al (2017)	2	2	4	1	2	Programme of person-centred group meetings and one individual home visit to prolong	N/A	Not mentioned	**11**

							independence in daily activities			
57	Blair (2012)	2	2	4	1	2	Volunteer ambassadors from ethnic and faith communities to perform information and referral services for elders	N/A	Not mentioned	**11**
58	Brown & Barton (1992)	1	NA	NA	1	1	Collaborative effort between a health services agency and a baccalaureate nursing program	N/A	Not mentioned	**3**
59	Connor et al (2007)	1	NA	NA	1	1	Community-partnership model to increase delivery of general health services (by students and faculty members)	N/A	Not mentioned	**3**
60	Cook & Wills (2012)	2	2	5	1	2	Lay health trainers targeting harder-to-reach people from their communities, offering one-to-one support for healthy lifestyle changes	N/A	Not mentioned	**12**
61	Cortinois et al (2012)	3	4	4	1	2	Telephone service for health information (Toronto's 2-1-1)	N/A	Not mentioned	**14**
62	De Paoli (2018)	1	NA	NA	2	2	Health service provision in refugee camps	N/A	Not mentioned	**5**
63	Devillé et al (2011)	2	4	C	2	2	Good practices for healthcare for immigrants in Europe	N/A	Not mentioned	**10**
64	Dutcher et al (2008)	1	NA	NA	2	2	Electronic resource for culturally and linguistically	N/A	Not mentioned	**5**

							appropriate health and medical information			
65	Eggert et al (2015)	3[P]	unspecified	unspecified	1	1	Community garden project to reduce health disparities	N/A	Not mentioned	**5**
66	El Ansari et al (2009)	2	1	C	1	2	Challenges of advocacy and language services-identification of possible ways forward to care for diverse populations	2 (Delphi method)	Not mentioned	**6**
67	Ferrera (2017)	3	3	5	2	2	Health promotion initiative that integrates principles of positive minority youth development	1	Not mentioned	**15**
68	Flores (2009)	1	NA	NA	1	2	Three successful interventions that reduce healthcare disparities (increase breastfeeding rates, enhance HIV-preventive behaviors in adolescents and insure uninsured children)	1	Not mentioned	**4**
69	Gawde et al (2015)	3[P]	unspecified	NA	**1**	**2**	Community-level partnership building to increase access to healthcare	1	Not mentioned	**6**
70	Goodkind et al (2011)	3	4	3	**2**	**2**	Community-based transdisciplinary mental health intervention that brings together refugees and undergraduate students	1	Not mentioned	**14**

71	Hesselink et al (2009)	3	3	4	**1**	**2**	Ethnic healthcare advisors	N/A	Not mentioned	**13**
72	Levine et al (1994)	1	NA	NA	**1**	**2**	Community-academic health center partnerships	1	Not mentioned	**4**
73	Luque et al (2013)	5	5	NA	**1**	**2**	Practice models for community-academic partnerships	1	Not mentioned	**13**
74	Mason (2016)	1	NA	NA	**1**	**2**	Community-based nursing approach to improve access to healthcare (linking social capital)	N/A	Not mentioned	**4**
75	McBride et al (2016)	3^{P}	3	4	**2**	**2**	A nurse led initiative to improve healthcare	N/A	Not mentioned	**14**
76	Miner et al (2017)	2	2	4	**1**	**2**	Home healthcare (HCC) services	N/A	Not mentioned	**11**
77	Mladovsky et al (2012)	1	NA	NA	**1**	**2**	Health services	N/A	Not mentioned	**4**
78	Pejic et al (2016)	2	NA	NA	**2**	**2**	Community-based interventions and services through a preventive, family systems ecological framework	1	Not mentioned	**6**
79	Pottie et al (2017)	2	2	C	**2**	**2**	Policy approaches to improve health systems for populations affected by migration	1	Not mentioned	**8**
80	Priebe et al (2011)	2	4	C	**1**	**2**	Good practice in migrant healthcare	N/A	Not mentioned	**9**
81	Shaw-Taylor et al (2002)	1	NA	NA	**1**	**2**	Culturally and linguistically competent health care delivery	N/A	Not mentioned	**4**
82	Shommu et al (2016)	5	5	NA	**1**	**2**	Community navigators to help immigrant and ethnic minority groups	1	Not mentioned	**13**

							overcome barriers to healthcare			
83	Tumiel-Berhalter et al (2011)	3	5	4	**1**	**2**	Community program with a participatory approach to improve the health of four underserved communities ("Good For The Neighborhood")	1	Not mentioned	**15**
84	Verhagen et al (2013)	0	NA	NA	**1**	**1**	Ethnic community health workers (CHWs)	1	Not mentioned	**2**
85	Verhagen et al (2014)	5	4	NA	**1**	**2**	Ethnic community health workers (CHWs)	1	Not mentioned	**12**
86	Weissman et al (2012)	1	NA	4	**1**	**1**	Free, student-run community health initiatives for refugees	N/A	Not mentioned	**7**
87	Yang & Kagawa-Singer (2007)	1	NA	NA	**1**	**2**	Ethnicity-specific subsystems of care	N/A	Not mentioned	**4**
88	No authors listed Victorian Government (2015)	1	NA	NA	**2**	**1**	Guidelines on the provision of community services for refugees and asylum seekers	N/A	Not mentioned	**4**
89	Ahmad et al (2013)	2	2	C	**1**	**2**	Semi-structured Focus groups with health professionals to explore strategies to increase BC screening in South Asian migrants	1	Not mentioned	**7**
90	Alzubaidi et al (2017)	2	2	C	**2**	**2**	Model for diabetes self-management care	N/A	Not mentioned	**8**
91	Bader et al (2006)	4^{P}	5	4	**2**	**2**	Linguistically and culturally-sensitive	N/A	**yes**	**17**

							CDV prevention program			
92	Choi (2012)	2^P	1	C	**1**	**2**	Use of a pictorial booklet for low literacy immigrants on breast health care	2 (Mayer's Cognitive Theory of Multimedia Learning)	Not mentioned	**8**
93	Escriba-Aguir et al (2016)	5	5	NA	**2**	**2**	Patient-targeted interventions to promote cancer screening	**N/A**	Not mentioned	**14**
94	Lew et al (2017)	3^P	2	2	**1**	**2**	Nurse-led, interactive group sessions providing combined diabetes prevention and self-management education	**N/A**	Not mentioned	**10**
95	Ornelas et al (2017)	4^P	2	C	**1**	**2**	Culturally tailored narrative educational videos to increase cervical cancer screening	2 (Behavioral model for vulnerable populations)	Not mentioned	**11**
96	Sethi et al (2017)	1	NA	NA	**2**	**2**	Community-based noncommunicable (chronic) disease care for Syrian refugees	**N/A**	Not mentioned	**5**
97	Shirazi et al (2015)	2^P	3	3	**1**	**2**	Culturally competent faith-based education to promote breast cancer screening	**N/A**	Not mentioned	**11**
98	Siddaiah et al (2013)	4	4	4	**1**	**2**	Culturally competent community-based respiratory health screening and education	**N/A**	Not mentioned	**15**
99	Van de Vijver et al (2015)	5	NA	NA	**1**	**2**	Community based CDV prevention program/model	**N/A**	Not mentioned	**8**
100	Wieland et al (2017)	2^P	2	C	**1**	**2**	Linguistically and culturally tailored	**N/A**	Not mentioned	**7**

							digital story-telling intervention for diabetes type 2 management			
101	Zeh et al (2012)	5	4	NA	**2**	**2**	Culturally competent interventions and innovations for diabetes management	**N/A**	Not mentioned	**13**
102	Cheng et al (2012)	1	NA	NA	? (not mentioned)	2 (? review)	Tripartite framework of gateway, core and ancillary services (review)	1	2 yes	6
103	Feldman (2006)	5	unspecified	NA	1	2 (? review)	Culturally and linguistically trained interpreters for health care visits, health literacy interventions (review paper)	2	2 yes	12
104	Griswold et al (2018)	1	NA	NA	1	2	Bilingual advanced practice nurse with a bilingual community advocate to conduct a program emphasizing community outreach and health promotion and prevention	2	2 yes	8
105	Kim et al (2002)	?	NA	4	2	2	Integration of Ethiopian immigrant liaisons in primary care as intercultural mediators; in-service training of clinical staff to increase cultural awareness and sensitivity; and health education community activities	2	2 yes	12

106	Levin-Zamir et al (2011)	3	unspecified	5	**1**	**2**	Nurse-community-health advocate partnership (team's role to link participants with service providers and to provide health information and ongoing health education to promote healthy behaviors.)	**2**	**2 yes**	15
107	McElmurry et al (2013)	1	NA	5	**2**	**2**	Partnerships between case workers and health professionals, translation services, comprehensive assessments, and international medical graduates in training that enhance the cultural sensitivity and competence of clinic processes.	**2**	**2 yes**	14
108	McMurray et al (2014)	4	4	4	2	2	Qualitative data of community and staff experiences with a refugee primary care model	2 (WHO)	**2 yes**	20
109	Phillips et al (2017)	3	2	3	**1**	**2**	Semi-structured interviews	2 (Camplex Adaptive Systems Model)	Not mentioned	**13**
110	Pottie et al (2014)	2	2	c	**1**	**2**	Generate consensus of primary care practitioners to identify and prioritize innovative strategies that could potentially improve the delivery	2 (Delphi method)	Not mentioned	**9**

							of primary health care for vulnerable migrants			
111	Bhagat et al (2002)	1	NA	NA	1	1	Community mobilization strategies to improve the health of pregnant women	2 (mobilization strategy)	2 yes	7
112	Hutchins & Walch (1989)	1	NA	NA	2 (African is mentioned not north African)	2 (short description)	Innovative government-led approaches to address special maternal and child health problems	1	2 yes	8
113	Jackson et al (2001)	1	NA	NA	1	1	Strategies to overcome barriers to women's care (by the National Centers of Excellence in Women's Health, COoEs)	2	2 yes	7
114	Krause et al (2015)	2	4	C	2	2	Minimum Initial Services Package (MISP) for reproductive health (a standard of care in humanitarian emergencies)	2 (Minimum initial services package)	2 yes	14
115	Reavy et al (2012)	3	4	4	2	2	New clinic model for prenatal and pediatric refugee patients (in particular the role of the Culturally Appropriate Resources and Education (C.A.R.E.) Clinic Health Advisor)	2 (Ecological model, cultural safety etc)	2 yes	19
116	Sheikh & MacIntyre (2002)	2	2	4	2	2	Intensive child health promotion and education campaign	2	2 yes	16

							using ethnic media and social network			
117	Yelland et al (2015)	0	NA	NA	2	2	Innovative programme of quality improvement and reform in publically funded universal health services that aims to address refugee maternal and child health inequalities	2	2 yes	8
118	Philis-Tsimikas (2014)	2	3	C	1 (Latinas)	2	Community based programme for self management of diabetes	2 (Chronic Care Model)	Not mentioned	10

Promising tools and best practices

Based on the total score shown in Table 6, a total of 15 interventions that best fit the set evaluation criteria were identified reaching a score of 20 points (1 publication), 19 points (1), 18 points (1), 17 points (4), 16 points (1) and 15 points (7).

Publication	*Ref number in Table 6*	*Area of intervention*	*Intervention*	*Score*
McMurray (2014)	108	Primary healthcare	Partnership between a dedicated health clinic for government assisted refugees, a local reception centre and community providers	20
Reavy (2012)	115	Maternal health	New clinic model for prenatal and pediatric refugee patients (in particular the role of the Culturally Appropriate Resources and Education (C.A.R.E.) Clinic Health Advisor)	19
Small (2016)	44	Mental health	Comparison of three different treatment modalities: treatment as usual (TAU), home-based counseling (HBC), and a community-based psycho-educational group (CPG)	18
Bader (2006)	91	Non Communicable Diseases	Linguistically and culturally-sensitive cardiovascular disease (CVD) prevention program	17
Sheikh & McIntyre (2002)	116	Maternal health	Intensive child health promotion and education campaign using ethnic media and social network	17
Williams & Thompson (2011)	52	Mental health	Community-based mental healthcare services	17
Kaltman (2011)	24	Mental health	Collaborative mental health care program implemented in a network of primary care clinics that serve the uninsured	17
Fondacarro (2016)	16	Mental health	Training program for psychology students (“Connecting Cultures”)	16
Levin-Zamir (2011)	106	Primary healthcare	Cross-cultural programme for promoting communication and health	15
Siddaiah (2013)	98	Non Communicable Diseases	Community-based, culturally competent respiratory health screening and education	15
Tumiel-Behalter (2011)	83	Health service provision	Community program with a participatory approach to improve the health of four underserved communities ("Good For The Neighborhood")	15

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Ferrera (2017)	67	Health service provision	Health promotion initiative that integrates principles of positive minority youth development	15
Tyrer & Fazel (2014)	50	Mental health	School and community-based interventions	15
Kaltman (2016)	25	Mental health	Mental health intervention for primary care clinics that serve the uninsured	15
Goodkind (2014)	18	Mental health	Community-based advocacy and learning intervention with refugees and undergraduate students	15

DISCUSSION

The literature review was carried out in March 2018 using a set of key words to search for community health care models, beast practices addressing migrants and refugees in the published literature. We used 3 large scientific databases using a combination of search terms following the PRISMA methodology and a standard set of items used to report on systematic reviews.

We developed an evaluation tool to assess and classify the search results for their scientific robustness based on their reported characteristics such as population size, type of intervention, achieved outcome, reproducibility and theoretical underpinning.

A large number or results was initially retrieved which was then reduced by applying specific exclusion criteria trying to focus on the identification of beast practices and interventions addressing migrants and refugees.

In the final set of identified practices/interventions 5 areas of action were identified: mental health, health services, non-communicable diseases, primary healthcare and maternal, women's and child health. Each publication was thoroughly assessed per category and then all identified interventions were aggregated and further assessed in Table 6 which produced a final prioritization of scientific soundness expressed by a numerical score.

Limitations

Clearly there is an abundance of published information regarding interventions for migrant/refugee health care. We identified a huge variation in the meaning of the terms community, community health or healthcare and best practice. Moreover, we found an interchangeable use of the terms migrants and refugees, as well as the use of similar terms such as immigrants, minorities, asylum seekers.

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Despite the richness of published information, we must bear in mind that there are more interventions/beast practices implemented which have not and will probably never get published following a peer-review process. Similarly, the health priorities identified through the literature review are defined based on the information retrieved from the searched databases. In this sense it is possible that some areas do not appear in the published literature prior to March 2018. Certainly, this does not mean that they are less important areas of migrant/refugee health; there could be a wealth of reasons why they do not appear in published form from lower prioritization of the health issue to lack of resources to cover the publications fees.

One of the objectives of searching the available literature was to identify beast practices and tools of community-based interventions for vulnerable migrants/refugees. A general comment after carrying out the search, is that to a very large extent, the best practices and the tools identified were mostly available in a general descriptive form and not as a hands-on tool that could be reviewed, assessed and evaluated on the spot. So the evaluation presented in this task is mostly based on indirect evidence. As one of the criteria of evaluation was the reproducibility of the intervention, we did not include in our results interventions and tools that required a fee to be paid in order to be applied in a different setting.

CONCLUSION

The majority of projects, activities, interventions identified in this review focus on the area of mental health and this is an important finding that needs to be examined further as there could be a multitude of reasons for this. The area of health service provision is also important, as well as the issue of chronic disease management. The primary healthcare setting is vital as it has close links to the community and facilitates the involvement of the local population. It is important to note, that in almost all of the sources identified, the elements of good communication, the linguistic barriers and the cultural element played a crucial role in the effective application of the intervention. Needless to say, that the close collaboration of the various stakeholders, the local communities and partnerships are key to the successful implementation of healthcare provision.

