Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance

D5.1 ***Methodological approach for needs assessment in Health access for Migrants and refugees in Europe***

V2.0 [Final]

WP5 – Needs Assessment

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Responsible Author	Adil Qureshi		Email	aqureshi@vhebron.net	
	Partner	VHIR	Phone		
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MYHEALTH CONSORTIUM

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4	*Migrantas e.V.*	*DE*	*Migrantas*
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11	*Hospital Charité, Universitaetsmedizin Berlin*	*DE*	*CHARITE*

ABBREVIATIONS

CDC	Center for disease control and prevention
CHAFEA	EU Consumers, Health, Agriculture and Food Executive Agency
ECDC	European center for disease prevention and control
FGs	Focus groups
FGDs	Focus groups discussions
ID	infectious diseases
IDIs	Individual in-depth interviews
ICT	Information and communications technology
MyHealth	Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance
MH	Mental Health
NCD	non-communicable diseases
VMRs	Vulnerable Migrants and Refugees
WHO	World Health Organization
WP	Work package

MyHealth Glossary

Asylum seeker	A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.[1]
Chronic disease	No uniform definition of chronic disease exists. Some sources use the term interchangeably with non-communicable diseases whereas others include chronic conditions of infectious origin such as HIV or mental illness such as Alzheimer. [2]
Community	The condition of sharing or having certain attitudes and interests in common.[3]
Community activity	For MyHealth project: A pursuit of civic responsibility and of wanting or feeling to do something to support one another and/or the wider society.
Community Health agent	Community health agents are those who work in communities to strengthen the links between the community and health services, usually not certified and outside of national healthcare services. This also includes non-health agents who work on the social determinants of health such as housing, inequalities, education, employment or the environment.[4]
Community involvement	For MyHealth project: The process of engaging in discussion and collaboration with community members.
Community participation	For MyHealth project: a meaningful active involvement of community members in the design, development, implementation, delivery, as well as evaluation of health services".
Country of origin	The country that is a source of migratory flows (legal or illegal).[1]
Country of transit	The country through which migratory flows (independent of administrative status) move.[1]
Health	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[5]
Health champions	People who, with training and support, voluntarily bring in their ability to relate to people and their own life experience to transform health and wellbeing in their communities.[6]
Health education	Health education is any combination of learning experiences designed to help individuals, groups, and communities improve their health, by increasing their knowledge or influencing their attitudes.[7]
Health Needs	For the MyHealth project: Deficiencies in health perceived by a stakeholders that requires some intervention. The perceptions could be similar or different

	between them.
Health promotion	Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. [8]
Host Country	The EU Member State / country in which a third-country national / non-national takes up residence.[9]
Immigrant	In the EU context, a person who establishes their usual residence in the territory of an EU Member State for a period that is, or is expected to be, of at least 12 months, having previously been usually resident in another EU Member State or a third country.[9] Any 3rd country national without an EU/EEA passport arriving in the EU.
Infectious, or communicable diseases	Defined as an illness caused by a specific infectious agent or its toxic product that results from transmission of that agent or its products from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate environment.[10]
Integration	As a state where an individual can maintain his or her own cultural identity while at the same time becomes active participant in the host culture.[11]
Irregular (administrative) migrant	Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal administrative status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation).[1]
Learning Alliance	Innovative methodology seeking to re-think the utilisation, appropriation and impact of research outcomes in the health services area in more integrated ways. Formally defined, it is "a series of connected multi-stakeholder platforms or networks (practitioner, researchers, policy-makers, service users) at different institutional levels (local, national) involved in two basic tasks: knowledge innovation and its scaling up." [12]
Mediator	A person who usually belongs to the immigrant community or is familiar with the cultural aspects of that immigrant community, translate (if necessary, adapt the information), and facilitate liaison between two entities, for example a hospital/institution and a service user.
Mental health	Mental health is defined by WHO as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.[13]
Migrant	At the international level, no universally accepted definition of migrant exists.

	The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family.[1]
Migrant worker	A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.[1]
Migration	A process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants.[1]
Minor	In a legal context and in contrast to a child, a person who, according to the law of their respective country, is under the age of majority, i.e. is not yet entitled to exercise specific civil and political rights.[9]
MyHealth	A transnational project co-funded by the health programme of the European Union to develop and implement models of health network to reach out to migrants and Ethnic minorities, in particular women and unaccompanied minors.
Network	A group or system of interconnected people, institutions or things.[3]
Non-communicable diseases	Non-communicable diseases (NCDs), also known as chronic diseases, tend to be of long duration and are the result of a combination of genetic, physiological, environmental and behavioural factors. The major types include cardiovascular diseases, cancer, chronic pulmonary disease, and diabetes.[14]
Pictograms	Pictograms are the visual language of Migrantas. Their simple, universally understandable images stir emotions: people from different backgrounds recognize themselves in the representations, while others gain new insights or modify their own perspectives.
Pilot	For MyHealth project: is a test of a tool/method/instrument before introducing it more widely.
Refugee	A person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR's mandate, and/or in national legislation.[15]
Social determinants of heath	The social determinants of health are the conditions in which people are born, grow, live, work and age.[16]
Screening	Screening is defined as the presumptive identification of unrecognized disease in an apparently healthy, asymptomatic population by means of tests,

	examinations or other procedures that can be applied rapidly and easily to the target population.[17]
Stakeholder	For MyHealth project: A person, group or organization that has interest or concern in the project. The general categorisation used in the project for grouping stakeholders is: public sector, civil society, and private sector.
Third-country national (TCN)	Any person who is not a citizen of the European Union within the meaning of Art. 20(1) of TFEU and who is not a person enjoying the European Union right to free movement, as defined in Art. 2(5) of the Regulation (EU) 2016/399 (Schengen Borders Code).[9]
Tool	For MyHealth project: is an instrument (leaflet, training, game, workshop, network...) or methodology that aids in accomplishing a particular objective or task.
Trafficking in persons	The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. [1]
Translator	A person who provides translation services. Can be professional or informal (such as family members).
Unaccompanied minor	A minor who arrives on the territory of an EU Member unaccompanied by the adult responsible for them by law or by the practice of the EU Member State concerned, and for as long as they are not effectively taken into the care of such a person; or who is left unaccompanied after they have entered the territory of the EU Member State.[9]
Undocumented migrant	See irregular migrant
Vulnerable migrants (or migrants in vulnerable situations)	There is no internationally recognized definition. IOM proposes a model that defines vulnerability within a migration context as the diminished capacity of an individual or group to resist, cope with, or recover from violence, exploitation, abuse, and violation(s) of their rights. It is determined by the presence, absence, and interaction of factors and circumstances that (a) increase the risk of, and exposure to, or (b) protect against, violence, exploitation, abuse, and rights violations .[18]

References:

1. *IOM. Key Migration Terms [Internet]. Grand-Saconnex: International Organization for Migration; 2018 [cited 2017 Sep 28]. p. 2. Available from: https://www.iom.int/key-migration-terms*
2. *Bernell S, Howard SW. Use Your Words Carefully: What Is a Chronic Disease? Front Public Heal [Internet]. 2016;4(August):2–4. Available from: http://journal.frontiersin.org/Article/10.3389/fpubh.2016.00159/abstract*
3. *English Dictionary, Thesaurus, & grammar help | Oxford Dictionaries [Internet]. [cited 2018 Nov 27]. Available from: https://en.oxforddictionaries.com/*
4. *Lewin S, Munabi-Babigumira S, Glenton C, Daniels K, Bosch-Capblanch X, van Wyk BE, et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. Cochrane Database Syst Rev [Internet]. 2010 Mar 17 [cited 2018 Nov 26];(3):CD004015. Available from: http://www.ncbi.nlm.nih.gov/pubmed/20238326*
5. *CONSTITUTION OF THE WORLD HEALTH ORGANIZATION 1 [Internet]. [cited 2018 Nov 26]. Available from: http://www.who.int/governance/eb/who_constitution_en.pdf*
6. *Health Champions - Altogether Better [Internet]. [cited 2018 Nov 27]. Available from: http://www.altogetherbetter.org.uk/health-champions*
7. *WHO | Health education. WHO [Internet]. 2013 [cited 2018 Nov 26]; Available from: http://www.who.int/topics/health_education/en/*
8. *WHO | Health promotion. WHO [Internet]. 2017 [cited 2018 Nov 26]; Available from: https://www.who.int/topics/health_promotion/en/*
9. *| Migration and Home Affairs [Internet]. [cited 2018 Nov 26]. Available from: https://ec.europa.eu/home-affairs/what-we-do/networks/european_migration_network/glossary_en*
10. *Last JM, International Epidemiological Association. A dictionary of epidemiology. Oxford University Press; 2001. 196 p.*
11. *Berry, J. W. (2001). a Psychology of Immigration | Prejudices | Immigration [Internet]. [cited 2018 Nov 26]. Available from: https://es.scribd.com/document/251351869/Berry-J-W-2001-a-Psychology-of-Immigration*
12. *Moreno-Leguizamon CJ. Learning Alliance Methodology Contributions to Integrated Care Research. Int J Integr Care [Internet]. 2018 Mar 12 [cited 2018 Nov 30];18(s1):125. Available from: https://www.ijic.org/article/10.5334/ijic.s1125/*
13. *WHO | Mental health: a state of well-being. WHO [Internet]. 2014 [cited 2018 Nov 26]; Available from: http://www.who.int/features/factfiles/mental_health/en/*
14. *Noncommunicable diseases [Internet]. [cited 2018 Nov 26]. Available from: http://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases*
15. *Refworld | UNHCR Master Glossary of Terms [Internet]. [cited 2018 Nov 26]. Available from: https://www.refworld.org/docid/42ce7d444.html*
16. *WHO | About social determinants of health. WHO [Internet]. 2017 [cited 2018 Nov 26]; Available from: https://www.who.int/social_determinants/sdh_definition/en/*
17. *WHO | Screening. WHO [Internet]. 2017 [cited 2018 Nov 26]; Available from: https://www.who.int/cancer/prevention/diagnosis-screening/screening/en/*
18. *Principles and Guidelines migrants in vulnerable situations [Internet]. [cited 2018 Nov 26]. Available from: https://www.ohchr.org/Documents/Issues/Migration/PrinciplesAndGuidelines.pdf*

OVERVIEW ON THE INTERLINKAGES BETWEEN WORK PACKAGES WITHIN MYHEALTH PROJECT

The project workload is distributed in 8 work packages (WPs): three transversal (**WP1 Coordination and Management**, **WP2 Evaluation** and **WP3 Communication and Dissemination**) and four technical WPs (**WP4 Mapping, WP5 Needs Assessment, WP6 Tools development and WP7 Pilots**). This structure has been defined with the scope of gathering all envisaged activities with their logical and temporal interconnections.

Finally, a participatory and social innovative approach is used to ensure that Vulnerable Migrants and Refugees (VMR) take a central role in the project (**WP8 Community involvement**). This participatory and social innovative approach guarantees a meaningful active involvement of community members in the design, development, implementation, delivery and evaluation of healthcare services (Figure 1).

