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Intersectoral approaches in achieving the right to health for refugees upon resettlement: A scoping review Protocol

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Primary Subject Heading:	Health services research
Secondary Subject Heading:	Ethics, Global health, Health policy, Public health, Qualitative research
Keywords:	intersectoral, refugees, human rights, integration, resettlement

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1 **Intersectoral approaches in achieving the right to health for refugees upon resettlement:**

2 **A scoping review Protocol**

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22 **Word count:**

23 **Keywords:** intersectoral, human rights, access, refugees, integration, resettlement

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ABSTRACT

Introduction: Global insecurity and climate change are exacerbating the need for improved management of refugee resettlement services. International standards hold states responsible for the protection of the right of non-citizens to an adequate standard of physical and mental health, while recognizing the importance of social determinants of health. However, programmes to protect refugees' right to health often lack coordination and monitoring. This paper describes the protocol for a scoping review to assess barriers and facilitators to provision of health services for refugees; the content, process and actors involved in protecting refugee health; and the extent to which intersectoral approaches and integration of services are leveraged to protect refugees' right to health upon resettlement, especially for vulnerable groups such as women and children.

Methods and analysis: Peer reviewed and grey literature will be searched to identify programmes and interventions designed to promote refugee health in receiving countries. Two reviewers will screen articles and abstract data. Two frameworks for integration and intersectoral action will be applied to understand how and why certain approaches work while others do not and to identify the actors involved in achieving success at different levels of integration as defined by these frameworks.

Dissemination: Findings from the scoping review will be shared in relevant conferences and meetings. A brief will be created with lessons learned from successful programmes to inform decision making in design of refugee programmes and services.

Registration: Registered on Open Science Framework at https://osf.io/gt9ck/

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STUDY SUMMARY

- Programmes to protect refugees' right to health often lack coordination and monitoring.
- This paper describes the protocol for a scoping review to assess barriers and facilitators to provision of health services for refugees.
- Peer reviewed and grey literature will be searched to identify programmes and interventions designed to promote refugee health in receiving countries.

Strengths and Limitations:

- Many fragmented programmes exist to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability. This scoping review will help to communicate lessons learned relating to barriers, facilitators, strategies and intersectoral approaches that are needed to aide in the design of future policies and programmes for integration of refugee health care and protect their right to health.
- This study will be limited by the quality of the literature on health care programs for refugees and protection to their right to health.

INTRODUCTION

The Office of the United Nations High Commission for Human Rights (OHCHR) identifies the right to the enjoyment of the highest attainable standard of physical and mental health as a fundamental part of human rights, first articulated in the 1946 Constitution of the World Health Organization (WHO).[1] While the right to health includes access to health care and the hard infrastructure associated with that – such as hospitals and ambulances – it also includes the underlying determinants of health including, safe drinking water, adequate sanitation, safe food, adequate nutrition and housing, healthy working and environmental conditions, health related education and information, and gender equality.[1] Freedoms which protect individuals from non-consensual medical treatment, torture and other degrading treatment are also included in this definition. Furthermore, entitlements under the right to health include universal health coverage – now a target under Sustainable Development Goal 3 – broadly covering access to preventative and curative services, essential medicines, timely basic health services, health related education,

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and participation in health related decision making at both national and community levels.[1,2] Especially relevant to the plight of refugees, the right to health includes non-discrimination whereby health services, goods and facilities must be provided to all without any discrimination. Lastly, these health services must be available in sufficient quantity, accessible, medically and culturally acceptable, and of good quality, which includes having a trained health workforce, safe products and adequate sanitation.[2]