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PART B: Consortium Partner-Specific Sources on Tools and Best Practices for Migrant and Refugee Community Health

By Kalkman S, Riza E

INTRODUCTION

Studies published in English in the international, scientific, peer-reviewed literature provide relevant, evidence-based insights into the potential of specific community-healthcare interventions for migrants and refugees. However, it is likely that many community-based interventions are developed at the local (municipal) or national level and thus rarely reach the international, academic literature. Thus, to provide a comprehensive overview of existing community healthcare tools and best practices for migrants and refugees in Europe, it is relevant to include country-specific sources and/or sources that are written in the national language (other than English).

METHODS

Consortium partners of the MIGHEALTHCARE project were asked to identify sources in their respective countries and languages providing guidance for community-based healthcare for migrants and refugees. Partners provided information on the following characteristics: full citation of the source, country of implementation; target population; type of health intervention/care/needs; main elements of model/intervention; successful elements; challenges and non-successful elements; and lessons learned (an indicative search protocol is presented at the end of the document)

RESULTS

Fifty-four sources were retrieved from eight countries: France (n=13), Spain (n=12), Greece (n=7), Italy (n=7), Malta (n=6), Austria (n=5), Germany (n=3) and the Netherlands (n=1). Among the identified sources were guidelines (institutional and governmental), guidance documents from expertise centers, (government-led) online information platforms and websites, reports (by government and NGOs), scientific journal articles, handbooks, and academic theses. Below are the results of the review per country by the number of sources contributed in decreasing order. For each country we tried to indicate the successful and the less successful elements and challenges.

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France

Successful elements: The suggestion is not to create specific services for migrants or ethnic minorities per se, but to include them into regular or existing services for vulnerable populations (1, 2); to cover the costs for healthcare and medical/psychological/social/legal support; to prioritize access to care, prevention, and human rights; to foster greater autonomy and better integration; to increase migrants' knowledge of their medical, psychological, social and legal situation; to respect privacy of personal health information to the maximum extent possible, to collaborate with different centers and services who work with migrants (3); to provide culturally- and linguistically-sensitive care (4); cultural brokering (5); consultations in transcultural psychiatry especially focused on migrants and refugees (6); to establish a medical anthropological clinical team comprising of psychiatrists, psychologists, anthropologists, a nurse and social worker; to provide all professionals with cultural competency training which allows them to take into account the cultural, linguistic and social dimensions of care (7); to conduct action research and organizing seminars to promote psychosocial clinical approaches (strong focus on dissemination!); to set up expertise centres that specialize in the links between mental health and social issues such as social deprivation, social exclusion, health inequalities, vulnerabilities and migration (8); to create expertise centers that treat people who have been subjected to torture or political violence (9); to establish an inter-university diploma courses for professionals, volunteers, and students working with migrants or interested in migration issues (8); to provide services for "rough sleepers" and other people out on the streets that require emergency lodging, social care and referral to medical care services (10); to arrange health check-ups for migrants who have been evacuated from the Paris camps to residential centres (by teams consisting of nurses and translators); to create hospital-community care networks that serve migrants living in precarious conditions irrespective of their administrative status; to establish systems of care and psychological counselling involving interpreters and cultural mediators; referral of migrant patients to local, regular primary and social care professionals to undertake care, treatment and follow-up (after initial screening and check-up in migrant centres) (11, 12); to provide legal support to asylum-seekers and foreigners and assistance and advice on how they can access their rights; to implement advocacy actions towards decision makers; awareness raising on migration issues among the general public opinion (13).

Challenges and non-successful elements: A policy that does not specifically target migrant health needs yet propagates the right to social and health care can result in paradoxical situations. For example, with respect to housing (a key determinant of health), under French law all French citizens will have a right to housing. This means that organizations whose mission is to ensure rights to housing for "excluded" people or "rough sleepers" may in fact principally be dealing with migrant populations. Challenges of community-based approaches in general: (1) the difficult living conditions and circumstances in which many migrants evolve are not conducive to such actions; (2) participatory research and action is time-consuming (lack of resources); (3) limited time and resources available to professionals and volunteers; France is a country built around a strong central (and thus decentralized) civil service, which counter runs local actions; (4) stimulating action from the non-healthcare sector, such as government (e.g., improving living conditions, reducing discrimination and stigma, promoting participation on the labour market, focus on cultural and social flourishing in the new country, language classes, engagement with host community members.

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Spain

Successful elements: tools for intercultural communication (14), culturally-sensitive care (15), transcultural healthcare services (15, 16), reflexive dialogues (17), the Purnell model for cultural competence and the Campinha-Bacote process of cultural competence in the delivery of healthcare services (15, 18), periodic evaluations (19), political support and commitment (20), inclusive socio-sanitary services (19), indicators and characteristics of the intercultural accommodation project (21), training programmes for healthcare professionals, guidebook with key phrases to facilitate communication (22), intercultural mediators (23), investigation of morbidity and mortality in migrant population (24), Second Languages and Immigration web portal (25), work networks for the exchange of experiences (17), role playing techniques and small-group discussions, cultural competence in mental health, transcultural psychopharmacology and ethnopsychopharmacology (15)

Challenges and non-successful elements: lack of resources that promote an agile and fast communication of data collection (22), programmes of multilingual telephone interpretation, multilingual guides for patients and intercultural mediation interrupted due to budgetary difficulties, ensuring that all healthcare professionals follow specialized training (14), ensuring generalizability to other communities (19), implementing intercultural services in every healthcare facility is challenging, development of flexible support structures that facilitate local integration (17), time constraints for medical examinations, different beliefs and attitudes towards illness (23), language barriers and difficulties learning a new language (25), professionals have to improve their knowledge of the social, cultural and anthropological aspects of the different immigrants collectives that reside in their environment, role of health mediator not acknowledged by health authorities (15).

Lessons learned: multicultural and culturally tailored services, follow-up evaluations of projects and interventions, improve professionals' knowledge, attitudes and behaviours to better respond to cultural diversity (22), linguistic and intercultural mediation, language class should focus on every day or otherwise relevant vocabulary (25), sustainability of training and education initiatives to ensure that knowledge is retained (17), improve socioeconomic (labour) conditions to improve health (24).

Greece

Successful elements: psychological support sessions for caregivers working with refugees in temporary hotspots (screening tools: Spielberger State-Trait Anxiety Inventory, Symptom Checklist Questionnaire-90, Albert Einstein College of Medicine Coping Styles Questionnaire, and the Athens Insomnia Scale) (26), public services and NGOs providing housing, water, food, clothing and medical services free of charge (for vulnerable subjects: through national child protection legislation) (27, 28), pregnant women and mothers with newborns receiving care separately (29), standard medical screening of asylum-seekers before they enter shelters (e.g., chest radiography and tuberculin testing) and additional lab screening for anemia and lead exposure in children originating from Asia (30), mandatory registration and data collection of all activities in refugee health units (29).

Challenges and non-successful elements: limited availability of on-site diagnostic tests and lack of electricity and running water in refugee camps (31)

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Lessons learned: set up task forces (led by universities, mental health specialists and psychologists) to address caregiver mental health (26), interview all key stakeholders involved in the management of the migration process in the country to assess health system performance, collaboration with the ministry of health to visit the most important locations and institutions receiving migrants (28), use of health cards for migrants and refugees, formation of a Refugees' Health Unit (staffed by one certified physician, one certified nurse, one translator or cultural mediator, and one administrative assistant) which will provide health services for resuscitation, hypothermia, dehydration, initial medical examination, follow-up, stabilization, evacuation or transfer, and care to special and vulnerable groups (29), on-site health care providers closely collaborating with partner groups and agencies (hygiene promotion, visiting dental teams, and mental health care) (31).

Italy

Successful elements: free health services for the uninsured and those without a legal residence permit after complex hospital discharge to ensure continuity of care (32), multidisciplinary teams (including social workers) offering health services and projects to promote individual autonomy and empowerment (32, 33), centres for first reception and identification of migrants (< 72 hours) that offer accessible social and healthcare services (standardized screening, examination and treatment) (34, 35), services assisting migrants to access the healthcare system (e.g., how to register to the regional health care system) and providing information about how local healthcare services are organized, use of cultural mediators, multidisciplinary, intercultural and holistic approach to healthcare delivery, ethnopsychology as an approach to address specific vulnerabilities, training of mental healthcare professionals in cross-cultural psychotherapy, establishing contact and collaborations with local hospitals and clinics, support from the private sector (e.g., local supermarkets and transportation companies) (32), an app where prefectures, reception centers and healthcare providers upload information about individual asylum-seekers to obtain a complete picture of each individual's situation and of the entire reception system in the region, use of the cultural identity card to foster integration (36), migration specialty clinics that use approaches from medicine, psychology and anthropology, issuance of "vulnerability certificates" by Médicins Sans Frontières (MSF) personnel to assist in asylum requests (37, 38).

Challenges and non-successful elements: funding is often public and yearly, which creates problems in long-term planning of individual projects (32), privately funded initiatives are not part of health services provided by local hospitals (sustainability/continuity issues), establishing independence of clinics, stronger collaboration between public services and private social services, making services more structural and consistent, achieving long-term funding for project to establish continuity of services.

Lessons learned: attentiveness towards vulnerability, holistic, multidimensional and intercultural approaches to care (32, 38), importance of establishing a network of different services to improve access to care, specialty training for workers in public services and reception centers, information for migrants how to make use of the healthcare system and to enhance autonomy.

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Malta

Successful elements: establishing project support from the local community, NGOs and government (39), nursing students providing services through a continuing medical education program (40), day centers run by community peers, involvement of migrants to become trained cultural mediators to support health professionals and migrants during medical consultations, ongoing awareness raising activities to reduce stigma and secure funding (39), standard training module for all migrant community members informing about mental health and how they can get help within the current system (41), mediators receiving a standardized training on cultural translation skills, professional health care providers receiving training on diversity, cultural issues and social norms of migrants (42), advocacy efforts to reduce stigma in the local (host) community (41).

Challenges and non-successful elements: programs and initiatives not able to reach all individuals in need of care, high demand, people with additional mental health issues (such as substance abuse and alcohol dependence) are not able to join community housing projects (39), discrepancy between general practitioners' beliefs about health promotion and prevention and their own behaviour (e.g., infrequent cholesterol checks) (43), frequent relocation of successfully trained cultural mediators required constant investment in training of new mediators (42), lack of streamlined standard operating procedures for how to request mediators and who arranges payments (e.g., for services provided or transportation costs), stigma associated with mental health problems among local community, stigma toward migrants living in community housing projects (39), lack of space to house migrants (39), barriers indicated by general practitioners are time constraints, patients not realizing benefits, no refunds for preventative screenings (43)

Lessons learned: general practitioners need to discuss risky life styles and offer adequate support to patients from the migrant community (44), community day centers to provide support to family members of persons suffering from mental health problems (run by volunteers, suitable opening hours) (41).

Austria

Successful elements: communication between service providers and patients, intercultural training (45), promoting health literacy among migrants, ensuring non-discrimination, participative approaches (engaging migrants and refugees), provision of information through patient-centered information events, guided tours, in-house and cultural events in hospitals (46), social networking (47), patient brochures, house magazines, written patient surveys (46), information videos and online offers, raising awareness about health issues in the migrant community (45), intercultural competence training among actors, health promotion initiatives through community outreach (kindergarten, schools, workplace, hospitals) (48), involvement of all stakeholders in and target groups in the design and implementation of projects (48).

Challenges and non-successful elements: language barriers (46), communication difficulties due to cultural differences in dealing with pain and death, eating habits (46), stronger or less pronounced sense of shame as well as different understanding of gender, prejudices and discrimination/racism of migrants by healthcare sector (47), lack of information about preventive and health-promoting measures in native languages or visual communication aids,

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prevention not considered as important among migrant community (45), need for improved, more tailored outreach approaches towards target community (45), need for better education for staff (especially in the treatment of migrant women).

Lessons learned: standards and guidelines for hospital staff to ensure patient information (46), multistakeholder engagement, higher number of interpreters, higher attention for successful outreach of health promotion programmes, nutritional optimization of meals and drinks offered in the area of communal catering (48), increase health literacy through independent, undistorted, gender equal, reliable, understandable and evidence-based information (49).

Germany

Successful elements: **training of service providers:** basic training (short courses) in cultural competence (50), integration of these courses in the specialist medical training, continuous training in transcultural psychiatry (50); regular lectures; one-day-symposia, trips to asylum centres, credit offered from state medical association for participating in training and workshops, training for social workers (50). **Education for migrants and refugees:** empowering migrants in their everyday lives in weekly sessions run by social workers. Intercultural health education and counseling (fact sheets and leaflets in different languages about, for example, healthy lifestyle). Informative health guides to help navigate national healthcare systems. Encourage continuous participation in health promotion programmes. **Facilities and services:** Translation of online information platforms in different languages (50), health meditators from the peer community, multiligual service providers, multicultural teams, in-house (professional) interpretation services, interpreter services by trained laymen and community peers (50), secure easy accessibility of intercultural meeting places, gender and age-related differentiation of measures and approaches. **Mental health services and general well-being:** daycare hospitals specialized in mental healthcare for torture victims (51), involvement of family in treatment, variety of activities and classes to reinforce self-esteem, well-being and promote integration including sports, games, music, arts, crafts, cooking, community gardening, language classes (51). **Organization:** outreach by community peers, multicultural treatment teams, community engagement between people with and without a migration background, collaboration between different service providers (referring versus treating healthcare professional), collaboration between different institutions and public bodies, culture-sensitive prevention programmes (e.g., HIV/AIDS and child immunization), establishing a nationwide database with contact details of all institutes, facilities, healthcare professionals and interpreter services experienced in working with migrants and refugees, and a website that can be searched for these contacts + online anonymous counselling (51). Secure sustainability with limited financial resources (50), collaboration with different organizations and institutions in the community (e.g., kindergarten to reach pregnant women), engaging migrant community in design and implementation of new service models, decentralized approaches, establish to commitment to continuity of service provisions (accessibility by phone, office hours, transparency about services that can be provided, state funded initiatives, persuade political actors to commit to (long-term) project financing, sensitizing professionals and the public towards migrant health issues and the need for particular approaches,

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Challenges and non-successful elements: high workload for professionals due to high demand (50), staff shortage, lack of time to attend training (due to clinical obligations) (50), time constraints in service provision (52), lack of (high-quality) interpreters (52), setting up interpreter services (responsibility!), communication barriers/misunderstandings (52) leading to excessive examinations or delayed diagnosis and costs (50), different expectations based on culture (52), hard-to-reach communities, fear of seeking help, vulnerability of migrants due to poor housing and living conditions, difficulty securing (sustainable) funding for projects (the majority are run with donations), hard to secure continuity (employees change all the time), limited capacity of spatial facilities, insufficient capacity to diagnose and treat (migration-specific) mental illness (aggravated by stressors brought upon by migration: uncertainty about residence status), lack of financial resources, lack of therapeutic self-help or group sessions specifically for conflict-related trauma or PTSS, lack of specialization on torture, persecution and displacement and planning project kick-offs in religious holidays (51), lack of knowledge on service providers' side about migrant health and needs, lack of coordination with federal agencies, difficult to sensitize authorities, isolation and lack of knowledge about health systems on migrants' side, printing delays for leaflets in specific languages, lack of social care services, travel costs to healthcare facilities, building trust and make actors take responsibility, need for migrant-sensitive concerted data collection, need for guidelines.

Lessons learned: increase access through gatekeepers (52), service provision during office hours in community day centres (52), in-house provision of medicines (52), professional interpreters for psychosocial screenings, training incorporated in national medical association's programmes, education about national social and healthcare system (51), addressing issues of residence status, material needs, family problems and language barriers, willingness "from both sides" to foster integration, overcoming cultural differences in terms of the definition of health, disease, medical practice and sexuality, development of intercultural concept of care by expert working groups, continuous assessments as to whether care is accessible to target community, integration of continuing education modules for professionals dealing with migrants in psychiatry, training for migrants in psychological medicine, sensitivity towards and engagement of family structures (51).

