D6.3: Pilot reports and final recommendations

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The partners in this project are:

No	Name of partner	Partner Acronym	Country
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
6	ECOLE DES HAUTES ETUDES EN SANTE PUBLIQUE	EHESP	France
7	CENTRE FOR ADVANCEMENT OF RESEARCH AND DEVELOPMENT IN EDUCATIONAL TECHNOLOGY LTDCARDET	CARDET	Cyprus
8	PERIFEREIA STEREAS ELLADAS	RSE	Greece
9	KOPERAZZJONI INTERNAZZJONALI - MALTA (KOPIN) ASSOCIATION	Kopin	Malta
10	UPPSALA UNIVERSITET	UU	Sweden
11	KENTRIKI ENOSI DIMON KAI KOINOTITON ELLADOS	KEDE	Greece
12	MINISTRY OF HEALTH	MINISTRY OF HEALTH	Greece
13	VEREIN MULTIKULTURELL	VM	Austria
14	UNIVERSITAT DE VALENCIA	UVEG	Spain

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Introduction

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.

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".

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".

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).

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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 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

The Mig-HealthCare project

The Mig-HealthCare project "Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities" is a project funded under the 3rd Health Programme **2014-2020** and deals with all of its four overarching objectives with special attention to objectives 3 and 4: contribute to innovative, efficient and sustainable health systems and facilitate access to better and safer healthcare for Union citizens. The project includes the development of effective community-based care models that will improve health care access of vulnerable immigrants and refugees while fostering their potential future integration in the EU community.
The project's **main goals** are to:

- ✓ Provide the current physical and mental health profile of vulnerable migrants/refugees in the EU 28 including needs, expectations and capacities of service providers based on existing information evidence and original research
- ✓ Develop a comprehensive roadmap for the implementation of community based care models following an assessment of existing health services and best practices. The roadmap will indicate requirements and prerequisites and include concrete steps to action, taking into consideration the different legal, organisational and institutional environments in Europe. The toolbox will include tools (also in ICT form) to facilitate the implementation of community based care models for refugees/migrants.
- ✓ Train community health and social care service providers on appropriate delivery of health care models for vulnerable migrants and refugees
- ✓ Pilot test and evaluate community based care models which emphasise prevention, health and mental health promotion and integration leading to final recommendations and the creation of on line European networks of collaboration.

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This knowledge will improve access to health care including mental health care services and support the inclusion and participation of migrants and refugees in European communities. The roadmap to effective community-based care models developed as part of the Mig-HealthCare project will facilitate the development of programs to improve access to healthcare and support the inclusion and participation of vulnerable migrants and refugees. This will help policy-makers and stakeholders plan customized interventions for vulnerable migrants and refugees. The Mig-HealthCare results, including the main conclusions of the pilots, will be valuable for transferring the lessons learned to other regions and health care systems; supporting the transformation of healthcare.

The community approach

"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/programs 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 especially valuable for the most vulnerable members of the community like migrants/refugees, older adults etc. (A glossary of terms for community health care and services for older persons - http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf

The Mig-HealthCare roadmap & toolbox emphasize an approach that can be implemented at a local community level by local health professionals.

The Mig-HealthCare Roadmap, Toolbox & Algorithm

The roadmap including the toolbox and algorithm is a user friendly on line application which focuses on the key steps for optimal health care delivery to migrants & refugees. The roadmap comprises the following:

1. The necessary actions a health professional needs to engage in during delivery of care to migrants & refugees namely:
    a. Continuity of information
    b. Language, Culture & Communication Issues
        i. Language and communication
        ii. Cultural issues
        iii. Health literacy
2. Health issues of particular importance for migrants & refugees that will pose challenges to health care services especially at the community level:
    a. Mental Health
    b. Vaccinations
    c. Maternal/ child health
    d. Health promotion

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i. Cervical and Breast cancer screening
ii. Colorectal cancer screening
iii. Alcohol
iv. Tobacco use
v. Nutrition

e. Oral Health/ Dental Care
f. Non Communicable diseases (NCDs) & chronic conditions

For each thematic category information for the following content is covered:

- Magnitude of the problem
- Reference to the problem concerning migrants/refugees
- Reference to issues of particular interest
- Important steps/ requirements for the Health care sector
- Examples of best practices
- Toolbox
- References

For each of the above mentioned issues examples of best practices and tools for health care professionals and migrants/refugees are provided through the Mig-HealthCare toolbox. In addition the Mig-HealthCare algorithm provides a step by step process through the different steps involved in the implementation of optimal health care to migrants/refugees.

This tool is valuable and useful for a wide variety of stakeholders both at the individual as well as the organizational level at EU level.

Targeted stakeholders include:

- Health professionals of all specialties including medical doctors & nurses working at different level, local, regional and national
- Health care administrators
- Managers & staff of health care services including hospitals and health care centers at local, regional and national levels
- Migrants/refugees and their representative bodies
- Patients, their families and caregivers

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Pilot Implementation

The **pilot phase** of the **Mig-HelathCare project** was implemented in Greece, Austria, Spain, Bulgaria, Italy, Germany, France and Malta and comprised the following **2 parts**:

a. Training of service providers and piloting of the Roadmap & Toolbox (Part A)
b. Piloting of specific elements (thematic categories) of the Roadmap & Toolbox (Part B)

The following section presents the training and piloting which took place in the various consortium countries. The full country reports are available as annexes.

Testing the Mig-HealthCare roadmap and toolbox

Partners from Greece, Austria, Spain, Bulgaria, Italy, Germany, France and Malta organised and implemented training among service providers in various settings offering health and social services to migrants & refugees.

The training was based on 5 modules developed by the consortium. These are listed below:

- Module 1: The Mig-HealthCare project
- Module 2: How the Roadmap & Toolbox was developed
- Module 3: Cross cutting issues in the delivery of optimal health care for migrants/refugees–a community approach
- Module 4: Health issues of concern to migrants/refugees
- Module 5: The Mig-HealthCare Roadmap, Toolbox & Algorithm

Survey evaluation results

Characteristics of the 91 professionals that completed the training of the Mig-Healthcare Roadmap & Toolbox are displayed in **Table 1**. Mean age of the sample was 38.8 years and 29 out of 90 professionals were males. Most of the participants were social workers (44%), psychologists (15.4%) and medical doctors (13.2%) and were working in the association for outpatient care for disabled persons (22.5%) and a camp or settlement health centre (19.1%). Half of the sample had at least 6 years of employment in general, 2 years of employment with migrants/refugees experience and had also worked for bare minimum of 2 years in their current place.

Table 1. Demographic characteristics of the participants that completed the training (A1 questionnaire) of the Mig-Healthcare Roadmap & Toolbox (N=91).	
Age (Mean± sd)	38.8±10.3
Males (%)	29 (32.2)
Profession (%)	
Social worker	40 (44)
Psychologist	14 (15.4)
Medical doctor	12 (13.2)
Nurse	8 (8.8)
Midwife	4 (4.4)
Administration	3 (3.3)
Student	3 (3.3)
Special pedagogy	1 (1.1)
Rescue Service Vehicle Operator	1 (1.1)
Administrative assistant	1 (1.1)

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Interpreter	1 (1.1)
Teacher	1 (1.1)
Intern in social work	1 (1.1)
Government worker	1 (1.1)
Sociologist	1 (1.1)
Place of employment (%)	
Association for outpatient care for disabled persons	20 (22.5)
Camp or settlement health center	17 (19.1)
Primary health care service	11 (12.4)
University	10 (11.2)
Social Care	9 (10.1)
Hospital	8 (9)
Social Service	3 (3.4)
Senior High School	3 (3.4)
Registration and Reception Center - Harmanli	2 (2.3)
NGO clinic or health center	2 (2.3)
Private practice	2 (2.3)
Regional government institution	2 (2.3)
Psychiatric residence	1 (1.2)
Months of employment (Median(range))	72 (22-156)
Months of employment with migrants/refugees (Median(range))	24 (8-48)
Months of employment in your current place (Median(range))	24 (8-48)

A1: Assessing training of the Roadmap & Toolbox

A questionnaire titled A1: Assessing training of the roadmap & toolbox was delivered to the training participants (N=88) following the end of the training session. The questionnaire assessed service providers' initial views and opinions.

Evaluation

Figures 1 and **2** present participants' general opinion regarding the training of the Roadmap & Toolbox. Regarding Austria, only 2 participants answered the question. One (1) had a very good opinion about the training and one (1) had a good opinion.

Figure 1. *Participant's opinion about the training of the Roadmap & Toolbox.*

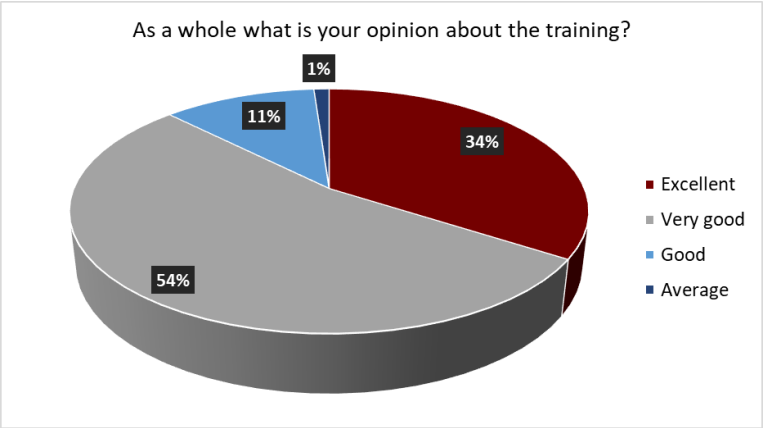

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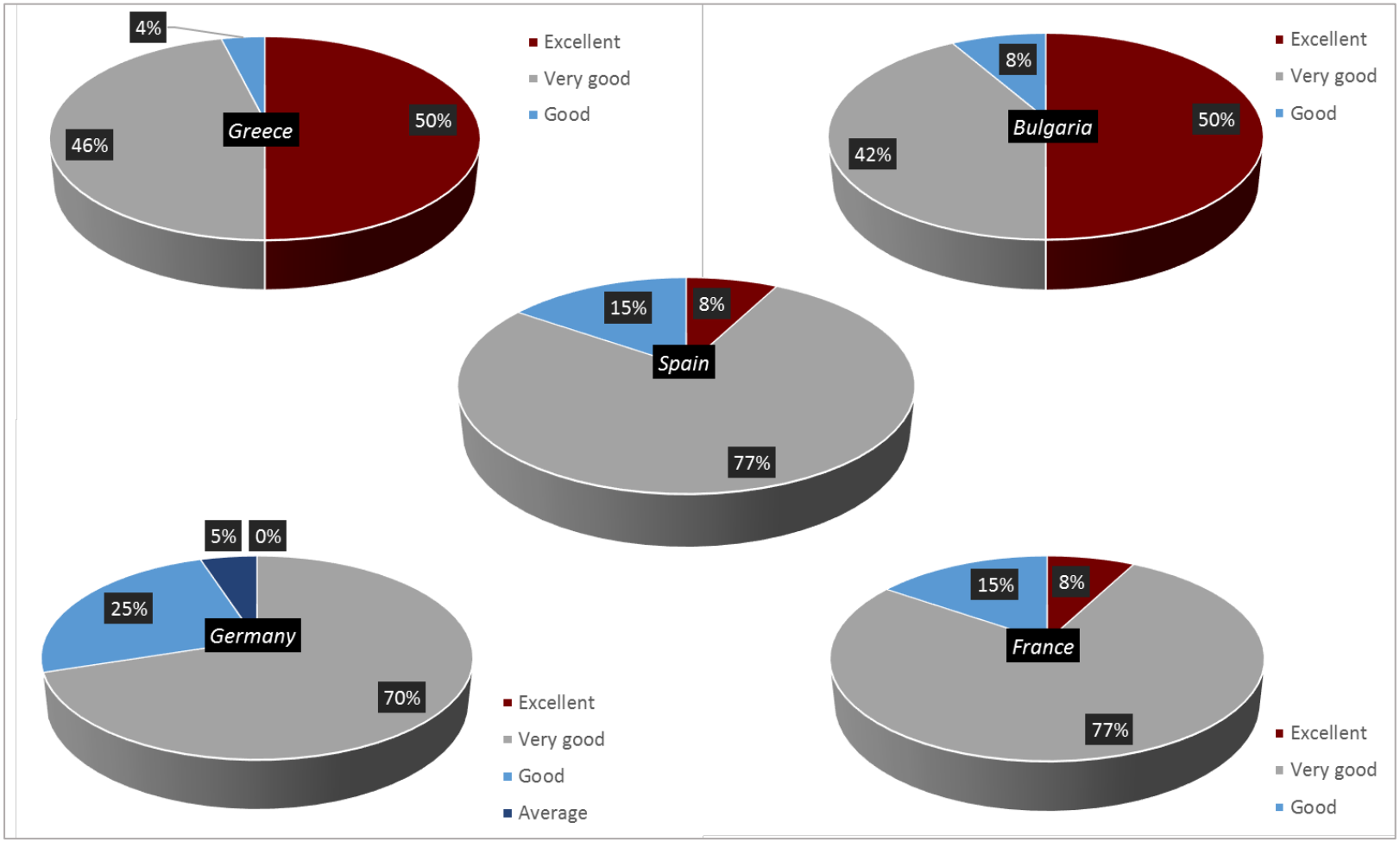
Figure 2. *Participant's opinion about the training of the Roadmap & Toolbox by country.*



A2: Piloting the Mig-Healthcare Roadmap & Toolbox

A questionnaire titled A2: Piloting of the Mig-Healthcare roadmap & toolbox was filled out by the service providers who used the roadmap and toolbox at the end of the piloting period (January 2020). This questionnaire was completed by 54 participants.

Evaluation of the Mig-Healthcare Roadmap

Half of the participants' ***total satisfaction*** regarding Mig-Healthcare Roadmap ***was more than 68.8%*** (Interquartile Range (IQR): 56.3-86.7) (score range 0-100%, higher values indicate better satisfaction). In more details, regarding:

- Greece, total satisfaction was 68.5±11.4%
- Bulgaria, total satisfaction was 91.7±8.5%
- Germany, total satisfaction was 51.1±13.7%
- France, total satisfaction was 66.7±13%
- Austria, total satisfaction was 78.6±10%

Evaluation of the Mig-HealthCare Toolbox

Half of the participants' ***total satisfaction*** regarding Mig-Healthcare Toolbox ***was more than 69.5%*** (IQR: 56.3-84.4) (score range 0-100%, higher values indicate better satisfaction). In more details, regarding:

- Greece, total satisfaction was 70.2±11%
- Bulgaria, total satisfaction was 94±7.3%
- Germany, total satisfaction was 48.7±16.1%
- France, total satisfaction was 66.7±13%
- Austria, total satisfaction was 75.3±8.1%

Evaluation of the Mig-HealthCare algorithm

Half of the participants' ***total satisfaction*** regarding Mig-Healthcare algorithm, ***was more than 66.7%*** (IQR: 50-83.3) (score range 0-100%, higher values indicate better satisfaction). In more details, regarding:

- Greece, half of the participants' total satisfaction was more than 75% (58.3-83.3)
- Bulgaria, half of the participants' total satisfaction was more than 95.8% (79.2-100)
- Germany, half of the participants' total satisfaction was more than 50% (33.3-50)
- France, half of the participants' total satisfaction was more than 58.3% (50-58.3)
- Austria, half of the participants' total satisfaction was more than 58.3% (50-75)

Needs covered by Mig-Healthcare Roadmap & Toolbox

Healthcare professionals reported that Mig-Healthcare roadmap & toolbox assisted their work with migrants and refugees, providing adequate tools for different health issues (59%; 28% totally agreed), in different languages (63%; 26% totally agreed) and up to date information about migrant/refugee issues (59%; 28% totally agreed).

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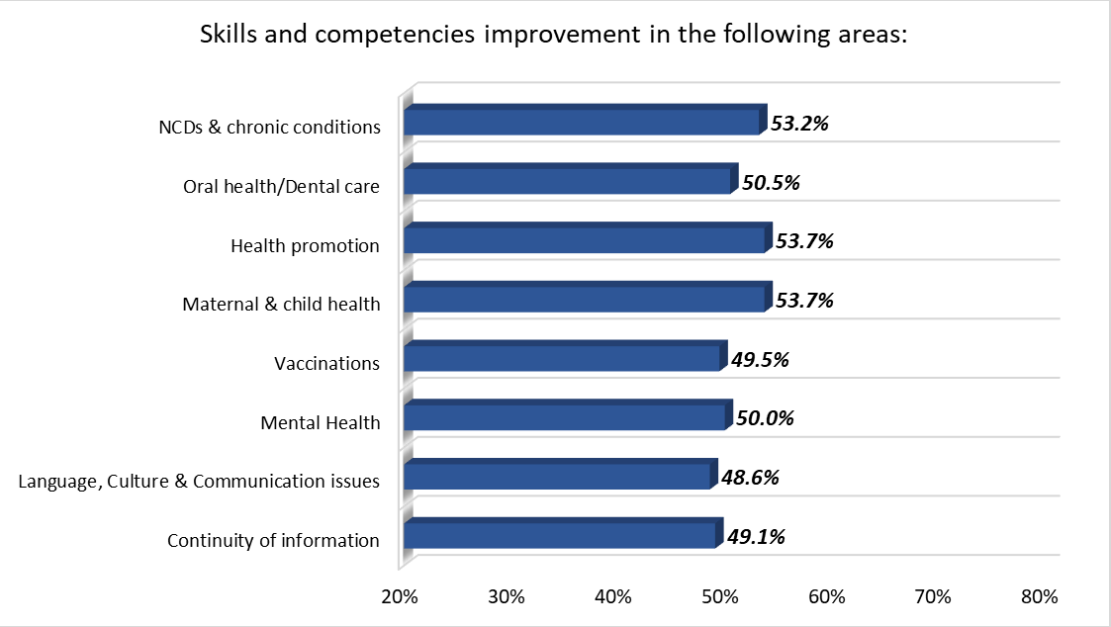
Most of the participants improved their skills and competencies after the pilot implementation. This improvement is presented in mean scores, for each area, in more details at **Figure 3**. Higher values indicate further improvement, starting from 0% (not at all) to 100% (very much). The highest improvement was observed in maternal and child health and in health promotion, where participants scored 53.7% out of 100% and the less one in language, culture and communication issues, where participants scored 48.6% out of 100%.

Figure 3. *Skills and competencies improvement mean scores in each area (range 0-100%, with higher values indicating further improvement).*



Other information about the Mig-Healthcare program

96.3% of the participants were aware of the Mig-Healthcare project and 87% had visited its website, 72% reported it is relevant for their professional development and 84.9% consider that the project contributes to addressing a major problem in European society. 19.6% were informed about the project by a newsletter, 78.4% by a training session, 7.8% from a dissemination event and 11.8% from their place of employment or a personal contact.

Key points after the pilot implementation

- In general, 9 out of 10 participants had an excellent or very good opinion about their training, while Germany reported the lowest percentages.
- Regarding the Mig-Healthcare Roadmap, median satisfaction was 68.8%.
- Regarding the Mig-Healthcare Toolbox, median satisfaction was 69.5%.
- Regarding the Mig-Healthcare Algorithm, median satisfaction was 66.7%.
- The highest satisfaction was observed in Bulgaria and the lowest in Germany.
- Most of the participants improved their skills and competencies at some point. The highest improvement was observed in maternal and child health, and in health promotion and the less one in language, culture and communication issues.

Qualitative research findings

In the frame of the Mig-healthCare pilots, a qualitative investigation has been conducted in order to get a deeper understanding (a) of the positive and negative aspects of the algorithm, the roadmap, and the toolbox, and (b) their sustainability. In March 2020, focus group discussions with health care professionals, who participated in the pilot testing, were conducted in Greece, Bulgaria, France and Germany.

Methodology

Using a common focus group guide, each national research team planned to conduct focus group discussions with the health care professionals who participated in the pilots. The main themes of the focus group discussions were (a) usefulness, effectiveness and satisfaction in the algorithm, roadmap and toolbox, (b) proposed improvements, and (c) sustainability. Thematic qualitative analysis was employed to analyse the data.

Results

Sample size

In total, 57 health care professionals participated in the qualitative evaluation. The participants' occupation is presented in Table 1 -absolute frequencies by country. The most common professionals in each country apart from Greece were social workers. In Greece, a variety of different professionals was observed in similar frequencies (medical doctor, nurse, social worker, midwife).

Table 1. Professions of the participants for each country

Bulgaria *(N=12)*	N
Medical Doctor	3
Nurse	1
Professional interpreter	1
Psychologist	1
Social worker	6
France *(N=13)**	
Medical Doctor	1
Nurse	1
Social worker	8
Government worker	1
Intern in social work	1
Teacher	1
Germany *(N=16)*	
Social worker	15
Office administrator	1
Greece *(N=16)*	
Medical Doctor	4
Nurse	3
Psychologist	2
Social worker	3
Midwife	3
Special pedagogue	1

**based on A1 questionnaire*

Positive aspects

Roadmap and toolbox

Content

The information provided by the roadmap and toolbox was described by the majority of participants from each country as **very useful and relevant.** Specific parts were deemed very useful, e.g. language, culture, communication and vaccinations. Participants emphasized on **the scientific and accurate information** that is provided in the toolbox, which makes it a rather **accurate and trustworthy source of information.**

- *"It is relevant to the actual problems". (Bulgaria)*
- *"Mig-HealthCare roadmap is focused on actual and important problems". (Bulgaria)*
- *"It gives a good point of view over important problems of the migrants". (Bulgaria)*
- *"I consider as the most important that the roadmap and toolbox provide useful information for different specialists". (Bulgaria)*
- *"I was very pleasantly surprised to explore features of the roadmap & toolbox and can assure you that especially the parts about Language, culture, communication; Vaccinations; Maternal and child health; and Non-communicable diseases & chronic conditions provide valuable information that is very useful in my daily work". (Bulgaria)*

The majority of participants mentioned that the toolbox covers a large amount of information. Moreover, they mentioned that **there is no other source covering such an amount and variety of information. The roadmap/toolbox improved their understanding and professional competence, adding some new ideas and thoughts on how to address healthcare problems of migrants. Even parts and issues that may not be relevant to their daily practice, could prove useful in the future, e.g. information on health promotion etc.**

- *"Well…I am not sure if there are some important issues missing in the website. Since you asked me this question, as far as I concern, I think they are all covered there and each topic is structured in the same way: magnitude of the problem, etc. " (France)*
- *"There was a lot of material, rich in information. I can't think of anything missing. It covered a wide scope of information." (Greece)*
- *"I read parts of the material at home. The sources of information were valid and I genuinely learned a lot about some topics I was interested in." (Greece)*
- *"This toolbox helps us a lot. We now have material with a wide range of topics which we can share with the migrants to help them deal with any problems they might have." (Greece)*
- *"I am a midwife, so the theoretical parts of this tool do not concern me, but they were very useful. Even seeing all the information in one place and reading it was very important for me as a health professional." (Greece)*
- *"I realized that there are parts in which I recognized a lot of issues which I'm dealing with on a daily basis and where I realize that these could indeed be helpful to support my work" (Germany)*
- *"It is very informative and easy to use and I started to recommend it to my colleagues". (Bulgaria)*
- *"There are a lot of advantages of such approach". (Bulgaria)*
- *"I found a lot of information I already knew and cannot say that I gained a lot of new knowledge. But for the future I can imagine the roadmap and toolbox to become my primary source of information for supporting my work. " (Germany)*

- *"The roadmap and toolbox offer health information in a very condensed way. It's also a question of trust. I would rather trust the information provided by the roadmap and toolbox, which relies on scientific research, than searching for information via e.g. google etc." (Germany)*
- *"A lot of statistical basis data. Scientific texts which were cited…that was something that I perceived as very positive, that the information relied on scientific data. I thought that this might be the reason why there were topics I felt familiar with" (Germany)*

Website

The website provided an additional advantage. It had a good layout and was described as "easy to use" and "well-designed".

- *"We had no issues with the website, everything was very simple and easy to understand. Overall, it was user-friendly." (Greece)*
- *"When I got into the website, I like the design and the map describing the road with traffic lights attached to each issue. I clicked the symbol "Start" and nothing happened. But I understood that as I scrolled down, some topics are presented systematically in each box with some resources inside"; "I think that when users see the picture (the map), it attracts them to know it more..."(France)*
- *"I enjoyed the way in which all the information is presented, it is very concrete and focused and it is easy to use it". (Bulgaria)*
- "*Even though my English is not really good, I know that to access some functionalities I just need to click the buttons appeared on the website and arrive directly on the requested page. For example, when I clicked the toolbox button, it brings me directly to a separate page, and there I can specify what I search on the left side" (France)*

Negative aspects

Roadmap and toolbox

Content

Some participants from Greece, who were not physicians, mentioned that in some cases the questions were difficult for them as well as the migrants. Both did not have the knowledge to handle the questions that addressed medical issues. This issue generated more concerns regarding the accuracy of the migrants' answers.