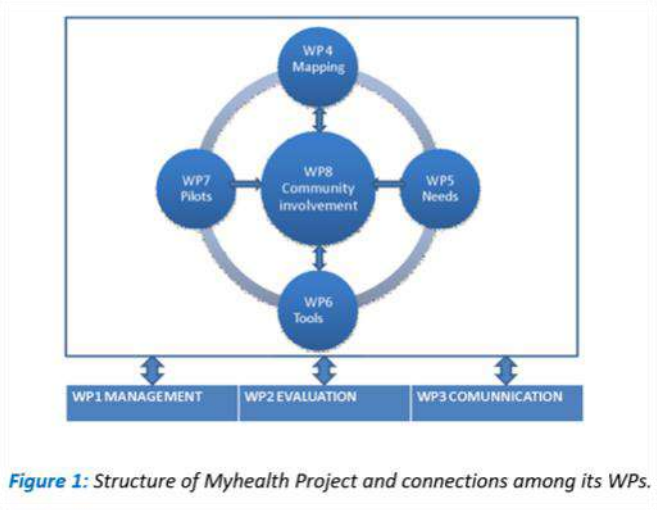


Figure 1: *Structure of Myhealth Project and connections among its WPs.*

Furthermore, project MyHealth is using a **Learning alliance (LA)** as an innovative methodology (details described in WP2). LA is a series of connected multi-stakeholder networks or communities (researchers, policy-makers, service providers and service users) at different institutional levels (local, regional and international) with the aim of improving the health conditions of VMR.

The following reports represent the outcomes of the tasks carried out under WP2 Evaluation:

- ✓ *D2.1 Evaluation plan*
- ✓ *D2.2 Interim and Final Evaluation reports*

In **WP3**, **Communication and Dissemination** tasks are carried out in order to communicate and disseminate project results and activities for raising awareness among stakeholders and general public. The following report summarized the outcomes of the tasks carried out under this WP:

- ✓ *D3.1 Dissemination package*

The **WP4** is devoted to **Mapping** the existing initiatives on Health for VMR. The tasks carried out under this WP are included in these reports:

- ✓ *D4.1 Data collection tool and protocol to gather reference sites, projects and ICT tools dealing with migrant population*
- ✓ *D4.2 Interactive map available online with the different exposed components (country health facts, reference sites, the available ICT tools, etc) and existing initiatives*

The overall aim of **WP5 Needs analysis** is to collect information on physical and mental health status of the VMR. The following reports are developed as the outcomes of the tasks carried out under this WP:

- ✓ *D5.1 Methodological approach for needs assessment in Health access for Migrants and refugees in Europe*
- ✓ *D5.2 Needs and capacity assessment report*

Tools development is the central part of **WP6** and it is based on the needs assessment's scientific results carried out under WP5. In this WP tools able to improve the health care access of VMR are identified or developed. The following reports summarized the outcomes of this WP:

- ✓ *D6.1 Report on defined models and consequent tools*
- ✓ *D6.2 Web platform based tools*

Pilots are carried out in **WP7** where the preliminary versions of tools identified under WP6 are tested in the clinical sites (Spain, Germany and Czech Republic). The following reports summarize the tasks carried out under this WP:

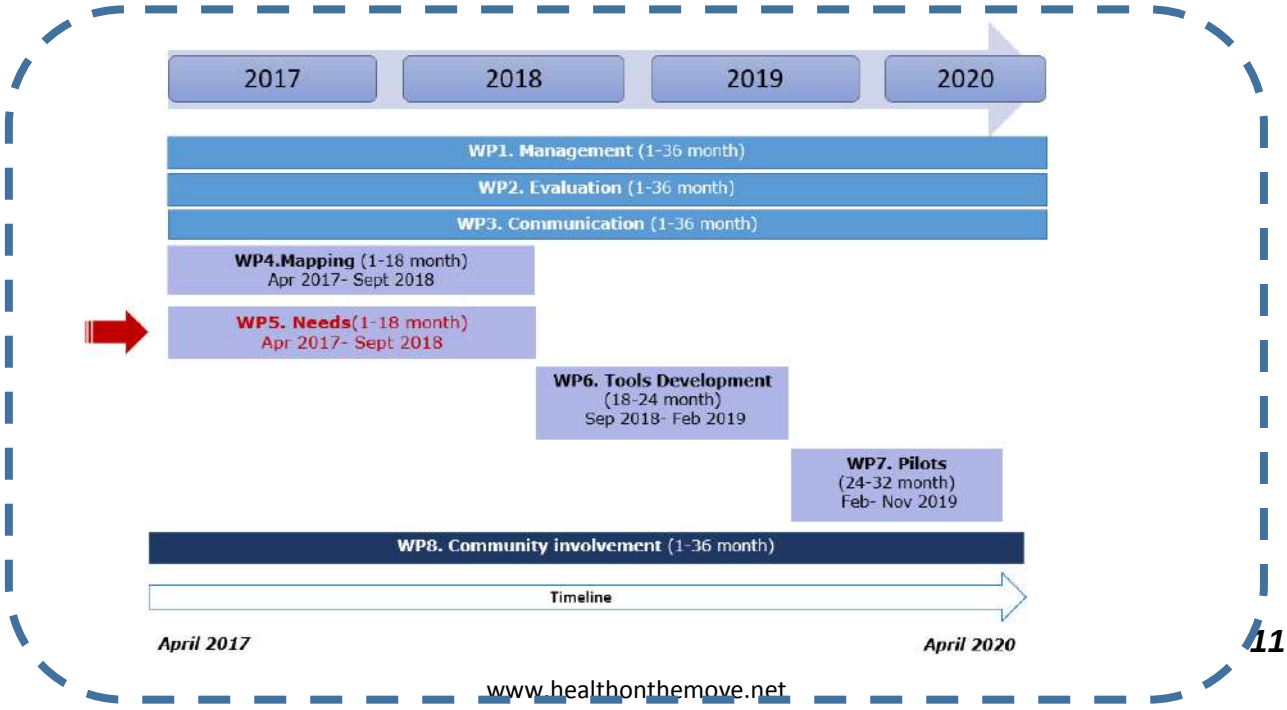
- ✓ *D7.1 Report on Economic analysis of comparative models*
- ✓ *D7.2 Evaluation report of the models*

Lastly, the outcomes of the tasks carried out under **WP8 Community Involvement** are described in the following reports:

- ✓ *D8.1 Model for Community Participation*
- ✓ *D8.2 Final health-educative suitcase for the informative sessions*

Where are we? *The present report corresponds to* **WP5 Needs Assessment.**

Timeline and connections among WPs of MyHealth are outlined in the following chart:



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Executive Summary

The current report describes the methodology used in MyHealth towards addressing key aspects of the needs of migrants, refugees and healthcare professionals in term of health access. Previous EC funded projects (SH-CAPAC, EUR-HUMAN, ORAMMA) demonstrate the importance for the identification of local health and social care needs as well as executable responses to these needs. The intent is not to repeat the work already done, but to give a qualitative and quantitative overview of the current situation in health access across Europe for vulnerable Migrants and Refugees, and in particular for women and unaccompanied minors. Previous endeavours have focused on health and social care professionals (e.g. CAPAC), a broad range of different moments of the migratory process (EUR-HUMAN), and maternal health (ORAMMA), all of which provide a strong basis from which this study departs. Because of the complexity of the issue, MyHealth opts for a specifically focalized approach, with a specific population group as well as in specific centres that have expertise and experience working with the target population.

The general objective of MyHealth is to improve the healthcare access of vulnerable Migrants and Refugees (VMR) newly arrived to Europe by developing and implementing models based on the knowhow of a European multidisciplinary network, funded by the EU Consumers, Health, Agriculture and Food Executive Agency (CHAFEA). This preparatory report will describe the process by which the different strategies were developed and put in place. We have decided the use: literature review of infectious diseases, non communicable diseases and mental health; focus groups, and individual interviews, in order to get a better understanding of the real needs in terms of health (quality and access), not only for the migrants/refugees, but also for health and social care professionals and other support services; and an online survey for quantitative assessment based on the results of the previous strategies. This is a methodological report compiled with inputs from the three "clinical sites" of MyHealth project (Barcelona, Berlin and Brno) and Sym Eirmos partner (Greece), but reviewed and discussed with all the members of the consortium.

The results of our analysis will be available in the Needs and capacity assessment report (D 5.2, November 2018).

How can our report be useful for you?

Either if you are a Health professional, a policy maker, or a migrant or refugee, we believe our methodological approach can be re-used, and implemented at the very moment you are in need of understanding key aspects of healthcare access.

Justification and Background

Between 2000 and 2015, Europe became the second most common destination for international migrants, receiving approximately 20 million migrants in total.[19] Countries throughout the European Union (EU) have significantly different entitlement regulations for access to health care for undocumented migrants.[20] These formal barriers delineate the services health care professionals can legally administer. In many countries, such as Germany, Denmark and Belgium, undocumented migrants are only offered access to emergency care or services for specific conditions.[21] Yet, in other countries including Sweden, Slovenia, the UK, Croatia, and Germany, health care providers are mandated to report undocumented migrants.[19] This fear of report to officials and perceived stigmatization hinders undocumented migrants from seeking crucial treatment.

Furthermore, informal, sociocultural barriers exist, which similarly alienate undocumented migrants from pursuing health care services. The primary impediment this population faces is insufficient language knowledge.[22] Without adequate language skills, undocumented migrants lack information regarding the constitution of the health care system in their host countries and their rights to accessing care. Likewise, language fluency aids good clinical communication when reporting symptoms and health needs. Adequate language skills additionally have proven to facilitate reporting of past traumatic events and psychological symptoms among undocumented migrants.[23] With low levels of education and health literacy, undocumented immigrants ultimately under-utilize health care services.

Beyond communication barriers, undocumented migrants and professionals alike must navigate bureaucratic and legal channels to support clinical treatment. Limited institutional capacity, time and resource constraints, and professional values limit access to health care.[23] Socioeconomic barriers also exist to prevent undocumented migrants from affording co-payments or sacrificing income to attend an appointment with a health professional.[24]

Ultimately, both formal and informal barriers contribute to the under-utilization of health care and thus, poorer health outcomes for undocumented migrants. Legal stipulations, fear of perceived racism, and language barriers serve as fundamental barriers currently affecting access to health care.

The current report addresses the Methodological approach for needs assessment in Health access for Migrants and refugees in Europe**.** *MyHealth*, and in particular the three clinical partners sites of Brno (FNUSA), Berlin (Charité), and Barcelona (VHIR/Vall d'Hebron) form the backbone of Workpackages 5 (Needs), 6 (Tools development), and 7 (Pilots), as all three sites have the clinical expertise/experience and knowledge, resources, and patient access necessary to effectively carry out all three steps. It is important to specify though that the development of the methodology has been a combined effort from all the partners to ensure their very diverse views and experiences.

The development of the needs analysis is based on a mix-approached methodology, to ensure that different actors could participate from different context.