The influx of refugees over the last few years makes the realization of these rights a legal and logistical challenge.[3,4] Different in definition from the term "migrant," "refugees" are those fleeing armed conflict or persecution as defined by the 1951 Refugee Convention which also identifies their basic rights, specifically that refugees should not be returned to situations that are deemed a threat to their life or freedom.[5] A key distinction is that refugee rights are not only a matter of national legislation, but also of international law.[6] Despite these legal protections, refugees face many challenges in accessing health services, especially more vulnerable groups like women and children.[3,4] Many states explicitly exclude refugees from the level of protection afforded to their citizens, instead choosing to offer "essential care" or "emergency health care," which is differentially defined across countries.[7] The Committee on the Elimination of Racial Discrimination, and the Committee on Economic, Social and Cultural Rights, both include general comments that hold States accountable to "the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services."[8]

However, the capacity of States to truly protect these rights is limited.[9] As the boundaries of the right to health have expanded due to increased understanding of social determinants of health and the health impacts of the lived environment, legal frameworks have been insufficient in

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ensuring the protection of these rights.[10,11] Refugees are not only more likely to have poorer health during resettlement, but they also face challenges in navigating legal, education, health, housing and employment services, which further threatens their quality of life and health status.[12] A lack of coordination and integration across these services undermines their effectiveness.[13] Much like the shift from the more vertical approaches of the millennium development goals (MDGs) towards the more integrated sustainable development goals (SDGs), the protection of the right to health too calls for an intersectoral approach whereby health is applied to all policies for all people.[14] Therefore, for states to effectively protect the right to health for refugees there is a need to work across sectors and disciplines to better integrate targeted programmes and initiatives, thereby improving standards of care during resettlement. Some evidence exists that supporting collaboration and coordination across social services improves the quality of care received and its effectiveness.[12] Furthermore, the refugee sub-population is diverse and requires extraneous considerations in ensuring the right to health, not only as compared to the general population, but also within the sub-population itself. Many fragmented psychosocial programmes exist to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability.[15,16] Better understanding, documentation, and reporting of the dynamic nature of such interventions and their means of health system integration and intersectoral collaboration, are necessary to ensure that lessons learned are communicated and implemented in the design of future policies and programmes. Therefore, we aim to conduct a scoping review to assess barriers and facilitators to health promotion services for refugees; the content, process and actors involved in protecting refugee health; and the extent to which intersectoral approaches and integration of services are leveraged to protect refugees' right to

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health upon resettlement. This paper will outline the protocol for this review. The specific research questions for the review will be as follows:

(1) What are the barriers and facilitators (context) in integrating targeted services for refugees across sectors?

(2) What strategies (content, process, and actors) are involved in addressing refugees' right to health upon resettlement?

(3) To what extent are intersectoral approaches used to protect refugees' right to health, particularly in women and children?

METHODS

Study Design

This study will be conducted using the scoping review methodology as described by the Joanna Briggs Institute Methods Manual for scoping reviews.[17,18] Scoping reviews are used to map key concepts in an area to identify the scope of practice, working definitions, conceptual boundaries, and the types of evidence available. We opted for a scoping review due to the complex nature of this topic, the changing global landscape around it, and the insufficient evidence base to support effective decision making.[18]

The five stages outlined in a methodological framework for scoping studies are as follows: i) identify the research question, ii) identify relevant studies, iii) study selection, iv) charting the data, and v) collating, summarising and reporting results.[18]

Protocol

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The Preferred Reporting Items for Systematic Reviews and Meta-analysis for Protocols (PRISMA-P) checklist in drafting this protocol.[19] It has been reviewed by the research team members.

Frameworks to address research questions

While some evidence suggests that improved collaboration and coordination across social sectors can contribute to enhancing refugee health, there remains a need for a stronger evidence base on the context, processes and actors involved in protecting refugees' right to health upon resettlement.[12] Therefore, the research questions identified for this scoping review focus on integration and use of intersectoral approaches to address the complex needs of this vulnerable population. Two frameworks are being used concurrently in order to comprehensively identify barriers, facilitators, processes, and actors involved at various stages in programme planning and implementation. The first is a framework for analyzing integration of targeted health interventions in systems, where integration is defined as "the extent, pattern, and rate of adoption and eventual assimilation of health interventions into each of the critical functions of a health system."[20] Elements in this framework include (i) governance, (ii) financing, (iii) planning, (iv) service delivery, (v) monitoring and evaluation (M&E), and (vi) demand generation.[20] To be considered integrated, a health system intervention needs to fulfill certain requirements across these six areas as defined by the framework.[20] We define an intervention here as *changes in service delivery, organizational models, process modification, or new technologies.* To satisfy governance needs for integration, governance and regulatory mechanisms for the intervention match those of the general health system.[20] For financing, full integration has occurred when funding is incurred from national or regional budgets.[20] In planning – which constitutes needs assessment, priority setting and resource allocation – full integration occurs when the same