The Netherlands

Successful elements: municipalities providing **appropriate housing** that matches migrants' health needs and care (taking into consideration: medical treatment trajectories, school trajectories, availability of social support, care provided by family and friends (53). **Promoting integration:** early detection of health problems through screening, early response to drop-outs in integration trajectories, uniform agreements about early detection and referral, creating care networks focused on health promotion (healthy life style), informing migrants how to navigate the local healthcare system. **Empowerment**: active enquiry into elements that promote empowerment, autonomy and independence, promoting health through sports and sociocultural activities. **Preventive healthcare for families and children:** coordination and collaboration between different services, community outreach through schools and social workers, child rearing support through courses offered at schools. Investment in preventive care and social support: activate organizations, initiatives and projects in community centers, sport clubs, religious/church organizations, group sessions to provide information and education, linking migrants to members from local community, individual life

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coaching, community peers and cultural mediators, create a 'social map' to visualize all the services that are active in a local community in migrant health (53).

Challenges and non-successful elements: migrants' lack of familiarity with professional help and negative attitudes towards the healthcare system

DISCUSSION

This study reviewed 54 sources that mention successful interventions, best practices, challenges and lessons learned with respect to community-based healthcare for migrants and refugees residing in seven European countries. Results could be categorized along the following themes: ***organization***, ***communication***, ***training***, ***education*** **and** ***facilities & services***.

Organizational measures that proved successful were close collaboration with different governmental authorities, NGOs, community organizations and various local service providers. For projects to be successful, engagement with members from both the host community and the migrant community in the design and implementation phases was essential. Also, the need to track all activities through data collection and periodic evaluations was raised as a means to evaluate effectiveness of systems. Funding was mentioned as important to secure continuity of projects and systems. To reduce health disparities, bridging *communication* barriers was considered a major facilitator. Sources point towards the use of interpreters, gatekeepers, cultural mediators, community peers and advocacy. Other methods include increasing the availability of reasonably understandable information through different platforms (web, telephone, individual and group sessions) in various languages relevant to the migrant community. Adequate training and support for service providers, especially mental health professionals, was highlighted. Particular emphasis has been placed on employing holistic, culturally-sensitive and family-oriented approaches to healthcare delivery and learning about migrants' particular health needs. Providing migrants and refugees *education* on a range of topics was considered beneficial. Culturally-tailored sessions on health promotion, prevention, child health, mental health but also on how to access health and social services available to them are mentioned. Other items of interest were promoting well-being through empowerment and autonomy. Engagement of the host community in such educational efforts was considered helpful to reduce stigma and discrimination. In terms of *facilities and services*, community day centers with regular opening hours were considered an effective strategy to provide health services to migrants and refugees. At first reception, standard medical screening and psychosocial risk assessment was recommended as well as the provision of food, water, housing and health services free of charge.

Major challenges reported were lack of funding (*sustainability*) and collaboration between agencies, responsibility and leadership among actors often unclear, lack of standardized protocols and guidelines (*organization*), cultural and *communication* barriers, healthcare professionals' limited knowledge of migrant health needs and culturally-sensitive delivery of care (*training*), migrants' fear of seeking help, lack of understanding of benefits of preventive health measures among migrants, migrants' limited familiarity with local healthcare systems, discrimination by host communities (*education*), staff shortage, time constraints, lack of spaces to attend to migrants' health needs, lack of housing, structural shortage of (high-quality) interpreters, lack of resources in refugee camps (e.g., diagnostic tests and

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equipment), limited availability of social care services, difficulty securing continuity in staff, need for specialty mental health services (e.g., trauma and torture) (*facilities and services*).

This study provides insight into local and national practices and challenges of delivering healthcare to vulnerable migrants and refugees in Europe. These findings add to what it already known about community-based health and social services as reported in the international peer-reviewed literature. We noted differences in the types of practices and challenges per country. For example, Greece is often the first country of entry to the European Union (EU) and has been receiving overwhelming numbers of migrants and refugees in a relatively short period of time. Migrant healthcare is thus greatly concentrated on acute support amidst humanitarian crisis. The Netherlands, on the other hand, on a yearly basis receives far less migrants and refugees, of which many have already spent considerable time in the EU. As a result, migrant healthcare is much more focused on decentralized efforts in municipalities focusing on integration in the long-term.

A first potential challenge in interpreting these results, is the conceptual difficulty in translating the term 'community' and affiliated terms into the languages of the different countries reviewed here. For example, in German we were unable to find an exact equivalent suitable to the context of Germany. Within the republican context of France the word 'community' has particular (negative) connotations with 'communitarianism' and is therefore not frequently used (54). The sociopolitical context of countries also affects the extent to which community-based approaches are adopted for migrant health. For countries that employ individual-centered integration strategies it tends to be more problematic to reconcile such approaches with the population- or community-targeted public health approach. For example, community approaches involving cultural brokers or mediators have at times been accused of hampering integration of migrants. Opponents have argued that a community-based approach may be like a Trojan horse introducing 'communitarianism' (5). In Sweden, the extremely decentralized nature of healthcare resource distribution to municipal and regional actors means that each area has a multitude of small projects, often run by adult education organizations or small citizen associations. Such efforts are likely not effectively studied or published anywhere. Moreover, Swedish migration policy – with its particular focus on integration – often aims its interventions at the population as a whole (so not tailored towards vulnerable migrants and refugees). Apart from translating the terms 'community' and 'community-based' into the various European languages, there are complexities of what constitutes a community.

CONCLUSIONS

Through the analysis of the country-specific sources, we can distinguish some common elements regarding tools and best practices towards refugee and migrant community health which can be summarized as shown in the following table:

	SUCCESSFUL TOOLS & BEST PRACTICES	CHALLENGES
ORGANISATION	* Close collaboration of various stakeholders including the host & migrant community	*Sustainable funding of activities to facilitate future planning and operation

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	*Accurate data collection & evaluation of activities	*Staff turnover should be kept to a minimum *Lack of standardized protocols and guidelines
COMMUNICATION	*Use of translators and mediators, community peers, advocacy *Use of various ways of communication preferably in own language e.g. websites, leaflets, telephone lines, group sessions	*Cultural barriers *Limited specialized staff *Large variation in refugee/migrant backgrounds
TRAINING	*Service providers and health professionals receiving training and support towards employing holistic, culturally-sensitive and family-oriented approaches to healthcare delivery and learning about migrants' particular health needs	*Limited knowledge of migrant health needs in healthcare personnel *Delivery of culturally-sensitive care
EDUCATION	*Educate migrants/refugees on promoting well-being through empowerment and autonomy with engagement of the host community to help reduce stigma and discrimination.	*Migrants' fear of seeking help *Lack of understanding of benefits of preventive health measures among migrants, *Migrants' limited familiarity with local healthcare systems, *Discrimination by host communities
FACILITIES & SERVICES	*Community day centers with regular opening hours were effective strategy to provide health services to migrants and refugees. At first reception centres, standard medical screening and psychosocial risk assessment was recommended.*	*Staff shortage, time constraints *Lack of spaces to attend to migrants' health needs, lack of housing, structural shortage of (high-quality) interpreters, *Lack of resources in refugee camps (e.g., diagnostic tests and equipment), *Limited availability of social care services *Need for specialty mental health services (e.g., trauma and torture)

It is important to note that all the described practices and tools of activities to address refugee/migrant health needs at the community level, were drawn from published sources and should therefore not considered exclusive, as it is possible that more practices and tools that have not been published, may exist.

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PART C: Review in grey literature of best practices and activities towards refugees and migrants

By Riza E, Kitsou V, Kouvari M, Tsichlas F, Weis M

INTRODUCTION

In order to identify additional best practices, activities and tools addressing refugee and migrant health, a thorough search in several grey literature sources was performed in July 2018.

To facilitate the search four (4) main search areas were identified to focus on, namely a) projects/activities in the EU, b) projects/activities in Canada and Australia, c) projects activities in the USA and d) projects/activities by International Organisations and NGOs.

A set of exclusion, core and qualifier criteria on how to select best practices and activities was used to screen the search results in each area based on a suggested EU document (ref) which defines a set of parameters required in order to establish relevance, characteristics, ethical issues, effectiveness, efficiency, equity, transferability, sustainability, participation and intersectoral collaboration.

Based on the above-mentioned document, an assessment procedure was defined taking into account specific definitions of what constitutes “best practice” and “community”, to create a common ground for comparison across the various areas.

Through the assessment procedure the identified projects/activities/tools were ranked according to relevance, effectiveness, efficiency ease of sustainability and transferability by using a table created for this purpose. A specific guidance document on this assessment procedure was created (shown at the end of the document) to ensure standardized assessment by all reviewers and to facilitate the compilation of results.

Best practice assessment table

	Exclusion Criteria				Core criteria				Qualifier criteria			
BEST PRACTICE	Relevance	Characteristics	Evidence-based	Ethical	Effectiveness	Efficiency	Equity	**Score***	transferability	Sustainability	Participation	Intersectoral collaboration
1												
2												
3												
4etc												

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Area A- Projects-Activities in the EU

Applying the set evaluation criteria for the grey literature search, 29 projects/activities were identified targeting refugee and migrant health addressing the areas of mental wellbeing, cultural mediation and intercultural communication, maternal and child health, violence against women, refugee/migrant health needs while living in camps, social activities, health literacy as well as setting up clinics and telephone help lines with multiple languages available (shown in the Table below).

No	Project Title	Description	Webpage	Tools / Materials / Items produced	Other Webpage
1	**Home away from home**	The overall objective of the project HOME AWAY FROM HOME: best practices in the integration of refugees, asylum seekers and migrants in European societies is to contribute to the better integration of refugees, asylum seekers and migrants in Europe through promoting innovative youth actions and empowering young volunteers and professionals. The specific project objectives are as follows: To document and disseminate inspirational practices of innovative community integration approaches initiated by youth or in which youth play a major role; To raise the capacities of young volunteers and professionals for supporting the integration of refugees, asylum seekers and migrants. Thus, the project seeks to address, promote and support the goals outlined in the Paris declaration – we want to contribute to sharing and safeguarding our fundamental values and ensure that they are passed onto future generations.	http://hafh.eu/	Educational and Training materials	
2	**UNINTEGRA**	UNINTEGRA is a comprehensive initiative addressed to provide support to stepwise integration of refugee/asylum seekers at the host society since the early stage. UNINTEGRA aims at efficiently managing immigrant populations while responding to the needs of those in need protection, at two levels: first, by directly working with new arrivals to address basic needs of inclusion, in conjunction with fostering receptive attitudes in target communities, and	https://unintegra.usc.es/index.php	Training to train staff/volunteers to enable them to assist third country nationals in need of international protection in the local receiving communities	

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		secondly, by establishing a normative framework in each host community.			
3	**I Get You**	I Get You spreads and improves the culture of welcome in Europe, creating inclusive communities where everyone is valued. I Get You was started by JRS Europe in 9 European countries with the goal of identifying community building initiatives for local citizens and refugees. It began with some questions: what are the best practices that community building initiatives have found for working with local citizens and migrants? How do these initiatives build understanding and friendship? How do they counter racism and xenophobia? The research side of the project will enable us to analyse and compare initiatives across Europe. We will produce a mapping report and after that go to interview people in the initiatives themselves to gather even more data. Finally, 9 national reports and one European report will be launched and disseminated amongst policymakers and practitioners to raise awareness about best practices.	http://www.igetyou-jrs.org/	Mapping of 300+ local refugee initiatives/programmes in 9 EU countries	
4	**CARE – Common Approach for REfugees and other migrants' health**	"CARE" aimed to promote a better understanding of refugees and migrants' health condition as well as to support the adaptation of the appropriate clinical attitude towards refugees and migrants' health needs and in particular towards the health needs of fragile subgroups, such as minors, pregnant women and victims of violence. Its main results included more appropriate health care deliveries, increased control of infectious disease risk at the early phase of migrant's care and better taking care of migrants' health over the European territory will have been obtained.	http://careformigrants.eu/ the-project/	Information material, Training to health professionals, Health Literacy	
5	**"Babel" - Day Centre for migrants' mental health**	Day Centre Babel provides mental health services to migrants (individuals, families and groups) of all ages in the community. Day care and rehabilitation interventions are carried out in hours and days that are dictated by the needs. There is an effort to mobilize community resources in order to meet multiple and complex needs of people. Much is done at the level of community sensitization and the support of other	https://ec.europa.eu/migrant-integration/intpract/babel ---day-centre-for-migrants-	Information material, mental health services mapping in Athens	http://syn-eirmos.gr/babel/index.php?option=com_content&view=article&id=89&Itemid=221

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		professional categories that work with this group. Key principles are: respect to cultural diversity, networking, mediation, focus on strengths, comprehensive approach.	mental-health		
6	**InBáze Community Centre**	InBáze is an independent community centre for migrants and Czech nationals located in the capital city Prague. The structure is made of several departments, all aiming at fostering the integration of migrants in the Czech Republic: the employment office provides guidance for job search, the legal department offers consulting services while the community department helps with social or family matters.	https://ec.europa.eu/migrant-integration/intpract/inbaze-community-centre	Social support activities, community-women-children activities	http://www.inbaze.cz/jazyky/english/
7	**Promoting integration through Equity in Health**	The Project sets up health services where staff members are more aware of the specific needs of migrants and better prepared to meet the challenges posed by the growing diversity of the Portuguese society	https://ec.europa.eu/migrant-integration/news/portugal-new-project-to-promote-integration-through-health-equity	8 Competency training seminars, Health Care Equity Standards tool designed as a benchmark to guide working groups	https://www.acm.gov.pt/-/-promover-a-integracao-atraves-da-equidade-em-saude-acm-e-oim-parceiros-em-novo-projeto
8	**Poland: First clinic specifically dedicated to foreigners opens in Warsaw (private clinic CenterMed)**	A new clinic has opened in Warsaw to provide medical services to foreigners living in Poland, regardless of their legal status. Foreign students, employees, entrepreneurs, holders of the Card of the Pole and other foreigners insured in the National Health Fund (NFZ) can access these services free of charge. Those who have no health insurance are offered a 20 percent discount for all services.	https://ec.europa.eu/migrant-integration/news/poland-first-clinic-specifically-dedicated-to-foreigners-opens-in-warsaw	Doctors employed in the clinic speak Ukrainian, Russian and English	
9	**MyMind - Accessible Centre for Mental Wellbeing for all, including minorities**	MyMind Centre for Mental Wellbeing is a not-for-profit provider of accessible mental health care. Centres in Dublin (North and South), Cork and Limerick provide multilingual online or offline counselling and psychotherapy services which are accessible to the migrant community. Fees are based upon employment status, offering the unemployed or students affordable services. Revenue generated from full fee clients is reinvested, enabling the Centre to provide services to all.	https://ec.europa.eu/migrant-integration/intpract/mymind---accessible-centre-for-mental-wellbeing-for-all-including-minorities		https://mymind.org/about/
10	**ETHEHEALTH-Towards**	The ETHEALTH project is an initiative of the Federal Public Health Service,	https://ec.europa.eu/mi	46 recommendations	https://www.unia.be/fr