1. Literature review.
2. Focus group discussions (FGDs) and individual in-depth interviews (IDIs).
3. Online surveys

This report here only details the *MyHealth* mixed approach to gain insight on the real needs in terms of access to health, from Migrants and Refugees, but also from Health and Social professionals involved in their physical and mental care. Results are presented in Deliverable D5.2 (Needs and capacity assessment report).

1 MyHealth approach for literature review

1.1 Infectious diseases and chronic diseases (non-communicable diseases)

The idea of this chapter is to define the current infectious diseases (ID) and chronic diseases (non-communicable diseases-NCD) of migrants living in Europe. This was done through two different strategies:

- Overview of scientific manuscripts about infectious diseases and non-communicable diseases among immigrants living In Europe. In this section there is a selection of scientific studies or grey literature based on the partner's experience. Results are more qualitative than quantitative. Articles published during the last 10 years were considered for this review.
- Systematic review of relevant studies analyzing prevalence of infectious diseases and non-communicable diseases of newly arrived immigrants in Europe since 2010. In this kind of review, studies were analyzed statistically with strict procedures. Specifically, we aim to identify the prevalence and estimations of communicable and non-communicable conditions in immigrants in Europe with the highest disease burden as reported by the latest Global Burden of Disease Study.[25]

1.2 Mental health

- The objective of this task is to define the mental health problems of migrants in Europe. This was done through a review of selected studies combined with systematic methods of study-selection. Relevant articles were examined with the objective of reaching saturation: once each new article (in a cycle of 10) failed to provide new information not previously encountered, the review process ended. Articles published from 2014 to the current time were explored.

2 MyHealth approach for focus group discussions (FGDs) and individual in-depth interviews (IDIs).

Although existing research can form an effective means by which to develop survey/questionnaire items, there is always the danger that certain issues or concerns are not fully covered by the body of research available, either due to the complexity or reticence (or both) of the phenomenon in question. To that end, qualitative approaches such as focus group discussions (FGD) and individual interviews (IDIs) with all relevant stakeholders are recommended as helpful tools by which to ensure as comprehensive coverage as possible.[26,27]

In a nutshell, the FGD and IDI are used to identify central concerns from all relevant stakeholders. On this basis, then, a large number of items can be generated, which will then go through an iterative process of being reviewed and then discarded or kept, adapted, rewritten, and so forth until all stakeholders are satisfied that the survey is sufficiently comprehensive, coherent, relevant, and accessible (i.e. not too long). In the next section we provide background on the FGDs.

2.1 Focus Group Background

There is a large body of literature that recommends the FGD approach for health and mental health needs analysis.[28,29] The FGD is particularly effective because it is both efficient as well as generative. It is effective and productive because it can accomplish in one session with a group what could be accomplished in multiple sessions with individuals. Hennink (2014) reports that the FGD could elicit almost 70% of the information that would be elicited by individual interviews with all the participants.[28] Additionally, the FGD is generative; it can engender information via the interaction of the participants that would not emerge in individual interviews. Furthermore, the FGD approach is designed to minimize the "leading" impact of the interviewer. A well-executed FGD will give the primary voice to the participants, thus potentially not simply responding to the questions of the interviewer. Further, the presence of the voices of the participants can serve also as "social moderation", that is, a quality check. In

an individual interview there is no "check" to determine the relevance or veracity of the statement made by the interviewee, whereas in the FGD other participants can comment on exposed ideas.

On the other hand, it must also be recognized that the FGD approach has certain limitations. For instance, the social context can also have an inhibitory impact. Although the group context is what gives strength to the FGD, it can also be problematic because participants may be concerned about the reactions of others, and thus may not share any ideas or thoughts that they fear would not be popular or would be accepted. In this sense, the FGD cannot guarantee confidentiality and thus certain topics—personal experiences, for example—can simply not be discussed. Although a maximum of homogeneity in each group (such as age and gender) is striven for, there could still be unexpected important differences among participants that could impact their participation in the groups. In order to try to overcome these limitations, we have combined IDIs with FGDs, a mixed approach that has been already recommended in the literature by different authors, such as Huffman.[30] We used the FGD where possible with both service providers, administrators as well as VRIs, and where this was not possible, either due to availability of the service provider or in those cases in which VMRs were not comfortable, individual interviews were used. We have no *a priori* reason to believe that either approach will have provided significantly different results.

2.2 Developing and conducting the Individual interviews & Focus groups

In our project, the IDIs and FGDs have been carried out following basic qualitative research methodology. Interview and focus group protocols were developed based on the literature review of health and mental health needs of the populations of interest. Two different protocols were developed, one for vulnerable migrants and refugees (VMR) and another for healthcare providers and administrator stakeholders. Although basic topics of questions were similar, the FGDs were somewhat different given the fact that VMR were asked about their own experience and the ones from their peers, whereas the providers and administrators were

asked about their perceptions in daily practice of the needs of VMR and if the existing services available were able to respond to these needs described.

Interviewers, MyHealth focus group facilitators

IDIs and FGDs have been carried out by team members with expertise in qualitative research and/or by community health agents who have been trained by the qualitative research experts (Annex 1). All of them had previous experience in carrying out FGDs and IDIs. Moreover, interviewers have been briefed on all aspects related to the ethical issues described above.

Interview protocols

Interview protocols were developed according to a preliminary qualitative analysis by MyHealth partners. It should be noted that the protocols were iterative, that is, they shifted and expanded given previous IDIs or FGDs (as is standard practice in qualitative needs analysis). Just the protocols were iterative, so too were the individual FGDs and IDIs; the interviewer used the protocol as a foundation, however, was free to depart from it to pursue a given line of conversation or to develop a specific idea or thought in greater detail. This was done in order to maximize coverage and ensure that the protocol questions did not serve to delimit possible findings.

The protocols themselves followed the so-called “hourglass” model, as described by Hennink (Figure 1).[28] In this model the goal is to begin with an introduction and very general open questions, which serve to get the participants to start to reflect on the topic at hand as well as to begin to feel comfortable in the interview/focus group process. As there are specific issues that must be covered to ensure comprehensiveness, once the participant(s) is/are engaged and is/are comfortable, the questions get more specific to ensure that key issues and points are addressed. On that basis, then, further, more exploratory and contemplative questions are asked that build on the specific ones provided.

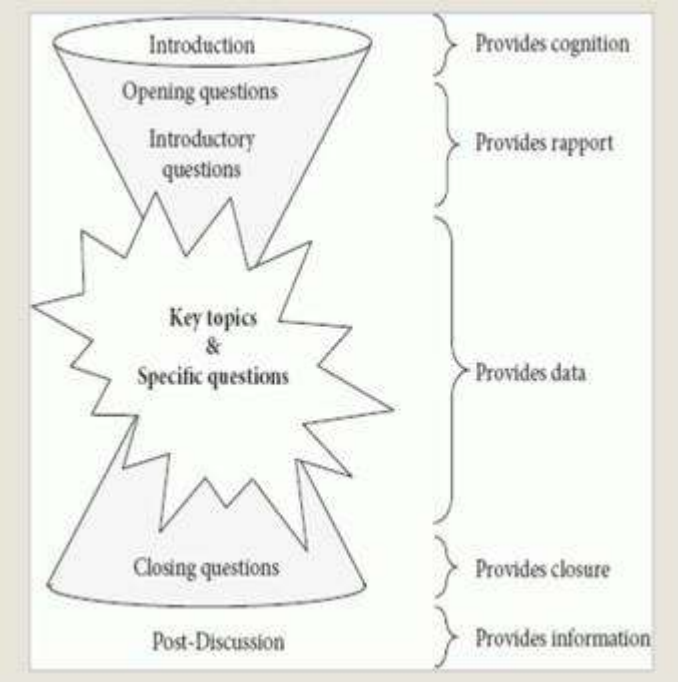

Figure 1: Hourglass design of the focus group discussion guide (Hennink, 2014)

Individual interviews

IDIs have been carried out in a location of convenience and comfort for the participant. In order to maximize confidentiality and anonymity for the most vulnerable, the trafficked refugee were not recorded. In addition to the interviewer, a note-taker was present to note down all that was stated during the interview.

Individual interview questions for migrants:

- How often have you used health services in the past years?
- What would you say are your/other refugees' primary healthcare needs? What do you/refugees/migrants need to be healthy? In order to be mentally healthy?What do you believe are your/other refugees/migrants primary physical and mental health care needs in order to fulfil your goals?

- What do you believe are the most important impediments to your/other refugees' health/mental health/well-being?
- Do you and others in your community know of existing healthcare services and how to access them?
- Do you and others in your community know of existing mental healthcare services and how to access them?
- How would you evaluate the (mental) health clinics that you have received care at?
    - Did you feel respected by the staff and healthcare professionals?
    - Was language an issue?
    - Did you feel that your provider appreciated your cultural background and refugee status?
    - What would you say that you and other refugees need in order to be mentally strong/healthy?

The focus groups

Focus groups were carried out in locations of convenience for participants and where privacy was ensured. The FGDs were audio recorded and then transcribed verbatim and lasted on average between 45 minutes to 90 minutes.

Below questions regarding each group are described:

Professional focus groups: 4- 6 open questions

1. What do you perceive to be the primary healthcare needs of migrants and refugees?
2. What do you perceive to be the primary mental healthcare needs of migrants and refugees?
3. Are these needs being met? How adequately? By the public healthcare system? NGOs? Other?

4. Does your system provide services of medical interpreters/intercultural mediators?
5. To your knowledge, are refugees aware of existing health and mental health services?
6. What do you perceive to be the primary barrier to refugees accessing healthcare? Mental health care?

Refugee/migrant focus groups: 4- 6 open questions

1. What would you say are your primary healthcare needs? What do you need to be healthy? In order to be mentally healthy?
2. What do you perceive to be the primary healthcare needs of refugees/migrants?
3. What do you perceive to be the primary mental healthcare needs of refugees/migrants?
4. What are the main barriers encountered when accessing healthcare?
5. What would you recommend to improve this access?
6. Show an existing health app amongst participants and ask for their opinion

Selection and recruitment of participants for focus groups:

Brno (FNUSA), Berlin (Charité), Barcelona (VHIR/VAll d'Hebron) were the three partners involved in the health needs assessment through focus groups and Individual interviews; however, due to the particular immigration flow in Greece, the partner in Athenes (Syn-Eirmos) was invited to to collaborate in this task. (Annex 2: Brief description on MyHealth partners).

In each of the sites (Barcelona, Brno, Berlin, and Athenes), a recruitment strategy was put in place in order to ensure a representative group of the local stakeholders and VMR. The candidates were chosen on variety and representative basis, in order to guarantee the most complete evaluation (gender, culture, origin, background...). As far as the participation to the survey was volunteer, the development of the study was made according to pre-existing network in every site and individual availability. The community health agents or mediators helped to find ideal candidates to attend the interviews.

PROFESSIONALS PARTICIPATING IN FOCUS GROUPS AND INDIVIDUAL INTERVIEWS

On Table 1, there is the list of professionals recruited for the focus groups and individual interviews in Brno (FNUSA), Berlin (Charité), Barcelona (VHIR/VAll d'Hebron), and Athens (Syn-Eirmos).