- *"There are some things, mainly medical topics, which I did not know and neither did the beneficiaries. I felt that this was quite difficult." (Greece)*
- *"I am a midwife. I might not be completely informed on some medical topics, but I can understand them. But for the migrants it was difficult. For instance, when we asked them whether they have large intestine cancer or even high blood sugar or cholesterol they did not understand us. They do not know what these are. So, I am not sure if the answers they gave were accurate." (Greece)*

Time

The limited time the participants had in order to understand and get familiar with the roadmap and toolbox, as well as the time they needed to explore the online tool in depth, significantly obstructed the use of the roadmap and toolbox on a daily basis, especially by staff working part-time in France and Germany. More than one participant said that they needed at least half a year

would to gain enough insight into the information and structure to begin to use such a roadmap. Thus, because of the long time required to go through the tool, the information provided by the roadmap and toolbox was considered too detailed and too theoretical.

- *"Time is a very big issue in our field of action regarding the use of the roadmap. Because it's too extensive. " (Germany)*
- *"If I imagine consulting the roadmap and/or toolbox via my smart phone searching for information while being with a client, I feel totally overstrained. " (Germany)*
- *"It's like a computer, which I want to consult but which takes a lot of time for loading updates every time I switch it on. So, I would not continue it in the future again." (Germany)*
- *"Because, a lot of information does not concern my specific working field. And before I would go on reading and clicking through all that stuff I would rather information concerning just the German context." (Germany)*
- *"We work most of the time on the field with minor migrants, and often we don't have much time to discover the whole website. It would be useful if it is indicated before accessing the tools on how much time it will take." (France)*
- "*I read a thorough theoretical information about what the roadmap and toolbox are. It was all in English and I was not sure if I understood it all, as my English is very limited. But apart from that, I saw that the information provided is very detailed" (France)*

Furthermore, participants in France underlined the fact that younger staff would rather rely on information provided by direct exchanges with more experienced colleagues to save time, than by consulting an online tool. Moreover, the older, more experienced staff would probably rely on information they already know and offline sources. For example, the more experienced a social worker was, the weaker the impulse to seek for further tools or more information.

- *"As a social worker accompanying minor migrants, I don't think I need to read the whole theoretical explanation about what community approach is, etc. Well...it might be interesting, but as a field actor, I think that the text, first of all, should be shorten and written to be more practical". (France)*

In Greece, quite a lot of participants mentioned that the time needed for the completion of the questionnaire posed a major barrier. The lack of cultural mediators/ translators constituted another barrier for the completion of the questionnaire.

- *"It was time-consuming, and we were often not able to keep an interpreter for so long in order to have the interview." (Greece)*

In Greece, lack of time was mentioned as a barrier mainly by physicians who were working in camps. They stressed the fact that migrants who are visiting the clinics in the camps are facing an emergency, i.e. they are in pain, or they have a fever etc. Both the physicians and the migrant patients neither want nor have the time to fill out the questionnaire. The situation is not the same for physicians working in hospitals in rural areas of Greece as well as the social workers working in the social services in the camps. Usually, migrants who are visiting social services have more time and are in the mood to open up and fill out such questionnaires.

- *"Neither we nor the migrants had time or were in the mood to reply to these questions. They come here because they are in pain, they want us to give them medicine to get better. It was difficult for them to reply to these questions. And it required time we did not have because patients were queuing outside." (Greece, physician in a camp)*

- *"We at social services did not have this issue. People come prepared to talk, to spend more time here. So for us, time was not an issue. Also, they open up to us more easily than at the camp clinic where they go to solve an immediate medical issue such as pain, a fever or a cough." (Greece, social worker in a camp)*

Difficulties in providing information to migrants

Some participants in Greece mentioned further difficulties concerning the provision of information to the migrants, due to: (a) lack of resources for making hardcopies of the online information, (b) lack of literacy and health literacy of the migrants.

- *"The material existed, in theory, but we could not give it to the migrants. First of all, we could not print it." (Greece)*
- *"Even if we managed to print them, many migrants would not have been able to understand it. There are many who cannot read, but even those who do, do not understand what some diseases are, e.g. diabetes." (Greece)*

Website

(a) Language

The most important disadvantage for French participants was the fact that the roadmap and toolbox were in English. All of the participants agreed that language was the main barrier that discouraged them from using the roadmap and toolbox. They protested because the information is not translated in different languages. French participants had underlined this point also during the training held in January 2020.

- "*It is very unfortunate that the language used in the website is only in English. It's really a major problem for me to understand what the roadmap is, what the toolbox is, etc. As soon as I knew that it is provided only in English, I didn't put much attention to that. This is why we have no big things to say when you invited me to talk about our feedback in using the roadmap and toolbox" (France)*
- *"I think that the language problem should have been the first consideration when making these tools. Are they addressed to field actors? To researchers? I made some efforts to go to google translate, but still, it is not practical" (France)*

(b) Design

Regarding the design of the website, French participants mentioned the lack of tracking of visited pages. Most of the users do not realize that the roadmap includes 6 points which are attached to each topic, e.g. the magnitude of the problem, reference to the problem, etc.

- "*There is abundant of information in the website and I usually forget what pages that I have consulted. Perhaps it would be more helpful if there is a place where I can know which page or which documents that I have seen before" (France)*
- "*It was tempting for me to click the button "Start" at the beginning, but nothing happened when I clicked it. Wouldn't it be more interesting to make this more interactive? Like when you click start button, the page moves down to the 1st topic, etc." (France)*

(c) Smartphone dysfunction

German participants expressed the need for a website version that would be more convenient for smartphone use.

- *"That's what we told you, if you try to use it on the way, you feel overstrained, because it doesn't work like an app." (Germany)*

Algorithm

Concerning the algorithm, in Germany it was not perceived as relevant to the specific working environment of the participants. In France, the name "Algorithm" was cited as ambiguous and unfamiliar to the professionals, since they connect the specific word with mathematics. They think that the name should be replaced, i.e. change into "Interactive User Help". In Greece, there were no barriers as far as the use of the algorithm is concerned.

- *"When I saw Algorithm, I thought that it has something to do with Mathematics. Honestly, I did not know what it was all about. The term for me is ambiguous and should be replaced by something more familiar...I don't know…maybe like "quick guide" or anything else". (France)*

Improvements

At this point, participants proposed improvements for the roadmap and the toolbox in terms of effective and friendly use as well as sustainability.

Translations

French participants proposed the translation of all information in the languages of participating countries, since language was one of the main barriers. Moreover, participants from all countries argued on the need for translations of the information materials into the languages of the migrants.

- *"Some tools are translated, but not all of them. It would help if we had translations in the languages of the migrants. This would produce more results." (Greece)*

Faster version of the questionnaire

As the completion of the questionnaire took quite a lot of time, participants from France and Germany proposed some changes for a faster and more accessible version:

(a) to include the estimated time that a user needs to spend in order to explore the roadmap and toolbox -to be indicated at the entry page.

- *"There are moments when I just need kind of a fast-accessible guideline for acting […]. (Germany)*
- *"It would be useful if it is indicated before accessing the tools on how much time it will take." (France)*

(b) to produce of a short tutorial video on how to use the roadmap, toolbox and algorithm –a 3 to 5-minute video placed in the entry page.

(c) to make the informative text shorter and written in a practical way.

- *"…as a field actor, I think that the text, first of all, should be shorten and written to be more practical". (France)*

Other improvements

(a) development of additional categories of information, i.e. COVID-19, sexually transmitted diseases, domestic violence, intercultural approach/methodology.

- *"I believe that you could add sexually transmitted diseases. We deal with these issues very often." (Greece)*
- *"There was no question for domestic violence. It is also an issue we face way too often." (Greece)*

(b) inclusion of regional tools - French and German participants also referred to the need for including regional tools and proposed to work along with migrants for the development of such a roadmap and toolbox.

(c) inclusion of geographic filters -the users could choose their region and get more results regarding the tools that might be useful on a national or even a regional level.

- *"Even on the regional or local level. Because I need information on health services in my surrounding, the Region of Hannover." (Germany)*

(d) development of a personal account - the users will be able to track what they have explored on the website.

- "*There is abundant of information in the website and I usually forget what pages that I have consulted. Perhaps it would be more helpful if there is a place where I can know which page or which documents that I have seen before*". *(France)*

(e) creation of a more interactive website

- *"It was tempting for me to click the button "Start" at the beginning, but nothing happened when I clicked it. Wouldn't it be more interesting to make this more interactive? Like when you click start button, the page moves down to the 1st topic, etc." (France)*

(f) development of a smartphone app that will contain the roadmap and the toolbox to be used by health care workers –mentioned by Germany and France.

(g) development of a smartphone app that will contain the roadmap and the toolbox to be used by migrants – mentioned only by Greece.

- *"This could become a smartphone app to be completed directly by the migrants. They could also read up on all the relevant information for any diseases they might have had. They might be more comfortable doing it themselves and they would be more informed, provided the material is in their language." (Greece)*

Sustainability

Regular updates

Participants from France, Greece and Germany stressed the importance of the sustainability of the platform including regular updates -data and content. Only participants from Bulgaria stressed the usefulness of the core information even without further upgrading.

- *"If we want to talk about a continuation, the information needs to be constantly updated and to include possibly important issues for each country, eg. COVID or anything else that arises per country." (Greece)*

Use of the MigHealth Care tools by social services and / or by health promotion units that need to be developed in camps in Greece

Participants in Greece report that these tools can be used by social services for migrants, such as those in camps. Those in charge can refer and inform the migrants accordingly.

- *"We could do this at social services. We have the time and the means of making the migrants open up and talk about health issues. Afterwards, we can refer the migrants where they need to go, according to the medical issues they mention to us." (Greece)*

Many participants in Greece argued on the need to create health promotion services in the camps that will undertake health promotion actions on an individual and collective level. These actions can be directed by the MigHealth Care tools –algorithm/roadmap/toolbox.

- *"It would be ideal to have a health promotion unit at every camp, where the participants could fill out this questionnaire and then be informed accordingly, individually or in groups, about smoking, vaccinations etc." (Greece)*

Use of the Mig-HealthCare tools for the development of an individual medical history of the migrants

Participants in Greece report that the Mig-HealthCare tools can provide a complete medical history of migrants that will accompany them throughout their journey andwhile living in the country.

- *"This could also be the start of a migrants' medical history to have with them at all times. A database for each migrant to accompany them wherever they go. Something like the little yellow book with WHO vaccination records." (Greece)*

Dissemination

Participants in Greece stressed the possibility of disseminating the Mig-Health Care tools among professionals. Participants are willing to aid in dissemination actions, i.e. inform colleagues, other migrant services about the existence and the usefulness of the Mig-HealthCare tools.

- *"First, we could disseminate it for free. We who did it and liked it, we could promote it to other collaborating healthcare professionals, camps etc." (Greece)*

Financial support

Regarding financial support, participants in Bulgaria think that it is important to have financial support/ funding, in order to sustain the implemented actions, i.e. organizing and delivering new trainings for professionals working with migrants.

- *"I would suggest to organize new training sessions for more specialists who work with migrants in order to show them advantages of the developed tools". (Bulgaria)*

Conclusions

The roadmap and the toolbox were positively received by the majority of the participants. When referring to the toolbox, the majority of participants spoke about the variety of information it includes as well as its scientific documentation. What was truly impressive was that some participants in Greece were studying the material in their spare time.

However, the inclusion of so much information made it difficult to put it into practice in France and Germany, since health professionals did not have time to study and become familiar with it. In Greece, the issue of time was also a major barrier, especially for physicians working in camps. As they mentioned, they did not have time to do the questionnaire and the migrants were not in the mood

to answer such questions. Migrants who visit these clinics usually have an urgent medical problem and seek immediate treatment. Physicians also have to manage many patients over limited time. It seemed that in Greece the most effective use of Mig-HealthCare tools was done by social services in the camps where migrants and health professionals were less hurried and more prepared to open up, due to the nature of such services.

Another barrier, mainly in France, was the language used in the roadmap and the toolbox. Lack of translation in the national language discouraged health care workers from further exploring the tools.

Concerning the algorithm, in Germany it was not perceived as relevant to the specific working environment of the participants. In France, the term “Algorithm” was cited as ambiguous and unfamiliar to the professionals, since they connect the specific word with mathematics. In Greece, there were no barriers in terms of the use of the algorithm.

To improve the MigHralth Care roadmap and toolbox participants suggest the following:

1. Translations into national languages
2. Translation of the informative materials into the migrants’ languages
3. Faster version of the questionnaire
    a. include the estimated time that a user needs to spend in order to explore the roadmap and toolbox -to be indicated at the entry page
    b. production of a short tutorial video on how to use the roadmap, toolbox and algorithm –a 3 to 5-minute video placed in the entry page
    c. composition of a shorter informative text written in a practical way
4. Development of additional categories of information, i.e. COVID-19, sexually transmitted diseases, domestic violence, intercultural approach/methodology
5. Inclusion of regional tools
6. Inclusion of geographic filters -the users could choose their region and get more results on the tools that might be useful on a national or even regional level
7. Development of a personal account - the users will be able to track what they have explored on the website
8. Creation of a more interactive website
9. Development of a smartphone app that will contain the roadmap and the toolbox to be used by health care workers
10. Development of a smartphone app that will contain the roadmap and the toolbox to be used by migrants

For sustainability participants suggest the following:

1. Regular updates of the content
2. Use of the Mig-HealthCare tools by social services and / or by health promotion units that need to developed in camps in Greece
3. Use of the Mig-HealthCare tools for the development of individual medical histories of migrants –mentioned mainly Greece
4. Dissemination among professionals, NGOs etc.
5. Fund raising in order to expand training to healthcare professionals

Country Pilots

Germany: The Circle of Health as a Framework for Promoting the Health of Migrants and Refugees

Main objectives:

- Healthy diet and physical activity as key factors in preventing important NCD's particularly in migrants
- Stimulate holistic and community-oriented approaches in Health Promotion
- Create shared knowledge and understanding among health professionals and migrant communities
- Assess the "Circle of Health" which is one of the practices identified in the Mig-HealthCare roadmap/toolbox as a hands-on, accessible tool/conceptual framework for reaching these goals

Target Groups:

- Professionals (health promotion)
- Members of migrant communities (intercultural health mediators)

Activities/implementation steps:

a. Gaining knowledge about the „Circle of Health"
b. Designing a workshop concept
c. Facilitation of the framework (Workshop)
d. Test and evaluation

The main results

A five hour workshop was organised in Berlin (12 professionals/5 mediators). The main results were:

Positive aspects	Negative aspects
Topics/ Categories highly relevant	Adapting the CoH in the daily work
CoH stimulated discussion	Continuity
Facilitated sharing and gaining relevant knowledge on health promotion	
Stimulation of networks	

Strengths & weaknesses

- Successful exchange of knowledge between professionals and members of the migrant communities on a highly relevant topic
- Circle of Health proved to be useful in facilitating this process
- Easy adaptable and highly elaborated tool

Weaknesses

- Limitations in applying the Circle in the daily work of health professionals (continuity)-
- Lack of time and resources to gain further insight

The way forward

- More time and resources needed for continuity and sustainability of the pilot
- Further research and facilitation needed
- Documentation of models of good practice needed (experience

Planned activities

- Online workshop„The circle of health as a holistic model to analyse and plan health promotion and prevention measures“ on 30 June 2020 -Freiburg, Germany
- Publication on the results of the pilot and the workshop planned for Dec2020
- Online course on COH offered for Furtwangen University- also open to practitioners
  Quaich learning centre for information on the workshops: https://quaichlearningcentre.wordpress.com

Spain: Health Education and Lifestyle Intervention to prevent the incidence of chronic conditions among Migrants addressing their acculturation process (HELP-MAP)

How was the pilot implemented

The pilot in Valencia (Spain) stressed the focus on developing and evaluating a community-based, health education and lifestyle intervention to reduce risk factors associated with Chronic Diseases.

The pilot was developed within the activities of two community services:

- RedCross–Humanitarian Response
- Primary care centres of Clinico Health Department

The target group was immigrants over 18 years old who were users of Red Cross humanitarian services, including temporary accommodation and persons in contact with the Social Worker within the primary care centres

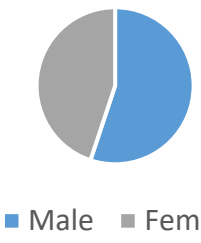
The intervention appraises 4 group sessions of over a 1 – month period.

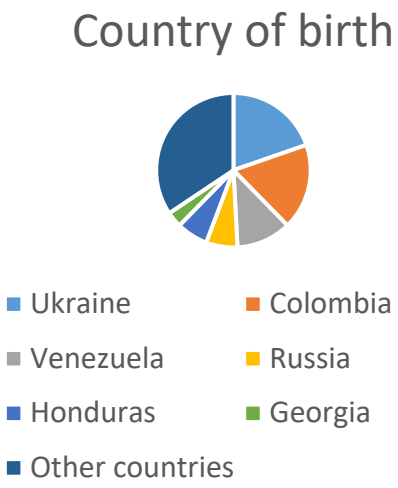
- The duration of each session was around 1 hour and a half.
- The groups consisted of 10 – 15 participants.
- The intervention is based on two main components regarding health education and lifestyle change to prevent chronic conditions :
  - Health literacy
  - Life styles
  - Physical health
  - Mental health
  - Dietary patterns

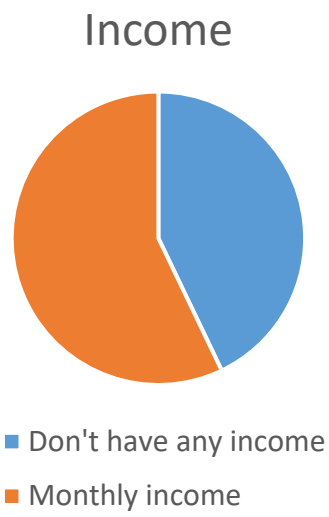
- Acculturation was taken into consideration as a key factor influencing the adoption of healthy lifestyles
- Staff involved in the intervention was trained on Motivational Interviewing and the Transtheoretical Model of Change

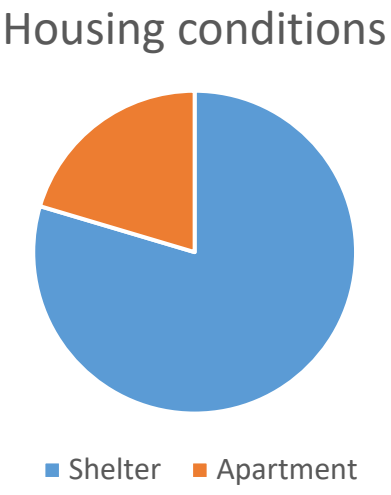
The main results

- A total of 97 migrants were participating in the different activities but just 49 participants followed the full intervention and participated in its evaluation.
- Average age 37,45 years old.









- A majority of participants reported that they strongly agree (63,3%; n=31) that through this pilot action they acquired important information concerning their health.
- Furthermore, 44,9% of the participants (n=22) strongly agree that the information they acquired through the pilot action improved their health.
- The majority somewhat (24,5%; n=12) or completely agrees (38,8%; n=19) with the improvement of their accessibility to healthcare access.

Migrants' point of view…

Likes…	Dislikes…
Self-reflection activities Approach to different themes Sharing experiences in group Dynamics of the group The professionals in charge of the different sessions Daily life topics Methodology	Low number of sessions Short sessions Deviations of the main topic

Professionals' point of view…

Strengths…	Weaknesses…
Content of the pilot The effort of the volunteers Integration of the group The intercultural approach to the health issues Professionals implementing the course Lifelong learning of the content of the intervention	Duration of the intervention along 1 month, being difficult for participants to attend 100% of the sessions Lack of visual materials to support the content

Conclusions & Lessons learned

Several characteristics of the intervention have been found to be essential or highly relevant to be taken into account for the success of their transferability to different European contexts:

1. The multi-component model of the intervention allows a flexible implementation going through one theme by others in each session.
2. The multi-cultural background of the intervention allows not to apply the intervention just to one cultural group.
3. Involvement of professionals and volunteers.
4. Involvement of migrants and refugees

France: Empowering minor migrants

Background

West NGO helps Under-aged migrants (UAMs) who are unrecognised by the French state. MDM runs a program aiming to enhance UAMs access to health care and rights through peer-support. Peer-support is intended to empower UAM and help them to be able to be the authors of their life (Le Grand, 2018). The role of empowerment in health access is established (Wallerstein, 2006).

Methods

Three (3) months ethnographical observations; 3 formal interviews with UAM, 10 with volunteers; informal interviews.

Research Objectives

The research aims at identifying the obstacles and levers in the implementation of the program.

Results

- We identify that some volunteers leave quite a large autonomy to UAMs while others find it difficult to alter the organisation to give space to UAMs.
- Helpers were involved in team meetings as regular volunteers. Their overall participation increased their self esteem.

- Self-help helped develop communication skills for those helping.
- Finally, isolated UAMs were more included into the program by the help received by peers.

Conclusion and key messages
The analysis shows that peer-support triggers empowerment which in turn increases self-esteem of UAMs. Empowerment develops UAMs skills and helps those isolated to participate more. Support from the team is paramount to implement peer-support.

Main messages
(1) Empowerment improved self-esteem of UAMs.
(2) The UAMs improved communication skills and are better included into the program.

Malta: Training on the roadmap & toolbox with an emphasis on mental health

How was the pilot implemented
Due to national context circumstances (political instability between November 2019 and early February 2020) and the COVID-19 pandemic the piloting could be implemented as planned. Because of these issues training of the roadmap and toolbox was adapted for deferred distance learning. Training was developed through government agencies that expressed interest for training.

The main results
- The toolbox is comprehensive, relevant and well structured
- Mostly useful to those professionals with restricted knowledge or experience of existence of such resources
- Needs to be tested further now that pandemic restrictions are lifting

Strengths & weaknesses
- Information is relevant and useful
- Useful for social services to refer to appropriate service
- Needs more languages and more resources in non-EU languages
- Time constraints for general practitioners who serve the general population

The way forward
- Training via distance learning and in presence
- Focus on mental health component
- Carry out main elements of pilot as previously planned

Italy: Health promotion - Cervical cancer screening

How was the pilot implemented
The Community Health Educator model is based on the recruitment and training of members of the ethnic minorities and/or disadvantaged communities who then participate in the implementation of health promotion initiatives in their neighborhoods/areas of residence.

Community Health Educators are people who, in coordination with health professionals, work mainly outside healthcare facilities using their social networks to approach community members to promote health and wellbeing issues.

Target group: migrant women with a focus on Indian communities.

Health promotion activities (October 2019-February 2020) have been carried out by the Indian mediator/educator in the Valdarno area (Arezzo). Meetings were organized both in the Family Counseling Centre and in other meeting places.

The purpose of these meetings was to:

- Raise the awareness of foreign communities on screening, reproductive health and the services offered by the Family Counseling Centre;
- Create a bond of trust with the participants in order to become a constant reference point;
- Spread the message about the activity performed by the Community Health Educator, which is fundamental to facilitate and improve access to services.

The main results

The activity reached about **100 women**. Despite a very short activation period, the pilot has proved to be an interesting experimentation for the promotion of community health at local level.

Some significant aspects of this experience were:

- A strong link with our Community Health Educator

Active dissemination of the message: **"Having met and talked to these people means having talked to thousands of other people they know".**

Bulgaria: Vaccination

How was the pilot implemented

- Promote the importance of vaccination for migrants
- Identify the difficulties
- Inform about immunization according to the local National immunization plan
- Providing information for migrants
- Providing information for health care providers
- Training of 12 service providers and piloting of the Roadmap & Toolbox (3 MDs, a nurse, 6 social workers, a psychologist, and a health mediator)
- Specific piloting of Vaccination topic
- Evaluation

The main results

- Trained health care providers, who can transfer the knowledge
- Provision of specialized support for migrants and for health care provider
- Evaluation of appropriateness, effectiveness, satisfaction, and sustainability
- Strengthened communication with migrants about vaccination programs, vaccine-preventable diseases, and advantages of vaccinations

Strengths:

- Improves health care services for migrants
- Easy access to wide set of collected tools
- Improves understanding and professional competence of health care providers

Weaknesses:

- Information is only in English

The way forward

- The main concern: future function of the roadmap & toolbox after the end of Mig HealthCare project

- Core information is useful even without further upgrading
- To continue updating the information as long as possible
- Add an additional part “HOT TOPICS” with information about measures for prevention of COVID-19 for example.

Greece: “A Webinar for Cultural Mediators”

How was the pilot implemented

Part of roadmap piloted: “Language, Culture and Communication”

Issues addressed: clash of civilizations & how to cope with the unexpected

Why? To ensure good will, understanding, positive attitude of professionals who deliver health care & other public goods to newcomers

Aim: to detect the prospects of creating an advocacy network/a social alliance in order to facilitate the smooth integration of physically and mentally healthy migrants

Trainees’ group: majority were female, had a master’s degree, were familiar with IT, work routine includes often contact with newcomers

Training material: “5 old values”, “Conflict & conflict resolution”, “Get Ready for Changes & Alternative Futures”

Activities & methods: synchronous & asynchronous (Webex by Cisco), writing a final paper, long distance learning, adults’ education, material distributed in advance, workshops.