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	intercultural health care	Environment and Safety of the Food Chain, whose objective is to provide a series of recommendations to the attention of the administration and the Federal Public Health Service, and other jurisdictions dealing with the issue of equal access to health care for migrants and ethnic minorities residing in Belgium. The purpose of this project is to develop recommendations to promote greater equality of health of migrants and ethnic minorities residing in Belgium.	grant-integration/intpract/belgium-ethehealth--towards-intercultural-health-care	were addressed to the attention of authorities, which can be summarized in four areas of action: Providing the strategic bases for information on ethnic health inequalities and for institutions and professionals culturally competent health. Provide the same opportunities for health to migrants and ethnic minorities in the socio-economic field and in the field of prevention and health promotion. Make particular attention to the most vulnerable groups such as migrants which do not have health coverage, women migrants or migrants with mental health disorders. Making health care accessible to all migrants and ethnic minorities, not only by reducing barriers but also by promoting proactive care culturally competent health and non-discriminatory.	/diversiteit/files/File/studies/2012/2011_12_16_rapport%20final_FR.pdf
11	**"I am a Mom in Poland" - a project for migrant moms**	The Polish Migration Forum in partnership with the Childbirth with Dignity Foundation have started a project "I am a Mom in Poland" addressed to migrant women expecting a baby in Poland. The aim of the project will be, on the one hand, to help women	https://ec.europa.eu/migrant-integration/news/poland-i-am-a-mom-	Brochures and leaflets with information on healthcare in Poland	http://mamawpolsce.wordpress.com/

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		prepare for labour and care of a new born baby in Poland, and on the other hand, to prepare medical staff to the needs of migrant mothers.	in -poland--- a-project- for-migrant- moms		
12	**New child protection service for migrant families launched**	The Migrant Family Support Service aims to offer practical advice to migrant families and foster parents of migrant children. The service is backed by the New Communities Partnership and run by a team of trained multi-lingual, multi-faith staff and volunteers.	https://ec.europa.eu/migrant-integration/news/ireland-new-child-protection-service-for-migrant-families-launched	Staff training on cultural sensitivity	
13	**Meeting the health literacy needs of immigrant populations - MEET**	he main aim is to propose actions aimed at reducing inequities including targeted health promotion and best practice exchange. Areas of work: (1) developing the new CHE model curriculum; (2) developing the required programme for management and staff in adult and community education and other key social and health care service providers to ensure their engagement with the delivery model proposed at management and implementation levels; (3) developing the e-learning platform to provide the necessary online environment to support the activities of all potential end-users.	https://ec.europa.eu/migrant-integration/link/meeting-the-health-literacy-needs-of-immigrant-populations	online training materials	http://migranthealth.eu/index.php/en/about/project-overview
14	**Multi-Purpose Centre for Refugees - POLYDYNAMO**	Since 1997, Hellenic Red Cross operates the Multifunctional Centre for Social Support and Integration of Refugees, one of the first pilot programs that operated in Greece, funded by the European Commission involved in integrating refugees into Greek society. Beneficiaries, recognizing the high level of services provided in Multifunctional Center participate in actions related to improving their living conditions as well as in educational, recreational and multicultural activities with great interest.	https://ec.europa.eu/migrant-integration/link/multi-purpose-centre-for-refugees	Telephone helpline for refugees to receive information, Various activities to help refugeees increase awareness, sensitization and utilization of health and social services provided.	https://eespolydynamo.wordpress.com/
15	**Project on integration of migrants through healthcare is**	The general objective of the project is to promote the values of an open and democratic society by supporting the integration of TCNs with legal stay in Romania, to the mutual benefit of the	https://ec.europa.eu/migrant-integration/news/roma		

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	launched by ICAR Foundation	migrants and our society. The main activities of the project consist of a module of integrated medical services and a module of psychological assistance. The medical services include: consultations, treatments and examinations, health education and prophylaxis, as well as psychological counselling and individual and group therapy. The project aims to develop a professional platform joining together Romanian and foreign doctors, who can meed and discuss modalities to develop and improve the assistance offered to TCNs with legal stay in Romania	nia-new-project-on-integration-of-migrants-through-healthcare-is-launched-by-icar-foundation		
16	**Opening Doors**	Opening Doors addressed the violence against migrant women, the issue that was not given much attention in the Czech Republic. The project was focused on the prevention of violence, awareness raising, empowerment and self defence training for migrant women.	https://ec.europa.eu/migrant-integration/intpract/opening-doors	Train migrant women to become "peer leaders", connect NGO's that help & support women victims of domestic abuse	http://www.opu.cz/en/
17	**Intercultural mediation in selected hospitals in Greece**	The Program focuses and highlights the value of Intercultural Mediation in Healthcare as a dynamic process which aims to facilitate effective communication and contact between immigrants (mainly third country nationals) and their doctors, the nursing staff and administration of hospitals, to achieve better access to health care, taking into account their ethnicity and their cultural backgrounds	https://ec.europa.eu/migrant-integration/intpract/intercultural-mediation-in-selected-hospitals-in-greece	Coaching system, Call Center Service	
18	**Home care image dictionary**	The Intercultural Network of Ghent developed a visual dictionary with the most commonly used home care related images. This tool was created in order to overcome language barriers between elder immigrants and home caretakers. The ambition of the pictogram dictionary is not only to increase the use of home care services by 65+ immigrants, but also to better adapt the offer to their demand.	https://ec.europa.eu/migrant-integration/intpract/home-care-image-dictionary	Pictogram	https://in-gent.be/publicaties/uitgaves/beeldwijzer-thuiszorg
19	**ORAMMA: Operational Refugee And Migrant Maternal Approach**	The ORAMMA project develops an integrated, mother and woman centered, culturally oriented and evidence based approach for all phases of the migrant and refugee women perinatal healthcare, including detection of pregnancy, care during pregnancy and birth, as well as support after birth. This approach implemented by multidisciplinary teams of experts,	https://oramma.eu/	Community capacity building, propagating key members and empowering migrant and refugee women; e-learning course for health and social care	

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		namely midwives, social workers and general practitioners, with the active participation of women from migrants and refugee communities, ensures a safe journey to motherhood.		professionals (HSCPs)	
20	**Re-Health project – Support Member States under particular migratory pressure in their response to health related challenges**	The project aims at improving the capacity of EU Member States under particular migratory pressure to address the health-related issues of migrants arriving at key reception areas, while preventing and addressing possible communicable diseases and cross-border health events. It will contribute to improved capacity of EU Member States under particular migratory pressure to help address health-related issues of arriving migrants, while responding to cross-border health threat, in particular at designated hotspots and reception facilities for refugees and other migrants. By achieving its specific objectives, the project will: establish links between hotspots and health systems; implement the EC/IOM Personal Health Record to promote health care provision with assessment of the health status/health needs of the arriving refugees and other migrants, as well as continuity in health care provision; facilitate collection and transfer of data at individual, at local level and potentially at destination country; and facilitate systematic health assessment and preventive measures provision (including vaccination) taking into account the needs of children and other vulnerable groups	http://re-health.eea.iom.int/	Electronic health database, personal health record, handbooks for health professionals	http://re-health.eea.iom.int/e-phr
21	**MiMi-With Migrants For Migrants**	A programme that recruits, trains and supports intercultural mediators to teach migrant communities how the German health system works as well as educate them in the specific health issues which they are at higher risk, healthy lifestyles, therapies and prevention.	http://www.ethno-medizinisches-zentrum.de/	multilingual guide for maternal care	http://www.ethno-medizinisches-zentrum.de/images/PDF-Files/ww_mtter_e_web.pdf
22	**Intercultural cord blood donation - Treviso project**	he aim of the Treviso project is to get through to migrant women living in our country in order to make them aware of the donation opportunity. Our message to these women is about the importance of intercultural blood donation for helping their sick fellow countrymen in need of a life- saving transplant and for increasing the number of cord blood units presenting different genetic characteristics. The	https://ec.europa.eu/migrant-integration/partner/intercultural-cord-blood-donation---	Multilingual handbook	https://parentsguidecordblood.org/en/banks/treviso-cord-blood-bank

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		growing number of immigrants determines an increase of request for stem cells transplants which is not counterbalanced by genetically matching cord blood units. The multilingual handbook is easy to read and it also answers to the most frequent questions. In order to improve communication with women we also created some videos in different languages reporting foreign mothers 'personal experience with the donation. Using multilingual handbook it is very useful to inform mothers showing difficulties with our language and to make them learn about our culture and society. In the near future our purpose is that of increasing the number of donations, reinforcing cooperation between associations and organizations involved in the process of donation.	treviso-project		
23	**Kultūrų įkalnė (Cultural Uphill), an inclusive and social day centre**	The centre located in Pabradė, a city in the Vilnius county, welcomes both asylum seekers and the local community around joint activities such as computer literacy classes, board game tournaments, as well as social, legal and psychological counselling for adults. It is linked to the Foreigners Registration Centre, where asylum seekers and undocumented immigrants are accommodated. The ultimate goal of the centre is to foster integration as a two way process, enhancing the multicultural coexistence of asylum seekers and locals: it helps Pabradė's local and migrant communities to meet. Its team, mostly consisting of volunteers, works to facilitate the adaptation of asylum seekers into the Lithuanian society, as well as to improve their intercultural competences and social skills.	https://ec.europa.eu/migrant-integration/intpract/kultr-kaln-cultural - uphill-an-inclusive-and-social-day-centre		http://www.vilnius.caritas.lt/
24	**"PHILOS – Emergency health response to refugee crisis"**	a programme of the Greek Ministry of Health, implemented by the Hellenic Center for Disease Control and Prevention (HCDCP). It's a new approach of the Greek Republic to address on the refugee crisis, by fulfilling the sanitary and psychosocial needs of people living in the open camps. The programme PHILOS introduces a comprehensive approach regarding the provision of health services to refugee's population and also reinforces the capacity of National Health System to	https://philosgreece.eu/en/	Printed informative material on health concerns etc, weekly epidemiological reports, training tools	

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		respond to the extra demand of health services as a whole.			
25	**Cultural mediators in Belgium's healthcare system**		https://www.health.belgium. be/fr/sante/organisation-des-soins-de-sante/qualite-des-soins/mediation-interculturelle-dans-les-soins-de	electronic services where migrants and refugees can book appointments with cultural mediators, guideline documents	
26	**Sundhed og Sygdom (Sickness and Health)**	The multi-lingual web-portal co-funded by the Danish National Health & Medicines Authority is one of the few positive examples targeting all migrant groups. It provides short informational clips about the health system, health insurance, pharmacy and interpreters in 8 languages.	http://detdanskesundhedssystem.dk/sundhed_filmen.html	20 short films about navigating the Danish health system	
27	**The PALOMA project – Improving mental health services for refugees**	develop a national model for mental health work with refugees and individuals from comparable backgrounds.	https://thl.fi/en/web/thl-fi-en/research-and-expertwork/projects-and-programmes/the-paloma-project-improving-mental-health-services-for-refugees	four seminars were organised in early 2017 on the topic of refugees' mental wellbeing.	https://thl.fi/en/web/thl-fi-en/research-and-expertwork/projects-and-programmes/the-paloma-project-improving-mental-health-services-for-refugees/seminars
28	**IENE 6 Project Contemporary large migration waves into Europe: Enabling health workers to provide psychological support to migrants and refugees and develop strategie for dealing with**	This proposal focuses on developing a knowledge hub (KHub) for nurses and other health professionals and volunteers who are dealing with or will be dealing with migrants and refugees from the current massive waves of displaced people which are reaching Europe and who are experiencing massive traumas and tragedies in their endeavours to flee to a safe and 'better' place for themselves and their families.	http://ienerefugeehub.eu /project/	Training webinars, online training, Tools for providing psychological support	http://ienerefugeehub.eu/support/

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	their own emotional needs.				

Some of these projects/activities address refugees/migrants directly by means of setting up health clinics or mediator centres in hospitals where multilingual services are provided, by printing brochures and leaflets on the country's healthcare system, by creating pictorial dictionaries, by providing electronic services to navigate through the health system, to request for a cultural mediator/interpreter, to arrange for appointments or seek legal advice, others address healthcare professionals by means of training seminars, guideline development, e-learning platforms and tools for psychological support tailored for refugees/migrants.

Note: regarding the tools developed through these projects, some sources provide a general description and a link to access to tool, whereas in most cases it is not possible to access the tool.

Area B:-Projects/ Activities in Canada and Australia

The initial search identified overall 81 projects/activities, 31 in Canada, 49 in Australia and 1 developed by the International Organization for Migration (IOM) for refugees/immigrants residing in countries of Mesoamerica. Applying the set evaluation criteria, the search resulted in 19 projects/activities in Canada and 20 in Australia (shown in the table below).

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Document	Search	Name	Short description	Topic Area	Country	Subpopulation	URL
1	asylum seekers wellness apps australia	Bright Ideas: The New Roots Project [Refugee Council of Australia]	providing men with assistance in orientation as a complement to settlement *casework and tips and tools* for self-help strategies to maintain *wellbeing* as they adapt to a new country and culture and *secure the necessities* of life; mobile app named "New Roots"	physical, social and emotional wellbeing	Australia	mostly men, aged 18-45 from Arabic, English, Farsi and Tamil, but also recent arrivals of all ages, nationality and gender	https://www.refugeecouncil.org.au/publications/bright-ideas-new-rootsproject/
2	asylum seekers wellness apps australia	Greater Dandenong – City of Opportunity	supports refugees and asylum seekers to help achieve a healthy, active and safe life in this community. It provides resources, online booklets and guidebooks, general information about various kinds of services as well as volunteer programmes.	housing, community support and access, language skills, facilities and health care services	Australia	asylum seekers and refugees	http://www.greaterdandenong.com/document/29951/refugees-andasylum-seekers-services-and-programs

			Inlcudes an app, named "EAS Network"				
3	aborigines health protection australia	National Aboriginal Community Controlled Health Organisation (NACCHO)	An Aboriginal Community Controlled Health Service is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.	health and wellbeing services	Australia	aboriginal community	https://www.naccho.org.au/
4	aborigines health protection australia	SA Health - Government of South Australia	SA Health is working to address the health inequities faced by Aboriginal people, reducing the gap in health outcomes between South Australia's Aboriginal people and the rest of South Australia's population	Health disparities, health care services and culturally responsive health system	Australia	aboriginal community	http://www.sahealth.sa.gov. au/wps/wcm/connect/public+content/sa +health+internet/about+us/about+sa+h

							ealth/aboriginal+health
5	immigrants health care tools canada	Caring for Kids New to Canada	Caring for Kids New to Canada helps health professionals provide quality care to immigrant and refugee children, youth and families. It was developed by the *Canadian Paediatric Society* with experts in newcomer health. Provides information, tools and resources for practitioners, as well as resources for immigrant families	health assessment & screening, including mental health, health promotion	Canada	immigrant children	https://www.kidsnewtocanada.ca/
6	immigrants health care tools canada	Canadian Civil Liberties Assosiation: Useful links and resources: Healthcare for immigrants, refugees and temporary foreign workers	Provides useful links and resources, such as studies and reports, about immigration and citizenship issues, including related organizations, government resources, guides, and legal information and tips for front line workers	Health disparities, health care services, health care access	Canada	immigrants, refugees and temporary foreign workers	http://newtobc. ca/faq_category/immigrationcitizenship- questions-answers/