In Barcelona:

Three focus groups for professionals (number of participants=14) were carried out between the 25th of October and the 17th of November 2017 (Table 2).

- Focus group with Social and Healthcare Professionals on 25.10.2017 (Number of participants=3): The professional profile of participants varies as follows: a social educator with Moroccan origins who works extensively with immigrant unaccompanied minor youth; a community health agent with Moroccan origins who works extensively with the Moroccan community and a pediatrician who works in a center that is in a catchment area with a high saturation of immigrants (>40%). Age range: ***35 to 50 years old. Activity in Spanish language. Duration 60 minutes***
- Focus group with Social and Healthcare professionals on 30.10.2017 (Number of participants= 8): The professional profile of participants varies as follows: A psychologist who works in an NGO that provides mental health services to adult refugees and immigrants; a social worker who works in a detention center for refugees; Family doctor; Pediatrician; Social worker; Nurse; Health referent; Psychologist and Cultural mediator. Age Range: 30 to 45 years old. Activity in Spanish language. Duration 70 minutes
- Focus group with on Social and Healthcare professionals on 17.***11***.201***7*** (Number of participants= 3): The participants were Social workers in contact with sexually trafficked

women. Age range: 30 to 45 years old. Activity in Spanish language. Duration 60 minutes.

Table 1: Characteristics of Professionals recruited from focus groups and individual interview in the three sites: Brno (FNUSA), Berlin (Charité), Barcelona (VHIR/VAll d'Hebron), and Athens (Syn-Eirmos).

Name of Position	Total Number of Professionals (n=40)
• Physicians: General Practitioner(2), Family doctor(1), Paediatricians (3), Nurse (4), Gynaecologist (1), Midwife, Medical assistant (1), Health referent (1) Ergotherapist (1)	15
• Social Work: Social Worker (2), Legal Consultant (1)	9
• Cultural Worker: Community health agent (1), Cultural mediator (1) Social educator (1), Social integration service unit manager (1), Social Integration Worker (3), Anthropologist (1), social science (1)	10
• Psychology: Psychologist (4), Psychiatrist (1), Psychotherapist (1)	6

Table 2: Characteristics of fourteen Professionals recruited from focus groups and individual interviews in Barcelona.

Total number of professional	Name of Position	Number	FGD or IDI
14	Social Educator	1	FGD
	Community Health Agent	1	FGD
	Paediatrician	2	FGD
	Psychologist	1	FGD
	Social worker	5	FGD
	Family doctor	1	FGD
	Nurse	1	FGD
	Health Referent	1	FGD
	Cultural Mediator	1	FGD

In Berlin

- Focus group with healthcare professionals was carried out ***on*** 1***6.11***.2017 (Number of Participants=8). The professional profile of the participants varies as follows: a psychologist with Afghanistan origins, a social worker with Turkish origins, a psychiatrist with an Egyptian background, a social worker of Russian origins, an Ergotherapist, a medical assistant, nurse,

and psychotherapist. Age Range: 23 to 55 years old. ***Activity in German language. Duration 80 minutes.***

Table 3: Characteristics of eight Professionals recruited from focus groups and individual interview in Berlin.

Total number of professional	Name of Position	Number	FGD or IDI
8	Psychologist	1 (Afghanistan)	FGD
	Social Worker	1 (Turkey)	FGD
	Psychiatrist	1 (Egypt)	FGD
	Social Worker	1 (Russia)	FGD
	Ergotherapist	1	FGD
	Medical Assistant	1	FGD
	Nurse	1	FGD
	Psychotherapist	1	FGD

In Brno

- Individual Interviews with healthcare and social service providers was carried out from the ***13.10.2017 to 27.11.2017*** (Number of participants=9). The professional profile of the participants varies as follows: a general practitioner, gynaecologist, paediatrician, nurse who works at a detention facility for foreigners, an integration service provider, a social

integration service unit manager, a social integration workers, a social service municipality unit representative, and a legal consultant who works in a integration service centre. Age range: 30 to 50 years old. Activity in Check language (5), English language (2), and Russian language (2). Duration between 10 to 56 minutes.

Table 4: Characteristics of nine professionals recruited from focus groups and individual interview in Brno.

Total number of professional	Name of Position	Number	FGD or IDI
9	General Practitioner	1	IDI
	Gynaecologist	1	IDI
	Paediatrician	1	IDI
	Nurse (Works at Detention facility for foreigners)	1	IDI
	Social integration service unit manager	1	IDI
	Social Integration worker	3	IDI
	Legal Consultant (Works in an integration services centre)	1	IDI

In Athens

- Focus group with professionals was carried on 30.03.2018 (Number of participants= 6). The professional profile of participants follows: a medical doctor who was A medical doctor who was working in a clinic for migrants and refugees, A midwife and a nurse who were both

working in an official accommodation scheme, A social anthropologist working as a coordinator in a health program in camps managed by an International NGO in one of the camps for refugees, A social worker working in an official accommodation scheme for refugees, managed by the local public authority, A social worker working in a camp in Athens, managed by a medical institution of the public sector. The age range was 25 to 60 years old. Activity in Greek language. Duration 2 hours.

- Individual interviews for professionals were conducted on 13.04.2018, 18.04.2018 and 25.04.2018 (number of participants =3). The professional profile was: two psychologist and one social scientist. Age range was 30 to 50 years old. Time range from arrival to Europe was 2 years to 3 years. Activity in Greek language. Duration: 30 minutes to 1hour and a half.

Table 5 Characteristics of nine professionals recruited from focus groups and individual interview in Athens.

Total number of professional	Name of Position	Number	FGD or IDI
9	Physician	1	FGD
	Midwife	1	FGD
	Nurse	1	FGD
	Anthropologist	1	FGD
	Social worker	2	FGD
	Psychologist	2	IDs
	Social scientist	1	IDs

PROFILE OF IMMIGRANTS PARTICIPATING IN FOCUS GROUPS AND INDIVIDUAL INTERVIEWS

The selection of immigrants participating for this task was done trying to be representative of the immigrant population profile in every site, according to the pre-existing network, and according to the MyHealth main goals (vulnerable immigrants arrived less than 5 years ago to Europe). The enrolment of unaccompanied migrants (minors) was unsuccessful for 2 main reasons: firstly, despite having ethical committee permission from each institution, one of the main challenges was the administrative aspects for having the permission of the relevant authorities responsible of minors in Berlin, Athens and Barcelona; secondly, in Brno the official data shows that the number of unaccompanied minors is negligible in the country, so the partner involved could not find a way to enrol them. Table 6.

In Barcelona:

Three focus groups and 8 interviews were carried out between the 20th of October and the 20th of November, 2017.

Focus Group

- Focus group with Women Immigrants/refugees on 27.10.2017 (Number of participants=6): The composition of groups regarding nationalities varied as: 1 woman from Honduras, 2 women from Equatorial Guinea, 1 woman from Pakistan, 2 women from Morocco. Age range: 22 to 58 years old. Time range from arrival to Europe: 13 months to 36 months. Activity in Spanish. Duration 60 minutes
- Focus groups with Mix- gender Youth Immigrants/refugees (ex-unaccompanied minors) on 14.11.2017 (Number of participants=6): The composition of groups regarding nationalities varied as: 2 men from Pakistan, 1 man from Equatorial Guinea, 1 woman from Equatorial Guinea, 1 man from Egypt, 1 man from Peru. Age ra***nge***: ***18 to 25 years old.*** Time range ***from arrival to Europe: 13 months to 45 months. Spanish activity. Duration 60 minutes***

Individual Interviews

- Individual interviews with women victims of sexual trafficking on 27.11.2017 and 28.11.2017 (Number of participants = 3). Two women from Nigeria and one from Venezuela. Age Rage 28-32 years old. Time range from arrival to Europe: 12-15 months ago. Two interviews in English language and one interview from Spanish language. Duration was 40 to 60 minutes.
- ***Individual interview with ex-unaccompanied minors*** on 23.11.2017; 28.11.2017; 30.11.2017 (Number of participants= 4). All from Morocco. Age range: 18 to 22 years old. Time range from arrival to Europe: 18 to 24 months ago. Activity in Arabic language. Duration was 30 to 45 minutes.

In Berlin

- Focus group with Refugee women was carried out on 15.11.2017 (Number of Participants= 6). The focus group consisted of female refugees from Syria carried out by a psychologist from Syria. Age range: 21 to 39 years old. Time range from arrival to Europe: 2 to 3 years. Activity in Arabic Language. Duration 90 minutes.
    - Focus group with female refugees was carried out on 17.11.2017 (Number of Participants= 5). The focus group of female refugees from Eritrea was carried out by a professional qualified interpreter and health care professional from the Eritrean community. Age range: 19 to 30 years old. Time range from arrival to Europe 3-5 years. Activity in Tigrinya language. Duration 60 minutes.

Individual interviews with female refugees from Afghanistan were carried ***on 16.11.2017 and 20.11.2017*** (Number of Participants= 2). The participants were from Afghanistan***, one was 26 years old and the other was 37 years old. Time from arrival to Europe was 2.5 years and 2 years ago.*** Activity in Farsi language. Duration ***50 and 45 minutes.***

In Brno

- Focus group with immigrants was carried out on 24.11.2017 (Number of participants= 2). There were two females from Russia. Age was 45 and 54 years old. Time from arriving to Europe was 1-2 years. Activity in Russian language. Duration 20 minutes.
- Focus group with immigrants was carried on 25.11.2017 (Number of participants= 8). The composition of groups regarding nationalities were 7 female migrants and 1 male from post-Soviet countries ***(2), Russia (2), and from Ukraine (4). Age range: 25 to 44 years old. Time range from arriving to Europe was 1-2 years.*** Activity in Russian language. Duration 35 minutes.

Athens

- Focus group with female refugee women was carried out on 17.04.2018 (Number of Participants= 5). The composition of groups varied as: 3 women from Syria, 1 woman from Iraq, 1 woman from Morocco. Age range: 30 to 50 years old. Time range from arrival to Europe was 5 months to 2 years. Activity in Arabic language. Duration 1hour and 30 minutes.
- Focus group with refugee women was carried out on 18.04.2018 (Number of Participants= 10). The women in the focus group were composed of 10 Afghan women, Farsi speakers. Range age: 25 to 50 years old. Time range from arrival to Europe was 2 years. Activity in Farsi language. Duration 1hour and 30 minutes.
- Focus group with refugee women was carried out on 26.04.2018 (Number of Participants=4). The composition of groups regarding nationalities varied as: 1 woman from Gabon, 1 woman from Cameroon, 1 woman from Democratic Republic of Congo (DRC), 1 woman from Central African Republic (CAR). Range age: 25 to 40 years old. Time range from arrival to Europe was 8 months to 2 years. Activity in French language. Duration 1hour and 30 minutes.Individual
- Interviews with refugee women were carried on 24.04.2018 and 27.04.2018 (Number of participants= 3). The participants were 1 woman from Morocco, 1 woman from Syria, and 1 woman from Sudan. Range age: 20 to 30 years old. Time range from arrival to Europe was 2 years to 3 years. Activity in Arabic language. Duration: 30 minutes to 1hour and a half.