Teaching techniques: discussion, questions, problem solving, peer-learning, active learning, discovery learning, flipped classroom, engagement of social media and smartphones.

Evaluation: initial and final evaluation, qualitative semi structured interviews & qualitative/quantitative evaluation final assessment (GoogleDocs).

The main results
The participants admitted improvement in:

- Understanding their own negative behavior against “what is different”
- Handling cultural diversity in workplace (immigration, stereotypes, prejudice)
- Conflict management / peaceful conflict resolution / mutually acceptable solutions
- Providing services to support and improve the care of refugees
- Decision making & continuity of safety
- Dealing with "changes" and the future

Strengths & weaknesses

Strengths in participants’ own words:

- The organization of the educational material (interesting, understandable, comprehensive, clear, enjoyable)
- Focus on the educational needs of the participants
- Experiential approach, interaction and collaboration activities between participants (workshops, role playing)

- The extended use of new technology
- Correlation with events in real life and in workplace.
- The webinar was a 'safe place' where one could express one's concerns without fear of being judged by others
- The interaction between the participants and the experiential exercises were very important

Weaknesses, as stated by the participants:

- The instability of the network lines
- Limited time, more time to develop issues further and to analyze in more detail the results we came up with

The way forward

- Necessary to **sensitize** citizens and professionals on cultural differences and on peaceful conflict resolution.
- Ideally, a **representative** of migrants' community invited.
- Emphasize the community approach: **holistic** approach; training on cultural mediation for key-persons in public organizations & professional associations to facilitate migrants' inclusion.

Webinar's sustainability: 4 **requests for co-operation** (staff of a refugee camp (in English language), an upper-secondary public school, a Teachers' Regional Union in S. Greece and educators of a N. Aegean island with a large number of migrants and refugee camps.

Greece: Testing the Algorithm

Implementation

- Piloting in Greece focused on testing the algorithm. It was tested among health professionals in the following locations:
  - Skaramagas refugee camp
  - Elaionas refugee camp
  - Regional health/social services in the area of Halkida including the town hospital

Participants comprised:

- medical doctors
- nurses, midwifes, psychologists, social workers
- administrative personnel
  - Training on how to use the algorithm took place in all sites
  - Participants were asked to fill in the Mig-HealthCare algorithm during their consultations with patients
  - Participants were asked to fill in at least 1 algorithm per week over a 3-month period
    - December 2019 – February 2020

The main results

- 114 completed algorithms were received
- Analysis was based on the responses of 17 professionals who tested the algorithm
- Main findings:
  - ✓ 74% of respondents were satisfied with the algorithm.
  - ✓ 88.2% agreed or totally agreed that the algorithm can be used in different healthcare structures/facilities and may facilitate with organizing necessary health promotion activities in migrant/refugee camps.
  - ✓ 76.5% agreed that the algorithm's questions are clear and may contribute to tracking health needs and improving the quality of health care for migrants and refugees.

- ✓ 70.6% considered that the algorithm is easy to use and that questions cover relative needs and issues for migrants and refugees.
- ✓ 70.6% believed that the algorithm can direct to useful tools.
- ✓ 52.9% agreed that they will continue its implementation after the pilot phase ends

Strengths:

- The algorithm is a useful tool to be used at first contact with a migrant/refugee patient enabling health professionals:
  - ➢ to acquire a better clinical picture of patients' health situation, and
  - ➢ track health needs which require further attention.
- The algorithm can be easily used in different settings and by different health professionals
  - ➢ to inform the care path of a specific patient
- The algorithm is more helpful for GPs and health professionals at first contact with migrant/refugee patients, as well as nurses and administrative personnel

Weaknesses:

- Time constraints
  – overloaded work schedules of health professionals §
- Language constraints
  – the algorithm needs to be available in the host country languages while a translator is also needed for questions directed to the migrant/refugee
- The algorithm was considered less helpful for specialised MDs

The way forward:

- ✓ Finalizing the translations of the algorithm in the consortium languages
  - ➢ Need to have the algorithm in the consortium languages also available online
  - ➢ Ensure that migrant/refugee patients receive adequate follow up concerning the health needs identified through the algorithm

Austria: Focus on Training

How was the pilot implemented
The Roadmap & toolbox was tested with health professionals from regional health services.

The main results

Regarding the Mig-HealthCare *algorithm*,

- 2 out of 5 reported that is useful for their work
- 3 out of 5 that is relevant for the health of migrants/refugees
- 3 out of 5 that provides a helpful outline of refugee/migrant health needs

Regarding the Mig-HealthCare *Roadmap &Toolbox*,

- 3 out of 5 reported that the knowledge they acquired from the Mig-HealthCare Roadmap & Toolbox improved their understanding and professional competence
- 5 out of 5 acquired new insight about the health problems of migrants/refugee
- 4 out of 5 gained me new ideas about how to address health care problems among migrants/refugees

Additionally, healthcare professionals reported that Mig-Healthcare roadmap & toolbox assisted their work with migrants and refugees, providing:

- adequate tools for different health issues in all participants (5 out of 5),
- in different languages (4 out of 5) and
- up to date information about migrant/refugee issues (5 out of 5).

Strengths & weaknesses

Strengths	Weaknesses
"It's useful to understand the specific needs and requirements of migrants and refugees which leads to effective and successful treatments"	*"It's very complex and not self-explaining; too much information, too few graphics/pictures"*
"All fields are covered, very informative"	*"Overload of information, not self-explanatory especially for elder people"*

Final Recommendations

Engage communities and emphasize community action, engage multidisciplinary teams of experts

The Mig-HealthCare contribution

Community action should include migrants/refugees themselves as well as local populations health professionals but also other related professionals such as social workers, cultural mediators, psychologists etc.

Community-based interventions which were piloted within the Mig-HealthCare project showed promising results for migrant/refugee health. More specifically the following practices were piloted:

- An intervention engaging migrant/refugee minors in peer-support activities to promote healthy habits in their community. Five positive impacts emerged:

  (1) Creating links between previously isolated groups of migrants/refugees
  (2) Boosting of feelings of recognition and social usefulness
  (3) Boosting of feelings of happiness
  (4) Better communication
  (5) Development of new skills

- A community-based health education and lifestyle intervention to reduce risk factors associated with chronic diseases reported satisfaction and increase in knowledge and skills among migrants/refugees and health professionals.
- Cultural mediation training sessions for professionals, including professionals working outside the strictly medical/health field showed increased satisfaction and increase in knowledge and skills concerning cultural issues of migrants/refugees.
- An intervention focusing on the training of professionals working with migrants/refugees so as to create shared knowledge and understanding regarding health promotion (the circle of health approach). Results showed an increase in awareness of the important factors to be taken into account when addressing health promotion.
- Community-based training implemented by members of the migrant/refugee communities on issues related to cervical and breast cancer screening.

➢ **Community health care services for migrants/refugees need to address issues related to continuity of information, language, culture and communication and health literacy. This will make services more inclusive and responsive to the multiple sociocultural needs of migrants/refugees**

The Mig-HealthCare contribution

- A unified tool for facilitating health assessment and creating a line of communication across EU states and across different services is necessary to make the retracing of medical information possible. Respecting confidentiality and securing consent is essential. Mig-HealthCare through the Roadmap and Toolbox offers guidance and examples of tools that can ensure efficient continuity of health information.
- Language and culture influence effective communication between health care professionals and migrant/refugee patients. Good communication between provider and patient results in better health outcomes and contributes to the overall health of the community. Translators and

cultural mediators are essential in health care facilities providing care to migrants/refugees. They should be provided by state health care systems as a person-to-person service or as a virtual platform-based one. Various tools can support this effort. The Mig-HealthCare Roadmap and Toolbox offers relevant guidance and tools on issues related to culture and communication.

- Efforts to inform health professionals on the importance of health literacy need to be taken. Specific focus needs to be put on the fact that limited health literacy is more common among ethnic minorities and migrants/refugees, as well as patients with low educational attainment and of older age. Relevant tools to assess health literacy are available for health professionals who can then tailor care according to actual health literacy needs. The Mig-HealthCare Algorithm provides an assessment tool to evaluate health literacy while the Roadmap and Toolbox provides information and relevant examples and tools that can be used to increase health literacy among migrants and refugees.

➢ **Health care delivery should also incorporate routine disease management activities addressing specific health concerns and health issues for migrants/refugees in addition to the emergency care entitlement. Such services are best effective at the primary health care and community levels.**

The Mig-HealthCare contribution

- According to the project's research findings, particular health conditions pose challenges for migrant and refugee health, such as mental health, chronic diseases and oral and dental health. It is anticipated that these issues will pressure the health care systems of migrant/refugee receiving countries. It is important to address these issues early on through the primary health care and community level. The Mig-HealthCare roadmap and toolbox offers information and tools on migrant specific health issues in the consortium and migrant/refugee languages. In addition, the algorithm highlights the main concrete steps in a comprehensive health needs assessment of migrant and refugee health. The algorithm can be utilized by community health services and specifically, GPs and family doctors, primary health care professionals and nursing staff as well as by health administration personnel taking the 1st interview from migrant/refugee patients.

➢ **Address health promotion and disease prevention and implement relevant interventions at the community level**

The Mig-HealthCare contribution

- Health promotion should be a core part of health care delivery following careful assessment of the target population's specific needs. Promoting cancer screening, as well as tackling smoking, alcohol, nutrition and physical activity issues is important. Rapid assessments with appropriate tools, understanding the situation, partnership with health professionals and migrants/refugees, as well as inclusive approaches are essential. Funding through partnerships between governments and community providers is also important.
- Elements of successful health promotion practices include inclusion of community members to ensure sustainability, tailor-made activities, cultural and linguistic adaptation of material, material in migrant/refugee languages, school-based interventions, and training of healthcare professionals.

➢ **Understand local community perceptions about migrants/refugees, identify misconceptions, design strategies to manage and overcome differences through appropriate action**

The Mig-HealthCare contribution

Community approaches to health care involve all members of a community, including citizens themselves. This entails understanding how migrants/refugees are perceived by community

members and addressing erroneous perceptions with tailored tools. Mig-HealthCare developed communication tools to be used for tackling misconceptions.

- **Offer health professionals easy access to language appropriate material and tools relevant to migrant and refugee health**

The Mig-HealthCare contribution

A plethora of information and research about migrant and refugee health exists mainly in the English language. A relevant finding from the Mig-HealthCare pilots showed that there is a need to offer resources in the host country language as well and easy access to tools and material that can facilitate the work of health professionals with migrants and refugees.

To address this need, a version of the Mig-HealthCare roadmap was translated in the consortium languages (i.e. Greek, German, French, Italian, Bulgarian, Swedish, & Spanish) while the toolbox includes tools in many migrant and refugee languages.

Conditions and prerequisites

Improving health for migrants and refugees and facilitating integration into the host communities requires that certain conditions are met. These include:

- Universal access to health and social care and services must be ensured for all migrants/refugees (including undocumented migrants, such as visa or permit 'over stayers', rejected asylum seekers and individuals who have entered a country without documentation). Guaranteeing the same legal entitlement as other residents of the country is a fundamental step towards improving migrant/refugee health.
- The integration of migrants/refugees requires fostering better living conditions in host countries, and access to fundamental needs (access to shelter potable water, adequate sanitary facilities), as well as employment and education and training opportunities.
- Within the EU, differences remain in terms of integration especially between first entry and destination countries. Implementing community based care is harder when migrants and refugees continue to remain in camps instead of integrating with the host population.

Annex 1: Country Pilot reports

Pilot Report Germany: The Circle of Health

Background

The Circle of Health is a conceptual framework (and hands-on tool) which was originally developed in the context of restructuring efforts of health promotion policies and practices in Prince Edward Island (PEI), Canada. Canada embarked on a new policy direction based on a population health approach, embracing principles of health promotion and primary healthcare as set out by the Ottawa Charter and Alma Ata Declaration. A restructured health system brought together disciplines within and outside of health including public health, hospital settings, social services, housing and justice to find new ways of thinking and acting in health promotion in a more holistic way to better match the needs of the diverse population on the Island.

Resulting from this development, The Circle of Health illustrates at one glance the various actors involved in health promotion, depicts multiple target groups to potentially aim at, contains the values on which action should be based on etc. It visualizes a holistic shape of health and health promotion. By that it can help to create a common knowledge on health and health care, facilitate discussion on and planning of targeted and effective health promotion measures, building networks of collaboration etc.

The Circle has already been successfully and widely used in different contexts and countries all over the world; also in Germany (e.g. with female migrants).

Due to the importance of the issue, not only regarding migrants, it was decided to focus the pilot on the topic of healthy diet and physical exercise as decisive factors in health promotion. The topic has also shown to be one of the most frequent issues promoted in the course of the “MiMi”-Programme (“with migrants for migrants”) which trains intercultural Health Mediators who, as key persons, reach out to migrant communities and inform them about different health topics and healthy life styles.

Link to the Roadmap & Toolbox

In regard to the Mig-HealthCare roadmap and toolbox, the Circe of Health relates both to the topic of health promotion as well as it touches on matters of language, culture & communication. Focusing on healthy diet and physical exercise as important health factors, the pilot action also relates to further important health issues like NCD’s (particularly diabetes, obesity and cancer), child health or oral health.

Community approach

The aim of piloting the Circle of Health in Germany was to create shared knowledge and understanding regarding health promotion among health care professionals and members of the migrant communities. This aimed at rethinking current health promotion programs often not sufficiently reaching out to migrant communities. By the same way, ideas for shaping more successful measures taking into account the needs and perspective of the migrant community (as well as the perspective of health professionals) should be developed. By involving key persons of the migrant community itself (experienced health mediators directly in contact with a variety of migrant communities) we hoped to stimulate an exchange of knowledge and experience between potentially affected migrants and health care staff offering health promotion. By involving representatives of the

community in this creative and collaborative process, we were thereby actively taking into account the community approach of the project.

Given the time and financial resources given, we decided to realize the pilot as a one-day workshop. To facilitate recruitment of migrant community members, we chose to rely on intercultural mediators as "professional" representatives of the migrant communities. These mediators already knew the Ethno-Medical Center, had sufficient German skills and felt comfortable to work together with health professionals. We preferred this strategy rather than trying to recruit and motivate lay members of migrant communities.

Objectives & Target group

Aims & Objectives

The general aim of piloting the Circle of Health in Germany was to create shared knowledge and understanding regarding health promotion among health care professionals and members of the migrant community and to thereby stimulate holistic and community-oriented approaches in Health Promotion. This should be done by an exchange of experience (best practice) and knowledge and by drafting recommendations for future health promotion actions. As a second main objective, the health promotion framework "Circle of Health" (see above) should be assessed regarding usability for reaching the before mentioned goals. For this purpose, a one-day workshop had to be conceptualized, planned and realized.

Target group

Target groups directly addresses by the pilot were, on the one hand, health professionals working in the field of promoting healthy diet and physical activity. On the other hand, members of different migrant communities participated. These were key persons actively engaged in making the case for the health of their communities as intercultural health mediators (see above).

Activities & methods

Through research but mainly through a supporting network of collaboration, knowledge on the Circle of Health was acquired by the EMZ staff to be able to share knowledge on its function and to assess its effectiveness and usability. The idea to pilot the Circle was stimulated and strongly supported by Mig-HealthCare partners in France, namely William Sherlaw from EHESP in Rennes, who already had experiences in using the Circle and who later offered the possibility to get into contact to one of the developers of the Circle, Patsy Beattie-Huggan from "The Quaich" Inc. in Prince Edward Island in Canada and additionally Stefanie Harsch from Freiburg University in Germany, who already had experiences in using the Circle in Germany.

Patsy Beattie-Huggan mainly provided support by offering knowledge on the development of the Circle, its underlying concept and ideas and on how to actually making use of the Circle in a workshop. Stefanie Harsch offered to share her experiences with the Circle and all contributed by giving feedback on the concept of the workshop.

To facilitate the application of the Circle in the German context, a translated version of the material was produced, so that 10 copies of the Circle would be at the the participants' disposal. Patsy Beattie-Huggan conducted an online session for the EMZ staff as preparation for the workshop.

In November and December, the concept was developed. Initially scheduled for the beginning of 2020, the workshop had to be postponed to 14 February due to few registrations and illness. To recruit health professionals particularly from the field of health promotion related to healthy diet and physical activity, respective institutions/organizations had to be identified, resulting in a list of about 50-60 addresses which were contacted via Email.

Berlin was chosen as the region to conduct the workshop because the local EMZ office provided adequate infrastructure to realize the pilot. At the same time, conducting the pilot in Berlin facilitated the recruitment of a sufficient number of health professionals and intercultural mediators.

The concept contained an introductory part on the Mig-HealthCare project and its goals, time slots for getting-to-know each other, a part on the Circle of health and its underlying concepts and structure, a part in which the participants collaborated in working on a case study and a final synthesizing discussion, which resulted in the formulation of recommendations for health promotion measures.

Agenda of the Workshop

1. **Welcome, and Warm-Up** **10:00 to 10:15**
   In this first part, the EMZ staff introduced themselves and instructed the participants on the agenda and organizational matters. As a warm-up or icebreaker, participants were asked: "What did you do for your health today?". The purpose was to activate the participants and to stimulate their sensitivity for the different dimensions of health, as they are also depicted in the Circle of Health.

2. **Introduction to the Mig-HealthCare project** **10:15 to 10:45**
   In this part, the participants were introduced to the activities and goals of the Mig-HealthCare project and the pilot itself.

3. **Short introduction of the participants** **10:45 to 11:00**
   The participants introduced themselves taking into account the different parts/dimensions of the Circle. At the beginning of this introductory part, the Circle had been handed out to the participants.

4. **Team working phase: Collaborating on a case study** **11:00 to 12:00**
   In this phase, three working groups were formed and handed out a case study. The case study dealt with a health problem (high prevalence of diabetes and obesity particularly in children) in a city district. The groups were given time to develop a concept to deal with the health problem, making use of the Circle of Health.

5. **Presentation of the working group results** **12:00 to 12:30**
   The working groups presented the results of their collaboration and gave hints in how they made use of the Circle in the process.

Lunch

6. **Analysis and discussion of the working group results** **1:15 to 2:00**
   In this phase, the results of the working groups were analysed by the participants and the EMZ staff taking into account the Circle of Health and whether it has been made use of and proved to be helpful or not.

7. **Outlook: Jointly draft of recommendations for designing community-orientated health promotion measures** **2:00 to 2:30**
   Summing up the results of the working groups and knowledge of best practices recommendations for a more community-orientated health promotion were formulated.

8. **Evaluation** **2:30 to 2:45**
   In addition to the verbal feedback in the discussion of the working group results, participants were handed out a questionnaire to evaluate the workshop and assess the Circle of Health as a framework for health promotion.

9. **Closing remarks and Farewell** **2:45 to 3:00**
   The most important results of the day were wrapped up at the end.

In the course of the preparation of the workshop, power point slides containing the main content and a case study were developed.

The workshop was finally conducted on 14 February with 17 participants including 12 health professionals and 5 intercultural mediators. The workshop lasted about 5 hours. The results generated during the workshop were documented on flipchart paper and photographed.

Evaluation results

The pilot of the Circle of Health was evaluated with the standard questionnaire B1 provided by the Mig-HealthCare project, which was filled in by 12 participants. Furthermore, participants were asked to give verbal feedback in the course of the workshop.

Profile of the participants

The participants came from a variety of health related fields including social workers, dieticians, health mediators and representatives of non-governmental organizations involved in health promotion, mostly female and aged between 23 and 63 with an average of almost 6 years of work experience in regard to migrants. All participants were German residents.

Expectation, satisfaction and relevance of the pilot

Regarding the workshop itself, half of the participants who answered the questions stated, that they the pilot rather met their expectations, four participants neither agreed nor disagreed to this question and two mentioned, that their expectations were not sufficiently met.

The issues discussed in the workshop and the topics touched by the Circle of Health were of very high relevance for the participants work and, from their perspective, also in regard to migrants' health.

The results further show, that half of the participants gained relevant knowledge for professional purposes during the workshop and were able to develop competencies in terms of delivering care for migrants. Most of those, who affirmed these questions, said, that they gained new perspectives, were able to build new networks with colleagues and gained new insights in models of best practice.

Assessing the Circle of Health

One of the main goals of the workshop was to assess the Circle of Health. During the workshop, the target groups were introduced to the concepts, purpose and functionality of the Circle of Health.

Collaborating in groups, it had to be used to develop a concept for solving a given health problem in a community in the shape of a case study.

In the feedback round after the presentation of the groups' results, all participants were asked, whether they had actually made use of the Circle and if, how they introduced it in their work. All participants tried to use the Circle to a certain degree. Some participants found the Circle very helpful in the sense that it raised their awareness for important factors which had to be taken into account in creating health promotion measures for the case study. Others felt quite limited by the request to use the Circle, because they were unsure of how the Circle had to be adapted to the respective case. As they tried to take into account all dimensions and factors depicted on the Circle, they said, that this kept them from developing own ideas and strategies and that they would rather rely on other helpful tools.

The results from the questionnaire show, that almost every participant (11 out of 12) agreed or at least somewhat agreed to the question, if working with the Circle covered relevant needs and issues for their work. 8 out of 12 stated, that the Circle would meet the needs of migrants/refugees and at least 7, that it could indeed help to improve the quality of healthcare for them. But only 5 out of 12 agreed or somewhat agreed, that they would continue to use the Circle of Health in the future, with also 5 persons stating that using the Circle would not be possible without additional funding.

Discussion

The goal of the pilot was to assess the Circle of Health as a Health promotion framework. This was realized by conducting a workshop, in which tow target groups, health professionals and members of the migrant communities, would collaborate on a highly relevant health issue. This should be done by making use of the Circle and its concepts to create a shared understanding and knowledge about how to shape health promotion more community-oriented.

A one-day workshop has been successfully planned and realized in the City of Berlin. The Circle of Health proved to be very useful in stimulating discussion and sharing knowledge on a specific health issue. The categories, factors, issues and areas of action depicted on the tool proved to be highly relevant for the target groups. Nevertheless, the evaluation and feedback have shown, that there were seen limitations in working with the Circle. Some participants had difficulties in making use of the Circle in the workshop and found it hard to imagine how they could make use of it in their daily working environment. Others just didn't have the need for such a tool for their work.

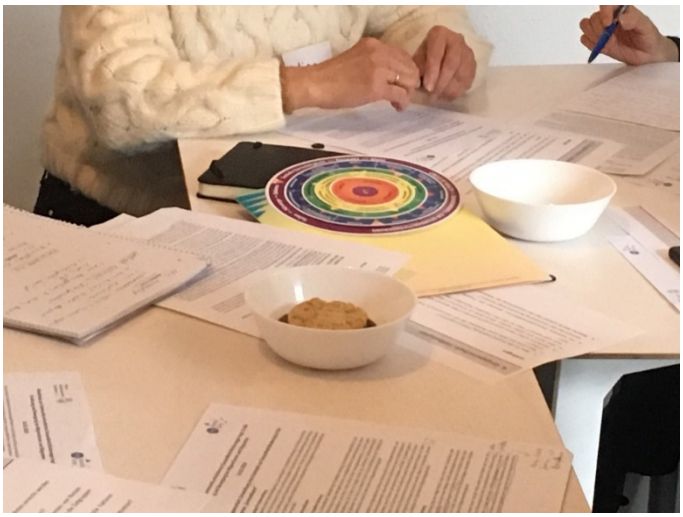
It is hard to precisely assess the reasons for these limitations. The Circle of Health has been widely and successfully used in projects around the world and has proven to be very useful in different contexts. It can be assumed, that there should have been more time to further explain the Circle and the possibilities of its application in different contexts to improve understanding of its use. It could be useful to include more practical examples and to show how it has already been used in other contexts.

As resources for the pilot in Germany were very limited, the pilot had to be reduced to a one-day workshop. This limited the possibilities of testing the tool over a longer period of time and to better understand, how it might be integrated in concrete health promotion measures.

Nevertheless, the pilot stimulated an exchange of knowledge and building of collaborative networks. Several participants showed interest in further future cooperation after the workshop.


Gesunder Start
in den Tag!
Problemstellung
Strategi
Zielgrupp
Gesundheit
toren


Strategien
Zielgruppen
Gesundheits-
faktoren




Robin

Pilot Report Spain: Health Education and Lifestyle Intervention to prevent the incidence of chronic conditions Migrants addressing their acculturation process (HELP-MAP)

According to Eurostat, the number of people residing in a European Member State with citizenship of a non-member country on 1 January 2017 was 21.6 million, representing 4.2 % of the EU-28 population. Moreover, during 2017 an estimated 2.0 million citizens of non-EU countries immigrated to one of the EU-28 Member States[1]. Spain reported the third largest number of migrants (53.1 thousand) in 2017. Migration includes risks and opportunities in social and economic conditions, as well as health. Poor socio-economic environments and living conditions, limited access to educational opportunities, and psychological stresses such as chronic work hazards are well examined causal factors leading to health inequalities[2]. Consequently, growing immigration flows have different implications for individual and population health[3] and also have highlighted new challenges for health and social care systems of respective host countries[4]. In this regard, literature documents the "healthy immigrant paradox"[5], identifying the relationship among the deterioration of the physical and mental health of the migrant population with the time that they spent in the host country, leading to the need for more medical services[6]. The prevalence of diseases can differ by individual conditions such as genetic predispositions but also by factors related to the migration trajectories, exposure to disease and living conditions. Furthermore, accessibility to healthcare services is an important determinant for migrants' health. In this regard, cultural differences, lack of language proficiency and health illiteracy or mistrust of the healthcare systems are seen as barriers for them to access to healthcare services in host communities. In Spain, the global use of healthcare services (primary care, specialised care, hospitals, emergency room and prescription drug use) has been seen lower for migrants than for nationals[7].