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institutions and stakeholders are involved as those planning general health/ other social systems.[20] If service delivery is the responsibility of general staff embedded in the system, the intervention is considered integrated.[20] Similarly, if monitoring and evaluation was conducted by those with overall M&E responsibility, then the intervention is considered integrated.[20] Finally, demand generation is seen as integrated where services were promoted and incentivized by general staff within the existing system.[20]

The second framework applied is that of the Health in All Policies (HiAP) framework for country action. HiAP is defined as a way for countries to protect population health through "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."[21] HiAP can be a powerful tool for enhancing accountability and safeguarding against distortions imposed by deleterious commercial and political interests. HiAP is in line with the human rights principles of legitimacy, protected by national and international law, accountability of governments to people, transparency of decision making, participation of the wider society, sustainability of policies to meet current needs without compromising future ones, and collaboration across sectors and levels of government.[11,21] The HiAP framework for action involves six components including: i) establish the need and priorities for HiAP, ii) frame planned action, iii) identify supportive structures and policies, iv) facilitate assessment and engagement, v) ensure monitoring and evaluation, and vi) build capacity.[21] These six components, adapted to refugee needs, will be used in the scoping review to frame barriers and facilitators in integrating refugee services across sectors through intersectoral collaboration. The framework for integration will then be used to assess the extent to which

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provisions for protecting refugees' right to health are integrated into existing social systems, and the content, process, and actors involved in integration.[22]

Identifying relevant studies

Population: Eligible studies and papers will include those targeting refugees as previously defined. We are not including other categories of migrants as their legal entitlements are different to those of refugees which are protected under international law.

Intervention: Eligible studies and papers will describe a programme, approach or technical innovation that aims to protect refugees' right to health, including interventions aimed at addressing the social determinants of health. Interventions outside of the health sector that affect health will be included. If the studies do not display some level of integration nor intersectorality, based on the combined frameworks for integration and HiAP, they will not be assessed further.[20,21]

Comparators: Eligible studies and papers do not necessarily have to display a comparator as this scoping review is meant to gauge the state of the evidence. Where comparators exist, any types are relevant for inclusion, for example those comparing a parallel approach to service provision for refugees versus an integrated approach.

Outcomes: Eligible studies and papers will include those discussing plans for action, strategies, barriers, facilitators or outcomes in integrating refugee health using an intersectoral approach. Studies or commentaries that solely discuss theories and conceptual models will be excluded.

Study design: Qualitative, quantitative, and mixed methods will be eligible for inclusion. Experimental designing including randomized controlled trials, non-randomized controlled trials and quasi-experimental models will be included, as well as observation and qualitative studies including cohort, cross sectional, case series, ethnographic, interview/based, and focus-group

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discussion based studies. Grey literature that explores plans, strategies, barriers, facilitators or outcomes of refugee health. Implementation research and operations research studies will also be included. Studies or report outlining stakeholder experiences and plans will also be included as case studies.

Time period: In order to ensure relevance, only studies from 2000 onward have been included, making the study period range over 16 years.

Setting: Eligible studies will be set in countries receiving refugees and asylum seekers (who may eventually qualify for refugee status) and serving as hosts for resettlement.