Table 6: Characteristics of Immigrants/Refugees (n=64) recruited from focus groups and individual interview in the three sites: Brno (FNUSA), Berlin (Charitè), and Barcelona (VHIR/VAll d'Hebron)

Characteristics		Number
Gender	Female	54

	Male	10
Country of Origin	Afghanistan	12
	CAR	1
	Cameron	1
	DRC	1
	Egypt	1
	Equatorial Guinea	4
	Eritrea	5
	Gabon	1
	Honduras	1
	Iraq	1
	Morocco	8
	Nigeria	2
	Pakistan	3
	Peru	1
	Russia/ Ukraine	10
	Syria	10
	Sudan	1
	Venezuela	1

Location of Interview	Barcelona	19
	Berlin	13
	Brno	10
	Athens	22
Type of interview	Focus Group Discussion	52
	Individual Interviews	12

CAR=Central African Republic; DRC = Democratic Republic of Congo

Pictograms as Results of Focus Groups

Taking the key findings of the need analysis of the research done by the partners *Migrantas* searched in their archive the drawings and existing pictograms that focused those themes and consolidated a new series of pictograms.

A workshop was done in Barcelona, where Migrantas invited the participants reflect together about health access. The former work of Migrantas is used to show the process of their work. Each personal experience (from the service providers and users) could be put into simple drawings, texts and questions which allow them to concentrate in the essential issues of the subject. Each drawing was shown and commented upon within the group. Talking collectively about the experience helped to overcome the perception that people have unique, isolated experiences and helps them acquire tools to better understanding.

Migrantas held some workshops with migrant women in Berlin and addressed the same issues. After a careful analysis of all the resulting drawings, *Migrantas* culled key elements and common themes from the drawings and translated these central motifs visually and

artistically into pictograms - a visual language and a language accessible to everyone. Photo 1, 2, and 3.

Photo 1 Workshop: explaining the drawing

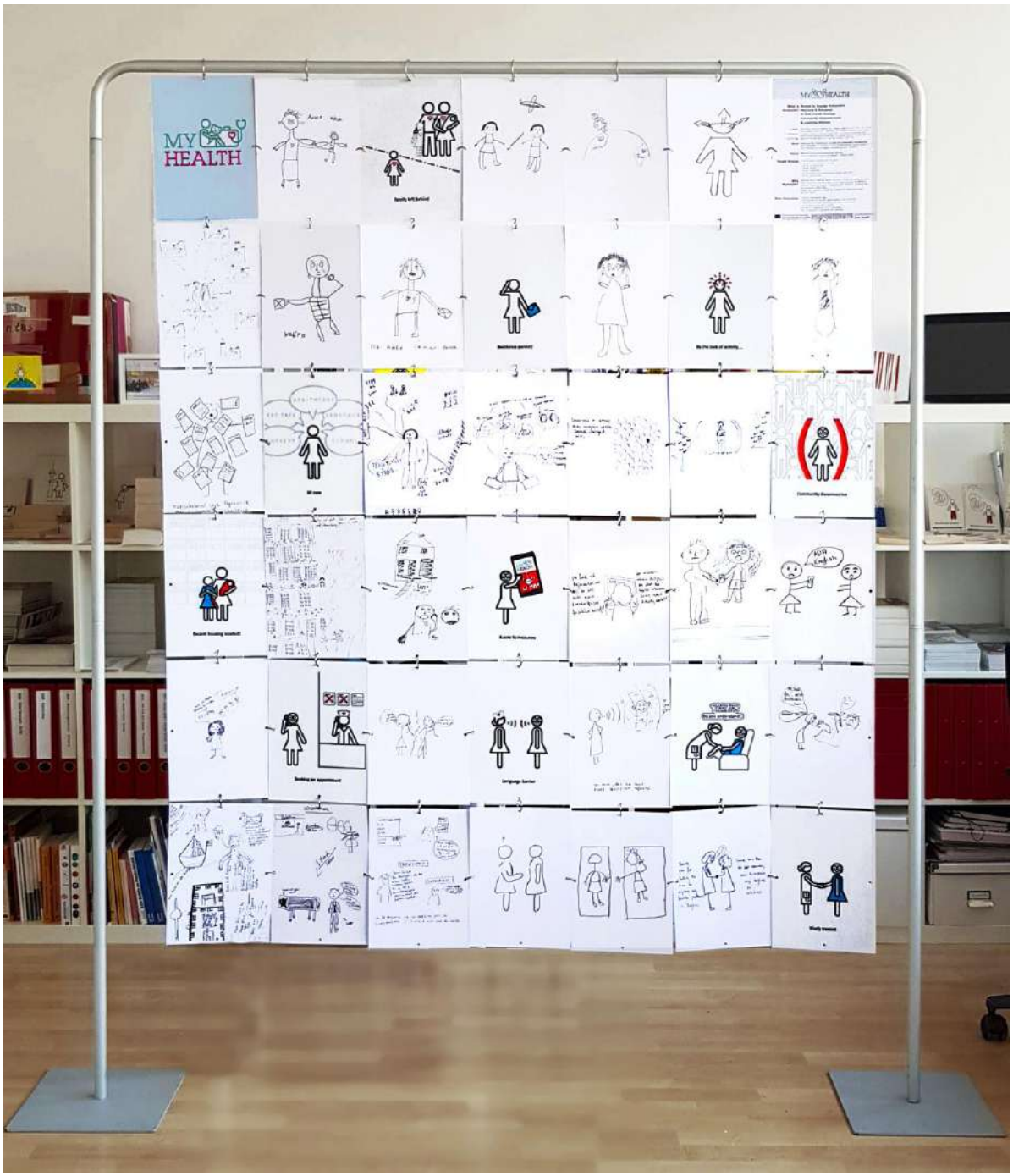

Photo 2 Exhibition panel of Drawings and Pictograms as a result of Needs Analysis and Workshops

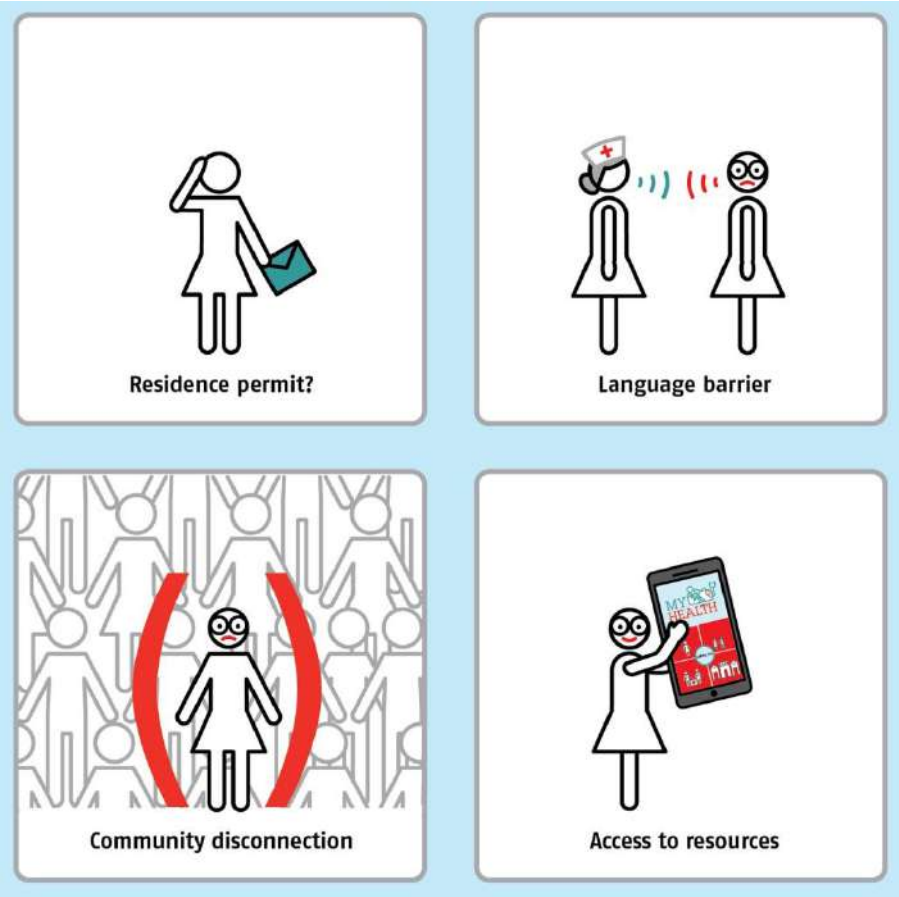

Photo 3 Final Pictograms

Analysis

Because the goal of this work package is to gain insights into the health and mental health needs of the target population, a content analysis approach has been employed.[28,29] This involves coding, categorizing, and theme identification. For coding, the transcripts or notes were broken down into short segments. These were then grouped into categories of specific health and mental health needs that emerge from the data itself. From these, broader themes were derived that identify more general sorts of health and mental health needs. The initial coded segments and categories were reviewed to allow for additional categories to emerge, on the basis to determine if further themes (needs) were present. This process was carried out by 3 researchers to ensure "triangulation", that is, to ensure that the categories and themes were not simply the product of one researcher's biases. Finally, a fourth researcher audited all steps to ensure coherence. The process was repeated until saturation was reached, that is, until it was evident that there were no more categories or themes to be derived from the initial codes. This was carried out across all of the IDIs and FGDs until getting final needs.

Details of the findings in each site and a synthesis of them will be presented in Deliverable 5.2; in the section that follows we provide an overview of the results of the needs analysis in all three sites.

Ethical approach

The project was evaluated and approved by the relevant Ethical Committee of each of the three "clinical sites" (Annex 3, 4, and 5). All participants were explained the purpose and scope of the IDI/FGD in a language that they could understand and signed consent form (Annex 5, 6, and 7). They were told that participation was entirely voluntary and that they could refuse to respond to any question and may leave at any time. They were also informed that no identifying information was to be recorded. All material has been kept in secured storage and it will be stored for at least 5 years after completion of the project.

The FGD facilitator/interviewer made every effort to ensure that no individual divulged personal information, nor discussed potentially traumatic material. In all FGDs, the facilitator had, on hand, an emergency protocol in the event that participants would find themselves distressed, which fortunately did not happen in any of the sessions.

3 Survey development

In this chapter the survey methodology will be explained. This strategy was chosen in order to complete MyHealth approach for needs assessment in immigrants' health. Two surveys are developed, one for professionals and the other for refugees. These surveys include closed-ended questions, including socio-demographic data as well as the needs and possible solutions identified. Online surveys are administered with the SurveyMonkey platform. The questions for the online survey are based on the pre-analysis of the previous steps (literature review, individual interviews and focus groups). These surveys were carried out in agreement with the community.

The surveys are anonymous and permission is collected online (www.healthonthemove.net). Both questionnaires are available in at least the 7 languages of the consortium (Catalan, Italian, English, German, Spanish, Greek, and Czech).