Link to the Roadmap & Toolbox

The Roadmap and Toolbox developed by Mig-HealthCare consortium combines evidence from original research and other information to present concrete steps in the provision of care to migrants and refugees at a community level. In this friendly on line application, users can find key steps for optimal health care delivery to migrants and refugees for the most relevant health issues for this population. The pilot in Valencia (Spain) stressed the focus on developing and evaluating a community-based, health education and lifestyle intervention to reduce risk factors associated with Chronic Diseases.

Community approach

Educational and community-based programs and strategies play an important role in reaching Sustainable Development Goals. Consequently, contemporary public health stresses a community-based approach to health promotion and disease prevention to ensure healthy lives and promote well-being for all at all ages (SDG3). Under this principle, the intervention piloted in Valencia aims to prove that reducing the health inequalities as well as facilitating social integration of migrants into local communities can have a positive impact reducing risk factors associated with chronic diseases. Moreover, the intervention recognizes the cultural, social and psychological values, skills and

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[6] Gotsens, M., Malmusi, D., Villarroel, N., Vives-Cases, C., García-Subirats, I., Hernando, C. & Borrell, C. Health Inequality Between Immigrants and Natives in Spain: The Loss of the Healthy Immigrant Effect in Times of Economic Crisis. Eir J Public Helath, 2015, 25(6):923-9.
[7] Gimeno-Feliu, L.A., Calderón-Larrañaga, A., Diaz, E., Poblador-Plou, B., Macipe-Costa, R. & Prados-Torres, A. Global healthcare use by immigrants in Spain according to morbidity burden, area of origin, and length of stay. Bmc Pulbic Health, 2016: 16, 450

resources of the migrants reducing the health inequalities and facilitating their social inclusion into local communities. Finally, the pilot has been designed to reach people outside traditional health care settings involving social workers in health care facilities as well as NGOs providing social and housing services to the migrant population in Valencia city.

Objectives & Target group

Aims & Objectives

The main objective of the piloted health intervention is to study the feasibility of a health promotion intervention aiming at reducing the health inequalities and facilitating social inclusion of migrants into local communities. Furthermore, the implementation of this community-based, health education and lifestyle intervention aims to contribute to the delivery of integrated social and health services by local NGOs as well as primary healthcare centres. In this regard, the pilot will support these community organisations to make the migrant population beneficiary of their programmes to take more control of their own health through greater health literacy and healthier lifestyles. This intervention will expand access to health services to vulnerable migrants by deploying the activity of community organizations to give direction to health education and lifestyle interventions targeting individual acculturation processes of migrants.

Target group

Migrants over 18 years' old who are from countries outside Europe and are being users of local NGO services or users of social work services in health primary care centres will be eligible to participate in this study. The term migrant will be interpreted by the definition given by the International Organization for Migration, including migrant workers and smuggled migrants.

Activities & methods

Polibienestar created a strong relationship of collaboration with the Department of Health of the Clinic Hospital and the local delegation of Red Cross in Valencia. Meetings with their representatives in order to arrange the pilot implementation. Both organisations have played a crucial role in the development of the pilot intervention participating in the recruitment process from their users. Moreover, each organisation has provided the physical space to conduct the sessions of the programme. The intervention appraises group sessions of over a 1-month period. Moreover, the duration of each session has been around 1 hour and a half and the groups consisted of 10-15 participants. The intervention is based on two main components regarding health education and lifestyle change to prevent chronic conditions:

Health education

Health literacy will be addressed through 2 sessions on health education. These sessions will provide basic knowledge and skills of how the healthcare system in Valencia works and their own rights in the healthcare system. The aim is to obtain adequate knowledge of how the healthcare system works and their own rights. This session will eliminate possible fears, stereotypes and misconceptions. Therefore, participants will identify assets to guarantee access to healthcare when they need it by discussing past experiences and examples, this will help them to identify correct pathways and resources to facilitate their access to the healthcare. The health education session will be covered in 1 session.

Lifestyle intervention

On the other hand, lifestyle sessions will address the increment of physical activity, nutrition and dietetics, stress management and smoking cessation. By providing all this information, the main objective is to influence decisions about meaningful choices of healthy lifestyles. Moreover, the acculturation process of participants will be taken into consideration in order to address the maintenance and adaptation of healthy lifestyles from the own culture and adopt healthier lifestyles

from the new culture. The lifestyle targets the following topics on health promotion in 1 session each one:

- Mental health and coping with stress on the social orientation process.
- How to increase physical activity.
- Healthy dietary patterns.

Implementation

The pilot has been conducted in 4 different settings directly working for the migrant population, involving 10 professionals and 97 participants from:

1. Local delegation of Red Cross in Valencia:
    a. Shelter for families seeking asylum.
    b. Apartments for individuals seeking asylum.
2. Department of the Clinic Hospital:
    a. Primary Health Care Centre: Clinic-Malvarrosa
    b. Primary Health Care Centre: Trafalgar

Training

Training regarding the Mig-Healthcare Project's Roadmap and the toolbox was offered to different professionals. A total of 15 professionals were trained on the 6th of March of 2020. The average age of the participants was 30,67 years old and 13 (86,7%) were women and 2 (13,3%) were men. Regarding their profession, most of the sample were health professionals (53,3%; n=8) and a total of 46,7% (n=7) were non-health professionals. Half of the health professionals were psychologists and the other half social workers. Form the 46,7% who were not health professionals there were 3 professionals working in administration, 3 students and 1 sociologist. The mean time of employment was 56,67 months, and specifically working with migrants 17,27 months. The place of employment was NGO clinic or health centre (13,3%; n=2), private practice (6,7%; n=1) and the 80% (n=12) were professionals working at the university.

Evaluation methods

The Mig-HealthCare Pilot's Evaluation Framework guides the implementation and evaluation of both the training and the intervention. Consequently, participants in both the training and the intervention group have been evaluated at two points in time:

Intervention:

The pilot included participation in 4 group sessions over a one-month period. As a consequence, the intervention addressed health education (one session) and lifestyle change to prevent NCDs (three sessions).

This intervention was developed in two phases. The first phase was its implementation with the collaboration of the Red Cross, and the second phase with the collaboration of the Clinic Health Department of Valencia. The first phase was developed from month 1 to month 3, and the second phase was implemented during months 4, 5 and 6.

Finally, both migrants and professionals involved were asked to report their feedback in a final evaluation.

Training: after training and one month after the training.

The training was conducted in 1 session with different professionals on the 6th of March of 2020. After the session was ended all the 15 participants answered a questionnaire evaluating the training and expressing their opinions about the Roadmap and toolbox. Following the evaluation framework, the planning was to reunite them to carry out a focus group one month later but the global COVID-19 pandemic caused that the Spanish Government approved a period of community-wide containment measures since the 15th of March of 2020 that still activated. Consequently, social distancing and the actual stress coped by health care professionals make impossible to follow the proposed strategy.

For that reason, the Spanish evaluation was carried outreaching the professionals by telephone interviews and exploring the main issues coming up during the piloting regardless of the actual circumstances.

Evaluation results
PILOT IMPLEMENTATION
Migrants:
A total of 97 migrants were participating in the different activities but just 49 participants followed the full intervention and participated in its evaluation. From these 49 participants, 44,9% were female (n=22) and 55,1% were male (n=27), being the average age 37,45 years old. Participants' country of birth were Ukraine (24,5%; n=12), Colombia (22,4%; n=11), Venezuela (14,3%; n=7), Russia (8,2%; n=4), Honduras (8,2%; n=4), Georgia (4,1%; n=2) and other countries. 79,6% of the participants (n=39) reported living in a shelter, and 20,4% reported living in an apartment. 9 participants (18,4%) report to don't have any income, and 12 participants (24,5%) acted that they have a monthly income. This income was reported to come from NGOs by 8 participants (16,3%), a paid job (6,1%; n=3) and family support (2%; n=1).

A majority of participants reported that they strongly agree (63,3%; n=31) that through this pilot action they acquired important information concerning their health, the 14,3% somewhat agree with that (n=7), 6,1% neither agree, nor disagree (n=3). However, some of the participants strongly disagree (4,1%; n=2) and somewhat disagree (2%; n=1) with this.

Furthermore, 44,9% of the participants (n=22) strongly agree that the information they acquired through the pilot action improved their health. The 20,4% agreed with that (n=10) and 14,2% neither agree, nor disagree (n=7). On the other hand, 8,2% of the participants strongly disagree (n=4) and 1 of the participants somewhat disagree (2%) with this.

Regarding the belief that the pilot has improved accessibility to health care just 4 participants strongly disagree with that (8,2%), and 9 participants just disagree. However, the majority somewhat (24,5%; n=12) or completely agrees with that (38,8%; n=19).

About the continuation of the actions, 51% of the participants (n=25) acted that they strongly agreed with the continuity of the health promotion workshops, and the 14,3% also agreed with that. On the other hand, 8 participants (16,3%) disagreed and 4 participants strongly disagreed (8,2%). Moreover, the majority of the participants strongly agreed that they would recommend the pilot (63,3%; n=31), also the 12,2% of the participants agreed with that (n=6), 3 participants neither agree, nor disagree (6,1%). However, 3 participants (6,1%) strongly disagree about recommend the pilot activities and 1 participant disagree (2%).

Participants reported several increments of their knowledge in different areas. The main areas were: general health information, nutrition, coping stress, health services information and healthy lifestyles.

The principal likes and dislikes of the activity were:

Likes…	Dislikes…
Self-reflection activities Approach to different themes Sharing experiences in group Dynamics of the group The professionals in charge of the different sessions Daily life topics	Low number of sessions Short sessions Deviations of the main topic

Methodology	

Evaluation of the professionals

A total of 6 professionals involved in the pilot implementation expressed their opinions regarding the intervention and the Mig-HealthCare project. Five of them were female, and the average age was 38,33 years old. A total of 3 were health professionals (1 nurse, 1 psychologist & 1 nutritionist) and the other three were social educators at the shelters where the intervention took place. The average years of employment were 11 years old, and regarding the years working with migrants/refugees was 4 years. 5 of the respondents worked at Red Cross and 1 at the health care centre.

50% of the professionals reported to be "somewhat agree" and the other 50% "strongly agree" with the intervention meeting their expectations. In this regard, 4 of them (66,7%) strongly agreed and the other two somewhat agreed (33,3%) that the intervention covered relevant needs and issues for their work.

Regarding the implementation, 3 of the respondents strongly agreed and the other 3 somewhat agreed that the intervention was adequate developed and implemented. Furthermore, all of them also strongly agreed that the materials used were intuitive and clear.

In terms of effectivity and impact, there is a strong agreement that pilot action fitted the needs of the migrants and refugees. Moreover, 5 of the respondents agreed that the pilot improved the quality of health care for migrants but 1 somewhat disagreed on that. Moreover, 5 of the participants strongly agreed that the intervention has added value to the community. Additionally, the intervention has a professional impact on 4 of the professional (66,7%) who stated that the pilot has improved their skills and competencies. The reported improvements involved: specific care skills in the healthcare sector, communication skills, emotional intelligence and the implementation of interventions addressing mental and physical health.

The sustainability of the action is supported by the strong agreement of the professionals on the continuity of the actions even when the pilot phase ended and 50% of the professionals agreed that the intervention will be followed in the time and they report to have the infrastructure to implement the action. However, 4 participants (66,7%) agreed that the action needs some additional funding to be continued. In this regard, 5 participants stated that it is easy for existing staff to implement pilot action in the future.

Regarding transferability of the pilot action, all the participants strongly agreed that it's possible to implement the pilot action in different settings.

The participants were asked to highlight the strengths and weaknesses of the pilot program:

Strengths…	**Weaknesses…**
Content of the pilot The effort of the volunteers Integration of the group The intercultural approach to the health issues Professionals implementing the course Lifelong learning of the content of the intervention	Duration of the evaluation Duration of the intervention along 1 month, being difficult for participants to attend 100% of the sessions Lack of visual materials to support the content

Regarding professionals' points of views of the Mig-Healthcare Project, all of them were aware and informed about the project, its aims and scope, and 4 of them also visited its website. Moreover, all

of them stated that the project is relevant for their professional development. Moreover, all of them agreed that Mig-Healthcare Project contributes to addressing a major problem in European society.

Training evaluation

A total of 15 professionals were trained on the 6th of March of 2020. They were asked to report their opinions about the training.

The 60% (n=9) of the professional expressed that the organization was excellent and the other 40% (n=4) expressed that was very good. Regarding the information received, 80% (n=12) said that it was excellent and 20% (n=3) very good.

In the context of the opportunity to ask questions, 66,7% (n=10) said that it was excellent, 26,7% (n=4) said that it was very good and the 6,7% (n=1) good. The way that questions were answered was marked as excellent by the 80% of the participants (n=12) and very good by the 20% (n=3).

The contribution of the training to the participants' work was rated as excellent by the 46,7% (n=7), very good by the 40% (n=6) and good by the 13,3% (n=2).

The opinion of the whole training experience was rated as excellent by the 66,7% (n=10) and very good by the 33,3% (n=5).

Moreover, 13 participants (86,7%) strongly agree that the training materials focus on the right issues/questions, and 2 just agreed with that (13,3%). In this regard, 9 participants (60%) strongly agreed that the training materials include information that will be useful for their work with migrants/refugees, 4 participants somewhat agreed (26,7%) and 2 participants neither agree, nor disagree (13,4%). Furthermore, the 73,3% of the participants (n=11) strongly agreed that the training material gave them new ideas on solving problems related to the health of migrants/refugees, the 20% somewhat agree with this (n=3) and the 6,7% (n=1) neither agree, nor disagree.

From the participants, 13 of them strongly agree (86,7%) that they will inform their colleagues about the Mig-HealthCare roadmap and toolbox, 1 somewhat agree with this (6,7%) and 1 neither agree, nor disagree (6,7%) on this.

Regarding the need of further training about the Mig-HealthCare roadmap and toolbox 7 participants (46,7%) strongly agree that they would need further training, 7 participants (46,7%) agreed with that too and 1 participant (6,7%) neither agree nor disagree.

Finally, 8 participants strongly agreed that they would need further training on health care of migrants/refugees, 5 somewhat agreed with that (33,3%), 1 participant (6,7%) neither agree nor disagree and 1 participant (6.7%) somewhat disagree with that.

After this training, all the professionals were invited to pilot the roadmap and toolbox, but the actual global COVID-19 pandemic has supposed a charge on the daily workload of the healthcare professionals raising difficulties for them to actually pilot the roadmap and toolbox. In this regard, 5 participants were reached out and could provide input on the roadmap and toolbox.

All the interviewed professionals agreed on the comprehensive development of the Mig-HealthCare project outputs and also, said that the roadmap and toolbox were useful supports for its decision-making process. In this regard, the interviewed professionals stated that the roadmap was informative and all them have gained knowledge exploring it. Moreover, its linkage to actual best practices was also highlighted as one of its strengths by the participants. However, participants also stressed limitations such as that there was not a Spanish version, being in some case a limitation for

its use. The participants also suggested the idea of making a version of the tool accessible for migrants and refugees could have a great impact on their accessibility to healthcare services by increasing their health literacy level. Professionals didn't use the algorithm because the actual limitations at this workplace but one of the psychologist pointed out that she was applying a mental health practice from the toolkit in its NGO clinic.

Discussion

Satisfaction of the target groups

Regards the satisfaction of the target groups, the overall results of the different activities carried out within WP6 have shown a great level of satisfaction in the three target groups: professionals trained on the Roadmap and Toolbox, migrants participating in the pilot activity and the professionals involved in the implementation of the activity. Even though the implementation of activities and its evaluation was interrupted because the current situation with the COVID-19, there are still positive feedbacks from all the target groups on the results of the project.

Increase in awareness and knowledge

One of the main objectives of the Mig-HealthCare project was to increase awareness and knowledge among professionals. In the frame of the activities performed within WP6, awareness has been achieved by different means. The first one was the implication of two main stakeholders in the implementation of the pilot (Red Cross and the Health Department of the Clinic), in this regard, the managers of both services were reached out. After this, professionals were contacted to organize the implementation in each centre. In this line, the participants raised also their awareness of the different issues that they have to face when accessing to healthcare services and also adopting a healthy lifestyle when in their social adaptation process. Finally, the training activity with professionals from the field supported the efforts on raising awareness.

Access to health care

As to accessibility to healthcare is defined as the potential capacity of use of healthcare services, the pilot implementation may have an impact on this. Due to the synergic work done by professionals and volunteers from different fields in the development of the health promotion workshops, and the training on the use of the project tools, Polibienestar has promoted a change in the Valencian healthcare system in a more cultural-competent way.

Networks of collaboration

In the line of the pilot activities, the strengthening of the coordination between primary health care and the third sector will facilitate the elimination of health inequalities and facilitating direct primary prevention strategies with this hard-to-reach population.

Other

Nowadays health disparities have increased in the light of COVID-19, for that reason community-based strategies to promote the health of the most disadvantaged populations are more required than ever. For that reason, the coordination between primary health care and NGO's would guarantee the sustainability of the action by using the NGO's as an element of engagement to public health strategies for the hard-to-reach population such as vulnerable migrants and refugees.

Conclusions & Lessons learned

The presented intervention relies on an envisaged system where the health and social care organisations work together to achieve shared objectives. In this regard, the consideration of the NGOs working daily with migrants and refugees as a point of engagement with these hard-to-reach populations when designing public health responses. Moreover, for the primary health care centres, another great achievement of this project is the openness of their facilities to the community use.

According to the results, we can elaborate on specific recommendations to increase the scalability of this pilot action. Several characteristics of the intervention have been found to be essential or highly relevant to be taken into account for the success of their transferability to different European contexts:

- **The multi-component model of the intervention allows a flexible implementation going through one theme by others in each session.** As vulnerable migrants and refugees don't stay longer at the shelters or social accommodations this type of interventions is useful because if the participant stays just in one session they could gain all the planned knowledge without limitations.
- **The multi-cultural background of the intervention allows not to apply the intervention just to one cultural group.** The intervention recognizes the cultural backgrounds and resources of each participant, aiming at reducing the health inequalities and facilitating their social inclusion into local communities.
- **Involvement of professionals and volunteers.** The intervention relies on a number of different expertise and activities. One of the most significant aspects is needed to better coordinate the human resources for the planning of meaningful sessions and its organisation.
- **Involvement of migrants and refugees.** The recognition of their cultural background is the first step, but the intervention presented is also based on a motivational background to orientate the acculturation process in a healthy way. In this respect, the recognition of the participants' assets and making them aware of their situation and what it is in their power to make a real change in their lives.

Limitations

The research team found several difficulties during the pilot implementation. Concretely, the NGOs acceptance took longer than expected, but also the organization of the available resources and the call for participation within their services. The same happened with the health care centres. Another limitation was the lack of capacity to follow-up the cases when the participant drop-out the intervention. Some of these cases were because they found a job but the majority because they were changed to another shelter or social resource. Finally, because the COVID-19 crisis the group sessions were cancelled making impossible to follow-up the cases.

Future research

The results of the pilot implementation stressed the need for further research on community-based strategies for health promotion.

In this light, the fragmentation of the resources and services providing care for migrants and refugees should not be a barrier for them when accessing basic services. In this regard, integrated care pathways considering the needs of the migrants and refugees and all the stakeholder along the continuum of care should be designed considering prevention, early detection, treatment and follow-up, and other services.

Finally, health disparities may make COVID-19 situation more difficult for migrants and refugees in Europe due to the lack of effective health promotion strategies targeting these hard-to-reach populations. Consequently, prevention and control of COVID-19 strategies for future outbreaks should be studied in order to guarantee the preparedness of health and social care services.

Pilot Report France: Empowering Minor Migrants

Background

Unaccompanied Minors whose minority is not recognized by the state and who appeal against this decision find themselves in a legal gap. Not being recognized as minors make their situations vulnerable where they cannot benefit from the Child Welfare Assistance. However, in terms of access to healthcare, the law prescribes that the National Health Insurance Fund should not require unrecognized minors to prove their presence on the territory for more than 3 months nor to justify their income in order to obtain the State Medical Assistance as it does for adults. In reality, to access health care services, unrecognized Minors often find difficulties for example with the absence of a legal representative on their side.

In the framework of Mig-HealthCare project, EHESP conducts a pilot in collaboration with Doctors of the World in Nantes aimed at improving minor migrants' health in obtaining access to health care and their rights through peer-support. The pilot has been started in April 2019 where an experimentation was set up in the Doctors of the World premises, with peer volunteers in its daily activity. Through peer-support mechanism, it is expected that the transformation of information among minor migrants will be facilitated including the access to care and rights by drawing on the experiences and experiential knowledge of their peers.

Link to the Roadmap & Toolbox

This pilot adopts the Mig-HealthCare's Roadmap on health promotion which puts forward the notion of health that goes beyond the absence of disease, but viewed in a holistic state of well-being. According to Mittelmark's definition, health promotion aims to empower people to control their own health by gaining control over the underlying factors that influence health. The main determinants of health are people's cultural, social, economic and environmental living conditions and the social and personal behaviors that are strongly influenced by those conditions (Mittelmark, 2008). Moreover, according to the WHO Ottawa charter, health promotion is 'the process of enabling people to increase control over and improve their health.

In this context, our pilot was designed to address the following aspects of health promotion:

- 'Creating supportive environments' as the pilot implies that space is given to the migrants in order for them to decide what they would like to do.
- 'Strengthening community actions' as the pilot is community driven, therefore the migrants will strengthen their community ties.
- 'Developing personal skills', because the pilot is implemented by migrants, they will develop their own skills on topics they think are valuable.
- 'Reorienting health services' as 'many of the answers to health lie outside the bounds of the health sector'

The pilot set with Doctors of the World in Nantes was a bottom up process, meaning that the actions that were proposed coming from the fields, including the peer-helping activities.

Discuss the community approach

Community approach can be defined as the involvement of people in a community in projects to solve their own problems (Joseph Rowntree Foundation, 2004). It involves the process of sharing decisions which affect one's life and the life of the community in which one lives.

The peer-helping activity is driven by the migrants wishes to perform activities either to help doctors of the world or to propose activities that they think will help them either in terms of health information or social activities that we know are also a great source of health improvement

(Wallerstein, 2006). The pilot explores the feasibility of involving minor migrants' community to help each other in providing information not only on access to health care but also on other practical aspects such as where to find food and shelter in the city. We believe that the minors may know better the practical information of the city than the volunteers of the association.

The community approach embodied in a peer-support mechanism is believed to benefit both the helped and the peers during the action. Being a peer helper improves their ability to understand the social context in which they now evolve, mainly regarding heath care access and health literacy. A peer support should be understood in parallel as an access to information (peer education) and also as a social support in everyday life from peer helpers to peer non-helpers.

The pilot is also closely linked to the concept of Empowerment. According to Fetterman and Wandersman, "Empowerment is a process that develops the skills of citizens so that they can collectively solve problems and make decisions autonomously" (Fetterman and Wandersman, 2007). From the above definition, two main elements emerge for the development of empowerment: on the one hand, strengthening people's skills and, on the other hand, making it possible, through the acquisition of these skills, to solve problems, take decisions and take action on the environment in order to reduce inequalities of power.

Furthermore, Wallerstein stated that "Empowerment is the result of a dynamic interaction between two levels: the development of individual (internal) competencies and the overcoming of structural (external) barriers" (Wallerstein, 2006). It implies that peer-help actions set up merely as actions that only aimed to improve skills are only half of an empowerment action. If they enable young people to solve problems and make decisions independently, then the action fulfils the criterion of an empowerment action, which is the objective of the pilot itself.

Objectives & Target group

Aims & Objectives

The main objective of the pilot is to empower minor migrants to be the authors of their own live. Practically, the pilot is aimed at creating a peer-support activity to improve access to prevention, care and rights of unaccompanied minors, followed by Doctors of the Worlds in Nantes. Through this experimentation, minor migrants will be guided towards developing their own actions regarding health and well-being.

In the meantime, the pilot also seeks to identify the obstacles and facilitators, and to study the conditions and effects of a peer education system for this public on the empowerment aspect as well as on access to rights and health.

Target group

The target groups of the pilot are twofold:

- The primary beneficiaries of the pilot are the minor migrants under 18 years old, who are followed by Doctors of the World. The number varies each year, and approximately 133 minors were seen in 2019 of which 40 were new to the program.
- The volunteers and the staffs of Doctors of the World. They are part of the target groups since the peer-support activity is expected to change their perspectives in helping minor migrants. Around 20 volunteers coming from various backgrounds such as nurse, doctor, and psychologists are actively involved in the institution's activities. Beside the volunteers, Doctors of the World is also managed by two internal staffs (a coordinator and a project officer) and an intern.