8	immigrants health care tools canada	Multicultural Mental Health Resource Center	Provides resources and clinical guidelines, especially useful for those involved in providing mental health and cultural assessments of asylum seekers as part of the refugee determination procedure	mental health problems, mental health promotion	Canada	immigrants, refugees and asylum seekers	http://www.multiculturalmentalhealth. ca/clinical-tools/guidelines/immigrantsrefugees/
9	immigrants health care tools canada	Mental Health Comission of Canada - The Case for Diversity	The Case Diversity Project identified programs, policies, treatments and supports that have the capacity to effectively address disparities in mental health service delivery in Canada.	mental health problems, health services accessibility	Canada	immigrant, refugee, ethnocultural and racialized (IRER) populations	https://www.mentalhealthcommission. ca/English/case-diversity-promisingpractices
11	refugees health care tools canada	refugee health Vancouver	Provides guidelines, tools and information resources	health services, health promotion	Canada	refugees	https://www.refugeehealth. ca/pediatrics/
12	refugees health care tools canada	Children's Hospital of Eastern Ontario (CHEO)	Provides clinical tools, such as templates and intake forms, community referrals, toolkits, and resources for professionals	health assessment, health promotion, health services	Canada	refugees	http://www.cheo.on.ca/en/Refugee-

			focusing on immigrant health, as well as the refugees themselves				Support-Resources
13	refugees health care tools canada	National Collaborating Centre for Infectious Diseases	With the current influx of Syrian refugees to Canada, the National Collaborating Centre for Infectious Disease (NCCID) is embarking on new knowledge translation to bring current evidence and information to public health practitioners and policy makers. Provides resources, such as reports, videos, webinars, and guides, as well as links of Major Organisations focusing on refugees' health.	health assessment, screening, health programmes	Canada	refugees, asylum seekers	https://nccid.ca/collection/refugees-andpublic- health/
14	refugees health care tools canada	cahm: Immigrant and Refugee Mental Health Project	The Immigrant and Refugee Mental Health Project offers online training via webinars and online courses, tools and resources to settlement, social and health service professionals working	mental health problems and disorders, health services,	Canada	immigrants and refugees	https://irmhp-psmir.camhx.ca/

			with immigrants and refugees. Funded by Immigration, Refugees and Citizenship Canada (IRCC)	treatments and supports, health promotion, prevention and screening			
16	refugees health care tools canada	Ontario College of Family Physicians: Refugee Resettlement	Ontario College of Family Physicians: Refugee Resettlement	health assessment, (primary) health services	Canada	refugees	https://ocfp.on.ca/tools/refugeeresettlement
17	immigrants health care apps canada	Government of Canada	Provides basic information on Canada's health care system including federal responsibilities and links to provincial and territorial health ministries, an resources.	health care system services, health promotion, mental health	Canada	immigrants	https://www.canada.ca/en/healthcanada/services/healthy-living/just-foryou/immigrants.html
19	immigrants health care apps canada	Canadian Centre for Refugee & Immigrant	Provides information and contact options for CCRIC clinics, which are volunteer-driven and offer health care services	health disparities, health care services	Canada	immigrants, refugees	https://www.healthequity.ca/

		Health Care	to immigrants and refugees.				
21	From "Government of Canada: Best Practices in settlement services" (following detached links)	Entry Program	The Entry Program is the first place for new immigrants to learn about living in Manitoba, Canada. Participants will learn about four major topics: Health, Employment and Education, Laws, and Places to Go.	health services, health care access	Canada	newcomers to Canada	https://alteredminds.ca/entry-program/
22	From "Government of Canada: Best Practices in settlement services" (following detached links)	Entry Program Online	Like the "Entry Program" the "Entry Program Online" educates new immigrants on the four major topics mentioned above. The Entry Program Online offers online courses especially designed for those who cannot attend in person the orientation classes at the downtown locations.	health services, health care access	Canada	newcomers to Canada	https://alteredminds.ca/entry-programonline/

24	best practices healthcare migrants canada	The Canadian Medical Protective Association	Providing physicians with general information and advice on how they should approach different kinds of immigrant health issues.	health screening, health coverage, health problems including mental ones, preventive care	Canada	immigrants and refugees	https://www.cmpa-acpm.ca/en/advicepublications/ browsearticles/ 2015/immigrant-health-issueswhat- physicians-should-know-and-do
26	best practices healthcare migrants canada	Mental Health Comission of Canada, Centre for Addiction and Mental Health (camh) : Understanding the issues, best practice and options for service	Discusses health care barriers, and suggests best practice and options in order to improve the existent health care services.	health care barriers, health promotion and prevention	Canada	ethno-cultural groups, immigrants, refugees, and racialized groups	https://www.mentalhealthcommission. ca/sites/default/files/diversity_issues_o ptions_consultation_eng_0_1.pdf

		development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups (report by the Mental Health Commission of Canada Task Group on Diversity, 2009)					
27	refugees oral health tools australia	Refugee and Asylum Seeker Oral Health Recall Tool - Development and Pilot (Final Report)	This is a tool for professionals to assess whether a client is at high risk of Health problems. It also provides "practice tips".	oral health assessment, proper oral treatment practices	Australia	refugees and asylum seekers	http://refugeehealthnetwork.org.au/wpcontent/uploads/Finalreport_Secure_2017_OralHealthTool-

							Report_online.pdf
28	refugees oral health tools australia	The University of Adelaide: The National Oral Health Promotion Clearinghouse	This website provides information as well as some resources of programmes or projects aiming at oral health promotion among immigrants, refugees or asylum seekers. It also briefly discusses the particular methodology, main findings and involved organisations of each project/programme.	oral health promotion, oral health evaluation	Australia	immigrants, refugees, asylum seekers	https://www.adelaide.edu. au/arcpoh/oral-healthpromotion/ research/migrantsrefugees/# capacity
29	From link attached above	Refugee Oral Health Sector Capacity Building Project	The aim of the Refugee Oral Health Sector Capacity Building Project is to support and strengthen the capacity of public dental services in Victoria to deliver responsive oral health care with clients of refugee and asylum seeker background. This website provides information and resources on the	oral health care services, oral health needs assessment	Australia	refugees and asylum seekers	http://refugeehealthnetwork.org. au/engage/refugee-oral-health-sectorcapacity- building-project/

			project, a detached link leading to a full Report of the results of their gap analysis (including discussion on need for learning and professional development around working with refugees and asylum seeker clients, and other resources to improve cross-cultural communication), and also a Model of Care for working with refugees and asylum seekers, a series of factsheets on identifying and caring for clients of refugee background, and the development of an Oral Health Targeted Education Programme.				
30	From link attached in Refugee Oral Health Sector	Targeted Education Program (TEP)	The programme aimed at supporting oral health staff and clinicians working in dense refugee and asylum seeker settlement areas using a mix of didactic,	oral health practice and services	Australia	refugees and asylum seekers	http://refugeehealthnetwork.org. au/engage/oral-health-

	Capacity Building Project		observational and experiential learning . This website offers information on the function of the programme, as well as resources of the overall project evaluation, such as a final report and final report appendices.				targetededucation- program-tep/
31	best practices refugee health care australia	phn Adelaide: Primary Health Care Service Access for Refugees and New Arrivals Consultation and Workshop - Summary Report (March 2017)	This report outlines the consultation processes that Adelaide PHN undertook regarding primary health care access for refugees and new arrivals.	health care needs, health care services	Australia	refugees and newcomers	http://adelaidephn.com. au/assets/Refugee_and_New_Arrivals_ Workshop_Summary_Report_March_2 017_Final.pdf
32	best practices refugee health care australia	Gold Coast Primary Health Network (GHPHN)	Provides general information on refugee health, as well as clinical resources, factsheets, guidelines, videos (both in english and	health care services and practices	Australia	refugees	https://www.healthygc.com.

			other languages), a toolkit for healthy eating in supporting accommodation and referral pathways, both for health care professionals and patients.				au/Resources/Population-Groups/Refugee-Health.aspx#9732
34	best practices refugee health care australia	A Rapid Review of Evidence-Based Information, Best Practices and Lessons Learned in Addressing the Health Needs of Refugees and Migrants (Report to the World Health Organization, April 2018)		health needs addressing	world	immigrants and refugees	http://www.who.int/migrants/publications/partnercontribution_review.pdf
36	best practices refugee health care	Western Victoria Primary Health Network	Includes tools for delivering care in general practice, such as templates, fact sheets, online guides,	health assessment, health	Australia	refugees and asylum seekers	https://westvicphn.com.au/healt

	australia		information sheets, booklets, and also useful links for GPs and other health service providers working with people from refugee backgrounds	services			hprofessionals/ refugee-and-asylumseeker- health
37	best practices refugee health care australia	Foundation House: Promoting Refugee Health Guides	Offers links and resources on refugee health care promoting guides, as well as the oppotunity to download the "Promoting Refugee Health: A Guide for doctors, nurses and other health care providers caring for people of refugee backgrounds (3rd edition)"	health promotion	Australia	refugees	http://www.foundationhouse.org. au/promoting-refugee-health-guides/
40	best practices refugee health care australia	South Eastern Melbourne Primary Health Network (SEMPHN)	Offers resources, links for training videos for professionals and refugees, online guides etc	health care assessment, health services	Australia	refugees, asylum seekers	http://www.semphn.org. au/resources/refugee-and-asylumseeker-

							health.html
47	smartphone apps for aboriginals health care australia	Services and gaps in ear health and hearing (pdf)	Includes two apps: "hearScreen" and "Sound Scouts". Automated hearing assessment apps capable of both screening and diagnostic testing of children aged five and upwards are appearing.	hearing assessment	Australia	Aboriginal & Torres Strait Islander children (aged 5 and upwards)	http://www.naccho.org.au/wpcontent/uploads/Australian-Hearing-QAIHC.pdf
48	smartphone apps for aboriginals health care australia	Exploring the cultural appropriateness and usefulness of a mHealth promotion program for infant feeding in an Urban Aboriginal Health Service: a qualitative study	The aims of this study were to explore whether a health promoting mHealth program is a viable approach to provide infant feeding support to parents of Aboriginal infants and to explore the key factors that need to be considered in developing such a program to ensure that it is culturally appropriate and engaging. Provides information on the "Growing Healthy Program"	infant feeding support	Australia	Aboriginals	http://healthbulletin.org.au/wpcontent/uploads/2017/08/bulletin_mHealth.pdf

49	smartphone apps for aboriginals health care australia	healthdirect app	"It's a gateway to evidence-based information which is checked for clinical accuracy, safety and relevance — that means trusted health intel at your fingertips." It offers handy tools, such as the "Symptom Checker", and information for access to health care services etc	health care services	Australia	all Australians, but offers specific information for Aboriginal health clinics	https://www.healthdirect.gov. au/blog/healthdirect-launches-newversion- of-health-app
52	smartphone apps for aboriginals health care australia	Orange Aboriginal Medical Service	Orange Aboriginal Medical Service or OAMS is making a difference to the health of Aboriginal families and the wider community of Central Western NSW. OAMS started in 2005, as a self determined Aboriginal organisation with a vision to be a leader in health and in the community. The webpage offers information, resources, links and tools about wellbeing issues, wellness	health care services, wellness programmes	Australia	Aboriginals	https://www.oams.net.au/

			programmes, and health care services.				
63	immigrants health care tools canada	Welcome to Alberta: Information for Newcomers (online guide)	This guide for newcomers to Alberta provides useful information for settling, working, and living in the province. The publication covers a wide range of topics, including housing, employment, education, health care, climate, banking, shopping, transportation, child care, the legal system, and social customs. It also includes information for Temporary Foreign Workers.	health care	Alberta, Canada	newcomers to Alberta	https://alis.alberta.ca/tools-andresources/ content/products/welcometo- alberta-information-for-newcomers/
72	(from "Victoria State Government: Refugee and asylum seeker health and	Cabrini Asylum Seeker and Refugee Health Hub	Provides access to a range of health services for people seeking asylum and newly arrived refugees.	health services	Australia	asylum seekers, refugees	https://www.cabrini.com.au/patientsand- families/services/directory/asylumseeker-

	wellbeing)						and-refugee-health-hub
76	refugee healthcare tools australia	Caring for Refugee Patients in General Practice	A guide for professionals working with refugees	health services	Australia	refugees	http://refugeehealthnetwork.org.au/wpcontent/ uploads/CRPGP_DTG_4thEdn _Vic_Online.pdf
78	best practices refugees healthcare canada	Refugee Youth: Good Practices in Urban Resettlement Contexts		practices for mental health support	Canada	refugees	https://www.uvic. ca/research/centres/youthsociety/asset s/docs/resources/cfys-refugee-youthresettlement- report.pdf
80	best practices refugees healthcare	Best practice guidelines for mental health	This resource provides health and social service providers (“practitioners”) with	mental health promotion	Canada	refugees	https://www.porticonetwork.

	canada	promotion programs: Refugees (pdf)	current evidence based approaches in the application of mental health promotion1 concepts and principles for refugees. It is intended to support practitioners, caregivers and others in incorporating best practice approaches to mental health promotion initiatives or programs2 directed toward refugees.				ca/documents/1399720/1402901/Refugees/3974e176-69a8-4a5f-843ba40d0a56299c
81	best practices refugees healthcare canada	Promising Practices and Partnership Building Resources	"This guide is for people who work with refugees in Canada, particularly those who provide settlement, health and other social support services. The material is written for front line workers, program managers and the leaders of agencies, and is informed by their ideas and expertise."	refugee mental health	Canada	refugees	http://issbc.org/wpcontent/uploads/2018/03/19_-_Refugee_Mental_Health_Promising_Practices_Guide.pdf

There is a general direction of priorities in most projects/activities towards the provision of services and the development of tools that facilitates the use of the health services available in these countries, following a regional/geographical background. Governments, regional and local authorities, professional organizations have all contributed with developing mobile, smartphone applications and a variety of other electronic services either for medical practitioners and other health professionals or directly for immigrant and refugee populations in their area.

In most cases, the development of mobile apps prevails again in 2 directions: either for direct use by the target populations i.e. indigenous groups, refugees, immigrants and foreign workers, or for health professionals with the aim to facilitate their work and to increase their awareness on specific issues that relate to these populations.

The apps may include: tips for self-help strategies to maintain wellbeing, resources, online booklets, guidebooks on many services, tips on housing, language skills.

In Australia, in particular, a substantial part of activities addresses the indigenous, aborigine populations (18 of 49 identified projects) through the development of apps on health services, sexual and reproductive health, hearing assessment, wellbeing, physical activity, infant feeding support, healthy eating and health checks. Moreover, apps for alcohol and drug users of these communities have been developed.

A good practice is the setup of a primary health care centre operated by the local Aboriginal community in the effort to create a culturally responsive health care system in their area.

For professionals, lots of information and resources for practitioners and for immigrant families in Canada have been developed, often with links for specific health services, health insurance providers and community services.

A multicultural resource centre set up in Canada, targets mental health problems providing clinical tools, community referrals, webinars, videos, guides and online training courses for refugee mental health.

In Australia, an entry programme has been set up for refugees and immigrants operating online and with physical attendance addressing issues falling under 4 major topics: 1) health, 2) employment and education, 3) laws and 4) places to go.

An oral health programme has been developed addressing health professionals on how to assess dental risk.

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Area C- Projects/ Activities in the USA

A total of 47 of the 89 sources identified in total, originated from or implemented in the US. The remaining 42 sources spanned Canada, South America, Australia, Europe, Asia, and Africa. Most interventions were in the primary intervention area, 61 were labelled as 'Health Disparities,' 19 as 'Health promotion,' 4 as 'Mental Health,' 3 as 'Psychosocial Screening,' and 2 as 'Reproductive Health.' Applying the set evaluation criteria, the search methodology identified 18 projects/activities of which 11 smartphone apps, with other interventions including clinical programming, trainings, brochures, and toolkits (shown in the table below).

In summary most interventions address then importance of good interpreting services, working with families and social services, cultural awareness of staff, develop educational programmes and information material for migrants, positive and stable relationships with staff, and clear guidelines on the care entitlements of different migrant groups

Some interventions are specific to a nationality e.g. Portuguese community in the US or native Indian tribes and include possible measures to be taken by governments of both countries of origin and residence and through public-private partnerships in order to reduce health vulnerabilities of migrants and their families.

Such an example is DomestiCare a private, affordable healthcare option for South African domestic workers jointly run by Occupational Care South Africa (OCSA) and CareCross Health, two of the largest healthcare companies in South Africa. DomestiCare is an occupational health solution offered through the private medical practitioners of the CareCross Health Group, the largest national network of general practitioners, radiologists and pathologists who jointly believe in providing affordable healthcare for all.