Several strategies were planned to enrol survey participants: in consultation rooms, mailings, congresses, workshops, and meetings. Each site was asked to reach at least 15 migrants/refugees and 5 health professionals or non-health professionals. The collection time was planned between April 2018 to October 2018.

Univariate analysis of our dataset included measures of distribution, central tendency (median or average if the standard deviation was > 20%), and dispersion (standard deviation and interquartile range-IQR). The statistical analysis was carried out using the SPSS 23.00® program

<u>What do we need to ask for in relation to the needs?</u>

As preliminary conclusions regarding needs, emerging from the first FGDs conducted, life conditions are clearly the most important. Unfortunately, only indirect actions (such a good mapping of the resources available) can be developed within MyHealth Project regarding this issue. In this regard the development of a ICT tool VMR friendly user, could be a good

tool for the lack of information about health care resources available in a comprehensive way.

On the basis of the preliminary issues 50 items were generated covering all areas identified in the needs analyses, especially as germane to accessing the health care system. This initial pool of items is circulated amongst all partners for review and comment. Partners provided feedback on coherence, relevance, perception of validity (that is, would this item serve to access the desired information), answerability (would participants respond to the item in a sincere and meaningful manner), and finally on the overall feasibility of the survey, which essentially meant both coverage and length.

On the basis of this first round, the item pool was reduced, and went through another 3 iterations of this process. Members of the community, in particular community health agents (i.e. individuals working in the healthcare system who represent different VMR communities) and health and social care professionals not directly linked to MyHealth were invited into the process to provide feedback on comprehension, validity, and answerability.

4 References

1. *IOM. Key Migration Terms. Grand-Saconnex: International Organization for Migration; https://www.iom.int/key-migration-terms. Published 2018. Accessed September 28, 2017.*

2. *Bernell S, Howard SW. Use Your Words Carefully: What Is a Chronic Disease?* Front Public Heal*. 2016;4(August):2-4. doi:10.3389/fpubh.2016.00159*

3. *English Dictionary, Thesaurus, & grammar help | Oxford Dictionaries. https://en.oxforddictionaries.com/. Accessed November 27, 2018.*

4. *Lewin S, Munabi-Babigumira S, Glenton C, et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases.* Cochrane Database Syst Rev*. 2010;(3):CD004015. doi:10.1002/14651858.CD004015.pub3*

5. **CONSTITUTION OF THE WORLD HEALTH ORGANIZATION 1.** *http://www.who.int/governance/eb/who_constitution_en.pdf. Accessed November 26, 2018.*

6. *Health Champions - Altogether Better. http://www.altogetherbetter.org.uk/health-champions. Accessed November 27, 2018.*

7. *WHO | Health education.* WHO*. 2013. http://www.who.int/topics/health_education/en/. Accessed November 26, 2018.*

8. *WHO | Health promotion.* WHO*. 2017. https://www.who.int/topics/health_promotion/en/. Accessed November 26, 2018.*

9. *| Migration and Home Affairs. https://ec.europa.eu/home-affairs/what-we-do/networks/european_migration_network/glossary_en. Accessed November 26, 2018.*

10. *Last JM, International Epidemiological Association.* A Dictionary of Epidemiology*. Oxford University Press; 2001.*

11. *Berry, J. W. (2001). a Psychology of Immigration | Prejudices | Immigration. https://es.scribd.com/document/251351869/Berry-J-W-2001-a-Psychology-of-Immigration. Accessed November 26, 2018.*

12. *Moreno-Leguizamon CJ. Learning Alliance Methodology Contributions to Integrated Care Research.* Int J Integr Care*. 2018;18(s1):125. doi:10.5334/ijic.s1125*

13. *WHO | Mental health: a state of well-being.* WHO*. 2014. http://www.who.int/features/factfiles/mental_health/en/. Accessed November 26, 2018.*

14. *Noncommunicable diseases. http://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases. Accessed November 26, 2018.*

15. *Refworld | UNHCR Master Glossary of Terms. https://www.refworld.org/docid/42ce7d444.html. Accessed November 26, 2018.*

16. *WHO | About social determinants of health.* WHO*. 2017. https://www.who.int/social_determinants/sdh_definition/en/. Accessed November 26, 2018.*

17. *WHO | Screening.* WHO*. 2017. https://www.who.int/cancer/prevention/diagnosis-screening/screening/en/. Accessed November 26, 2018.*

18. Principles and Guidelines Migrants in Vulnerable Situations*. https://www.ohchr.org/Documents/Issues/Migration/PrinciplesAndGuidelines.pdf . Accessed November 26, 2018.*

19. *Suphanchaimat R, Kantamaturapoj K, Putthasri W, Prakongsai P. Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens.* BMC Health Serv Res*. 2015;15(1):390. doi:10.1186/s12913-015-*

1065-z

20. *Winters M, Rechel B, de Jong L, Pavlova M. A systematic review on the use of healthcare services by undocumented migrants in Europe.* BMC Health Serv Res*. 2018;18(1):30. doi:10.1186/s12913-018-2838-y*

21. *De Vito E, de Waure C, Specchia ML, et al. Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union?* Public Health Rev*. 2016;37(1):13. doi:10.1186/s40985-016-0026-3*

22. *Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC. Healthcare Barriers of Refugees Post-resettlement.* J Community Health*. 2009;34(6):529-538. doi:10.1007/s10900-009-9175-3*

23. *Humphris R, Bradby H.* Health Status of Refugees and Asylum Seekers in Europe*. Vol 1.; 2017. doi:10.1093/acrefore/9780190632366.013.8*

24. *Vito E De, Parente P, Waure C de, Poscia A, Ricciardi W.* A Review of Evidence on Equitable Delivery, Access and Utilization of Immunization Services for Migrants and Refugees in the WHO European Region*. WHO Regional Office for Europe; 2017. http://www.ncbi.nlm.nih.gov/pubmed/29300441. Accessed October 23, 2018.*

25. *Wang H, Naghavi M, Allen C, et al. Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980–2015: a systematic analysis for the Global Burden of Disease Study 2015.* Lancet*. 2016;388(10053):1459-1544. doi:10.1016/S0140-6736(16)31012-1*

26. *Hughes D, DuMont K. Using focus groups to facilitate culturally anchored research.* Am J Community Psychol*. 1993;21(6):775-806. doi:10.1007/BF00942247*

27. *Mcmillan SC, Borders LD.* Use of Focus Groups in Survey Item Development*. Vol 7.; 2002. http://nsuworks.nova.edu/tqr/vol7/iss1/3. Accessed November 27, 2018.*

28. *Hennick M, Hutter I, Bailey A. Focus group discussions. In:* Qualitative Research

Methods*. ; 2011:135-168.*

29. ***Ho MY, McBride ML, Gotay C, et al. A qualitative focus group study to identify the needs of survivors of stage II and III colorectal cancer.*** **Psychooncology*. 2016;25(12):1470-1476. doi:10.1002/pon.3988***

30. ***Huffman SA, Veen J, Hennink MM, McFarland DA. Exploitation, vulnerability to tuberculosis and access to treatment among Uzbek labor migrants in Kazakhstan.*** **Soc Sci Med*. 2012;74(6):864-872. doi:10.1016/j.socscimed.2011.07.019***

ANNEXES

Annex 1 Focus and IDIs facilitators

Barcelona:

- Adil Qureshi and Lucia Cellerino, both psychologists with more than 10 years of experience.
- Abdallah Denial, community health agent from the Tropical Medicine and International Health Unit from Vall d`Hebrón-Drassanes.

Berlin:

- Meryam Schouler-Ocak, Prof. for intercultural psychiatry.
- Rascha Nasar, psychologist
- Freweyni Habtemariam, professional qualified interpreter and healthcare professional from the Eritrean community.
- Shahram Anwarzay, psychologist.

Brno:

- Dr. Narine Movsisyan, MD, MPH, trained in medicine and public health.
- Mgr. Eva Matuchova, MS, psychologist.

Annex 2: Descrition of MyHealth project partners

Annex 3 Ethical approval form, Barcelona.

Vall d'Hebron Hospital

Pg. Vall d'Hebron, 119-129
08035 Barcelona
Tel. 93 489 38 9
Fax 93 489 41 80
ceic@vhir.org

ID-RTH052

INFORME DEL COMITÉ ÉTICO DE INVESTIGACIÓN CLÍNICA Y COMISIÓN DE PROYECTOS DE INVESTIGACIÓN DEL HOSPITAL UNIVERSITARI VALL D'HEBRON

Sra. Mireia Navarro Sebastián, Secretaria del COMITÉ ÉTICO DE INVESTIGACIÓN CLÍNICA CON MEDICAMENTOS del Hospital Universitari Vall d'Hebron,

CERTIFICA

Que el Comité Ético de Investigación Clínica del Hospital Universitario Vall d'Hebron, en el cual la Comisión de proyectos de investigación está integrada, se reunió en sesión ordinaria nº 311 el pasado 29 de septiembre de 2017 y evaluó el proyecto de investigación PR(AG)334/2017 presentado con fecha 01/09/2017, titulado "*"MyHealth: Modelos para involucrar a los inmigrantes vulnerables y refugiados en su salud, a través de la Capacitación de la Comunidad."*" que tiene como investigador principal a la Dra. Nuria Serre Delcor del Servicio de Enfermedades Infecciosas de nuestro Centro.

Y que tras emitir un informe aprobado condicionado en dicha reunión y evaluar la documentación recibida posteriormente en respuesta a este informe

Versión de documentos:

- Consentimiento informado para menores maduros Versión 3
- Memoria Version 2: 10 de octubre 2017

El resultado de la evaluación fue el siguiente:

DICTAMEN FAVORABLE

El Comité tanto en su composición como en los PNT cumple con las normas de BPC (CPMP/ICH/135/95) y con el Real Decreto 1090/2015, y su composición actual es la

siguiente:

Presidenta: Gallego Melcón, Soledad. Médico
Vicepresidente: Segarra Sarries, Joan. Abogado
Secretaria: Navarro Sebastián, Mirela. Química
Vocales: Armadans Gil, Lluis. Médico
Azpiroz Vidaur, Fernando. Médico
Balasso, Valentina. Médico
Cucurull Folguera, Esther. Médico Farmacóloga
De Torres Ramírez, Inés M. Médico
Fernández Liz, Eladio. Farmacéutico de Atención Primaria
Fuentelsaz Gallego, Carme. Enfermera
Fuentes Camps, Inmaculada. Médico Farmacóloga
Guardia Massó, Jaume. Médico
Joshi Jubert, Nayana. Médico
Hortal Ibarra, Juan Carlos. Profesor de Universidad de Derecho
Iavecchia, María Luján. Médico Farmacólogo
Rodríguez Gallego, Alexis. Médico Farmacólogo
Sánchez Raya, Judith. Médico
Solé Orsola, Marta. Diplomada Enfermería
Suñé Martín, Pilar. Farmacéutica Hospital
Vargas Blasco, Víctor, Médico

En dicha reunión del Comité Ético de Investigación Clínica se cumplió el quórum preceptivo legalmente.