Activities & methods

The beginning of Peer-support activity implementation

In April 2019, the peer-support activity among minor migrants is implemented in Doctors of the World's premises in Nantes. Prior to that, EHESP team and the NGO have been engaged in several discussions/meetings on the research framework and the implementation of the pilot.
Two questions appeared among volunteers and staff of the institution on how to involve minor migrants in the peer-support activity:

- Should the empowerment approach, which is the core of peer-support activity, be discussed first internally before presented or proposed to the minors?
- Or should the minors be involved since the beginning in the meetings along with the volunteers and the internal staffs?

The first meeting with the whole team of volunteers and internal staffs of the NGO was conducted without the minors. During the meeting, two opposite sides emerged. Those who are vigilant with minors' involvement in the activity preferred that the minors do not decide what actions to be implemented in peer-support activity. They considered that it is on the volunteers and internal staffs of the NGO to do such decision. In the other hand, the second side of the team is in favor of involving the minors in the process of peer-support activity in order to comply with a definition of empowerment. They believed that if all actions are thought out in advance by the whole team without involving the minors, it is no longer empowerment.

The meeting finally agreed that the peer-support activity will be followed by two interns of the NGO and the first discussion with minors shall be conducted to hear their views on the activity.

The term peer-volunteers

Before the peer-activity takes place, a discussion emerged within Doctors of the World on what title to give to the minor migrants who help other minors. Some of the members refused to use the term "volunteers" because it may bring confusion with the adult volunteers. In addition, Doctors of the World's volunteers were selected and signed the charter as well as having an access to migrants' personal data.

There was no consensus among Doctors of the World's members, but gradually the term "peer-volunteers" was used. Therefore, in the framework of peer-activity implementation, the term peer-volunteers refers to minor migrants who are willing to take a role as volunteer to help other minors. Most of them are French native speakers coming from western African countries. It is not a requirement to master French, however it becomes an inevitable skill when dealing with local actors. The peer-volunteers are also those who have knowledge and understood how the French administration works, especially when it comes to accompaniment for example in the hospital, in the regional council, etc.

There are 7 peer volunteers involved in the peer-support activity. These 7 young people know and understand how French administration works. It certainly correlates with their length of stay in France. When the survey was conducted, 4 of them had been living in France for more than a year, and the other 3 people had arrived between January and March 2019.

Involvement of minors in the peer-support activity

Since May 3rd 2019, every Friday morning within the Doctors of the World's premises, a meeting is held with the presence of minors and internal team of the NGO. Through participatory process where the minors were actively involved, the first meeting led to the creation of five practical tools in peer-support activity:

1. A list of young people with detailed information such as surname, first name, country of origin and languages spoken. The minors also proposed themselves what actions/activities that can be done in the framework of peer-support: welcoming the newcomer of minors coming to Doctors of the World's premises, distributing vouchers and hygiene products, accompaniment to medical or cultural appointments and providing translation.
2. A poster summarizing the key terms to present the Doctors of the World;
3. A set of internal rules
4. A map of the city (Nantes) where important places for the minors are identified
5. Service schedules in Doctors of the World's office where minors can be present to help other minors in need of help

During the meeting, the process of tools creation as mentioned above is a prove of how an empowerment action can be done with minors. The main point to be highlighted here is that the minors are the actors who have decided on these tools, and through this process, they have developed organizational skills as the action have been thought out and done by young people.

Actions done in the peer-support activity

The role of minors is important in determining what actions will be done in peer-support activity. The volunteers and internal staff of Doctors of the Worlds were engaged to facilitate their initiatives. The types of actions that the minors do in peer-support are as follow:

1. Welcoming the new minor migrants visiting Doctors of the World
   Every Monday and Thursday afternoon from 2 pm to 4 pm, Doctors of the World opens its office for unaccompanied minors who would like to have:

   - a consultation with volunteers (medical or non medical matters)
   - basic needs items such as toiletries products, blanket, etc.
   - assistance in filling in various administrative papers to obtain a free transport card, to get State Medical Aid, etc.
   - or simply to see other minor fellows while having some snacks and drinks provided by the Institution

It is important to note that during the service schedule, different actors of Doctors of the World are present: the volunteers, the peer-volunteers and the internal staffs. The 1st floor is dedicated for minors who wish to have private consultation with adult volunteers. Meanwhile on the ground floor, the space is used for other needs such as basic items distribution, assistance in completing administrative forms, etc. In other words, the ground floor is where the peer-volunteers and internal staffs perform their duties.

Before the implementation of peer-support activity, the tasks above were all handled by the internal staffs and volunteers. Minor migrants were placed as passive beneficiaries of the services provided. When the activity takes places, minors who possess experiences and practical information about migrants related aspects in Nantes (shelter, food, medical, etc.) could become peer-volunteers if they wish, and contribute to the institution's tasks.

In practice, during the service schedules on Monday and Thursday afternoon, the peer-volunteers are present to guide the visitors (mainly newcomer minor migrants in Nantes) to put their names on the paperboard and specify their needs: either for a consultation, having basic needs items, etc. Afterwards, peer-volunteers will direct those who are in need of consultation on the first floor, and for other needs on ground floor. The peer-volunteers also explain to the new minors the scope of activities of Doctors of the World in their own language and how they can benefit from the assistance provided by the NGO.

Certain tasks that previously done by internal staff of the institution were now performed by peer-volunteers such as listing and distributing basic needs items to those who are in need of them, helping the new minors filling in the administrative papers needed to have a free transport card, etc.

At the end of each service schedule around 4.30 or 5 pm, a debriefing is held to sum up the activities done by all actors involved. It is usually led by the project officer of the Doctors of the World who asks the whole team to give the highlights of what happened on the ground floor and on the 1st floor. During this time, the peer-volunteers are also welcomed to share their thoughts about the service schedule that day and give their advices if any.

2. Accompaniment during and outside service schedules

The peer-volunteers possess practical information and experiences dealing with local services and various actors. To certain extent, they know better than internal staffs and volunteers of Doctors of the World as they face themselves different situations in their daily life in Nantes. Their knowledge is a valuable asset that should be used to benefit other minors in the same situations.

Since the peer-support activity takes place, the peer-volunteers are present during the official service schedules in Doctors of the World's premises on Monday and Thursday afternoon as explained in the previous point. We may consider this as their formal contributions and their actions are observable by the internal staffs and the volunteers.

During the service schedules, peer-volunteers provide accompaniment in completing administrative forms for other minors, mainly the state medical aid form, and they explained in their own language the next steps to take to proceed these forms. This task used to be performed by the internal staffs and take a lot of time. Thus, the role of peer-volunteers in this context is very helpful for the internal staffs, for the minors that they help and also for themselves as their skills and knowledge are valued. Only if peer-volunteers have hesitations, they ask the internal staffs for more information.

Contacts and networks among minors are also made during the service schedules. If formally peer-volunteers perform their duties within the Doctors of the World's premises, they can also accompany other minors outside the office. Based on our observation, the types of accompaniment that the peer-volunteers do is mainly linked to medical appointment or administrative procedures in governmental institutions (the prefecture, regional council, etc.). Information sharing is also made among the group of minors for instance on finding shelters, where to have free food, or cultural events that they can attend.

3. Peer-activity regular meeting

Since the implementation of peer-activity, every Friday morning, a weekly meeting is organized in the Doctor's of the World's office. It gathers peer-volunteers and the internal staffs. The meeting is the space dedicated mainly for peer-volunteers to share their ideas and discuss with their fellows about their contributions. It is a place where we can observe that the initiatives are thought out and decided by the minors themselves. For example, they propose to organize a meeting with local

lawyers that provide legal assistance to minors, in order to know their rights and obligations. Some of the peer-volunteers was in charge to organize the meeting, and the others list the questions to be asked.

Another initiative from minors that came up during the Friday meeting was the creation of practical tools used in peer-support activity. As explained above, the minors managed to co-construct a list of young people, a poster resuming key terms used in Doctors of the World, a set of internal rules, identifying important places on a city map, and also the role that they can play during service schedules.

The place of girls in peer-support activity

All of the peer-volunteers involved in the activity are males. It does not mean that there is no female among minor migrants followed by Doctors of the World. As a matter of fact, there are 15 girls out of 300 minors and given a priority in terms of accommodation in host families as they have greater risk of sexual violence. They are aware of the existence of peer-support activity and were invited to come to Friday meetings, however none of them came.

The girls are involved in another program run by Doctors of the World for more than a year, which is a self-support group only for females. Within this group, the girls get to know each other and share their experiences. The meetings sometimes are facilitated by AIDS Information Service who provides a training on reproductive and sexual health. Through this group, the girls have also created the trust boundaries among them where they can talk about sensitive issues such as excision and gynecological issues, and more importantly they feel less isolated.

The role of EHESP in peer-support activity

EHESP co-constructed the peer-support activity with Doctors of the World within the framework of MIG-HealthCare project. Both of institutions have complimentary roles in its implementation. EHESP brings its expertise in research field while ensuring that the actions taken are scientifically legitimate. While in the other side, Doctors of the World possess field experience with migrants especially in health related programs. EHESP observes the implementation of the activity and also conduct the evaluation to draw the obstacle, the levers and the lessons learnt.

Evaluation results

The main objective of conducting the evaluation of the peer-support activity is to highlight the effects, levers and obstacles of its implementation through a qualitative research methodology. Given the experimental nature of the activity and the public characteristics such as mobility, heterogeneity, random participation in on-call services, it was not possible to carry out a quantitative survey. Instead, EHESP team used a comprehensive approach by interviewing the minors, peer-volunteers, professionals, and volunteers of the NGO. A continuous observation was also made before and throughout the activity implementation to capture its dynamics.

In France, to undertake the research that involves personal data and to ensure that it complies to the ethical procedures, the evaluation/research plan of the MIG-HealthCare project had to be examined at the first place, by the Inserm ethics committee. The EHESP team obtained the Committee's validation to conduct this research: IRB00003888, IORG0003254, FWA00005831; opinion n°19-588 of 21 May 2019.

It also explains that the questionnaire B2 addressed to migrants/refugees requested by the coordinator of MIG-HealthCare cannot be performed due to the ethical reasons. In fact, any information related to the personal data (as demanded in the questionnaire) such as age, country of

birth, country currently living in, place to live right now, have to be anonymous according to the Inserm ethic committee's decision.

Throughout the evaluation period, the EHESP team has done 19 interviews with the following details:

- 3 staffs of the NGO
- 7 peer-volunteers
- 4 program members or ex program members
- 5 employees or volunteers from other NGOs, apart of Doctors of the World

Two distinctive perceptions of the peer-support activity

Our observation suggests that the whole actors (NGO's staffs, interns and adult volunteers) are in favour of peer-support activity implementation and believe that it is a good initiative to empower the minors. However, when it comes to the way of involving them into the activity, there are slight differences which can be classified into two groups.

The first group are the stakeholders. This category involves people who hold the responsibility of the Doctors of the World's programs such as the Coordinator, the staffs and the Project Manager. Undoubtedly, they wish to involve the minors into the peer-support activity by asking their opinions on the decisions made by the adults. Meaning that the empowerment initiative according to this group, should be done gradually (step by step) by respecting the NGO's framework. They emphasized that at the first place, the activity may not be a participatory action and secondly, it is on the adults to think of how it should be implemented beforehand. Initially, this group was not sure either to involve the minors in the meetings.

The second group consists of those who convinced themselves they know better the concept of "empowerment" in the peer-support activity. They believed that the minors should be involved since the beginning of the activity's implementation, and that the decisions should be made by the minors not by the adults. The top-down notion as seen in the first group, cannot be considered as empowerment. Most of the actors who belong to this group are the two interns and also some adult volunteers.

The impacts of peer-support activity

The results obtained from all of the interviews conducted in this evaluation, indicate that at least there are five positive points that emerged from peer-support activity.

1. Creating links
   Statements made by some peer-volunteers highlighted the problem of "missing link" among the minors. It relates to the fact that they might feel alone or isolated living in Nantes. The peer-support activity gives them a "collective space" to share how they feel and being connected to the NGO's volunteers, professionals and also other minors.
   A helped minor said that "*African cultural codes prevent us from expressing what we feel to adults, we don't dare to do that, it is not our culture*". In this context, the presence of peer-volunteers, has helped them to feel more comfortable to talk about the issues that they face, and in turn, the peer-volunteers transfer the relevant information to the minors in their own language. Thus, the role of peer-volunteers in this context is to bridge the gap between "the adults' world" and the minors' and fulfill each other's expectations

2. Recognition and social usefulness

   One of the aims of empowerment is to raise the awareness of one's capacities. The peer-volunteers stated in the interviews that they feel "proud" to be useful both to other minors and to the adults who have put the trust on them in the peer-support activity, such as: "*It makes me proud... If you –The NGO- ask me to come, it's because I'm useful and worth something, it brings value, to who I am... It brings me something positive personally*".

3. Feeling good

   One of the health indicators used in research is the perceived health indicator. It has been widely recognized as a good predictor of mortality as well as other medical indicators which depends on the subjectivity of the patient. With regards to the peer-support activity, many statements made by the minors indicate that they feel better off: "*It helps me a lot mentally, because sometimes when you're alone you're sad so you come to the field (get with the others) and you feel good*".

4. Communicate better

   Being a peer-volunteers has brought them to communicate often with various actors. Not only with the helped minors but also with their fellows and other NGO's professionals. The social relations built by the activity has made them feel more comfortable talking and meeting other people. For example, one respondent said: "*I used to be uncomfortable because I was shy*"; "*On Fridays (peer volunteers' regular meeting) when we come, it's not only you who talk, it's us who do it, it helped me and I think it helps others too*".

5. Developing useful skills for their future projects

   As underlined by peer-volunteers, their involvement in the activity has developed certain skills which are useful for their professional or other personal projects. As one of them said it has facilitated him to have an internship program in a garage premise, having a self-confidence, and easier access to school, etc. By looking at these witnesses, the positive impacts of peer-support activity should not only be seen from "the time that the minors spent as a volunteer" but also in a wider perspective, that these positive impacts benefit him in his life course as a whole.

Constraints of conducting peer-support activity

1. Turn-over

   One of the important issues in starting a peer-support activity is the fact that young people are in a changing situation and therefore their commitment is short term. As an example, in May 2019, 20 minors came to the service schedule, and in September, some of these young people are either recognized as minors by the judge or (in the case of one of them) enrolled in a high school. Therefore, in September and October, there has to be a peer-volunteers team renewal and the process may not be easy.

   One of NGO's staff said that it is interesting despite the turn-over, the peer-support activity continues. The problem will remain and one of the solutions may be to try to motivate peer volunteers to motivate other young people to become volunteers. It has also been underlined by a peer-volunteer that: "*We have to inform them first, at each service schedule, it's important. And it's also up to us peer volunteers to convince them, so that they can integrate... Because if it's an adult volunteer who's talking, they won't... but if we're talking about "yeah, please come because the day you came like that... you too can give your friends maximum support*", *that's what will push them to come,*".

   Another solution would also be to have one of the two service schedules on Wednesday afternoons because the minors, even when they are in school, they are free on Wednesday afternoons; so they could keep coming and passing the role. However, with the departure of

one of the two NGO's employees and the other one does not work on Wednesday afternoons, the latter says that it is difficult to put this solution in place.

2. Time constraint

The question of time is vital in the implementation of peer-support activity, which is often said by the whole actors involved within. From minors' point of view for example, doing accompaniment outside NGO's premises to go to the hospital or any medical appointment take a lot of time.

On the other side, team members (adult volunteers and staffs) said that: "*we have to go fast*", "*sometimes it's hard to take the time to explain*", "*if we do it ourselves, we save a lot of time, if they do things, it takes [a long time]*". For staff it is a temptation to do the work rather than letting the peer-volunteers doing it. Indeed, the minors take longer time since they are learning to proceed some tasks themselves. However, since the peer-activity takes place, NGO's adult volunteers and staffs are aware that the role of minor volunteers should be enhanced to correspond to the empowerment definition and also the fact that they should be willing to invest their time to handover some duties to the minors.

An example of a witness of the NGO intern who accompanied a minor to a medical appointment: "*I went to the hospital with Mamadou, a 16-year-old Malian with a basic proficiency of French. When he went to the secretariat before his appointment, the secretary recorded some data in a computer. I had left Mamadou at the front and she spoke directly to him. He managed to understand and give her the papers she wanted but could not answer the question "in which city were you born?". He turned to me with questioning eyes, he did not understand the question and in particular the word "city". At that moment, I think that if I had had the answer, I would probably have given it in a burst of spontaneity and so as not to make the people behind us wait too long*".

The fact that young people can provide accompaniment is one way of compensating for the lack of adult volunteers. Accompaniments are mainly an opportunity to show new minors some important places in Nantes such as the charitable restaurants where young people go for lunch, doctors' surgeries, medical laboratories, pharmacies, etc. They also have an opportunity to accompany their peers to the doctor's office, the hospital or the city, or to attend the appointments for translation needs. Such accompaniments can last several hours. More than that, time management for adult volunteers who have other activities is more complex, for example if the accompaniment of a minor to a general practitioner is done at 2pm, the adult volunteer who does the accompaniment has no information when it is going to end.

Discussion

Satisfaction of the target groups

Our qualitative evaluation results suggest that the first beneficiaries, which is the minor migrants, are satisfied with the peer-support activity. Comprehensive interviews were done with all actors involved. As elaborated in the section of impacts of the activity above, throughout its implementation, peer-volunteers were able to (1) create links among the minors, with the adult volunteers, as well as with the NGO's staffs; (2) minors feel that their skills are recognized and socially useful; (3) feeling good of being involved within the activity as it allows them to be in contact with many people and not being excluded; (4) learn how to communicate better and (5) develop their skills for future projects.

From adult-volunteers and NGO staffs' point of views, all of them are convinced that peer-support activity is an efficient tool of empowerment and throughout its implementation, they have seen how it benefited the minors. The slight differences among the adult volunteers lie on how to involve them. The first group is very careful about minors' involvement, where it has to be done gradually, not from the beginning of the activity. In the meantime, the second group consist of the convinced ones, who believe that minors have to be involved since the beginning of the activity and they have to take the lead on the actions that they want to pursue. In practice, despite these differences, the adult-volunteers and NGO's staffs collaborate well with minors to support the activity.

Increase in awareness and knowledge

Peer-support activity creates a better channel of communication and information dissemination among minor migrants. As explained previously, the formal service schedules every Monday and Thursday afternoon, as well as the regular meeting of peer-volunteers on Friday morning play an important role. These meetings are the occasion of sharing information from peer-volunteers to the new minors about administrative procedures, medical appointments, important places in the city, where to find shelters and other practical information. The adult volunteers and NGO's staffs can also spread some updates easier with regards to the minors' regulations or situations, since the peer-support activity takes place.

The minors stated that they learn to communicate better with various actors since they take part as peer-volunteers. As they helped other minors to understand better local information and do the accompaniment, they also get used to meet other actors outside the NGO's premises. These actions have helped them to be more confident about their skills.

In Friday meeting, some new initiatives from minors emerge. For example, the needs of having more information about minors' rights and obligations according to the French Law. To meet this need, they organize themselves a meeting by contacting suggested speakers by NGO and also gather other minors who are interested to come. They also learn to express their ideas on the subject that they are interested in. For instance, concerning one of the NGO's staff whose work contract came to an end. The minors share their view on a letter on behalf of all minors, to the NGO's coordinator, stating that the staff has contributed a lot in helping them and it is important that the NGO's extend the concerned staff's work contract. The two previous examples describe that indirectly this process has taught them an organizational skill.

Access to health care

In terms of access to health care, at the first place, peer-support activity has contributed a lot in facilitating the administrative procedures. During service schedules, the peer-volunteers help the new minors in fulfilling the administrative forms to obtain the State Medical Aid. They explain in their own language about the information requested and the next steps to take. If peer-volunteers face difficulties in this process, they can ask directly the NGO's staffs and adult volunteers for further assistance.

Outside the service schedule, peer-volunteers accompany the minors to medical appointments mainly in the hospitals. In many cases, language barrier is an inevitable problem that the new minors might face to explain their situations to the health professionals. Thus, in this context, the role of peer-volunteers is very important as a translator.

Networks of collaboration

MIG-HealthCare project has brought EHESP to collaborate with Doctors of the World which share the same interest in migration health related questions. Through the experimentation of peer-support activity, both have been involved closely in co-construction process and its implementation. EHESP

provides its expertise in research methodology and scientific approach, while the NGO brings its field experience dealing with minor migrants.

EHESP has also worked with other local NGO namely Tremplin Association who works with minor migrants in Vitré, a small city located in the eastern part of Rennes. Our collaboration with Tremplin in this project, focuses on professional training and the use of Roadmap and Toolboxes. During the training, we also had a discussion on common issues that they face with minor migrants and how they can be inspired from the pilot project that EHESP and Doctors of the Worlds conduct.

Other

The pilot adopts the Mig-HealthCare's Roadmap on health promotion which puts forward the notion of health that goes beyond the absence of disease, but viewed in a holistic state of well-being. According to the WHO Ottawa charter, health promotion is 'the process of enabling people to increase control over and improve their health'. The peer support activity aims at empowering minor migrants' skills to be the actor of their actions. It implies that instead of placing minor migrants as passive beneficiaries of actions decided by institutions (NGO, Governmental bodies, etc.) the minors are enhanced to use and develop their skills to decide and to implement what actions correspond to their needs.

EHESP and Doctors of the World have seen the benefits of implementing the peer-support activity for minors' health, as detailed in previous sections above. To implement this pilot, financially, it does not take a lot of budget. However, it requires a lot of time investment of adult volunteers and NGO's staffs, which should be well anticipated in terms of work organization.

In terms of sustainability, the peer-support activity will last beyond the MIG-Healthcare project schedule. The engagement of Doctors of the World to continue the activity is a result of positive impacts that it produces especially to the minors.

Conclusions & Lessons learned

In the framework of Mig-HealthCare project, EHESP conducts a pilot in collaboration with Doctors of the World in Nantes aimed at improving minor migrants' health in obtaining access to health care and their rights through peer-support activity. It has been started in April 2019 where an experimentation was set up in the NGO's premises. Peer-volunteers are minor migrants who possess life experiences in Nantes, understand very well how French administration works, master French and/or other foreign languages, and more importantly posses the engagement to help other minors.
This activity has proven to improve the integration of minor migrants where the peer-volunteers devote their time to help others during the service schedules every Monday and Thursday afternoon, and propose the accompaniment outside the NGO's office.

It has also facilitated a better health care access mainly in terms of administrative procedures, information dissemination and also accompaniment to medical services. Practically, peer-volunteers help the minors to fill the State Medical Aid papers and inform them the next steps to take. Should the minors need accompaniment during their medical appointments, it is also possible, where peer-volunteers usually play the role as translator.

The peer-helping activity explores the feasibility of involving minor migrants' community to help each other in providing information not only on access to health care but also on other practical aspects such as where to find food and shelter in the city. This community approach is driven by the migrants and has helped them to develop their skills and increase their knowledge.

In terms of sustainability, the peer-support activity was initially designed within the MIG-HealthCare framework schedule. Given its benefits to the minor migrants' health, the activity will last beyond April 2020 within the Doctors of the Worlds premises.

Limitations

One of the main interests of public policies is to define a program model that has been proven effective in one institution, to be transferred to the other organizations having the similar contexts. In practice, this "transferability objective" remains complicated. In the field of health promotion, prevention and health, this transferability is difficult to carry on. Depending on the context in which it is implemented, a programme is rarely transferable as it stands to another location. Current research on transferability issues, as well as complex evaluation, shows the interest, not on the results itself, but rather on the processes that led to the achievement of those results and to see whether they are reproducible somewhere else.

Future research: For ethical reasons, we cannot provide some photos.