Information sources and search strategy

Based on the study team's concepts for the review, an experienced team of librarians from Karolinska Institutet will conduct a search of articles from 2000 onward in the following electronic databases: MEDLINE, Web of Science, Global Health, and PsycInfo Embase. The three concepts used to create the search strategy will include: i) refugees; ii) type of service provision (health sector service delivery, intersectoral, partnerships, etc.); and iii) health equity, human rights and social determinants of health. See appendix I for search strategy.

The search of the peer-reviewed literature will be supplemented by a search of grey literature through government websites, particularly governments of countries that receive the highest refugee burden, reports from multi-nationals and non-governmental organizations, conference abstracts, dissertations, and news articles. Any additional report and articles will be identified by reaching out to relevant stakeholders in the authors' professional networks, including those involved in the European refugee response.

Study selection process

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Search results will be cleaned for duplicates and uploaded to an excel document, which will be used for screening using the eligibility criteria described above.

Two members of the study team will screen results based on the screening tool discussed. Inter-rater reliability will be assessed based on a set of 100 initial screens, and adjustments and clarifications to the screening tool will be made if reliability is not as high as desired (above 80%). Once a set of included studies and papers are identified, two reviewers will continue on to a full-text screen in order to further refine the results using the aforementioned frameworks for integration and intersectorality (HiAP). Eligible studies will be those displaying some attempt at integration or intersectorality (which will be defined as satisfying at least 2 of the 6 elements in either one of the integration or HiAP frameworks). A third reviewer has been identified in the event of disagreement between the two reviewers. This will be followed by data abstraction from the finalized set.

Data abstraction and charting process

General data collected will include study design, setting, and journal discipline. Demographic data collected will include target study group (gender, age, ethnic background), number of participants, economy status of setting based on World Bank classifications, and level of the health system where applicable. Intervention-specific data collected will include the type of intervention, the social determinant of health being addressed, the primary sector(s) involved, duration, resources, funding source, and conceptual framework applied if any. Outcome data collected will include barriers, facilitators, strategies, plans, qualitative findings from interviews and focus groups, and any unintended consequences. In the final set of included studies – those displaying some level of integration or intersectorality – key elements will be charted according to the two frameworks described above.[18,20,21] Data will be charted to include types of

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stakeholders involved in (i) governance, (ii) financing, (iii) planning, (iv) service delivery, (v) monitoring and evaluation (M&E), and (vi) demand generation.[20] This will assess the extent of integration while data charted against the six components of the HiAP framework will assess the intersectoral potential of the intervention.

The data abstraction form will be tested by both reviewers using 5 studies. Where there is a sufficient level of agreement across reviewers (above 80%), data abstraction will continue as designed. If agreement falls below the required range, the data abstraction form will be clarified.

Risk of bias assessment

In line with the manual used to design this scoping review, risk of bias assessments will not be conducted.[17]

Results

Frequency tables will be used to describe included studies quantitatively while narratives will be used to describe interventions, barriers, facilitators, and other qualitative outcomes. Stakeholders will be presented based on the combined integration and HiAP frameworks, with their roles and involvement in the studies outlined. If a sufficiently diverse range of studies are identified, stratification by health system level and country economy status will be done. As this is a scoping review, meta-analysis will not be conducted.

Charted data will be mapped out into subcategories to allow for a narrative description of barriers and facilitators, including barriers specific to vulnerable groups (women, children, torture survivors, those with disabilities, etc.). Two members of the study team will code studies on NVivo software[23] using a coding guide based on the two frameworks used for the review. New themes will be added where necessary and elements of integration and/or intersectorality

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that are more or less prevalent across included studies will be highlighted. Finally, context, content, process and actors will be mapped based on charted data in accordance with the Walt Policy Triangle.[22] Vulnerabilities of specific groups such as women and children will be highlighted