Title	Short Description	Topic Area	Country	Sub-Population	URL
MiMi – with migrants for migrants	Mobilizes, trains, and certifies bilingual (mostly female) migrants as intercultural health mediators, empowering them to carry out information events on health themes to members of their community in their respective mother tongue.	Health disparities-health system access	Germany	Migrants	https://ec.europa.eu/migrant-integration/intpract/mimi---with-migrants-for-migrants
Mobile Creches	Has worked to provide care and education for the young children of marginalized and migrant populations employed in the construction sites and slums of Delhi, India. Concentrating on children from the earliest days through twelve-years-old, many of whom live on the construction sites or slums in which their migrant parents work, Mobile Creches strives to identify at-risk children and engage the community in learning more about this underserved vulnerable population.	Health promotion-primary health care	India	Migrants	https://www.mobilecreches.org/
Cultural Consultation Service	The Cultural Consultation Service (CCS) is the only UK-based organisation that provides cultural consultation, training, research and policy at multiple levels, including the individual, teams, organisations and social systems.	Health disparities-health system access	UK	Vulnerable Populations	http://www.culturalconsultation.org.uk/about-us/
Promotor(a) de Salud Programs	MHP Salud implements Community Health Worker programs to empower underserved Latino communities and promotes the CHW model nationally as a culturally appropriate strategy to improve health.	Health promotion-primary health care	**US**	Migrants	http://mhpsalud.org/wp-content/uploads/2013/11/Evaluation-Toolkit-for-Promotora-Programs.pdf
Health Outreach Partners	Recruit and train local women and men to be Community Health Workers (CHW) improve the coordination and information flow between community residents and community resources	Health disparities-health system access	**US**	Migrants	https://outreach-partners.org/
MigrantApp	MigrantApp is developed by the International Organization for Migration (IOM) to provide migrants in Mesoamerica with easy access to information about organizations and services available for them in Mesoamerica.	Health disparities-health system access	Mesoamerica	Migrants	https://www.iom.int/news/un-migration-agency-launches-mobile-app-migrants-mesoamerica

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RefAid	RefAid is a free app that connects refugees with services when and where they need them.	Health disparities-health system access	World	Refugees	http://www.infomigrants.net/en/post/10096/smartphone-apps-helping-migrants-to-find-local-services
Maseltov	A new smartphone app called Maseltov, which is partly funded by the European Commission, is being developed with the aim of helping migrants find their way in a new culture - and will be trialled with Turkish migrants in Austria.	Health disparities-health system access	Austria	Migrants	https://www.thelocal.at/20140707/smartphone-app-to-help-migrants-integrate
ImMigRant	ImMigRanT, Immediate Migrants Resources and Tools, is a project conceived to support immigrants providing them with simple communication tools to help them face any potential medical emergency they are not able to manage as they miss contacts and references. To this end, ImMigRant designed a Smartphone App allowing immigrants to handle medical emergencies quickly and efficiently by making use of comic strips illustrating several injury cases or emergency situations, from the simplest to the most serious. The use of cartoons make simple information available regardless of language barriers.	Health promotion-primary health care	World	Immigrants	https://play.google.com/store/apps/details?id=com.titanka.immigrant
KRISTINA	A Knowledge-Based Information Agent with Social Competence and Human Interaction Capabilities (Telemedicine App)	Health disparities-health system access	EU	Migrants	http://kristina-project.eu/en/
New Roots	Smartphone app to help refugees navigate Australian life	Health Promotion-primary health care	Australia	Refugees	http://www.abc.net.au/news/2016-01-06/new-roots-app-to-help-refugee-men-navigate-australian-life/7059394
Miniila	A new smartphone app called Miniila has been launched in Brussels. It is designed to help child migrants on the move in Europe learn about their rights and the services available to them.	Health disparities-health system access	Belgium	Migrants	http://www.infomigrants.net/en/post/8652/miniila-app-helps-child-migrants-in-the-eu
Peace Geeks: Services Advisor	The Services Advisor web app was created by PeaceGeeks in collaboration with the United Nations High Commissioner for Refugees (UNHCR), and is now available in Jordan and Turkey. The app is designed to address a common coordination problem in refugee areas, in which essential organizations that provide medicine, food, shelter, and protection, are unable to serve those most in need.	Health disparities-health system access	Jordan and Turkey	Refugees	https://peacegeeks.org/services-advisor
ALMHAR	A German refugee support organization has developed apps for smartphones to help migrants living with psychological symptoms of stress. The online mobile therapy service is available in Farsi, English and Arabic. With ALMHAR offers exercises that can be done independently or incorporated into a course of therapy. It provides support for self-help and, ideally, early intervention to stop the symptoms getting worse.	Mental health- youth mental health	Europe	Refugees	http://www.infomigrants.net/en/post/8582/apps-for-refugees-suffering-psychological-trauma-and-depression
SMILERS	A German refugee support organization has developed apps for smartphones to help migrants living with psychological symptoms of stress. The online mobile therapy service is available in Farsi, English and Arabic. SMILERS, which is available only to iPhone users at this point, is aimed at people with milder symptoms of depression. It is a self-help app that is specifically aimed at Arabic speakers. It can be used without the need for any direct contact with a therapist. The SMILERS app takes users through seven modules over the course of seven weeks.	Mental health- youth mental health	Europe	Refugees	http://www.infomigrants.net/en/post/8582/apps-for-refugees-suffering-psychological-trauma-and-depression
REFUGEE SPEAKER	Deploying the award-winning application Universal Doctor Speaker for the refugee crisis	Health disparities-health system access	Europe	Refugees	http://www.refugeespeaker.org/
Mobile Healthcare Association - Native American National Coalition of Mobile Health Clinics	The goal of the Mobile Healthcare Association - Native American National Coalition of Mobile Health Clinics is to build a nationwide network of like minded individuals working toward improvement of health and increased access to health care for Native American communities. As with all mobile medical programs, we are helping to bridge the gap of health disparities and access to health care.	Health disparities-health system access	**US**	Native Americans	http://www.mobilehca.org/regnativecoalitions.html
Start A Mobile Clinic: Tips & Tools	Start a mobile clinic with resources and research pooled from a collective of over 700 mobile health clinics across the United States, Mobile Health Map can help you build a strong program. Harvard Medical School.	Health disparities-health system access	**US**	Underserved	https://www.mobilehealthmap.org/start-a-mobile-health-clinic

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Area D- Projects/ Activities by International Organisations/ NGOs

The **International Red Cross Federation** has developed the eCBHFA community-based program which is operational in 109 countries. This programme mobilizes communities and their volunteers to use simple tools adapted to local context to address the priority health needs of a community and to empower them to be in charge of their own development. In the context of this program an e-learning training as well as useful modules have been developed to be used by health professionals from the standpoint of primary health care as well as mental health and health promotion.

The **Pharos organization** has developed handbooks in the context if school programs in refugee youth in primary and secondary education as well as a toolkit for girl's circumcision and booklets and questionnaires for recognition and orientation of torture victims, applied to health professionals and other practitioners i.e. teachers/educators.

Médecins Sans Frontières has developed medical guides for health professionals related to refugees' mental health, primary health care as well as reproductive health that are available either as pdf files or through an application. Additionally, on-line material to support women's health during pregnancy in emergency conditions is available for download by professionals.

Caritas International has developed on-line material to support women's mental health in the form of storytelling.

These organizations have developed various tools and materials in the form of booklets, handbooks, leaflets and on-line resources mainly as regards the fields of health care system access, primary health care as well as mental health for adults and children.

Applying the set criteria for evaluation of projects/activities/tools the following applications for refugees were identified:

1. **"RedCross Refugee Buddy" app:** This app provides up to date and relevant information to refugees and asylum seekers in countries like Norway, Netherlands, Canada and Cyprus.
2. **REFUGEE AIDAPP (REFAID app):** The Refugee Aid App mobile app shows migrants, refugees and aid workers where services are closest to them on a map with a very simple interface. A web based content management and communication system allows official aid organizations to manage and update their services and to get their critical aid to where it is most urgently needed.
3. **ALMHAR app – Mental health aid for refugees**: This app is designed for refugees who had to flee from their homes and who are may be living in exile.
4. **SMILERS app (Smartphone Mediated Intervention for Learning Emotional Regulation of Sadness)**: This is a self-help program for Arabic-speaking people suffering from depressive symptoms.
5. **TOGETHERapp:** The TOGETHER app, made through a collaboration between International Organization of Migration, the UN Migration Agency, and Sheffield Hallam University's CENTRIC research center, is a tool for collecting and sharing positive stories of migration.
6. **SAVE Travel & Work Abroad App:** This app, made by the International Organization of Migration, aims at preventing refugees from human trafficking.

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7. **IOM_MigApp:** This app, made by the International Organization of Migration simplifies access to migration-related information and equips the user with a host of tools to improve daily life in destination countries.
8. **MigrantApp:** This app, made by the International Organization of Migration was designed to provide migrants in Mesoamerica with easy access to information about organizations and services available for them in Mesoamerica.
9. **Integreat application:** This app aims at supporting the integration of refugees in the society through the following thematic units: a. first steps, b. German Language, c. education and work, d. family, e. health, f. housing
10. **Ankommen (Arrival) application:** This app supports the integration of refugees in the German society.
11. **mAdapt_app:** This is a mobile health application which assists women and girl refugees to find information and locate local services that address pregnancy care, family planning methods, teen health and gender-based violence.
12. **"ICOON for refugees" app:** An app illustrating a non-verbal, universal language guide with 1,200 symbols and photos overcomes language barriers, in Germany.

DISCUSSION

The search for successful projects/activities/tools in the grey literature was divided in 4 major areas, to facilitate the search, namely projects in the EU, in the USA in Canada and Australia and by International Organisations working in the field of refugee/migrant health. After retrieving the search results based on the search terms applied, a set of evaluation criteria (exclusion, core and qualifier) was applied which refined the results. Following the initial screen based on the exclusion (relevance, characteristics, evidence-based, ethical) and core (effectiveness, efficiency, equity) criteria, the emphasis was put on the qualifier criteria (transferability, sustainability, participation and inter-sectorality).

The terms 'migrant,' 'immigrant,' 'refugee,' and 'asylum-seeker' not only have different legal definitions in different countries, but the terms are often used interchangeably throughout the grey literature. It is very common to also blend these terms with the specific vulnerable groups in each setting e.g. 'Native Americans,' "Aborigins', 'Minorities,' 'Vulnerable,' 'Underserved', 'immigrants' and others.

The United States of America, Canada and Australia have a major immigration history, therefore there are numerous tools for healthcare professionals as well as the immigrants themselves described online. Most of these tools provide information or even education on health issues and play a vital role in establishing the foundations of health awareness and improving access to the healthcare system for immigrants. However, most of these tools) are websites which provide information or resources - mostly having to do with health care services available for immigrants and refugees, whereas more practical/handy models such as smartphone applications, (online) leaflets, brochures, seminars etc were really hard to find - in some cases the links for applications, which are mentioned in websites, had expired or were no longer to be found. The use of those websites is undeniably helpful both for professionals and the immigrants, so the decision on their reproducibility in other settings was mostly based on description rather than on practical, hands on application.

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The observation is also valid for the majority of the EU funded projects, but less so for the tools identified while searching among International Organisations and NGO's. However, it must be noted that most of the EU projects had a much larger scope and the development of tools was a part of the projects' deliverables, whereas International Organisations and NGO's mostly focused on the development of applications for groups of refugees and refugees.

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PART D EXPLORATORY INTERVIEWS: Best Practices and Tools for Community Healthcare and Social Care for Vulnerable Migrants and Refugees: Experiences of Service Providers

By Riza E, Kalkman S, Coritsidis A

Introduction

European providers of community healthcare and social care face challenges to attend to the needs of vulnerable migrants and refugees on almost a daily basis. However, these professionals have often succeeded in establishing successful approaches to overcome the challenges. In the process of working with migrant and refugee populations, professionals learn to identify health and social needs, barriers and facilitators. In response, some service providers may attempt to assess the effectiveness of their actions and self-devised interventions directly in practice. Such evaluations are often unsystematic and outside the context of health research. Therefore, such knowledge is rarely disseminated through published (academic, peer-reviewed) literature. However, especially in the field of community medicine, such bottom-up knowledge is considerably valuable. This exercise attempts to capture the best practices and tools for effective community healthcare and social care for vulnerable migrants and refugees, as experienced by service providers in countries through informal interviews.

Methods

In this exploratory exercise, consortium members approached community healthcare and social care providers in their respective countries through purposive sampling. Respondents were asked a set of questions in an informal, semi-structured interview on-site (indicative set of questions used is presented at the end of this document).

Results

We conducted 5 interviews in Greece and 5 in the USA, two countries with a strong migration background at different phases with much different experiences and health system structure.

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Lessons from Greece and the USA

Interviews with healthcare professionals from Greece

Polina, social worker

"I have been at this site for eight months now, and I am the only social worker here. Before I came, I did not receive any training or guidance. There was no information about who was working at the camp. The organization asked me to write a task description myself. You learn as you go what the needs are of the people residing here. I noticed that people need help with obtaining social insurance, so that is what I started doing. People know me now. I give them a small piece of paper with my name so they can find me at the site. I inform people where they have to go and what they have to do. A major challenge in my work is the shortage of interpreters. Luckily, through engaging with the migrant community on site I got to know an English-speaking person who helps out. Often, I use Google Translate on my [private] phone to communicate with people who can read. But there are other challenges. There is a divide between what I can do and what I wish to do. Basic facilities, for example. For a long time, I did not have locked space to speak to people in private. There was no phone. The majority of people are single men. What they need, is to be treated as people and to feel a sense of community. A simple "How are you today", can make a huge difference. But I noticed that these young men also need to be educated in health and home economics. Like, how to take care of yourself. In their cultures, mothers usually provide a lot of care and assistance. But here they are alone. More social workers on site are needed to assist all these people. We could subdivide the work into categories, such as child, family or administrative help. What I missed in terms of occupational risk, looking back, is education about infection prevention. Nobody ever told me anything about that yet is really important."

Eleni, Greek language teacher

"For the past three months, I have been teaching Greek to adults at this site. Almost every class I start with the Greek alphabet. New people come in all the time, and many drop out. I give my students homework to encourage them to come back. Only men come to class, women simply do not attend. First, I thought it was because the women did not want to be in the same physical space as the men. But even offering all-female classes was unsuccessful. We tried to encourage women to come by asking a member of the migrant community to approach them. But the answer is always no. There is also a general lack of interest in learning the Greek language, unfortunately. People would rather learn English or German because they do not intend to stay in Greece. In class, we do not really speak about the war, culture or religion. I know from experience that talking about the war can be very traumatizing for people. The classroom has almost everything I need, though I do not need much. Curtains and shutters [in the counter] would be helpful to keep the sun out. And of course, a bigger white board, more paper and notebooks. We do not use books, my classes are very basic."

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Anna, psychologist

"The municipality stationed me at this site almost six months ago. From my organization there are five psychologists and one social worker. We work pretty much individually, we do our own thing. We do not function as a team, really, because we lack a person who is in charge. Nobody carries the overarching responsibility for what we do here. That is really an issue. Another problem we have to deal with every day is the shortage of interpreters. We are allowed to "borrow" the interpreter from the IOM [International Organization of Migration] for four hours per week. That is not a lot, especially if you consider that we offer psychotherapy sessions. Evidently, that is impossible without an interpreter. I also do counselling, referral and follow-up. But there are so many wasted hours because of the lack of an interpreter. Honestly, most of the time I just hang around. That is really frustrating because I want to help people. I also never received any training on how to care for patients from the migrant population. There are no guidelines on how to go about your work here. There is no proper infrastructure for mental healthcare. We do our sessions in a container in which professionals from different disciplines work. At first, we did not have a private room. You should only start sessions when you can assure that kind of privacy. When working with my patients, I try to establish a connection with them. It is important that they see one professional for their mental health needs, that person needs to be their focal point at the site. My patients know where to find me and they trust me. They need to know you are reliable, and once you establish that connection, most people express great gratitude. My recommendations to improve mental health care are to increase the availability of interpreters, to establish practice guidelines and to introduce more activities and recreational facilities to improve pastime and well-being."