Pilot Report Malta: Mental Health

Background

The research carried out by Kopin (as part of this project's Work Package 4) identified mental health as one of the major concerns in migrants' lived experiences. In fact, almost half of migrant interviewees indicated that their main current concern is a psychological one, including problems in sleeping due to worrying.[8] International research has proven that refugees are frequently subjected to traumatic events and severe losses. On top of this, they undergo ongoing stress in the host country. As a consequence, they may experience various mental health difficulties, including PTSD, depression, anxiety and grief.[9] Evidently, differences may exist with regards to the prevalence of mental health difficulties among different migrant groups; however this issue has not been researched well enough to determine these differences.[10]

Accessing medical care can be particularly difficult for irregular migrants, who might not have the means to pay for mental health treatment. They might also be reluctant to make use of health care services. This might stem out of fear they might be reported to the authorities and face negative consequences, including deportation.[11] Furthermore, while treatments to lessen the symptoms of war-related PTSD which have been found promising are various (including cognitive behavioural treatment (CBT), testimonial psychotherapy and narrative exposure therapy (NET)), there is also the need for knowledge, by service providers, of the particular needs of vulnerable migrants, including cross-cultural differences and the use of interpreters.[12]

Interviews held with service providers in Malta indicate that service providers do not feel they are prepared or well-equipped to provide mental health services to migrants undergoing trauma[13]. This is not particular only to Malta. Research assessing mental health services for migrants and refugees in Canada indicates that service providers are often unfamiliar with the challenges of addressing migrants' health care needs, especially trauma. Limited knowledge and training in transcultural and trauma-informed care indicates the importance of using a transcultural approach in assessment, screening and treatment processes, in order to enable an effective and high-quality care for vulnerable migrants experiencing mental health difficulties.[14]

Understanding cross-cultural differences requires training for service providers on such elements as cultural, traditional and religious beliefs of migrants' contexts, as well as health systems in their home countries. In sub-Saharan Africa, for example, mental health services and professionals in low-income countries are hugely lacking, and are given less priority by governments than those in high-income countries. Furthermore, the stigma attached to mental health in this region is rooted in cultural beliefs and the associations that some communities make between mental health problems

[8]Kassahun, S. 2018. *MigHealth Care Project – A Brief Summary and Additional Findings.* Unpublished.
[9]Ehntholt, K.A. and Yule, W. 2006.*Practitioner review: assessment and treatment of refugee children and adolescents who have experienced war-related trauma.* Journal of Child Psychology and Psychiatry vol. 47: 12. https://doi.org/10.1111/j.1469-7610.2006.01638.x
[10]World Health Organization – Regional Office for Europe. 2018. *Mental Health Promotion and Mental Health Care in Refugees and Migrants: Technical Guidance*. http://www.euro.who.int/en/publications/abstracts/mental-health-promotion-and-mental-health-care-in-refugees-and-migrants-2018
[11]Ibid.
[12] Ehntholt, K.A. and Yule, W. 2006. *Practitioner review: assessment and treatment of refugee children and adolescents who have experienced war-related trauma*. Journal of Child Psychology and Psychiatry vol. 47: 12. https://doi.org/10.1111/j.1469-7610.2006.01638.x
[13] Kassahun, S. 2017. *MigHealth Care Project – Interviews with Stakeholders.* Unpublished.
[14] Wylie, L., Van Meyel, R., Harder, H., Sukhera, J., Luc, C., Ganjavi, H., Elfakhani, M. And Wardrop, N. 2018. *Assessing trauma in a transcultural context: challenges in mental health care with immigrants and refugees.* Public Health Reviews vol. 39: 22. 10.1186/s40985-018-0102-y

and witchcraft,[15] sorcery and evil spirits. In a study conducted in rural Ghana, for instance, it was found that families have very little support from formal health services, and they struggle in caring for severely mentally ill relatives. When mentally ill relatives are violent or aggressive, or threaten violence, families often chain them to trees or logs to protect themselves. Psychiatric services are difficult to access and considered to be little effective. Traditional and faith healers are highly popular, despite regular maltreatment of the mentally ill in their facilities.[16] Governments in sub-Saharan Africa at times also use incarceration as a solution to prevent people with mental disorders from injuring themselves or the public.[17]

Mental Health Services in Malta

As emerges from the Kopin research[18], mental health in Malta is not a priority for government and the whole sector is underfunded. Social services like Appoġġ (the national agency for children, families and the community) is both underfunded and understaffed. A recent audit of Mount Carmel Hospital (MCH, the national hospital for people with mental illness) revealed that while the government pledged to invest a large sum of money to address the hospital's current dismal physical condition, MCH faces much more widespread operational challenges, inefficiencies and ineffectiveness, including human resources shortages (particularly nurses), strained relations between management and staff, inadequate security, and hospitalising people who do not need to (requiring, instead, other targeted services). Additionally, MCH's community clinics and day centres are also understaffed and lack the management's required attention. The same audit also notes that a comprehensive national strategy for mental health is still not in place, leading to a lack of vision and overall direction for the mental health sector.[19] Promisingly, the Office of the Commissioner for Mental Health states that it is tackling, with migrant communities themselves, challenges presented by mental health issues linked to migration from Africa and the Middle East.[20] Other services include NGOs like Richmond Foundation, which offers such mental health services support groups, support at work, assisted living and residential therapeutic care for children[21]; while the Mental Health Association (MHA) offers support to relatives of people with mental health problems[22]. The Agency for the Welfare of Asylum Seekers (AWAS) has a newly set up therapeutic services unit; while NGOs working with migrants and migrant organisations such as Jesuit Refugee Services (JRS), Foundation for Shelter and Support to Migrants (FSM)[23] and Migrant Women Association (MWAM)[24] also offer some form of mental health support to migrants.

Needs for Awareness-Raising and Facilitating Access

The discussion presented in the Background section above, as well as the Kopin research[25], indicate that the main challenges and needs for vulnerable migrants to access mental health services in Malta are the following:

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[15]Woldetsadik, M.A. 2015. *Mental Health Care in Sub-Saharan Africa: Challenges and Opportunities*. https://www.rand.org/blog/2015/03/mental-healthcare-in-sub-saharan-africa-challenges.html

[16]Read, U.M., Adiibokah, E. and Nyame, S. 2009. *Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana.* Globalization and Health vol. 5:13. https://doi.org/10.1186/1744-8603-5-13

[17]Woldetsadik, M.A. 2015. *Mental Health Care in Sub-Saharan Africa: Challenges and Opportunities*. https://www.rand.org/blog/2015/03/mental-healthcare-in-sub-saharan-africa-challenges.html

[18]Kassahun, S. 2017. *MigHealth Care Project – Interviews with Stakeholders.* Unpublished.

[19] National Audit Office. 2018. *Performance Audit: A Strategic Overview of Mount Carmel Hospital.* http://nao.gov.mt/loadfile/b1adb86a-4ab4-49ac-95cf-534dc99c741c

[20] Office of the Commissioner for Mental Health. 2017. "*Breaking Silos, Building Bridges. Annual Report 2017*." https://deputyprimeminister.gov.mt/en/CommMentalHealth/Pages/Annual-Reports.aspx

[21] Richmond Foundation. n.d. *Our Services*. https://www.richmond.org.mt/our-services/

[22]Mental Health Association. 2019. *Our Mission*. http://www.mhamalta.com/page/our-mission

[23]Kassahun, S. 2017. *MigHealth Care Project – Interviews with Stakeholders*. Unpublished.

[24]Migrant Women Association Malta. 2016. *Our Work.*http://migrantwomenmalta.org/our-work

[25]Kassahun, S. 2017. *MigHealth Care Project – Interviews with Stakeholders*. Unpublished.

1. *Encouraging and enabling migrants to access services*:

    a. This includes combating the stigma surrounding mental health problems within migrant communities.

    b. Encouraging and enabling migrants to access mental health services also means doing this through the most effective means available. Thus, taking into consideration that many migrants in Malta obtain and exchange information (and find solace) in migrant communities, these channels can be used to disseminate information.

    c. Migrant communities can also be utilised as peer-to-peer support groups.

    d. Nonetheless, this does not exclude encouraging people with mental health problems to access the formal mental health services: on the contrary, these services need to be demystified and made financially (and otherwise) accessible.

2. *Training (and providing resources for) service providers to deal effectively and ethically with mental health difficulties:*

    a. By service providers' own admission, there is a feeling of not being ready / able to meet migrants' mental health needs. Training and resources are thus needed on specific mental health issues that vulnerable migrants are prone to (e.g. trauma), but also in engaging with migrants' lived experiences, both in their home countries, the journeys to Europe and their realities in Malta. As part of this, experience already possessed by entities working in the field (as well as migrants themselves) can contribute to training, for example, mental health service providers who have only limited contact with migrants.

    b. Training is also needed in how best to provide and implement services for migrants (e.g. through the use of cultural mediators, interpreters, transcultural services).

    c. In such cases where the mental health services provided are residential, there would also need to be sensitisation of the other residents. Unless staff is trained on such issues, it is difficult for residents to be sensitised. It might also be the case that other residents have completely different histories and difficulties (e.g. low IQ, difficult childhoods) while migrants might have mental health problems due to trauma, etc. (although of course there might also be migrants who have a history of mental health difficulties). This links to 2b and the need to train service providers in issues more specific to migrants' experiences and to which mental health service providers in Malta might not be so exposed to.

    d. Training of migrants in providing peer-to-peer mental health support (see 1c).

Note: It is to be noted that there are other issues (such as lack of funding and staffing, lack of community-based mental health services, need for more education on mental health, stigma on mental health in Maltese society, etc.) which beleaguer the mental health sector in Malta but which cannot be dealt with in this project.

Link to the Roadmap & Toolbox

See Activities & Methods.

Discuss the community approach

The involvement and engagement of civil society entities working in the field is deemed as crucial in order to increase the reach of such initiatives as well as to increase the capacities of those service providers that are embedded within the community. The inclusion of such entities in the piloting is a direct logical consequence of the findings of Kopin's research as well as the wide consultation embarked upon during the same research phase. The challenge expected to be encountered in this case would be to avoid burdening a sector that is stretched to the limits of its capacities as it addresses a wide spectrum of needs and issues. The engagement of the community is interwoven in this plan, as will be seen in the subsequent sections below.

Objectives & Target group

Aims & Objectives

The pilot objectives are divided along two main paths, one specifically centred on the roadmap and toolbox, while the second path is a 'by-product' of (and secondary to) the first one, dealing more with awareness raising. While the main objective of the pilot and training centres around the need for, and efficiency of, the roadmap and toolbox, these aspects are interlinked with the Maltese background laid out above, and thus the need for more awareness and knowledge on behalf of service providers and migrants on migrants' mental health issues. The objectives are thus the following:

Path 1: Roadmap and Toolbox

1. To evaluate the importance and the efficacy of the roadmap and toolbox for mental health service providers and social service providers who identify and refer migrants to mental health services.
2. To provide recommendations on the usefulness of the roadmap and toolbox for these providers and on possible improvements of the tools with the ultimate aim of improving mental health services (including access to the same services) for vulnerable migrants.

Path 2: Awareness-Raising

1. To facilitate the access of vulnerable migrants to mental health support through raising awareness (on transcultural and mental health problems specific to vulnerable migrants) with mental health service providers; and on the importance of mental health services to migrants.

Target group

The target groups are divided into three types: the priority group comprises the main stakeholders which will be targeted through the piloting and training. The secondary group comprises those stakeholders which are not top priority (because they do not fit exactly into the target description) but which come into contact with migrants or people with mental health problems. This second group will be targeted in the event of unavailability / unwillingness of priority stakeholders, or in the event of the number of priority stakeholders not reaching the target aimed by the study. The third group is made up of those stakeholders who, while not coming in contact with migrants themselves (or have minimal contact), have the capacity to put research team in contact with target stakeholders. Some of the stakeholders in the first and second groups will also play this role.

Priority Group:

1) Migrant Health Liaison Office[26]: an office within the Department of Primary Health which liaises with government entities to address issues pertaining to migrant health, assists migrants in accessing health care, and provides health education and training to migrants, cultural mediators and social care professionals.
2) Agency for the Welfare of Asylum Seekers (AWAS): the government agency managing reception facilities and in charge of the wefare of asylum seekers. The Agency comprises aTherapeutic Services Unit which provides psycho-social support services to asylum seekers.
3) Perinatal Mental Health Services: a team of medical specialists and social workers providing assessment, advice, support and treatment for women who have mental health problems in pregnancy or after birth. Services are provided through the national public hospital (Mater Dei Hospital).
4) Malta Health Network (MHN): a network of non-governmental and not for profit organisations which promotes the health-related interests of patients and the wider community.
5) LEAP Centres: government-funded centres targeted at reducing poverty and social exclusion with children, elderly, unemployed and working poor.
6) Aġenzija Appoġġ: the national public agency for children, families and the community which safeguards and promotes their wellbeing through the provision of spychosocial welfare services.

Secondary Group:

1) Jesuit Refugee Service (JRS) Malta: an NGO providing legal asisstance and social work services (including healthcare and psychological support) to asylum seekers and forcibly displaced persons who arrive in Malta.
2) Foundation for Shelter and Support to Migrants (FSM): an NGO working towards the integration of migrants through support services, education and capacity building.
3) Migrant Women Association Malta (MWAM): an NGO providing services and support to migrant women.
4) Cultural mediators
5) Richmond Foundation: an NGO supporting people experiencing mental health problems.
6) St Jeanne Antide Foundation: an NGO supporting vulnerable and poor families.
7) Mental Health Association: a voluntary organisation helping families of persons suffering from ill mental health.
8) Migrant communities (e.g. Somali community, Sudanese community, Eritrean community, West African migrant communities).

Tertiary Group:

1) Office of the Commissioner for Mental Health: a public entity which promotes and protects the rights and interestes of person with mental disorders and their carers.
2) Department of Counselling (University of Malta): offering a Master of Arts in Transcultural Counselling.

Activities & methods

The original plan was to have the pilot and training in Malta conducted with national mental health service providers (including social service providers), NGOs working with migrants and providing mental health services to migrants, and vulnerable migrants[27] identified as a priority when it comes

[26]The name of the organisation links to their website.
[27]The term 'vulnerable migrants' is being used here to denote migrants who ask for asylum in Malta and includes those that have their applications rejected but are not able to be returned to their country of origin.

to mental health difficulties. However, due to two situations outside of our control on a national scale, Kopin was not in a position to proceed with the plan as detailed above.

The national political instability between October and January culminated in the resignation of the then Prime Minister, Joseph Muscat, together with a number of cabinet ministers in relation to heavy accusations of complicity in the assassination of the independent journalist Daphne Caruana Galizia or influence in delaying justice in the case. This was followed by the election of the party leader and eventual Prime Minister. One of the candidates for the leadership was the Health Minister.

All of this resulted in huge delays and stagnation within the public service. The Ministry of Health was reluctant to actively support the activities of the project always citing overstretched resources due to own EC funded projects and few hands at the Migrant Health Liaison Unit.

Our attempts at mitigating this through the involvement of civil society organisations (such as those providing services to migrants and the Migrant Health Network) were effective only up to a certain point. It was effective with research and information sharing but not when it came to the last activities of the project.

Kopin proactively contacted the top level management of the state hospital directly (without going through the Ministry first) in order to implement the piloting and the training at the start of the year. Departments such as the Medical Training Centre could not help as first they claimed to have their schedules full in the first weeks and then all staff were called on standby due to the emergency crisis response to COVID-19 and adaptation to that. In fact, all training was suspended indefinitely and had not restarted by late April.

Our attempts at delivering the training to non-essential and non-medical service providers such as cultural mediators that are regularly utilised by the Migrant Health Liaison Unit was also unsuccessful due to their busy schedules (many are asylum seekers themselves and cannot afford to attend training – considered non-official – instead of attending work). Social distancing measures were also a huge limiting factor for us once these were in place.

Kopin saw potential, in the circumstances, to adapt the training in a way that could be delivered in virtual settings and thus ensuring that these are available through various platforms and entities such as the MCAST (that provides the only course for cultural mediators) beyond the lifetime of the project.

In view of the above-mentioned delays, the need to adapt to the new scenarios as an organisation and the social distancing restrictions, Kopin had to restrict itself to request healthcare and social professionals from a wide variety of sectors that come in contact with migrants to familiarize themselves with the Roadmap and Toolbox, following which they would provide feedback through the questionnaire used by all the project partners.

Feedback was requested through email correspondence and follow-up telephone conversations from ten (10) governmental entities or departments. Ministry of Health units include the Migrant Health Liaison Unit, the Perinatal Mental Health Services Unit, the Primary Health Care Unit and the Office of the CEO of Mater Dei State Hospital.

The Agency for the Welfare of Asylum Seekers distributed an official request to all its psychosocial staff that includes social workers and residence centre coordinators. Kopin also sent the information on the project and the specific request for feedback to Appoġġ (the national agency responsible for the provision of psycho-social welfare services).

Kopin was also in regular contact with the coordinators within the LEAP unit within the Foundation for Social Welfare Services. LEAP was set up to combat social exclusion and poverty through employment, capacity building , social integration and social mobility. Through the project, Kopin was regularly consulting and involving LEAP Centre coordinators to gather information, insights, feedback and also to raise awareness about LEAP's potential in supporting migrants to access healthcare services.

With regard to the Malta Health Network, Kopin adopted a capillary approach and contacted specifc professional associations that are members of the MHN. These include the Malta Association of Physiotherapists, the Chamber of Pharmacists, the Malta Association of Occupational Therapists, the Malta Association of Public Health Medicine, the Malta Medical Students Association and the Malta Midwives Association.

Kopin also distributed the request to all the entities listed in the Secondary and Tertiary target groups. The Faculty for Social Wellbeing at the University of Malta included Kopin's request in its weekly newseltter that reaches all faculty lecturing staff as well as stakeholders that follow the Faculty's work. This was featured prominently in three consecutive newsletters.

Evaluation results

Kopin received 4 responses to the evaluation questionnaire (Appendix 2 – General piloting of roadmap & toolbox), two from healthcare professionals (a GP doctor and a nurse) and two from social professions that brings them in regular contact with migrants. All four respondents were women.

The overall feedback was positive and respondents generally agreed that the information is relevant, consistent, useful, realistic and of high quality. In comments, respondents also stated that the toolbox is comprehensive, extensive (also in terms of languages covered) and the roadmap was innovative in its design. The toolbox also provides a point of reference for a wide spectrum of health related documents and support materials.

In terms of weaknesses, it was pointed out that in some instances (especially for general practitioners), the scope is far reaching and presents time constraints for those who serve the general population. Another response felt that the roadmap could be improved with the addition of user-friendly tips on practical issues that would help healthcare professionals in supporting migrant patients or clients.

Another respondent suggested that there is the need to address the issue of racism within the healthcare professions as this affects negatively quality access to healthcare by migrants.
Finally, another response highlighted the fact that the toolbox did not include any information on substance abuse, related health concerns and treatments involved. Also no information was available on domestic violence - health concerns, treatment and cultural issues with domestic violence.

Discussion

Satisfaction of the target groups

Further to the responses to the online questionnaire, verbal responses through phone calls with representatives of the primary and secondary target groups listed above confirmed that this output of the project is useful, relevant and of good quality.

The Agency for the Welfare of Asylum Seekers expressed its interest in allowing its social workers and psycho-social support team to receive training on the use of the toolbox and the roadmap.

Increase in awareness and knowledge

The respondents to the questionnaire acknowledged an increased awareness about certain aspects of the challenges and solutions available in terms of health access for migrants and asylum seekers.

Networks of collaboration

The networking aspect was slightly strengthened with the notification of the availability of the roadmap, toolbox and algorithm. The responses from central stakeholders as well as the interest in the final event of the project, was encouraging and can be seen as a keen interest in further testing and evaluating the potential of this tool.

Other

Although it was not possible to get the involvement and engagement of civil society entities working in the field as planned, it is Kopin's intention to use the adapted training modules to increase the capacities of those service providers that are embedded within the community.

The virtual and asynchronous nature of the training, together with use of subtitles in a variety of languages should address the challenge that was expected to be encountered.

Future research

The production of videos, blending the presentation of the toolbox and the content (including subtitling in languages such as Arabic, Amharic, Tigrinya, Somali, Swahili), together with some practical examples of the use of the algorithm is expected to be enticing and to overcome challenges related to time constraints in attending half-day trainings, face-to-face trainings, language barriers etc. This will ensure sustainability of the training beyond the project.

Kopin has plans for training to be provided to cultural mediators that are used by the state hospital, by UNHCR and other refugee support NGOs.

Pilot Report Italy: Health promotion - Cervical cancer screening

Background
Link to the Roadmap & Toolbox

According to the WHO (2018), targeted screening of at-risk populations may be considered as a component of the comprehensive assessment of health, particularly for arriving refugees and migrants. A literature review including 27 centres across different European countries showed that women from minority ethnic groups were not adequately addressed and included in breast cancer surveillance programmes.

It is necessary to address cancer screening at the community level through culturally sensitive and linguistically appropriate services and to raise awareness about the prevention of cancers such as cervical and breast cancer.

The objective is to reduce inequities through targeted health promotion and best practice exchange.

Discuss the community approach

In order to tackle inequality of access to health services, the pilot recognises that barriers exist between migrant communities and services. It therefore incorporates a component of professional development whereby health professionals involved will also undergo a training programme that helps them understand the pilot action plan and its practice. This component facilitates the building of partnerships among health professionals. Members of the targeted communities and health professionals should be systematically involved in all aspects of planning, implementation and evaluation of health promotion programmes.

Health need analysis and other contextual information gleaned at this stage can be used to focus health promotion/literacy programme, formulate training strategies, and agree on evaluation strategy and success indicators, in accordance with resources and budget available.

Based on the information and analyses, a health promotion/literacy programme can then be constructed. In this stage, «community health educators or health advisors or intercultural mediators» can identify their own knowledge and training needs. The recruitment of these members is also an important part at this stage. Their social networks and their understanding of their neighbourhood is crucial for the success of the pilot, as they will have direct access to members of the target community and are readily recognised and accepted by them.

The implementation stage provides the health promotion/literacy programme a systematic planned period of implementation. At this stage, the day-to-day management activities of the pilot will be intensified. Health co-ordinators will need effective leadership and change management skills to support the intercultural mediators during this period, and good facilitation skills to maintain good working partnership with all stakeholders.

The core information should be programme-specific with knowledge of the issue involved, e.g. breast or cervical cancer.

It is important to involve health professionals such as practice nurses, doctors, radiographers, community midwifes and public health directors in the training programme.

Objectives & Target group

Aims & Objectives

Access to services and care is a psychosocial product which involves on the one hand, the organization of services and the operators' training and skills; on the other hand, the social status, the socio-economic, cultural and biographical situation, the patients' degree of health literacy and their knowledge of how services work. All these aspects add to the symbolic representations, stereotypes, prejudices, personal and social resources of both parties: operators (doctors, nurses, midwives, social workers, etc.) and users. For health workers and health organisations, reinforcing the awareness of all these elements is an important objective on their way to improving the quality and effectiveness of care and the system's efficiency and to opposing the growing health inequalities that affect disadvantaged groups, including immigrants.

The pilot starts from the model proposed in the UK by the National Health Service and developed by Dr. Lai Fong Chiu, aimed at making the prevention message as effective as possible among the so-called "hard to reach" communities.

The Community Health Educator model is based on the recruitment and training of members of the ethnic minorities and/or disadvantaged communities on which it is intended to intervene, who then participate in the implementation of health promotion initiatives in their neighbourhoods/areas of residence. Community Health Educators are people who, in coordination with health professionals, work mainly outside healthcare facilities using their social networks, e.g. reaching users at home, at meeting places, on holidays or anniversaries, where Health Authorities could not reach them.

This active supply model bases its potential for effectiveness on building personal and collective capacity of health protection. The most significant feature is undoubtedly empowerment, which means strengthening both the communities and individuals. Foreign citizens trained as Community Health Educators increase their knowledge and self-confidence and the awareness of their role in relation to their fellow countrymen, often to the point of developing real leadership skills. At the same time, they are a permanent resource for their group, constantly increasing awareness of specific health issues among members.

Target group

Migrant women with a focus on Indian communities

Activities & methods

The analysis of 2016 data concerning both the participation in cervical screening in the territory of the province of Arezzo and the country of birth of the main nationalities living in the territory shows *a low participation of Bengali and Indian women in the screening programme, with more than 20 percentage points of difference if compared to Italian women.*

We carried out two focus groups: the first one on September 18, 2019 at the Family Counselling Centre in San Giovanni Valdarno (AR) and the second one on October 9, 2019 at the Oxfam office in Arezzo. The focus groups saw the participation of four midwives (two of them are in charge of the Family Counselling Centre) and two cultural and linguistic mediators of Oxfam Italia Intercultura. The focus groups' objective was twofold: to introduce the Mig-HealthCare roadmap and its potential, and to improve the organization of services, identify the elements that hinder access to them, and formulate improvement activities.

The cervical screening service is organized as follows:

- The target population is made up of women in the age group 25-64 years. They are invited to have a smear test every three years. The target population in the province of Arezzo is

composed of approx. 95,000 women. Every year, 32,000 women are invited to take a smear test.
- The invitation is sent by letter and signed by a general practitioner.
- The programme is regional and each ASL (*Azienda Sanitaria Locale*, Local Health Authority) invites women residing in its territory. This is done in order to avoid double invitations. The programme structure is regional and has a national level, too: the National Screening Observatory, a body belonging to the Ministry of Health, establishes guidelines to be implemented at regional level and put into practice as operational activities.

The two focus groups brought to light the following elements that can hinder access to social and health services:

Barriers pertaining to migrants

- The most important barrier is the linguistic one, which always prevents people from fully enjoying the services offered. In this specific case, the letter concerning the screening service is not understood by Bengali and Indian women. As the head of the Family Counselling Centre puts it, "When Indian women receive a smear test response, the few of them who come to the Centre do not understand the positive response, both because they do not read Italian and because the text is not clear enough. So they take this document in their hand and they fold it, but they do not understand". A cultural and linguistic mediator said, "Some women told me that they didn't understand the letter".
- The "cultural barriers and cultural mistrust" which prevent a real understanding of the services' importance: "Many women do not know what a smear test is. Married women go and take it but they're afraid that something bad will come out, and in this case, what will they tell their husband's family?
- Lack of knowledge of the screening service in the country of origin.
- The characteristics of women: many of them arrive as a consequence of family reunification. They get married young, often before the age of 25.