DISCUSSION

Implications

This scoping review will identify programmes, approaches and interventions both within and outside the health sector that promote and protect refugees' right to health directly or indirectly through social determinants of health. To support country-level decision making and resettlement efforts, this review will provide a snapshot of the extent of integration and intersectoral collaboration currently reported in this area, barriers and facilitators to provision of such services and their integration, and key stakeholders involved as well as those often missing. Findings will be shared with WHO colleagues working in this area, the Alliance for Health Policy and Systems Research contacts, and a network of policy makers who will in turn share with their national and local networks. Other expected outputs include an improved understanding of contextual factors that are necessary in supporting the right to health for refugees as well as a narrative exploration of whether intersectoral collaboration and the idea of "Health in All Policies" (HiAP) also works to protect and promote the health of persons outside of the traditional definitions of citizenry. These discussions will stimulate dialogue on how receiving countries can strengthen the resilience of their social systems to enhance their capacity for effective resettlement and improved health outcomes in their refugee populations.

Dissemination

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In addition to the study team's respective networks, this review will also be disseminated at relevant conferences, meetings, and communities of practice focused on enhancing use of evidence in policy making. A brief of key learnings will be created to support evidence-informed decision making in this area.

ETHICS APPROVAL

Ethics approval is not required for this scoping review as human subjects are not involved.

AUTHOR'S CONTRIBUTIONS

DJ drafted the paper and will be acting as primary reviewer, EVL, SH, PF, and GT provided feedback and comments. SH and EVL will be acting as secondary reviewers. PF and GT, of SIGHT will be providing continued support and connecting to relevant actors working in this area.

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COMPETING INTERESTS AND FUNDING STATEMENT

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Appendix I

1. Medline(Ovid)

Date of Search: 2016-11-03 Number of hits: 2019 Comments:	Field labels: .tw,kf. = title, abstract, keyword exp/ = MeSH, exploded / = MeSH, not exploded adj3 = within two words

1. Refugees/
2. exp "Emigrants and Immigrants"/
3. "Emigration and Immigration"/
4. "Transients and Migrants"/
5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).tw,kf.
6. or/1-5

7. Delivery of Health Care/
8. Health Services Accessibility/
9. Patient Acceptance of Health Care/
10. "Health Services Needs and Demand"/
11. Quality of Health Care/
12. Interinstitutional Relations/

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13. Interdepartmental Relations/
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15. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).tw,kf.
16. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).tw,kf.
17. or/7-16

18. Healthcare Disparities/
19. Social Determinants of Health/
20. Health Status Disparities/
21. Health Equity/
22. exp Human Rights/
23. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).tw,kf.
24. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).tw,kf.
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2. Web of Science (Thomson Reuter)

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#1 TOPIC: (refugee* or immigra* or migrat* or migrant* or asylum* or transient*)

#2 TOPIC: (("health care" or healthcare or "health service*") NEAR/3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization))

#3 TOPIC: ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) NEAR/3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*))

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#4 #3 OR #2

#5 TOPIC: ((health or "health care" or healthcare or "health service*") NEAR/3 (situation or difference*))

#6 TOPIC: (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or "human right*" or "civil right*" or "citizen* right*" or "social right*" or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*)

#7 #6 OR #5

#8 #7 AND #4 AND #1

#9 Timespan: 2000-2016.

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3. Global Health (Ovid)

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Date of Search: 2016-11-03 Number of hits: 497 Comments:	Field labels: .ab,ti. = title, abstract exp/ =thesaurus term, exploded / = thesaurus term, not exploded adj3 = within two words

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16 1. refugees/
17 2. immigrants/
18 3. migrants/
19 4. immigration/
20 5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).ab,ti.
21 6. or/1-5
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24 7. health care utilization/
25 8. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or
26 provision* or seeking or quality or utilization)).ab,ti.
27 9. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or
28 interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-
29 institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat*
30 or approach* or partnership* or relation*)).ti,ab.
31 10. or/8-9
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34 11. exp disparity/
35 12. exp discrimination/
36 13. human rights/
37 14. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab.
38 15. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or right* or injustice* or
39 discrimination* or determinant* or disadvantage* or vulnerab*).ti,ab.
40 16. or/11-15
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43 17. 6 and 10 and 16
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46 18. limit 17 to yr="2000 -Current"
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4. PsycInfo (OVID)