En el caso de que se evalúe algún proyecto del que un miembro sea investigador/colaborador, éste se ausentará de la reunión durante la discusión del proyecto.

Lo que firmo en Barcelona a 23 de octubre de 2017

MIREIA NAVARRO SEBASTIAN

Sra. Mirela Navarro

Secretaria del CEIm

Annex 4 Ethical approval form, Berlin

CHARITÉ

Charité | 10117 Berlin
Frau
PD Dr. med. Meryam Schouler-Ocak
PUK Charité im St. Hedwig-Krankenhaus
Große Hamburger Straße 5-11
10115 Berlin

Meryam.schouler-ocak@charite.de

Ethikkommission
Ethikausschuss am Campus Benjamin Franklin
Vorsitzender: Prof. Dr. Ralf Stahlmann

Geschäftsführung: Dr. med. Katja Orzechowski
ethikkommission@charite.de

Korrespondenzadresse: Charitéplatz 1, 10117 Berlin
Tel.: 030/450-517222
Fax: 030/450-517952
http://ethikkommission.charite.de

Datum: 03.11.2017

Models to engage vulnerable migrants and refugees in their health, through community empowerment and learning alliance (MyHealth)
Antragsnummer: EA4/185/17
Vorgang vom 27.10.2017, Eingang am 03.11.2017, am 27.10.2017 per E-Mail

Sehr geehrte Frau Dr. Schouler-Ocak,

hiermit bestätigen wir den Eingang Ihres Schreibens vom 27.10.2017 mit folgenden Anlagen:

- Ethikantrag, Version vom 27.10.2017
- Studieninformation, Version vom 27.10.2017

Die Auflagen laut Votum vom 23.10.2017 sind damit erfüllt. Wir wünschen viel Erfolg bei der Durchführung der o.g. Studie.

Mit freundlichen Grüßen

Prof. Dr. med. R. Stahlmann
-Vorsitzender-

Anex 5 Ethical approval form, Brno.

Fakultní nemocnice u sv. Anny v Brně
Pracoviště: Etická komise
Pekařská 53, 656 91 Brno, Česká republika
Tel.: +420 543 184 195, Fax: +420 543 184 195, www.fnusa.cz

FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

STANOVISKO ETICKÉ KOMISE K ŽÁDOSTI O SOUHLAS S PROVÁDĚNÍM GRANTOVÉHO PROJEKTU
OPINION OF THE ETHICS COMMITTEE ON THE GRANT PROJECT

Číslo jednací/*Reference Number:* **7G/2017**

Datum a místo jednání/ *Date and Place of Ethics Committee's Session:* FN u sv. Anny v Brně, dne **13.09.2017,** 13.00-15.30 hod.

Jméno a pracoviště žadatele/*Trial Site and Name of Investigator:*
FN u sv. Anny v Brně, Mezinárodní centrum klinického výzkumu, Pekařská 53, 656 91 Brno, Česká republika/*CzechRepublic*
Hlavní zkoušející/*PI:* **Narine Movsisyan, MD, MPH**
Spoluzkoušející/*SI:* Mgr. Jana Jarešová

Název grantového projektu/*Full Title of Grant Project:*
Modely pro zapojení ohrožených migrantů a uprchlíků do zdravotní péče prostřednictvím Sdružení pro posilování a vzdělávání komunit

Datum doručení žádosti/*Date of Submission of the Application Form:* 30.08.2017

Seznam předložené dokumentace/*List of Submitted Documents:*
Žádost o schválení grantového projektu ze dne 29.8.2017
Anotace
Výzkumný protokol, Project acronym: MYHEALTH PROJECT
Ústní souhlasy:
Ústní souhlas k detailnímu rozhovoru s uprchlíky/migranty (3.1)
Ústní souhlas k detailnímu rozhovoru s poskytovateli zdravotní péče (3.2)
Ústní souhlas k diskuzi s cílovou skupinou uprchlíků/migrantů (3.3)
Příručky:
Detailní rozhovory-příručka pro dotazování poskytovatele zdravotní péče/zástupce občanského sdružení (4.1)
Detailní rozhovory-příručka pro dotazování uprchlíků/migrantů (4.2)
Skupinové diskuze- příručka pro dotazování skupiny uprchlíků/migrantů (4.3)
CV hlavního zkoušejícího: Narine Movsisyan, MD, MPH
CV spoluzkoušejícího: Mgr. Jana Jarešová

Dokumenty prostudoval předseda EK/*The documentation reviewed and introduced member of the EC:* paní Lenka Vítovcová

Etická komise vydává souhlasné stanovisko s prováděním grantového projektu v místě FN u sv. Anny v Brně (rozhodnuto hlasováním)./Etická komise vydává souhlasné stanovisko s prováděním výzkumného projektu v místě FN u sv. Anny v Brně (rozhodnuto hlasováním)./*The Ethics Committee issued a favorable opinion on the grant project in the St. Anne's Faculty hospital (adjudicate by voting).*

Z přítomných členů etické komise se hlasování neúčastnil/*Of the EC's members present at the meeting, the following members abstained from voting:* doc. MUDr. Richard Chaloupka, CSc., MUDr. Jan Tomčík, Mgr. Jana Fogašová

Řešitel je povinen zaslat etické komisi:
1. Všechny změny protokolu v průběhu řešení projektu před jejich provedením
2. Zprávu o ukončení grantového projektu.

V Brně dne/*In Brno, date* 13.09.2017

FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ
656 91 BRNO, Pekařská 53
Multicentrická etická komise
1

prof. MUDr. Vladimír Soška, CSc.
předseda Etické komise FN u sv. Anny v Brně/
Chairperson of the Faculty Hospital St. Anne's EC

Strana 1 (celkem 2)

Annex 5 Consent form Barcelona (Migrants and refugees version)

CONSENTIMIENTO INFORMADO ADULTOS (≥ 18 ANOS)

Título del estudio:

"MyHealth: Modelos para involucrar a los inmigrantes vulnerables y refugiados en su salud, a través de la Capacitación de la Comunidad."

Algunos grupos de inmigrantes y refugiados vulnerables, pueden afrontar dificultades para acceder a una atención sanitaria de calidad. Dichas limitaciones pueden ser por diferentes razones. La base fundamental de este proyecto es dar a conocer las barreras al acceso al sistema de salud por parte de los inmigrantes y refugiados vulnerables y desarrollar actividades para la promoción y educación de la salud adaptadas a la realidad cultural de cada comunidad.

Con los resultados obtenidos del estudio en que participará, se obtendrá información de gran valor sobre las necesidades sentidas y las posibles estrategias/soluciones que podrían facilitar el acceso a la salud de los inmigrantes más vulnerables y refugiados.

Si decide participar en el estudio se procederá a una entrevista sobre su proceso migratorio y las dificultades sentidas o percibidas en el acceso al sistema de salud. Toda la información será registrada de forma anónima y sin que se pueda identificar a las personas.

De acuerdo con la Ley 15/1999 de Protección de Datos de Carácter Personal, los datos personales que se obtengan serán los necesarios para cubrir los fines del estudio. En ninguno de los informes del estudio aparecerá su nombre, y su identidad no será revelada a persona alguna. De acuerdo con la ley vigente, tiene usted derecho al acceso de sus datos personales, a su rectificación y cancelación si así lo desease.

Su participación en el estudio es totalmente voluntaria, y si decide no participar recibirá todos los cuidados médicos que necesite y la relación con el equipo médico que le atiende no se verá afectada.

Yo…….(nombre y apellidos del participante)
He leído la hoja de información que se me ha entregado.
He podido hacer todas las preguntas que he considerado sobre el estudio.
He hablado con:…….. (nombre del investigador).
Comprendo que mi participación es voluntaria.
Comprendo que puedo retirarme del estudio: Cuando quiera, sin tener que dar explicaciones y sin que esto repercuta en mis cuidados médicos.

Fecha y firma	Fecha y firma	Fecha y firma
del representante legal	del investigador	del participante

CONSENTIMIENTO INFORMADO MAYORES DE 12 AÑOS

Título del estudio:

"MyHealth: Modelos para involucrar a los inmigrantes vulnerables y refugiados en su salud, a través de la Capacitación de la Comunidad."

Algunos grupos de inmigrantes y refugiados vulnerables, pueden afrontar dificultades para acceder a una atención sanitaria de calidad. Dichas limitaciones pueden ser por diferentes razones. La base fundamental de este proyecto es dar a conocer las barreras al acceso al sistema de salud por parte de los inmigrantes y refugiados vulnerables y desarrollar actividades para la promoción y educación de la salud adaptadas a la realidad cultural de cada comunidad.

Con los resultados obtenidos del estudio en que participará, se obtendrá información de gran valor sobre las necesidades sentidas y las posibles estrategias/soluciones que podrían facilitar el acceso a la salud de los inmigrantes más vulnerables y refugiados.

Si decide participar en el estudio se procederá a una entrevista sobre su proceso migratorio y las dificultades sentidas o percibidas en el acceso al sistema de salud. Toda la información será registrada de forma anónima y sin que se pueda identificar a las personas.

De acuerdo con la Ley 15/1999 de Protección de Datos de Carácter Personal, los datos personales que se obtengan serán los necesarios para cubrir los fines del estudio. En ninguno de los informes del estudio aparecerá su nombre, y su identidad no será revelada a persona alguna. De acuerdo con la ley vigente, tiene usted derecho al acceso de sus datos personales, a su rectificación y cancelación si así lo desease.

Su participación en el estudio es totalmente voluntaria, y si decide no participar recibirá todos los cuidados médicos que necesite y la relación con el equipo médico que le atiende no se verá afectada.

Yo……(nombre y apellidos del participante)
En presencia de mis padres o representantes legales,…….. (nombre y apellidos del padre, madre o representante legal)
He leído la hoja de información que se me ha entregado.
He podido hacer todas las preguntas que he considerado sobre el estudio.
He hablado con: …….. (nombre del investigador).
Comprendo que mi participación es voluntaria.
Comprendo que puedo retirarme del estudio: Cuando quiera, sin tener que dar y sin que esto repercuta en mis cuidados médicos.
Presto libremente mi conformidad para participar en el estudio.

Fecha y firma	Fecha y firma	Fecha y firma
del representante legal	del investigador	del participante

CONSENTIMIENTO INFORMADO MENORES DE 12 AÑOS

Título del estudio:

"MyHealth: Modelos para involucrar a los inmigrantes vulnerables y refugiados en su salud, a través de la Capacitación de la Comunidad."

Algunos grupos de inmigrantes y refugiados vulnerables, pueden afrontar dificultades para acceder a una atención sanitaria de calidad. Dichas limitaciones pueden ser por diferentes razones. La base fundamental de este proyecto es dar a conocer las barreras al acceso al sistema de salud por parte de los inmigrantes y refugiados vulnerables y desarrollar actividades para la promoción y educación de la salud adaptadas a la realidad cultural de cada comunidad.

Con los resultados obtenidos del estudio en que participará, se obtendrá información de gran valor sobre las necesidades sentidas y las posibles estrategias/soluciones que podrían facilitar el acceso a la salud de los inmigrantes más vulnerables y refugiados.