Eleni, psychologist

"I work as a psychologist for KEELPNO [Hellenic Centre for Disease Control and Prevention] and perform psychological assessments and referrals. I can send patients to a specialized clinic that provides care for substance abuse and offers psychotherapy. I have been here for 15 months. What I do here is not based on guidelines. There simply aren't any. You gain experience through working with the people. The UN guidelines for violence against women are helpful, though. I see many of my patients struggle with anxiety resulting from uncertainty. They don't have information about their asylum request or how to apply. They also lack information on how to get a job and how to get social or health insurance. It is difficult to attend to people's mental health needs without my own space. There is also no possibility to keep my files confidential. My files are just lying around an office that accommodates other service providers and patients as well. I think this is really an issue of ethics. Guaranteeing privacy is crucial. Also, when I refer patients and they are taken to the clinic there is no adequate informed consent. I know that is how it works here and people do go, but it is not how it should be. My core lesson learned is to be empathetic and a human being. Listen and try to understand their situation. Make them feel safe. Trust is an incredibly important aspect. So, I would say we need practice guidelines, meaningful informed consent for referral, better equipped spaces, information about STDs, and more attention for protection of women's and children's rights."

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Virna, social worker

"I work in an NGO which addresses women and children mainly from Afghanistan. We provide space to relax, we host Greek language sessions and we provide psychological and medical services. The majority of our visitors are families living in apartments, not in camps. I have often seen cases where the women do not understand not only the language, but also the meaning of looking after your health. I often escort patients to the hospitals and I find myself trying to explain to the doctor what the health problem is and then trying to communicate his/her medical advice to the migrant woman. I do this in cases where I want to make sure that the Afghan woman will actually go to her medical appointment. Quite often, we as an NGO go to great lengths to set up an appointment with a doctor, especially in urgent cases and the woman does not go or even notify us that she is not going, so that we could cancel. That makes us look unreliable. It is not my responsibility to escort patients to the health services. This way, I may spend my whole working day looking after one person only and I leave my spot at the NGO uncovered. It is a great expense of resources. Sometimes, I write a note describing the medical problem, to be given to the doctor by the patient and I stand by the phone in case they contact me. Also the children do not have a health card and we do not have any idea about their vaccinations. Healthy nutrition is also an issue. We see mothers coming in our centre holding sweets and crisps. They refuse to listen to healthy diet advice. We have established a good communication line with the municipal clinics of the Athens municipality, especially with the paediatricians and the dermatologists working there. The availability of translators at the health service point is of utmost importance. We collaborate with a network of translators supported by the Hellenic Red Cross, but they have to meet demands from many other NGOs and they are not readily available. It is also necessary for the translators to be educated in health related issues, because quite often they do not understand basic health concepts.

Interviews with healthcare providers in the USA

Sister Margaret works for HRHCare in Riverhead as a coordinator of healthcare and other services. HRHCare is a privately run healthcare program that operates in Suffolk County, Long Island, NY. Sister Margaret works with immigrants of all backgrounds, but primarily Hispanic immigrants.

- Physicians should deliver diagnoses in simple terms, and make sure patients understand the full picture of what their diagnosis means. Patients are often intimidated to ask questions, illiterate, or health illiterate.
- Doctors should educate themselves about the legal and financial situations of the population groups that they are treating.
- Sister Margaret helps to organize education classes on diabetes, Lymes disease (an endemic problem on the eastern end of Long Island) and how to use coupons at the local supermarket to shop for a diabetes-friendly diet.
- Sister Margaret will push for physicians who see immigrants to have phone-in translation services installed in their offices.
- Sister Margaret will help individuals fill out in advance medical paperwork before they visit with a doctor.
- SM has an email list of volunteers who will respond to her requests to accompany people to their doctor's appointments. For example, recently there was a 12-year-old boy who needed to go to several doctors' appointments with a specialist, and his working parents could not afford to bring him. In this case, someone from the emailing list volunteered to bring him to

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these appointments and explain to both him and his parents what transpired in the doctors office.
- Sister Margaret thinks improvement can be made in reaching out to members of the community to let them know that they are eligible to get affordable healthcare.

Sindy Daun is an outreach worker for HRHCare Community Health. She coordinates patient transportation, health insurance, and financial aid.

- Patients who come into the health clinic and need to see a specialist are referred to physicians within the HRH health system. Transportation is only arranged in cases where public transportation is impossible.
- Sindy described that many employees within HRH act as coaches for patients in order to educate them about the healthcare system, and to make sure that they go to their appointments.
- There is also a special voucher system for migrant/immigrant workers who work in agriculture. This voucher is valid for a year and allows them to be seen by a primary care physician as well as a specialist for $10 each. These agricultural workers and their families also only pay $10 for a wide range of testing services.
- For patients who need to be on long-term medication, the HRH has a program with specific pharmacies that allows them to receive discounts on medications.
- Many of the patients find it comforting that many of the employees speak Spanish.
- Advertisement is important to get the message out to the community that services exist to help them.

Sarika Saxena works with non-profit health centers on policy initiatives to increase health care access to immigrants and undocumented migrants. She is a lawyer at a non-profit that specializes in immigration services and health care.

- Language access for patients is hugely important. Protocols and resources are needed to ensure that patient is getting service in a language that they understand. Time needs to be spent to make sure they fully understand everything.
- Interdisciplinary collaboration between social workers, doctors, lawyers, and hospital administrators yields successful interventions.
- One has to be VERY thoughtful when using interpreters. Not having professionally trained translators can cause many problems. Even using healthcare providers such as nurses as interpreters can create problems; if the nurse is stressed or tired then she may not take the necessary time to translate to a patient.
- Sarika strongly believes that trainings need to be done for professionals (doctors, nurses, etc.) to recognize their conscious or unconscious biases and prejudices.

Joanie is a social worker that works for Broadway Dialysis Center, which is located in Elmhurst Hospital Center in Queens, NY. Elmhurst is a public hospital that serves one of the most ethnically diverse immigrant communities in the US.

- Joanie believes that being a social worker for a dialysis center that is located within a hospital is the most ideal setting for patient care. Hospital doctors and services are more readily available and accessible for patients this way.
- Joanie believes the dialysis center is successful at serving a large immigrant population because of its location and the good cooperation between the dialysis center and hospital employees that enables them to get services for patients.

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- Joanie finds all the paperwork that needs to be completed and translated into various languages for patients to be extremely time consuming and at times a hindrance to getting other aspects of her job done.
- Patient compliance is a challenge, and the language barrier makes things difficult. Sometimes patients just answer yes or no unaware of what they are saying yes or no to. Social worker has to explain to them who they are and confidentiality policy.
- The clinical staff's positive interactions with patients at the dialysis center foster good communication and follow up with the patients.
- The center has phone interpreters and staff interpreters. A lot of the staff is multilingual and that is extremely helpful.
- It is really important to take the time to explain things to patients in terms of the health care system and what they need to do. A lot of the times doing this can take twice as long as with an English speaking patient.

Andrea Shaw is a pediatrician and internist who works primarily with refugee immigrants at a community clinic through Upstate Medical University in Syracuse, New York.

- Dr. Shaw sees immigrants mainly from the Middle East and sub-Saharan Africa. She practices in a clinic setting, but also travels to the refugee community. She is involved in education and community outreach initiatives. Dr. Shaw goes to the refugee resettlement agencies to educate them on health related matters.
- The primary clinic purpose is to be family centered and to focus on resettled refugees that are within the first 90 days of their resettlement. Standard screening tests such as blood tests and immunizations are done. Primary care physicians follow the children for about 2-3 years.
- There is a huge range in how many years individuals have spent in refugee camps- between 2 and 20 years. Some children were born and began to grow up in refugee camps.
- Many of them are extremely resilient and as soon as they immigrate they want to immediately begin working and lose time caring for any potential physical or mental health issues that they might have.
- Diseases that are seen are Hepatitis B, hypertension, diabetes, malnutrition, and even lead exposure.
- Dr. Shaw emphasizes establishing a close relationship in which confidentiality about their health is stressed.
- The resettlement agencies are the go to for the community. The refugee/migrant communities trust them. A lot of former refugees work at the resettlement agencies, further contributing to the great amount of trust between the agencies and the communities that they serve. They are a huge resource for the refugee community.
- Through the Center for Disease Control and New York State guidelines, there are protocols for initial screening for parasites, and other chronic diseases. Different recommendations exist for different ethnic groups. There are protocols that are standard for all refugees and immigrants.
- There are health centers that are uniquely set up so that they have dental, OBGYN and other health services all in one location. The more streamlined things are together, the easier it is for people to take advantage them.
- Dr. Shaw also discussed communities that adopt families, one person in the community volunteers to take a family under their wing. These people will house them, help them navigate employment, and navigate the health care system. Models like this also exist in Canada and New Haven. These "adoptions" offer support and guidance in the first year.
- Dr. Shaw has found a refugee health survey that screens for depression/ PTSD to be very helpful. The survey screens for symptom of anxiety and not necessarily gives a direct diagnosis of depression of PTSD. Rather, it highlights patients that might be at risk of suffering from

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these diseases. **RHS15** is the name of the survey. If they test positive, their primary care physician then tries to connect them with a therapist and if needed to a psychiatrist. Always recommends therapy before psychiatric/medical intervention if possible. All refugees in NYS/USA are eligible for therapy because they initially have Medicaid when they immigrate to the US.

- Shaw emphasized that its important to deal with mental health sensitively, as many cultures will view this diagnosis as meaning that there is something wrong with their head or that they are "crazy".
- There is a need to work with refugees to support them with obtaining jobs- in many cases unemployment creates more instances of depression as previously employed members of family begin to feel that they cannot provide for their family in the same way as in their original country
- Dr. Shaw will also work closely with case managers to come up with plans to help them with chronic diseases. There is also a social worker in the clinic that they can refer people to.
- Every single migrant and refugee she has encountered has had a severe adjustment reaction, and part of the process is taking one thing at a time and getting through it/ triaging the most important things first
- We have to remember that we are trained in a Western model of medicine, and other cultures have more of a bio-cultural approach to medicine and illness. If physicians don't take time to listen to the patients' perceived state of health then they don't get important information from the patient. It is important to do your best to explain your point of view and understand theirs.
- Helpful to come up with plan to stay healthy and manage disease. This takes different angles, stopping to take a different course when things are not working. Not one plan works for everyone.
- Certain communities have certain resources. Last year, a child health home grant came out in a community, so any child that had a chronic disease would be able to find health help and this created an opportunity for continued health care.
- Case managers are crucial because they teach families to make appointments, to take public transit. Families will usually only receive 3 months of help from case managers.
- A helpful doctor knows certain community resources and leans on them. They know if there is an Arabic-run pharmacy somewhere in the region, if there is a certain nurse midwife that speaks several different African languages, a Swahili receptionist in a certain doctors office, etc. This knowledge can be extremely useful for new immigrants.
- People who embrace refugee go the extra mile by arranging for interpreters, etc. As a result, not everyone in the community gets the same support. It is a patchwork.
- Dr. Shaw says to always try to make communication better. At every clinic she hopes there could be a phone line interpreter for refugees to make appointments instead of them needing to walk physically into doctors offices to make appointments.
- The more you can pool your resources and collaborate, the better you can care for people.
- Health literacy is another big challenge. Confusion over insurance, how to get medication refills, why is this a chronic med, what are specialists. All of those things take a lot of time to teach. For example, teaching people to visit the dentist twice a year even if they do not have any current tooth complaints.
- Preventive medicine and health maintenance education takes a lot of teaching.
- Dr. Shaw tries to spend time in the community to teach these things. She also gets medical students, physical therapy students, and other students involved to do the teaching. In many cases the educators do not need to be physicians. When young professionals volunteer to teach, they are able to learn the levels of health literacy held by the refugee community.

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DISCUSSION

Despite the fact that the two countries, Greece and the USA have distinct differences in the healthcare system and the availability of resources, the issues noted by health professionals with regards to migrant/refugee health issues and parameters are very much comparable with each other.

Greece

- The main points uncovered by the interviewed health professionals are:
- Lack of specialized training of healthcare workers
- Shortage of interpreters results in waist of valuable time
- Language barrier and low health literacy of refugees/migrants
- Lack of basic facilities especially in camps for private conversations and consultations
- Confidentiality and safe record keeping in camps is an issue
- Shortage of specialized staff
- Lack of coordinated activities-lack of standardized protocols- sometimes the provision of services is done on an ad hoc basis (without any central guidance)
- Courses offered to learn the local language are not attended as much, differences between men and women.
- Collaboration across the various sectors is essential for proper health service provision
- Mental health issues mostly present, children vaccination coverage and healthy diet.

USA

- Low health literacy of migrants
- Health professionals should be trained on how to communicate using simple terms and on cultural issues, sensitive approach
- Translation services are very important- health services employees speaking other languages is helpful
- Volunteers from the community may be used to facilitate transportation to the medical appointments, to escort migrant patients and to help with the paperwork required by the health system
- Arrangement for discount in the cost of long term medication with local pharmacies
- Interdisciplinary collaboration is important, i.e. doctors-lawyers-social workers-clinic administrative staff
- Involvement of students in educating the refugee/migrant community on health issues
- Use of standard protocols for disease screening
- Mental health issues present, chronic disease management, some infectious diseases (hepatitis B).

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CONCLUSIONS

- Common issues identified by healthcare professionals working in the field of migrant/refugee health:
- Need for specialized training of healthcare professionals, including students
- Need to use standard protocols
- Need to educate refugees/migrants on health issues due to low health literacy
- Need for culturally sensitive translation services
- Need for interdisciplinary collaboration to increase positive effect
- Need to involve the local community to facilitate service provision

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SYNOPSIS OF FINDINGS WITHIN TASK 5.1

Evidence synthesis of needs, tools & best practices identified

The review of the published literature (**Part A**) revealed an abundance of reported practices on mental health at the community level addressing refugees and migrants. There was large variation of population groups targeted, methodologies used and settings to which they were applied.

The area of health service provision was also identified, as well as the issue of chronic disease management. The primary healthcare setting is vital as it has close links to the community and facilitates the involvement of the local population. It is important to note, that in almost all of the sources identified, the elements of good communication, the linguistic barriers and the cultural element played a crucial role in the effective application of the intervention. Needless to say, that the close collaboration of the various stakeholders, the local communities and partnerships are key to the successful implementation of healthcare provision.

The practices identified through the literature search are presented in 5 tables by area of intervention following an initial evaluation on research methodology criteria and according to standard definitions of community, community-based healthcare and best practice. All practices were then evaluated in terms of scientific robustness based on relevance to the profile of the refugee/migrant populations in Europe, the accuracy of the research methodology, the clarity of the reported outcome and the presence of a theoretical background (shown in Table 6).

Based on the total score, we ranked a total of 15 interventions that best fit the set evaluation criteria.

From top to bottom: max 20 points (1 publication), 19 points (1), 18 points (1), 17 points (4), 16 points (1) and 15 points (7).