Barriers in the provision of health and social services

- The programme is for resident women only, thus excluding a population segment.
- Correspondence concerning the service, in particular the screening response, is not understood by participants. Since the programme is regional, approval by the Regional Centre is required to carry out any variation, including the simple translation of the letter.
- Scarce participation in the second level.

Proposals to improve the migrant population's access to health and social services

- Translating the letter
- Promoting L2 courses for women with small children
- Requiring the presence of a cultural and linguistic mediation service
- More actively involving general practitioners
- Introducing and promoting the screening during childbirth courses in the women's language
- Involving people who are not mere mediators, but real community educators with a recognized role also at the institutional level.

Orientation meetings and coordinated activity planning have been organized in each area with the participation of educators and health workers. Due to the departure of the Bengali mediator, health promotion activities have been carried out by the Indian mediator/educator only in the Valdarno area.

Meetings have been organised both in the Family Counselling Centre and in other meeting places.

The purpose of these meetings was to:

- raise the awareness of foreign communities on screening, reproductive health and all Family Counselling Centre services in general;
- create a bond of trust with the participants in order to become a constant reference point;
- spread the message about the activity performed by the Community Health Educator, which is fundamental to facilitate and improve access to services.

Our Community Health Educator(s) have therefore organized these meetings working either alone, at home or in other common meeting places (private, public or open to the public), or together, in more "institutional" areas, extending the invitation to the members of different communities.

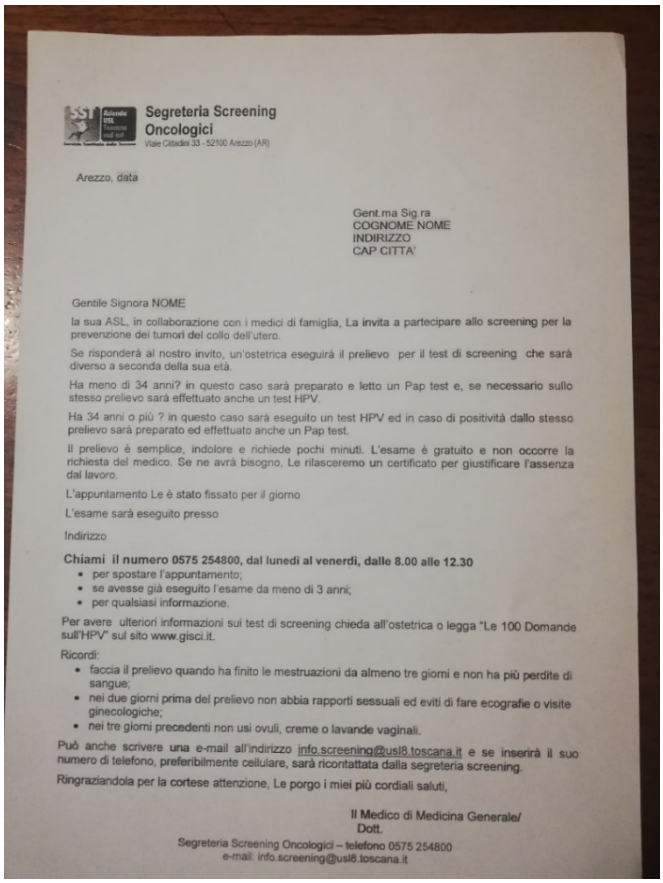
The intervention programme was carried out over a very short period of time, from October 2019 to February 2020, and reached about 100 women.

Health promotion meetings were held at the Family Counselling Centre. Two more meetings took place on Saturdays at the Ipercoop shopping centre: one during the Italian language course for foreign women and the other one during the driving licence course. Some of these meetings were also attended by health workers in order to better illustrate the services offered, to answer many questions, and to establish a relationship with potential users of the service.

Alongside these types of meetings, informal meetings with small groups were held at homes or in other informal meeting places.

Unfortunately, organizing a meeting at the Sikh temple was not possible because it was being renovated.

The invitation letter was translated from Italian to Indi e used during the meetings.



Segreteria Screening Oncologici
Viale Cittadini 33 - 52100 Arezzo (AR)

Arezzo, data

Gent.ma Sig.ra
COGNOME NOME
INDIRIZZO
CAP CITTA'

Gentile Signora NOME

la sua ASL, in collaborazione con i medici di famiglia, La invita a partecipare allo screening per la prevenzione dei tumori del collo dell'utero.

Se risponderà al nostro invito, un'ostetrica eseguirà il prelievo per il test di screening che sarà diverso a seconda della sua età.

Ha meno di 34 anni? in questo caso sarà preparato e letto un Pap test e, se necessario sullo stesso prelievo sarà effettuato anche un test HPV.

Ha 34 anni o più ? in questo caso sarà eseguito un test HPV ed in caso di positività dallo stesso prelievo sarà preparato ed effettuato anche un Pap test.

Il prelievo è semplice, indolore e richiede pochi minuti. L'esame è gratuito e non occorre la richiesta del medico. Se ne avrà bisogno, Le rilasceremo un certificato per giustificare l'assenza dal lavoro.

L'appuntamento Le è stato fissato per il giorno

L'esame sarà eseguito presso

Indirizzo

Chiami il numero 0575 254800, dal lunedì al venerdì, dalle 8.00 alle 12.30

- per spostare l'appuntamento;
- se avesse già eseguito l'esame da meno di 3 anni;
- per qualsiasi informazione.

Per avere ulteriori informazioni sui test di screening chieda all'ostetrica o legga "Le 100 Domande sull'HPV" sul sito www.gisci.it.

Ricordi:

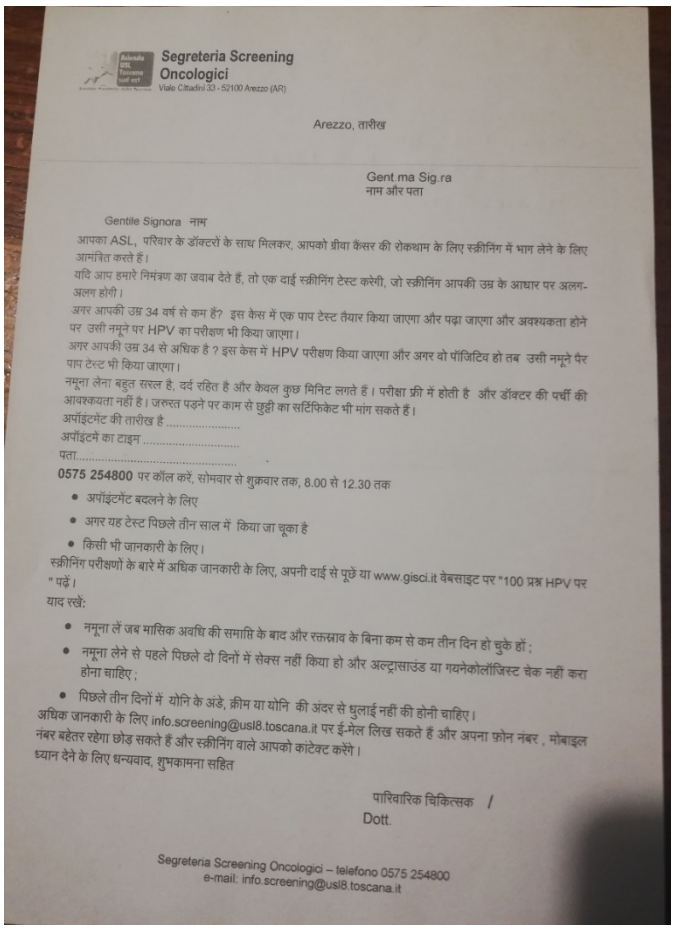
- faccia il prelievo quando ha finito le mestruazioni da almeno tre giorni e non ha più perdite di sangue;
- nei due giorni prima del prelievo non abbia rapporti sessuali ed eviti di fare ecografie o visite ginecologiche;
- nei tre giorni precedenti non usi ovuli, creme o lavande vaginali.

Può anche scrivere una e-mail all'indirizzo info.screening@usl8.toscana.it e se inserirà il suo numero di telefono, preferibilmente cellulare, sarà ricontattata dalla segreteria screening.

Ringraziandola per la cortese attenzione, Le porgo i miei più cordiali saluti,

Il Medico di Medicina Generale/
Dott.

Segreteria Screening Oncologici – telefono 0575 254800
e-mail: info.screening@usl8.toscana.it



Segreteria Screening Oncologici
Viale Cittadini 33 - 52100 Arezzo (AR)

Arezzo, तारीख

Gent.ma Sig.ra
नाम और पता

Gentile Signora नाम

आपका ASL, परिवार के डॉक्टरों के साथ मिलकर, आपको ग्रीवा कैंसर की रोकथाम के लिए स्क्रीनिंग में भाग लेने के लिए आमंत्रित करते हैं।

यदि आप हमारे निमंत्रण का जवाब देते हैं, तो एक दाई स्क्रीनिंग टेस्ट करेगी, जो स्क्रीनिंग आपकी उम्र के आधार पर अलग-अलग होगी।

अगर आपकी उम्र 34 वर्ष से कम है? इस केस में एक पाप टेस्ट तैयार किया जाएगा और पढ़ा जाएगा और अवश्यकता होने पर उसी नमूने पर HPV का परीक्षण भी किया जाएगा।

अगर आपकी उम्र 34 से अधिक है ? इस केस में HPV परीक्षण किया जाएगा और अगर दो पॉजिटिव हो तब उसी नमूने पैर पाप टेस्ट भी किया जाएगा।

नमूना लेना बहुत सरल है, दर्द रहित है और केवल कुछ मिनिट लगते हैं। परीक्षा फ्री में होती है और डॉक्टर की पर्ची की आवश्कयता नहीं है। जरुरत पड़ने पर काम से छुट्टी का सर्टिफिकेट भी मांग सकते हैं।

अपॉइंटमेंट की तारीख है .....
अपॉइंटमें का टाइम .....
पता.....

0575 254800 पर कॉल करें, सोमवार से शुक्रवार तक, 8.00 से 12.30 तक

- अपॉइंटमेंट बदलने के लिए
- अगर यह टेस्ट पिछले तीन साल में किया जा चूका है
- किसी भी जानकारी के लिए।

स्क्रीनिंग परीक्षणों के बारे में अधिक जानकारी के लिए, अपनी दाई से पूछें या www.gisci.it वेबसाइट पर "100 प्रश्न HPV पर " पढ़ें।

याद रखें:

- नमूना लें जब मासिक अवधि की समाप्ति के बाद और रक्तस्राव के बिना कम से कम तीन दिन हो चुके हों ;
- नमूना लेने से पहले पिछले दो दिनों में सेक्स नहीं किया हो और अल्ट्रासाउंड या गयनेकोलॉजिस्ट चेक नहीं करा होना चाहिए ;
- पिछले तीन दिनों में योनि के अंडे, क्रीम या योनि की अंदर से धुलाई नहीं की होनी चाहिए।

अधिक जानकारी के लिए info.screening@usl8.toscana.it पर ई-मेल लिख सकते हैं और अपना फ़ोन नंबर , मोबाइल नंबर बहेतर रहेगा छोड़ सकते हैं और स्क्रीनिंग वाले आपको कांटेक्ट करेंगे।

ध्यान देने के लिए धन्यवाद, शुभकामना सहित

पारिवारिक चिकित्सक /
Dott.

Segreteria Screening Oncologici – telefono 0575 254800
e-mail: info.screening@usl8.toscana.it

The collaboration with ASL Toscana Sud Est and the constant connection with the reference person for migrants' health within ASL Toscana Sud Est was fundamental for the pilot.

Evaluation results

Despite a very short activation period, the pilot has proved to be an interesting experimentation for the promotion of community health at local level. Some significant aspects of this experience were as follows:

- a strong link with our Community Health Educator
- the dissemination of the message: "Having met and talked to these people means having talked to thousands of other people they know".

In general, the initial objective of building a scenario for the promotion of women's health has been achieved, although within such a short time frame we cannot assess the impact in terms of access to screening programmes. We believe that two types of results have been achieved: one in terms of real processes of change, which materialized in the meetings in the Family Counselling Centre and in the teams, and the other one in terms of knowledge, information and self-reflection on both sides (health workers and foreign women) which are useful to improve communication and mutual listening.

Discussion

Satisfaction of the target groups

Profile of the 11 migrant women who filled in the questionnaire

Gender	Nationality	Age
F	Morocco	41
F	India	28
F	India	43
F	India	44
F	India	29
F	India	41
F	India	37
F	India	34
F	India	37
F	India	31
F	Morocco	33

All eleven participants in the questionnaire strongly agree that through the pilot they acquired important information about their health and access to the health system. They also wish to continue the pilot and recommend it to the others.

Increase in awareness and knowledge

All eleven participants who filled in the questionnaire declared that the pilot increased their awareness and knowledge.

Networks of collaboration

As for the results in terms of networking and peer education among Indian women, we must point out that the meetings in the Family Counselling Centre were attended, especially in the first appointments, by acquaintances of our Community Health Educator or by women who had already established a contact with the Centre. On the contrary, the meetings held at the supermarket or at the Italian course for foreigners allowed to intercept a more distant audience.

Other

In the territory of ASL Toscana SudEst, sustainability can be guaranteed thanks to the work that Oxfam has been carrying out for years in the field of cultural and linguistic mediation. In addition, in Tuscany there is a growing number of experimentations concerning the Community Health Educator model.

Conclusions & Lessons learned

For the integration of migrants/refugees:

- The pilot is important for the integration process of migrants because the relationships between public institutions, private social organizations and communities in a given territory facilitate access to prevention and treatment resources through the active provision of services and orientation (outreach). The reorganization of services with a view to greater usability and the involvement of the population in empowerment processes has a positive impact on the integration process.

For the health care services:

- The most important lesson learnt is the ability to work "in a network", that is, in an integrated system of services and skills where public health institutions take over a stewardship role in promoting and governing collective health protection actions and private social associations guarantee co-planning, support and intermediation between services and the target population. The network allows the enhancement of experiences and skills, facilitates the processes of equal exchange, brings accumulated knowledge to a synthesis and puts resources together.

Emphasize the community approach:

- It is essential to involve communities (seen as groups of people who live or work together, or share relationships, interests and customs) so that they become active agents of change. This strategy is based on the idea that communities contribute to the "common good" not only as a good subject to "common property" but also as a product that is "built together". For the health system, the possibility of "going towards" individuals and communities is the necessary prerequisite for understanding the complex nature of the needs which arise in the territory, since this possibility allows to go beyond the express requests submitted to health offices. Intercepting the needs that do not have the strength or capacity to become express requests is particularly important because the most relevant fragilities often remain silent. This dynamic also takes place in the opposite direction, "bouncing" back to the services which are reorganized according to the detected needs and take charge of them, including through the valorisation of the communities' internal resources.

Emphasize sustainability and scaling up:

- In order to be effective in the medium and long term, such strategies need to be embedded in cross-sectoral programmes that go beyond the health sector and aim to address other social determinants of health such as work, housing and education. They also need to take into account socially produced conditions and dynamics that merge with biological factors and contribute to influencing the health-and-disease processes.

Limitations

The most critical aspects are two: the short time span which does not allow to carry out an impact analysis, and the need for these practices to be permanently embedded in public services.

Pilot Report Bulgaria: Vaccination

Europe is facing one of the greatest migration inflows in its history. Migrants and refugees are exposed to significant risk factors for communicable diseases. Migrants are often exposed to malnutrition, overcrowding and unsanitary conditions. WHO-UNHCR-UNICEF stated that migrants, asylum seekers and refugees should have “non-discriminatory and equitable” access to vaccinations and recommended to vaccinate migrants in accordance with the immunization programs of the hosting country. Nevertheless, it is usually difficult to reach migrant populations in order to ensure the full vaccination schedule.

Link to the Roadmap & Toolbox

“Vaccination” part of the roadmap was addressed using various tools from the toolbox, namely:

- Vaccines for immigrants and refugees;
- Promote vaccinations among migrant populations in Europe: A toolkit for health professionals;
- Promote vaccinations among migrant populations in Europe: Immunization record cards;
- Immunization handouts for staff;
- European vaccine action plan 2015-2020.

Provision of health care at reception centers of newly arrived migrants and refugees should be comprehensive, integrated and person-centered. Measures to reduce the risk of communicable diseases include implementation of health prevention and management. Access to vaccination is of prime importance. Vaccinations for migrants and refugees should be considered in accordance with national guidelines. Vaccination records should be provided to the migrants and refugees, especially when they are moving between countries.

Discuss the community approach

Pilot activities were focused on training of health providers how to use roadmap and toolbox, created by Mig-HealthCare project, to strengthen communication with migrants about vaccination plans, vaccine-preventable diseases and advantages of vaccinations.

Objectives & Target group

Aims & Objectives

The aim was to favor adequate protection of migrants and refugees from vaccine-preventable diseases. An important public health measure is to achieve high immunization coverage in order to prevent morbidity.

Target group

The target group consisted of migrants. Twelve health care providers: medical doctors, nurses, social workers, psychologists, who work on daily basis with migrants/refugees were trained.

Activities & methods

The health care providers working with migrants were trained how to use roadmap and tools from the toolbox of Mig-Health Care project. Their attention was especially focused on vaccinations: their importance and useful tools.

Evaluation results

Results were evaluated using the following indicators:

- Appropriateness of the implemented actions for service providers and the target groups
- Effectiveness
- Cost effectiveness
- Satisfaction of refugees/migrants
- Satisfaction of local community service providers
- Satisfaction of the local population and impact on social inclusion

After the training, the health care providers filled questionnaires. As the questionnaires showed, nearly all of the health care providers included were very much satisfied from the usefulness of the toolbox and the roadmap created by Mig-Health Care project. They considered the tools appropriate and the piloting as an excellent opportunity.

Discussion

Satisfaction of the target groups

Health care providers were trained to use roadmap and tools of the toolbox of Mig-Health Care project and to apply them in their routine work with migrants/refugees. Satisfaction of the target group was high (A1 questionnaire). At the end of the training, the health care providers were asked to give their marks. Mostly very good and excellent marks were received. They evaluated organization, usefulness of the information, opportunity to ask questions and to receive answers, etc. Most of the trainees strongly agreed that the training material gave new ideas on solving problems related to the health of migrants/refugees. Most of them shared their thoughts about need of further training.

Increase in awareness and knowledge

Most of the migrants have uncertain vaccination status, including incomplete vaccination history and/or missing documentation of previous vaccinations. Approaches to engaging migrant populations in vaccination vary among countries but health care providers always play a key role. Most of EU/EAA countries apply their national vaccination schedule for migrant vaccinations, which is a response advocated by WHO and others. The health care providers included in our group found the community approach and integration as the two most important advantages of online provided information by Mig-Health Care. The knowledge and tools that are provided support effective implementation of community care models for migrants/refugees.

Access to health care

According to Bulgarian low, foreigners who are in process of granting international protection have the right to health insurance, accessible medical care, free use of medical care under the conditions and procedure for the Bulgarian citizens.

The medical examination of persons seeking international protection shall be carried out in the health offices of the Territorial Units of the State Agency for Refugees at the Council of Ministers.

Conclusions & Lessons learned

Community-driven health promotion programs in migrant populations rely on various promotional strategies. Community-driven intervention is perceived as a culturally acceptable, sustainable, sensitive and relevant approach to solve problems of diverse needs identified by community members. Provision of health care at reception centers of newly arrived migrants and refugees include access to vaccinations in accordance with national guidelines. The roadmap and tools from the toolbox of Mig-Health Care project were found very useful by the health care providers working with migrants.

Pilot Report Greece: A Webinar on Cultural Mediation

Background

Link to the Roadmap & Toolbox

"Language, Culture and Communication" was the part of the roadmap which was piloted with the webinar addressing issues of clash of civilizations and of unexpected future changes. It is important to ensure the good will, the understanding and the positive attitude of the professionals who have to come into contact with the newcomers and deliver health care to migrants/refugees as well as other public goods (e.g. education, safety etc) available to all.

Discuss the community approach

At first, we approached people of the wider local society who are active in their fields and due to the lock-down had enough time to be involved in long distance training. We made an initial, informal inquiry on whether they believed in the need for training on cultural mediation and how willing they would be to participate in such a pilot project. The response was really encouraging since they admitted that they often feel helpless when they have to handle difficult situations resulting from clash of civilizations especially when such troubles arise in their working environment.

Aims & Objectives

The aim of the proposed pilot webinar was to detect the prospects of creating an advocacy network among several professional stakeholders (education - law enforcement bodies - public departments – barristers - health professionals etc) in order to facilitate the smooth integration of physically and psychologically healthy migrants into the rapidly changing European societies.

Our objective was dual: on the one hand, we pursued the creation of a positive attitude on behalf of the local professionals who have to come into contact with migrants by training for the elimination of stereotypes, false images and prejudice; on the other hand, we tried to reduce the potential obstacles that migrants could face due to misinformed, untrained, professionals.

We also aimed to supply the locals with the knowledge of certain necessary techniques like peaceful conflict resolution and skills like setting goals and planning alternative future as not to be surprised by "sudden" changes and avoid the undesirable reflex like resistance to change and latent hostility against migrants.

Target group

As mentioned above, we approached people of the wider local society who are active in their fields and due to the lock-down had enough time to be involved in long distance training.

To be more specific, the selected **trainees' group** was familiar with the IT and consisted of various professionals in order to enhance learning outcome through interaction; analytically, there were professionals like: a lawyer, a police officer, a coast guard officer, an army officer, teachers in mainstream schools and in a refugee camp, secondary school directors with a number of migrant students, executives of the Ministries of Education and of Interior Affairs (Dept of Foreigners & Migration) and a psychologist. They were invited to participate in the webinar as trainees because their work routine includes often contact with newcomers and migrants in general. The majority (80%) of the trainees hold a master degree, they are female (60%) and the age range is 26-56 years old.

Activities & methods

The people we approached had not received any previous training on cultural mediation and they mentioned several cases when they thought that they should have been supplied with some professional training on how to handle things better. After their positive response and relevant discussions, we composed the final **training material** which would focus on three units: "5 old *values", "Conflict & conflict resolution*" and "*Get Ready for Changes & Alternative Futures*"; the background information was based on adapted material derived from EU & UN sources, case studies, quizzes and experiential workshops.

The **synchronous** part of the webinar would last 20 hours in total and be concluded in three continuous days; it was really fast-paced but on the other hand, exhausting. In addition, there was **asynchronous** training which would request about 15 hours of homework (preparation, material study, paper writing) by the participants. The platform used was Webex by Cisco since we have already established a good relation with their affiliated company in Greece and they are the official providers of the Ministry of Education on a non-profit basis for the current covid19 era, too.

Regarding the **training method**, it was based on the principles of the long distance learning and of the adults' education while the process followed was from the specific to the general. Material for the activities was distributed electronically in advance, the whole educational package was sent to the participants after the conclusion of the training course and the teaching techniques included discussion, questions, problem solving, peer-learning, active learning and discovery learning; it is worth noting that we made maximum use of new technology and of social media throughout the training course (e.g. one-to-one video calls on Viber in order to prepare the role playing workshops).

As far as the **evaluation** of this pilot program is concerned and due to its short duration, we made only an initial and a final evaluation, thus omitting the interim one. The tools of evaluation included qualitative semi structured interviews prior the implementation of the program and a qualitative/quantitative evaluation with Likert scale and open questions after the training. The questionnaire was adapted to be uploaded to GoogleDocs and the trainees answered them on-line and anonymously.

After the relevant requests, the Region of Central Greece will provide the participants with Certificates of Participation/Attendance to reinforce their CVs.

Evaluation results

Strengths, as stated by the participants in GoogleDocs on-line questionnaire, were the following:

- "*The organization of the educational material, the group activities, the focus on the educational needs of the students ...*
- *Interaction and collaboration activities between participants.*
- *Use of material that is understandable, comprehensive, clear, enjoyable -Very good organization of the material*
- *The collaborative nature of the activities*
- *The use of new technology, good subject matter and team composition*

Workshops, play roles

- *The relevant workshops because I consider the experiential approach always very strong, essential and educational.*

- *Immediacy in participation and especially correlation with events really in my workplace.*
- *Understandable structure and material for recipients of different subjects -Excellent participants, who were willing to actively engage in substantive analysis of the topics . In this way we could express ourselves freely, but we did not expand by insisting on specific issues. - The webinar was a 'safe place' where one could express one's concerns without fear of being judged by others.*
- *The interaction between the participants and the experiential exercises were very important.*
- *very good presentation of the topics and the material presented, which was interesting and understandable.*
- *organization of matter, material, experiential activities*

And the **weaknesses,** as stated by the participants in the above mentioned questionnaires, were:

- "*The stability of the network lines*
- *Limited suggestions for actions due to the few hours of the seminar.*
- *It should take more time*
- *Limited time*
- *Flawless organization and presentation by the trainer*
- *Some images were a bit vague*
- *I would like the webinar to last longer.*
- *Preparing participants in all actions without taking into account the spontaneous behavior of the moment and the operation under a regime of stress and pressure that often operate people who deal with immigrants and mainly refugees but also them.*
- *I would like more time to analyze in more detail the results we came up with.*
- *We focused on many interesting issues, which may have taken longer to develop further.*
- *the duration should be longer*"

Discussion

Satisfaction of the target groups

The participants admitted that the webinar helped them significantly to improve their knowledge, skills and abilities in terms of (*in their own words*):

- *Conflict management conflict resolution in particular*
- *In decisions for decision making and continuity of safety*
- *Better manage many different people and work together*
- *Dealing with "changes" and managing them properly for a better future.*
- *Conflict resolution*
- *Immigration, resolving disputes and conflicts, creating a plan*
- *Providing services to support and improve the health and care of refugees*
- *Accepting the different and understanding my negative behavior against it*
- *It has significantly improved my ability to resolve conflicts, and in particular the way in which conflicting interests are weighed, by finding a mutually acceptable solution*
- *The sensitization and removal of stereotypes that I had*
- *Understanding and dealing with situations in my personal and professional life resulting in my best possible reaction and behavior*
- *Improvement in conflict resolution and management"*

Increase in awareness and knowledge

The participants had the option to write a paper in addition to their online training and thus increase their time of attendance for the Certificate. Indicatively, we present the short English versions of two papers and the data for the decision trees at the Annex of this evaluation report. The assessment analysis examines the alternative scenarios for two current problems/crises, it is accompanied by proposals and it is somehow the implementation of the decision tree method we studied in the "Changes & the Future" unit of our training course.