Si decide participar en el estudio se procederá a una entrevista sobre su proceso migratorio y las dificultades sentidas o percibidas en el acceso al sistema de salud. Toda la información será registrada de forma anónima y sin que se pueda identificar a las personas.

De acuerdo con la Ley 15/1999 de Protección de Datos de Carácter Personal, los datos personales que se obtengan serán los necesarios para cubrir los fines del estudio. En ninguno de los informes del estudio aparecerá su nombre, y su identidad no será revelada a persona alguna. De acuerdo con la ley vigente, tiene usted derecho al acceso de sus datos personales, a su rectificación y cancelación si así lo desease.

Su participación en el estudio es totalmente voluntaria, y si decide no participar recibirá todos los cuidados médicos que necesite y la relación con el equipo médico que le atiende no se verá afectada.

Yo……(nombre y apellidos del padre, madre o representante legal del participante)

Yo……(nombre y apellidos del participante)

He leído la hoja de información que se me ha entregado.

He podido hacer todas las preguntas que he considerado sobre el estudio.

He hablado con: ..... (nombre del investigador).

Comprendo que mi participación es voluntaria. Comprendo que puedo retirarme del estudio: Cuando quiera, sin tener que dar explicaciones y sin que esto repercuta en mis cuidados médicos.

Presto libremente mi conformidad para que ……(nombre y apellidos del participante) de quien soy representante legal, participe en el estudio.

Fecha y firma	Fecha y firma
del representante legal	del investigador

Annex 6. Consent form from Berlin

PUK Charité im St. Hedwig-Krankenhaus / Große Hamburger Straße 5-7 / 10115 Berlin

Versorgungsbereich Wedding und Tiergarten
Klinikdirektor: Prof. Dr. Dr. Andreas Heinz
Chefarzt: Prof. Dr. Felix Bermpohl

Ltd. OÄ PD Dr. Meryam Schouler-Ocak
Sekretärin: Xandra Herrmann

TEL: 030 2311-2124
FAX: 030 2311-2251

E-Mail: meryam.schouler-ocak@charite.de
Internet: www.puk-charite-shk.de

IHRE NACHRICHT VOM: **IHR ZEICHEN:**
UNSER ZEICHEN:

Datum: 18.09.2017

Einverständniserklärung zur Fokusgruppe

Studientitel:

Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance (MyHealth)

Hiermit erkläre ich,

_____ _____
(Vorname der Probandin/des Probanden) (Name der Probandin/des Probanden)

_____ _____
(Geburtsjahr der Probandin/des Probanden) (Probandin/Probanden -Nr.)

dass ich schriftlich und mündlich über das Wesen, die Bedeutung, die Tragweite und Risiken der wissenschaftlichen Untersuchung im Rahmen der o. g. Studie informiert wurde und ausreichend Gelegenheit hatte, meine Fragen zu klären.

Ich habe insbesondere die mir vorgelegte Probandin/Probandeninformation vom _____ verstanden und eine Ausfertigung derselben und dieser Einwilligungserklärung erhalten.

Annex 7. Consent form from Brno

Oral Consent Script for In-depth Interview with Refugees/Migrants

Hello, my name is …. You have been asked to participate in an interview for a research study called MyHealth Project, or Models to Models to engage migrants and refugees in their health, through Community Empowerment and Learning Alliance.

International Clinical Research Center at St Anne's Hospital University in Brno, Czech Republic as a part of a larger multi-country consortium is conducting individual interviews to better understand the health needs of recently arrived migrant population with the ultimate aim to improve their access to existing health services.

If you agree to participate, we will ask to share your opinion about your health needs and healthcare services in the Czech Republic. Your participation is voluntary. You can stop the interview at any time or skip any questions you do not feel comfortable answering.

You will not be asked to provide your name or other identifiable information. Any personal information will be kept confidential and will not be disclosed in the study results. There are no known risks or direct benefits from participating in this study.

You may choose to take part in this research or not. No penalties will come from refusing. Those participating will not receive any money or other compensation for participation.

The interview will last approximately 30-45 minutes and upon your permission we will record it for transcribing.

If you have any questions please feel free to ask them now or anytime throughout the interview.

Do you agree to participate?

[If yes] Thank you, shall we continue?

Oral Consent Script for In-depth Interview with Healthcare Providers

Hello, my name is …. You have been asked to participate in an interview for a research study called MyHealth Project, or Models to Models to engage migrants and refugees in their health, through Community Empowerment and Learning Alliance.

International Clinical Research Center at St Anne's Hospital University in Brno, Czech Republic as a part of a larger multi-country consortium is conducting individual interviews to better understand the health needs of recently arrived migrant population with the ultimate aim to improve their access to existing health services.

If you agree to participate, we will ask to share your opinion about health needs of migrant communities and the accessibility of healthcare services to migrants in the Czech Republic. Your participation is voluntary. You can stop the interview at any time or skip any questions you do not feel comfortable answering.

You will not be asked to provide your name or other identifiable information. Any personal information will be kept confidential and will not be disclosed in the study results. There are no known risks or direct benefits from participating in this study.

You may choose to take part in this research or not. No penalties will come from refusing.

The interview will last approximately 30-45 minutes and upon your permission we will record it for transcribing.

If you have any questions please feel free to ask them now or anytime throughout the interview.

Do you agree to participate?

[If yes] Thank you, shall we continue?

Oral Consent Script for Focus Group Discussion with Refugees/Migrants:

Hello, my name is…. You have been asked to participate in a focus group for a research study called MyHealth Project, or Models to Models to engage migrants and refugees in their health, through Community Empowerment and Learning Alliance.

International Clinical Research Center at St Anne's Hospital University in Brno, Czech Republic as a part of a larger multi-country consortium is conducting this focus group discussion to better understand the health needs of recently arrived migrant population with the ultimate aim to improve their access to existing health services.

If you agree to participate, we will ask to share your opinions about the health needs in your community and the relevant healthcare services in the Czech Republic.

Your participation is voluntary. You can leave the group at any time or let us know if you are uncomfortable with a question.

You will not be asked to provide your name or other identifiable information. Any personal information will be kept confidential and will not be disclosed in the study results. There are no known risks or direct benefits from participating in this study.

You may choose to take part in this research or not. No penalties will come from refusing. Those participating will not receive any money or other compensation for participation.

The discussion will last approximately 60-90 minutes and upon your permission we will record it for transcribing.

If you have any questions, please feel free to ask them now or anytime throughout the interview.

Do you agree to participate?

[If yes] Thank you, shall we continue?

ANNEX 8. DESCRIPTIVE TEXT ON MYHEALTH PARTNER INSTITUTIONS' PROFILE

1. Vall D'Hebron Institut de Recerca (VHIR)

VHIR is a public sector institution that promotes and develops innovative biomedical research and was created in 1994 to serve and support the research of University Hospital Vall d'Hebron (HUVH). HUVH, the leading hospital complex in Catalonia, is one of the largest in Spain with more than 1400 beds and a team of around 7,000 professionals. It is structured into three main healthcare areas (General, Mother and Child, and Orthopaedics and Rehabilitation) and encompasses practically all medical and surgical specialities and the necessary forms of healthcare to cover them, including clinical services and clinical support units, university, educational centres, public health service companies, research centres, laboratories and other installations to round out its activities in healthcare.

2. Institut Català de la Salut

With a staff of over 38,000 professionals, the Catalan Health Institute is the public health service largest in Catalonia and provides health care to nearly six million users across the country. It currently manages eight hospitals (Vall d'Hebron, Bellvitge Trias, Arnau de Vilanova in Lleida, Tarragona Joan XXIII, Josep Trueta in Girona, Verge de la Cinta de Tortosa Viladecans) and 287 primary care teams, three of which through a partnership with the Hospital Clínic of Barcelona and a quarter with another partnership with the city of Castelldefels.

3. Syn-eirnos

Syn-eirmos NGO of Social Solidarity was founded in 2005 and is active in the fields of social solidarity, social economy, welfare and wellbeing of adults and children. In particular, the organization aims to support the activities of local communities, local governments, cooperation initiatives, collective social actors and volunteers.

4. Migrantas

Working with public urban spaces as a platform, migrantas uses pictograms to provide visibility to the thoughts and feelings of people who have left their own country and now live in a new one. Mobility, migration and transculturality are not the exception in our world, but are instead becoming the rule. Nevertheless, migrants and their experiences remain often invisible to the majority of our society. Migrantas works with issues of migration, identity and intercultural dialogue. Their work incorporates tools from the visual arts, graphic design and social sciences.

5. Consonant

consonant

Consonant is a national charity in the UK supporting refugees, asylum seekers and migrants. It was established in 1984. It supports approximately 4,000 individuals per annum through a wide range of services which include: legal advice, health access/inclusion information and advice, employment and training advice, English language courses, informal education courses, IT courses, health and well-being courses, empowerment & media/policy work.

6. EIWH

The EIWH advocates for an equitable and gender-sensitive approach in health policy, research, treatment and care. The EIWH aims to reduce inequalities in health, in particular due to sex/gender, age and socio-economic status. The EIWH highlights that sex/gender is an important determinant of health and our understanding how vulnerability to, onset and progression of specific diseases vary in men and women must be improved.

7. The University of Greenwich

The University of Greenwich is a major British University which combines various teaching traditions that are complemented with regional links, international links, lifelong learning, and excellence in both teaching and research. It has a particular tradition of teaching mature and part time students, many coming from developing countries. The Faculty of Health and Education, implement teaching, research and consultancy in all themes related to public health issues.

8. Asserta

Asserta brings together a team of professionals with years of experience in clinical practice, health management, teaching and research, who are putting their knowledge and expertise at the service of improving processes and results in the healthcare area.

9. FNUSA-ICRC

St. Anne´s University Hospital Brno – International Clinical Research Centre (FNUSA-ICRC) is an emerging centre of excellence in the European Research Area. It is an innovative science and research centre and a top-quality public healthcare centre focusing on prevention, early detection and treatment primarily of cardiovascular and neurological diseases. ICRC has almost ten years of successful cooperation between St. Anne´s University Hospital Brno and the Mayo Clinic in Rochester, Minnesota (USA).

10. The Regional Agency for Health and Social Care of Emilia-Romagna Region

The Regional Agency for Health and Social Care of Emilia-Romagna Region (RER-ASSR) operates as a technical and regulatory support for the Regional Health Service (SSR) and the Integrated system of interventions and social services. It promotes and addresses research in health services and develops research projects to experiment methods, technologies and social and organizational innovations, and it participates in the welfare policy change aimed at implementing strategies based on community and intersectional approach.

11. Charité

Charité is one of the largest university hospitals in Europe. It's main objectives are the clinical care, research and teaching. Charité extends over four campuses, and has close to 100 different Departments and Institutes, which make up a total of 17 different Charité Centers. Having marked its 300-year anniversary in 2010, Charite employs 13,100 staff (or 16,800 including its subsidiaries), and is wholly-owned by the Federal State of Berlin. Ist main revenue is from hospital services, patient fees, the Federal State of Berlin as well as external funding (German, European and International).