Publication	*Ref number in Table 6*	*Area of intervention*	*Intervention*	*Score*
McMurray (2014)	108	Primary healthcare	Partnership between a dedicated health clinic for government assisted refugees, a local reception centre and community providers	20
Reavy (2012)	115	Maternal health	New clinic model for prenatal and pediatric refugee patients (in particular the role of the Culturally Appropriate Resources and Education (C.A.R.E.) Clinic Health Advisor)	19

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Small (2016)	44	Mental health	Comparison of three different treatment modalities: treatment as usual (TAU), home-based counseling (HBC), and a community-based psycho-educational group (CPG)	18
Bader (2006)	91	Non Communicable Diseases	Linguistically and culturally-sensitive cardiovascular disease (CVD) prevention program	17
Sheikh & McIntyre (2002)	116	Maternal health	Intensive child health promotion and education campaign using ethnic media and social network	17
Williams & Thompson (2011)	52	Mental health	Community-based mental healthcare services	17
Kaltman (2011)	24	Mental health	Collaborative mental health care program implemented in a network of primary care clinics that serve the uninsured	17
Fondacarro (2016)	16	Mental health	Training program for psychology students ("Connecting Cultures")	16
Levin-Zamir (2011)	106	Primary healthcare	Cross-cultural programme for promoting communication and health	15
Siddaiah (2013)	98	Non Communicable Diseases	Community-based, culturally competent respiratory health screening and education	15
Tumiel-Behalter (2011)	83	Health service provision	Community program with a participatory approach to improve the health of four underserved communities ("Good For The Neighborhood")	15
Ferrera (2017)	67	Health service provision	Health promotion initiative that integrates principles of positive minority youth development	15
Tyrer & Fazel (2014)	50	Mental health	School and community-based interventions	15
Kaltman (2016)	25	Mental health	Mental health intervention for primary care clinics that serve the uninsured	15

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Goodkind (2014)	18	Mental health	Community-based advocacy and learning intervention with refugees and undergraduate students	15

Through the analysis of the country-specific sources (**Part B**), we can distinguish some common elements regarding tools and best practices towards refugee and migrant community health which can be summarized as shown in the following table:

	SUCCESSFUL TOOLS & BEST PRACTICES	CHALLENGES
ORGANISATION	* Close collaboration of various stakeholders including the host & migrant community *Accurate data collection & evaluation of activities	*Sustainable funding of activities to facilitate future planning and operation *Staff turnover should be kept to a minimum *Lack of standardized protocols and guidelines
COMMUNICATION	*Use of translators and mediators, community peers, advocacy *Use of various ways of communication preferably in own language e.g. websites, leaflets, telephone lines, group sessions	*Cultural barriers *Limited specialized staff *Large variation in refugee/migrant backgrounds
TRAINING	*Service providers and health professionals receiving training and support towards employing holistic, culturally-sensitive and family-oriented approaches to healthcare delivery and learning about migrants' particular health needs	*Limited knowledge of migrant health needs in healthcare personnel *Delivery of culturally-sensitive care
EDUCATION	*Educate migrants/refugees on promoting well-being through empowerment and autonomy with engagement of the host community to	*Migrants' fear of seeking help *Lack of understanding of benefits of preventive health measures among

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	help reduce stigma and discrimination.	migrants, *Migrants' limited familiarity with local healthcare systems, *Discrimination by host communities
FACILITIES & SERVICES	*Community day centers with regular opening hours were effective strategy to provide health services to migrants and refugees. At first reception centres, standard medical screening and psychosocial risk assessment was recommended.*	*Staff shortage, time constraints *Lack of spaces to attend to migrants' health needs, lack of housing, structural shortage of (high-quality) interpreters, *Lack of resources in refugee camps (e.g., diagnostic tests and equipment), *Limited availability of social care services *Need for specialty mental health services (e.g., trauma and torture)

The review of the grey literature spanned into 4 different areas a) projects/activities/tools implemented in the EU, b) projects/activities/tools implemented in Canada and Australia, c) projects/activities/tools implemented in the USA and d) projects/activities/tools developed by International Organisations and NGOs.

In summary, based on the applied evaluation criteria, in the EU 29 projects/activities/tools were identified such as Home away from Home, UNINTEGRA, I get You, CARE, BABEL day centre, In Base community centre, MyMind, CentreMed, Specialised clinic in Poland, ETHEHEALTH, I am a Mom, Child pretention service, MEET a health literacy programme, POLYDYNAMO centre for refugees, OpeningDoor, ORAMMA, health image dictionary, ReHealth, MiMi, PHILOS, IENE6 and PALOMA.

In Canada and Australia projects/activities/tools identified such as Bright Ideas: The New Roots Project, Greater Dandenong – City of Opportunity, National Aboriginal Community Controlled Health Organisation (NACCHO), Caring for Kids New to Canada, Canadian Civil Liberties Assosiation, Mental Health Comission, Canadian Centre for Refugee & Immigrant Health Care of Canada.

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In the USA projects/activities/tools identified such as Cultural Consultation Programs, Promotora de Salud Programs, Health Outreach Partners, Mobile Healthcare Association - Native American National Coalition of Mobile Health Clinics, Start A Mobile Clinic: Tips & Tools.

The International Organisations and NGOs have produced a series of tools mostly focusing on health service accessibility, linguistic barriers and mental health support such as the RedCross Refugee Buddy" app, ALMHAR app – Mental health aid for refugees, SMILERS app (Smartphone Mediated Intervention for Learning Emotional Regulation of Sadness), TOGETHERapp, the IOM_MigApp and the REFUGEE AIDAPP (REFAID app).

The conclusions based on the input from the exploratory interviews (**Part D**) with healthcare professionals working in the field of refugee/migrant health are:

- Common issues identified by healthcare professionals working in the field of migrant/refugee health:
- Need for specialized training of healthcare professionals, including students
- Need to use standard protocols
- Need to educate refugees/migrants on health issues due to low health literacy
- Need for culturally sensitive translation services
- Need for interdisciplinary collaboration to increase positive effect
- Need to involve the local community to facilitate service provision

Proposed areas of intervention/tools to pilot test in WP6

The objective of the present document is to report on approaches, programs, national and regional initiatives in relation to social and health care for vulnerable migrants including preventive health and health promotion following an extensive review, search and evaluation of community – based healthcare models, best practices and tool serving refugees/migrants.

Given the abundance of information in this area and in order to have a systematic approach, we separated our search in 4 work streams, namely a) systematic search of the peer-reviewed literature, b) input from the partner countries, c) review of the grey literature and d) exploratory interviews with healthcare professionals working in the field of refugee/migrant health. Our aim following the evaluation is to indicate a series of positively evaluated best practices, implemented activities and tools that could be used in different legal, organizational and institutional environments in Europe in order to promote integration of refugees/migrants especially in the area of health.

The evaluation of the peer-reviewed literature indicated actions in the fields of mental health, health service provision, non-communicable diseases, primary healthcare and maternal health. The input from the partner countries indicated the elements of successful partnerships and intersectoral collaboration at the community level, as well as the need for effective verbal communication, linguistic efficiency of the health service providers, specialized training of healthcare professionals in refugee/migrant health, education of the incoming refugee/migrant population in health issues and pointed out at the issues of staff

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shortage, staff stability and availability of funding. The suggestions from the review of the grey literature indicated the issue of mental health as a leading health priority, followed by the management of chronic diseases such as cardiovascular disease, diabetes and cancer screening. Finally, the exploratory interviews highlighted the importance of structural management in the provision of health services especially for refugees/migrants, the need for adequate communication and cultural mediation, as well as the necessity for standardized protocols in data collection and patient management.

Based on the results of the present task 5.1 and the refugee/migrant survey of WP4 major issues for the piloting phase of the project should be a) provision of mental health services, b) management of chronic diseases and c) dental health. It must be note that dental (oral) health did not come up as a major health issue in the review of task 5.1, only as a small reference of activities in the Aboriginal communities in Australia. However, the results of the WP4 survey, highlighted the need for dental care provision in the studied sample.

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Appendix: Evaluation tools (checklists) to assess models/interventions in Task 5.1

Appendix 1: Assessment/evaluation table of identified sources (projects/ activities/ interventions/ best practices) in the systematic review (Part A)

Table 6. Level of evidence for the effectiveness of interventions and models for community-based healthcare for migrants and refugees (sample table).

No.	Authors (year)	Study design	Sample size (*n*)	Duration of follow-up	Middle eastern/ north African individuals included in target population	Does article have reported outcomes/or advocate evidence-backed approach	Intervention	Theoretical underpinning	Ranking
1	Ahmad et al (2012)	4[P]							
2	Areán et al (2008)	2							
3	Bäärnhielm et al (2015)	3							
4	Beehler et al (2012)	?							
5	Behnia (2003)	2							
6	Bhattacharyya & Benbow (2013)	5							
7	Birman et al (2008)	1							
8	Brar-Josan (2017)	2							
9	Chase & Rousseau (2018)	2							
10	Chen et al (2014)	3							
11	Chiumento et al (2011)	2							
12	Choi (2017)	4							
13	Dura-Vila et al (2013)	2							
14	Ellis et al (2013)	?							
15	Fernando (2005)	1							

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Criteria and ranking used

Study design: 0 = protocol, 1 = review/description (no data), 2 = qualitative or quantitative data, 3 = mixed methods, 4 = experimental study (randomized, controlled or pre-posttest design), 5 = literature review, ^{P} = pilot study

Sample size (number of participants): NA = not applicable, 1 = <10, 2 = 10-50, 3 = 51-100, 4 = > 100 or ≤ 10 papers, 5 = > 1000 or > 10 papers

Duration of follow-up: NA = not applicable, C = cross-sectional, 1 = days, 2 = weeks, 3 = months, 4 = 1-5 years, 5 = > 5 years

Study population of Middle Eastern/ North African descent? 1= no 2= yes

Does article have reported outcomes/or advocate evidence-backed approach? 1= no 2= yes

Theoretical underpinnings: NA = not applicable, 1 = not present in publication, 2 = present in publication

Reproducible: Not mentioned 1=no, 2=yes

Ranking: sum of scores of each variable

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Appendix 2: Protocol sent to partners as guidance to search information on projects/activities/intervention in their own countries (Part B)

Search protocol in Country-Specific Sources (in Your Local Language)

1. Select 1-3 literature databases you are accustomed to working with
2. Conduct a search using a combination of the following terms (or synonyms): [migrant(s)/refugee(s)/asylum-seeker(s)] AND [healthcare/social care] AND [community-based] AND [model(s)/best practice(s)/approach(es)]
3. Consult national experts on the topic of migrant health for additional sources (guidelines, reports, academic publications)
4. Include all sources that:
    a. Report on **models/best practices** for community-based healthcare for migrants/refugees, (or similar subpopulations) OR
    b. Report on **interventions/tools/strategies** to reduce health inequalities/improve access among migrants/refugees (or similar subpopulations)

    AND
    c. Were originally published in your country's language, OR
    d. Are published in English, but are specific to your country
5. Details of eligibility:
    a. No publication date limit (but differentiate findings pre and post 2012)
    b. Not restricted to illegal status/vulnerable migrants only, but also consider best practices for similar subpopulations such as ethnic or racial minorities (e.g., Roma populations)
    c. Not restricted to type of care/needs (i.e., including mental health, pediatric medicine, acute versus chronic illness, communicable versus non-communicable disease, general/primary care versus specialized care)
    d. Broad conception of community (e.g., national healthcare systems versus self-help in refugee camps) definitions attached
6. Extract data from sources according to template (as shown below)

Table sent to partners as guidance to record information on projects/activities/intervention in their own countries (Part B)

AUTHORS	SUCCESSFUL ELEMENTS	TOOLS/MATERIALS THAT CONTRIBUTED TO SUCCESS	NON-SUCCESSFUL ELEMENTS	LESSONS LEARNED	CHALLENGES TO OVERCOME	NOTES

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Appendix 3: Protocol of assessing criteria for best practices/tools in the grey literature search (Part C)

ASSESSING CRITERIA OF BEST PRACTICES in grey literature

Definition of BEST PRACTICE: any relevant policy or intervention in real life setting. Favourable in terms of ethics, evidence, equity, effectiveness and efficiency regarding PROCESS and OUTCOMES.

Must have elements of transferability, sustainability, intersectorality and participation of stakeholders.

Indicative search terms: [migrant(s)/refugee(s)/asylum-seeker(s); healthcare/social care; community-based; model(s)/best practice(s)/approach(es); mental health; public health; chronic disease prevention; health disparities; health system access; psychosocial risk screening; health promotion; primary health care; cancer screening; reproductive health] in combination with the 4 search areas identified Europe, European Union, United States, Canada, Australia along with websites from relevant organizations related to public and community health yet most importantly refugees' and immigrants' health such as the websites of United Nations (www.un.org), World Health Organization (www.who.int), National Institute of Health (NIH) (www.nih.gov), Centers of Disease Control and Prevention (CDC) (www.cdc.gov), International Organization for Migration (https://www.iom.int/), Minesota – Department of Health http://www.health.state.mn.us/), Institute of Medicine (http://www.iom.edu.np/), United Nations High Commissioner for Refugees (http://www.unhcr.org/), European Migration Network (http://emn.ie/) as well as non-governmental organizations with relevant initiatives in the field of migration and health with national and international activities such as International Federation of the Red Cross (http://media.ifrc.org/ifrc/), Pharos (http://www.pharos.nl/nl/home), Médecins Sans Frontières (https://www.msf.org/), Caritas International (https://www.caritas.org/), Save the Children (https://www.savethechildren.nl/), The Salvation Army (https://www.salvationarmy.org.uk/refugees), Medecins du Monde (https://www.medecinsdumonde.org/en) and other national organizations from various countries such as Netherlands, Germany, Belgium, Greece, Ireland etc.

ASSESSMENT PROCEDURE

Step 1: Through search identify "best practice" based on the definition

Step 2: Assess adequacy, based on EXCLUSION and CORE criteria. If these criteria are NOT fulfilled (see table), **stop assessing** the "best practice". Use the table.

Step 3: Apply the Qualifier criteria (relevant columns in the table)

Step 4: Produce a final list of best practices that can be transferred/proposed into MIGHEALTHCARE.

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EXCLUSION CRITERIA

Relevance: is it a public health priority? Is it relevant at a local/regional/national or European level? Does it support implementation of legislation?

Characteristics: defined target population, description of the methodology used, SMART objectives, process, output and outcome indicators, description/estimate of the contribution of target population, healthcare professionals, other stakeholders, human resources, materials, budget requirements, evaluation process, availability of documentation (guidelines, protocols etc).

Evidence-based: supported by scientific evidence, published, perr-reviewed, grey literature or anecdotal, the use of techniques or principles are stated and justified.

Ethical issues: the basic rules are followed autonomy, justice, beneficence, benefits outweigh harms, intervention does not exclude target groups, conflict of interest issues, no advertisement of a specific product or commercial initiative.

CORE CRITERIA

Effectiveness: Issues related to time consumed under real conditions at the lowest possible cost.

Efficiency: ICT tools used (e.g. websites, platforms)

Process and outcome evaluation (e.g. internal or external evaluation, clinical outcomes, health outcomes, study performed, financial evaluation, possible negative effects identified and stated)

Equity: target population needs are met when allocating resources (e.g. age, gender, socio-economic status, rural/urban area, vulnerability) and reduction of health inequalities.

IF THE EXCUSION AND CORE CRITERIA ARE **NOT** MET **STOP HERE**.

QUALIFIER CRITERIA

Transferability: clear use of instruments, manuals available to allow for repetition, description of the whole process, description of the beneficiaries, actions taken to overcome legal, managerial, financial, or skill-related barriers, availability of dissemination plan, communication strategy, implementation in other settings.

Sustainability: existing organizational/institutional support, financial support, staff training provided, continuation ensured.

Participation: mechanisms to facilitate participation of several agents, elements to empower target population participation e.g strengthening health literacy, ensuring right skills, stress management, self-care.

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Intersectoral collaboration: joint action with other organizations, multi-disciplinarity, promotes continuity of health care.

Best practice assessment table

	Exclusion Criteria				Core criteria				Qualifier criteria			
BEST PRACTICE	Relevance	Characteristics	Evidence-based	Ethical	Effectiveness	Efficiency	Equity	**Score***	transferability	Sustainability	Participation	Intersectoral collaboration
1												
2												
3												
4												
5												
6 etc.												

- If score of exclusion+core is lower than 4 (2-3 from exclusion **and** 1-2 from core are absolutely necessary), consider stopping assessing the best practice

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Appendix 4: Indicative set of questions used in the exploratory interviews (Part D)

Do you have experience with community-based healthcare provision for migrants/refugees (please describe)?

What is your professional involvement?

Please describe your work setting and the main health issues encountered

Are there protocols/guidelines available (please describe)?

Which tools/interventions are useful/helpful according to your opinion?

Which elements are NOT successful?

How do you think your service could improve to better meet the health needs of migrants/refugees?

Do you have any suggestions/other issues to add?

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