Other

Refer to sustainability, the community approach and integration aspects – summarize again why the specific issue is important for the health of migrants/refugees

Conclusions & Lessons learned

For the integration of migrants/refugees: it is necessary to sensitize citizens and professionals of the local community on the issues of cultural difference and on peaceful conflict resolution. Ideally, there should be invited representative of the migrants' community and develop some discussion at the closing of the seminar.

For the health care services: it applies the same as for the other professionals; they need special training on cultural mediation as well.

Emphasize the community approach: it is necessary to have a holistic approach on the topic. Training on cultural mediation should be offered to key-persons from all public organizations and professional associations who deal with migrants so as to create a social alliance for a more tolerant society and to facilitate migrants inclusion.

Emphasize sustainability and scaling up: Until now, we have received four requests for further implantation of the program, from the staff of a refugee camp (in English language), from the Head of an upper-secondary public school, from a Teachers' Regional Union in S. Greece and from educators of an Aegean island with a large number of migrants and refugee camps.

Limitations

Due to the Covid19 epidemic, we were forced to run the seminar on-line and restrict the number of participants as well as the duration of the training course.

Case studies - MigHealthCare -**Webinar**: "Cultural Mediators"

CASE STUDY 1 - Title: "*The influx of refugees in Europe has increased and there is a problem for host societies*" by Maria Matthteou

The issues that arise concern many parameters. However, in this paper we will examine the issue of inclusion & integration in two parameters:

(A) the local host communities and (B) the refugees

It is worth noting that the concepts of integration and integration are not identical. The second is a longer and more complicated process (see relevant literature at the end of the paper)

ALTERNATIVE SCENARIOS:

(A) In local communities there can be three main types of citizens in terms of their attitude towards refugees: I. Enemies II. Reserved III. Friendly

Enemies may:

a / change attitude if there are certain conditions (eg acquaintance with refugees, notable people, as workers, love, etc.). This change can be:

* constant, so people then show tolerance or

* be temporary and people become hostile and xenophobic

b / remain racist and always be fanatical.

Reserved may under certain conditions:

a / remove their caution to be characterized by tolerance and possibly to act as intermediaries

b / remain cautious and to overcome xenophobia

Friends may:

a / show full acceptance of the new situation in society and to act in two ways: 1.conflicting, as firmly and under any circumstances and circumstances due to their political ideological beliefs defend the rights of refugees ignoring the objective difficulties of adapting / adapting society, or 2. As mediators, since they recognize the needs of both sides

b / be “humanitarian”, in the sense of philanthropic mood and action. They may:

* participate in occasional actions and "withdraw" from time to time or

* participate consistently and constantly in acts of offering and caring for refugees

(B) Refugees, depending on the circumstances that forced them to take refuge, their particularities, aspirations and desires may be distinguished into two groups:

I. Those who seek to “live the dream” and II. Those who just want to survive.

Those who seek to live the dream of a better life in societies that provide opportunities for economic well-being, secure rights, etc. possibly:

a / seek their advancement to another target country. Some of them may

* manage it legally or

* be trapped. They may: i. try to "leave" legally or illegally, at which point they will remain on the social margins ii. consider the case to remain, in which case: either they will adapt to the

requirements and character of the host society, i.e. they will appear "open" or they will remain a "closed group"

b / from the beginning to consider the possibility of remaining, in which case for them the above will apply, perhaps with a more positive sign.

Those who simply want to survive at this stage, as their asylum may be dictated by an extremely pressing, unexpected need e.g. war, natural disaster, etc., may be divided into two groups. To those who:

a / have the expectation of return. In this group, two subgroups may be distinguished:

* those that remain "closed" to the local host community, whose contacts are limited to the level of survival. They voluntarily stay on the sidelines and

* those who use the unspecified time until their return to their homelands, and take advantage of all the opportunities and positives offered by structures of the host society, especially in education (e.g. learning a foreign language, developing skills, etc.)

b / consider from the outset the possibility of staying, consider their losses as an opportunity for a new beginning. They will follow the same course that has already been presented either as an "open group" for its integration and in the future its integration into the host society or as a "closed group" that will remain, as far as possible, on the sidelines.

PROPOSALS FOR IMPORTANT FUTURE PROGRESS:

As can be seen from the possible developments in the treatment of refugees in reception societies by residents and refugees themselves, their integration into these communities is a prospect.

However, it is affected by various parameters that favor or hinder it to varying degrees. Specifically:

<u>For the host community we are referring to, these are:</u>

a / REACTION: racism-fanaticism-xenophobia → difficult to deal with, but not impossible, through law and education. However, it is essential that they are not ignored, and "smoothed out", in order to be weakened as possible factors of social unrest.

b / DIFFICULTIES: friendly-conflicting types are a permanent possible parameter of anomaly because they reflect the reaction of the enemy-racists and because by intervening extreme they make it difficult for them. Moderate, balancing actions of the authorities and the local community in favor of the refugees, deeming them inadequate. Therefore, decisions must be made on this parameter as well. In my opinion, these are mainly about the legal framework for their intervention. So we need a strong state.

c / SUPPORT: They can offer a large team, consisting of: i / friendly → mediators ii / friendly → humanitarian iii / former reservists → mediators iv / former enemies → tolerant of different quality and intensity, depending on the specific characteristics of each sub-group. Positive attitude and

action are systematically cultivated through education, so that this new group can function actively and catalytically continuously, in the face of reaction and difficulties.

From the refugees:

a / SUPPORT: from those who choose in a positive mood to stay in the host societies. Decisions should be made to address a range of actions that will systematically and gradually familiarize refugees with the new social context in which they will be integrated. So education in various fields (language-history, professional skills, culture with emphasis on osmosis points, etc.) is the main tool that will be used. This group is also the first to join and to be integrated faster.

b / DIFFICULTIES: Those who choose to stay as a "closed group" will always be a source of difficulties. Necessary for them is the planning of educational activities that will cover their real needs but also that will exercise them to "walk" the distance that differentiates them from the host society.

c / ADMINISTRATION: For those who manage to be promoted to desirable "target states", the shape of the possibilities of smooth inclustion to integration or survival in cultural-social margin in the new host societies, influenced by their own characteristics, applies.

FINAL PROPOSAL:

Design of educational specialized and personalized actions towards refugees and locals to get acquainted with the different, development of tolerance, acquisition of professional and social skills, consolidation of the sense of security and democracy.

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CASE STUDY 2 - Title: “A pandemic affects our world - Covid19” by Maria Anastasiou

1. The problem

The pandemic Covid19 hit the whole planet and Greece, too. The present paper is an appreciation of situation analysis of the problem, as well as the measures taken for its immediate and indirect consequences, through a "decision tree". To formulate the decision tree on Covid19, the systematic methodology of problem analysis and solution synthesis was selected. Thus, the structure of the tree from the base to the branches follows the logical order: central issue, individual problems, goals, criteria and indicators of achieving goals, means of achieving goals. In particular, at the last level, where the composition is made and the means of achieving the goals are described, the

categorization is done both per target and per implementing body. In power, therefore, at the last level of branching we have in essence, a three-dimensional decision tree, where in the first dimension the flow of the problem extends, in the second the categorization of the means per target, and in the third the categorization of the means per implementing body. In particular, by grouping the individual problems / consequences of the pandemic, the health issues themselves are identified, the quality of life issues related to health protocols and restrictive measures, but also the issues of economic recession that the whole situation entails. For each of the individual problems, goals are described that, if met, lead to their inhibition or limitation.

So, for the health issue, as goals we have:

- The reduction of deaths,
- the reduction of cases and
- the future protection of the population from coronavirus are highlighted.

On the issue of living, it turns out that the desired goals are:

ü to replace the social-urban functions that are interrupted due to restrictive measures and
ü the inhibition of collective fear / insecurity / pressure and in general all the negative emotions that the current situation creates.

Finally, for the economic implications, two objectives are pointed out:

Ø the developmental one related to the shielding of enterprises from the consequences of the pandemic and
Ø the social one concerning the protection of the economically weak members of society (unemployed, fired, vulnerable groups, etc.).

For each of these 7 objectives, corresponding criteria and indicators of their satisfaction are established. This is an intermediate stage that causally and quantitatively connects the goals with the means of achieving them that follow.

Indicatively, for the purpose of "case reduction", the criterion is the comparison of Greece's performance with other countries and as a special indicator the number of confirmed cases per population unit (e.g. per million people). Subsequently, almost all of the actions, regulations, initiatives and actions taken by each of the targets, the social partners, i.e. the Government, the Local Government, the companies-organizations and the citizens themselves, are developed in groups. Thus, for example, the goal of "business shielding" was served by the Government with measures of benefits for affected professionals, tax cuts, and suspension of obligations to the State. All the individual problems, goals, criteria indicators and objectives of the goals are described in detail in the decision tree.

2. Alternative possibilities of evolution

Systemic analysis through the decision tree selected to describe the problem involves structural determinism, that is, specific measures create specific results in an unambiguous way. For a multifactorial and dynamic phenomenon such as pandemics, this assumption obviously limits the

ability to draw comprehensive conclusions, but is considered sufficient for the depth of analysis required by the present.

It should also be noted that the economic consequences are largely due to the restrictive measures themselves. As a result, the different targets and their respective measures, in many cases, act as communicating vessels, and ultimately the extension of one measure (e.g. restriction of movement) will lead to an increase in the health problem and the obstruction of the target "restriction" cases. With this data, it can be said at the outset that if any of the measures described were not taken, then the corresponding target would be served to a lesser extent and the corresponding problem would become more unfavorable. It is clear that if the analysis was quantified (e.g. with weights per target and criterion, and with a score of the means of achievement) the correlation of each change of achievement measures could be assessed by the change in the degree of achievement of the target. Moreover, the fact that the interaction, and in fact the negative correlation between the means of achieving the health risk (and the quality of life) with the economic problem, leads to the political part of the decision. That is, the "dosage" of health protection measures and measures to shield the economy, which in turn goes back to the value system of the decision maker and the society he serves.

Finally, as a general observation, it can be said, precisely because of the already mentioned limitations of the deterministic approach, that most likely phenomena such as a pandemic are applicable and approaches to Chaos theory, according to which imperceptible changes in data (in this case means of achieving objectives) can cause incalculable consequences for the dimensions of the problem.

3. Suggestions for optimal future prospects

The detailed submission of improvement proposals is obviously extremely precarious, especially given that the economic side of the problem is in full swing. However, some general conclusions can be drawn from the following:

- Further assessment analysis of the current pandemic for future use.
- Stronger shielding of the National Health System.
- High readiness of public and private organizations for a possible new need for restructuring of operation, with IT technologies, teleworking, etc.

Pilot Report Greece: Algorithm

Background

Since the Middle East crisis began in 2011 Europe has seen increased flows of migrants and refugees arriving mainly at the Mediterranean shores. According to UNHCR data, 70.8 million people were forcibly displaced from their homes. Since 2015, over 2.000.000 refugees and migrants arrived in Europe, while large migrant/refugee flows continue to arrive to date. The need to address migrant/refugee health issues and facilitate health care access for this vulnerable population group is increasing. The UN's Covenant on Economic, Social and Cultural Rights, article 12.1 cites that "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN 1966). In the European context, the Charter of Fundamental Rights states that everyone should have the right to access preventive health care and to benefit from medical treatment. Still, problems in health care access for migrants and refugees exist.

Inequalities are the result of legal barriers that exist in many EU MS in accessing care among migrants, refugees and asylum seekers and especially undocumented migrants. However, inequalities are also attributed to the economic situation of migrants who may lack the means to access or to pay for health services. Inequalities are also the result of language barriers, discrimination and what is referred to in many articles as lack of cultural competence from healthcare providers (Lebano et al., 2018). Migrant and refugee populations in Europe are in general young healthy adults, but they also include a substantial proportion of families, elderly and disabled people (WHO, 2018). Their health needs place them in a disadvantaged position as a result of exposure to many risk factors, such as long and perilous journeys, homelessness, lack of insurance coverage, exposure to violence, mental and physical trauma and exploitation (WHO, 2018). These are indications that migrant and refugee populations may present with worse health outcomes than the host population, such as increased infant mortality, adverse gynecological outcomes and unregulated chronic disease outcomes. Moreover, factors such as cultural and language barriers, unemployment or low paid, illegal or insecure jobs put them at increased health risks (WHO, 2018).

Fortunately, 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.

Link to the Roadmap & Toolbox

The Roadmap & Toolbox is a user-friendly **online application** which focuses on the key steps for optimal health care delivery to migrants and refugees including useful tools that can be used either by healthcare professionals or migrants and refugees as well as examples of best practices. It also includes an algorithm, to be used as a guide for health professionals that can assist in providing better health to patients from a migrant/refugee background.

The Mig-HealthCare Roadmap comprises:

1. **The necessary actions a health professional needs to engage in during delivery of care to migrants and refugees,** namely:
    - Continuity of information

- Language, Culture & Communication Issues
  - Language and communication
  - Cultural issues
  - Health literacy

2. Information concerning health issues of particular importance for migrants and refugees

- Mental Health
- Vaccinations
- Maternal/ child health
- Health promotion
  - Cervical and Breast cancer screening
  - Colorectal cancer screening
  - Alcohol
  - Smoking
  - Nutrition
  - Physical activity
- Oral Health/ Dental Care
- Non-Communicable diseases (NCDs) & chronic conditions

3. Promising practices

The Mig-HealthCare partners reviewed and evaluated relevant interventions that address health issues among migrants/refugees. Some of these interventions which were positively evaluated and are considered as Best Practices could be used in different settings. More information about these and other promising practices can be found on the project's website http://www.mighealthcare.eu/ by accessing the report titled 'D5.1: Report on models of community health and social care and best practices'.

4. Tools

The toolbox includes approximately 300 tools belonging to the different categories mentioned above. The toolbox can be accessed directly from the Mig-HealthCare website or through the different Roadmap categories. Searching for tools is facilitated by various filters (thematic category, language, end user, type of material).

5. The Mig-HealthCare algorithm which is a tool to guide health professionals through all the necessary steps on identifying health issues of particular importance when delivering care to migrants/refugees.

Community approach

"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, which 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 especially valuable for the most vulnerable members of the community like migrants/refugees, older adults etc. (A glossary of terms for community health care and services for older persons http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf)

The Mig-HealthCare roadmap & toolbox emphasize an approach that can be implemented at a local community level by local health professionals.

Aims & Objectives

The pilot objectives were to test the Mig-HealthCare algorithm at a local level in order to determine its usefulness for facilitating health care provision for migrants & refugees. The algorithm is available from the project website https://www.mighealthcare.eu/roadmap-and-toolbox.

Target group

The algorithm was tested among health professionals in the following locations:

- Skaramagas refugee camp
- Elaionas refugee camp
- Regional health/social services in the area of Halkida including the town hospital

Participants comprised:

- medical doctors
- nurses, midwifes, psychologists, social workers
- administrative personnel

Activities & methods

Training on how to use the algorithm took place in all sites. Participants were asked to fill in the Mig-HealthCare algorithm during their consultations with patients. Participants were asked to fill in at least 1 algorithm per week over a 3-month period between December 2019 and February 2020. In the absence of computers and/or on site access to the internet these were provided by the project. Participants were asked to save and store the completed algorithms. The consortium was also able to access completed algorithms directly from the website through google analytics.

Evaluation results

In total 114 completed algorithms were received from the participants.

Demographic characteristics

Before pilot implementation, participants completed a questionnaire for demographic characteristics. Demographic characteristics of the participants are displayed in **Table 1**. The mean age was 40.6 years and 8 out of 21 professionals were males. 1 out of 3 were medical doctors, about 1 out of 5 nurses, psychologists and midwifes and lower than 10% social workers and administrative assistants. Most of the sample was working in a camp or settlement health center (one third), in a primary health care service (one fourth) or in a hospital (one fourth) and the rest 20% in National Public Health Organization or in a social service. Half of the sample had higher than 10 years of employment (in general), 2 years of employment with migrants/refugees experience and 2 years of employment in their current place.

Table 1. Demographic characteristics of the participants at baseline (N=22).	
Age (Mean± sd)	40.6±7.2
Males (%)	8 (38.0)
Health profession (%)	
Medical Doctor	7 (31.8)
Nurse	4 (18.2)
Social worker	2 (9.1)
Psychologist	4 (18.2)
Midwife	4 (18.2)
Administrative assistant	1 (4.5)
Place of employment (%)	
Primary health care service	5 (25.0)
Hospital	5 (25.0)
Camp or settlement health center	6 (30.0)
National Public Health Organization	2 (10.0)
Social Service	2 (10.0)
Years of employment (Median(range))	10 (0.5-26)
Years of employment with migrants/refugees (Median(range))	2 (0-6)
Years of employment in your current place (Median(range))	2 (0.08-8)

Following the pilot implementation of the Mig-Healthcare program, 17 participants completed a post questionnaire to assess the pilot action in general and the algorithm element (thematic category) of the roadmap.

Assessment of algorithm

The 17 participants that completed the pilot study and the questionnaire regarding the algorithm were ***74±14% satisfied with the results*** in general. More specific:

- 15 of 17 (88.2%) agreed or totally agreed that algorithm can be used in different healthcare structures/facilities and may lead to actions for health promotion in migrant/refugee camps.
- 13 of 17 (76.5%) agreed or totally agreed that algorithm's questions are clear, unambiguous and may contribute to tracking health needs and improving the quality of health care for migrants and refugees.
- 12 of 17 (70.6%) agreed or totally agreed that algorithm is easy to use for themselves and the existing staff, algorithm's questions cover relative needs and issues for migrants and refugees and using algorithm discovered useful tools from toolbox for healthcare provision.
- 11 of 17 (64.7%) agreed or totally agreed that algorithm is directly connected with Mig-Healthcare roadmap & toolbox, further implementation of algorithm is possible and completeness of the algorithm helped them track health needs of migrants and refugees.
- 9 of 17 (52.9%) agreed or totally agreed that algorithm can contribute to tracking access difficulties to health services for migrants and refugees and they will continue its implementation after the pilot phase ends.
- 11 of 17 (64.7%) do not think that use of algorithm can continue without additional funding.

Additionally, participants answered three open-ended question concerning the strengths and weaknesses of the algorithm and whether they had improved skills and competencies after using the algorithm.

The results are presented in Table 2.

Table 2. Reports of the participants regarding the three open-ended question.	
Improved my skills and competencies	(positive answers/N)
In nothing	1/13
With more knowledge	5/13
Better clinical picture of migrant and refugee patients	10/13
More familiar and improved communication with migrants and refugees	3/13
Strengths	
Variety of different information	5/12
Easy to use	4/12
Clear questions	2/12
Plenty of gynecological information	2/12
Useful tools	1/12
Electronic form	1/12
Focuses on medical information	1/12
Well organized	1/12
Facilitate the reference to the appropriate expert	1/12
Weaknesses	
High implementation time	3/14
Need for translator	2/14
Not much gynecological & maternal health information	2/14
Not much mental health information	2/14
Not much dental information	1/14
General questions	1/14
Unavailable medical record, they rely only on oral speech	1/14
Material in few languages	1/14
Internet is necessary	1/14
Not much psychosocial information	1/14
Few questions for patient's lifestyle	1/14

Pilot action assessment

The seventeen participants who finished the pilot study and completed the questionnaire regarding the pilot action were ***73.8±9.6% satisfied with the results*** in general. In more detail:

- 14 out of 16 (87.5%) agreed or totally agreed that the pilot action can be implemented in different settings.
- 14 out of 17 (82.4%) agreed or totally agreed that the materials used are intuitive and clear.
- 13 out of 17 (76.5%) agreed or totally agreed that the pilot action has added value for the community.
- 12 out of 17 (70.6%) agreed or totally agreed that the pilot action fits the needs of migrants/refugees and can improve their quality of health care, also the infrastructure to implement the pilot action exists and they would like the action to continue after the pilot phase ends.
- 11 out of 17 (64.7%) developed relevant competencies in terms of delivering health care to migrant/refugee patients.
- 10 out of 17 (58.8%) agreed or totally agreed that the pilot action was adequately developed and implemented, covers relevant needs and issues for their work and they will continue implementing the action after the pilot phase ends.

- 9 out of 16 (56.3%) agreed or totally agreed that the pilot action facilitates health care access for migrants/refugees.
- 9 out of 17 (52.9%) agreed that the pilot action was in-line with their expectations, it is easy for existing staff to implement the pilot action and they acquired relevant knowledge for professional purposes during this pilot action.
- 10 out of 17 (58.8%) do not think that the pilot action can continue without additional funding.

Discussion

Results showed that the participants were satisfied with the algorithm and considered it as a useful tool that can be used at the community level. We noted that the algorithm was an important tool for health professionals who come into 1st contact with migrants/refugees while specialized medical doctors such as gynecologists did not find it as useful. We conclude that this tool could be useful for people working in 1st reception facilities. Finally, we need to keep in mind that the algorithm requires a certain amount of time which is not always available as often centers responsible for the health and social care of migrants/refugees are overwhelmed with large numbers of beneficiaries. Of particular importance is the feedback we received from social care professionals who considered the algorithm an important tool to diagnose otherwise undiagnosed medical conditions and facilitate referral for appropriate care. Additional comments concerned the availability of the algorithm questions in different languages including migrant/refugee languages.

Key points after the pilot implementation

- Participants who finished the pilot study were 74% satisfied with the results of the algorithm and the pilot action in general.
- The algorithm was rated as an easy to use tool with a variety of different information, but it requires a significant amount of time to be completed.
- Most of the participants do not think that the pilot action and the use of algorithm can continue without additional funding.

Networks of collaboration

The Mig-HealthCare experience in Greece was important as it created networks of cooperation between the different participants working in different refugee/migrant camps as well as professionals working at the local level. These different actors in the field of migrant and refugee health had the opportunity to participate in the project final event and exchange experiences concerning their participation in the project. This collaboration we hope will be continued beyond the lifetime of the project.

Future research

Provided appropriate funding is secured future research will focus on developing the algorithm in different migrant/refugees languages.

Pilot report Austria: Focus on Training

Background

The Austrian pilot focused on testing the roadmap and toolbox among health professionals working in regional health services in the wider area of Innsbruck. Training focused on all elements of the roadmap and toolbox. Internal problems of the partner in combination with the COVID-19 situation made the pilot difficult to be implemented as initially planned.

Aims and objectives

The Austrian pilot focused on testing all elements of the roadmap & toolbox.

Target group

Health professionals working in regional health services in the wider area of Innsbruck.

Evaluation results

The A2 questionnaire was completed by 5 participants from Austria. The main results are presented below:
Regarding the Mig-HealthCare *algorithm*,

- 2 out of 5 reported that is useful for their work
- 3 out of 5 that is relevant for the health of migrants/refugees
- 3 out of 5 that provides a helpful outline of refugee/migrant health needs

Regarding the Mig-HealthCare *Roadmap &Toolbox*,

- 3 out of 5 reported that the knowledge they acquired from the Mig-HealthCare Roadmap & Toolbox improved their understanding and professional competence
- 5 out of 5 acquired new insight about the health problems of migrants/refugee
- 4 out of 5 gained me new ideas about how to address health care problems among migrants/refugees

Additionally, healthcare professionals reported that Mig-Healthcare roadmap & toolbox assisted their work with migrants and refugees, providing:

- adequate tools for different health issues in all participants (5 out of 5),
- in different languages (4 out of 5) and
- up to date information about migrant/refugee issues (5 out of 5).

Two participants also answered two open-ended question for the strengths and weaknesses of the Mig-HealthCare roadmap & toolbox after the pilot implementation and the results are presented below:

Strengths	Weaknesses
"It's useful to understand the specific needs and requirements of migrants and refugees which leads to effective and successful treatments"	*"It's very complex and not self-explaining; too much information, too few graphics/pictures"*
"All fields are covered, very informative"	*"Overload of information, not self-explanatory especially for elder people"*