Date of Search: 2016-11-03 Number of hits: 667 Comments:	Field labels: .ti,ab,id. = title, abstract, keyword exp/ = subject heading, exploded / = subject heading, not exploded adj3 = within two words

1. exp Human Migration/
2. Immigration/
3. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).ti,ab,id.
4. or/1-3

5. Health Care Delivery/
6. Health Care Utilization/
7. Health Care Seeking Behavior/
8. Health Service Needs/
9. "Quality of Care"/
10. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).ti,ab,id.
11. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).ti,ab,id.
12. or/5-11

13. Health Disparities/
14. Social Equality/
15. exp Human Rights/
16. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab,id.
17. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* human right* or civil right* or citizen* right* or social right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).ti,ab,id.
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Topic	Item No	Checklist item
Administrative information		
Title:		
Identification	1a	**Intersectoral approaches in achieving the right to health for refugees upon resettlement: A scoping review Protocol** Report is identified as scoping review (Page 1,2)
Update	1b	NA
Registration	2	Registered on Open Science Framework at https://osf.io/gt9ck/
Authors:		
Contact	3a	Provided (Page 1)
Contributions	3b	Provided (Page 13)
Amendments	4	NA
Support:		
Sources	5a	NA
Sponsor	5b	NA
Role of sponsor or funder	5c	Provided (Page 14)
Introduction		
Rationale	6	Provided (Page 4-5)
Objectives	7	Provided (Page 5)
Methods		
Eligibility criteria	8	Provided (Page 8-10)
Information sources	9	Provided (Page 9)
Search strategy	10	Provided (Page 9-10; Page 16-19)
Study records:		
Data management	11a	Provided (Page 10)
Selection process	11b	Provided (Page 10)
Data collection process	11c	Provided (Page 11)
Data items	12	Provided (Page 11)
Outcomes and prioritization	13	Provided (Page 12-13)
Risk of bias in individual studies	14	NA

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Topic	Item No	Checklist item
Data synthesis	15a	Provided (Page 12)
	15b	Provided (Page 12)
	15c	Provided (Page 12)
	15d	Provided (Page 12)
Meta-bias(es)	16	Provided (Page 12)
Confidence in cumulative evidence	17	NA

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BMJ Open

Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: A scoping review Protocol

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Secondary Subject Heading:	Ethics, Global health, Health policy, Public health, Qualitative research
Keywords:	intersectoral, refugees, human rights, integration, resettlement

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Manuscripts

Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: A scoping review Protocol

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Word count: 3,150

Keywords: intersectoral, human rights, access, refugees, integration, resettlement

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ABSTRACT

Introduction: Global insecurity and climate change are exacerbating the need for improved management of refugee resettlement services. International standards hold states responsible for the protection of the right of non-citizens to an adequate standard of physical and mental health, while recognizing the importance of social determinants of health. However, programmes to protect refugees' right to health often lack coordination and monitoring. This paper describes the protocol for a scoping review to explore barriers and facilitators to the integration of health services for refugees; the content, process and actors involved in protecting refugee health; and the extent to which intersectoral approaches are leveraged to protect refugees' right to health upon resettlement, especially for vulnerable groups such as women and children.

Methods and analysis: Peer reviewed (through four databases including Medline, Web of Science, Global Health, and PsycInfo) and grey literature were searched to identify programmes and interventions designed to promote refugee health in receiving countries. Two reviewers will screen articles and abstract data. Two frameworks for integration and intersectoral action will be applied to understand how and why certain approaches work while others do not and to identify the actors involved in achieving success at different levels of integration as defined by these frameworks.

Ethics & dissemination: Findings from the scoping review will be shared in relevant conferences and meetings. A brief will be created with lessons learned from successful programmes to inform decision making in design of refugee programmes and services. Ethical approval is not required as human subjects are not involved.

Registration: Registered on Open Science Framework at https://osf.io/gt9ck/

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Strengths and Limitations:

- Many programmes exist to attempt to address the unique challenges faced by refugees but these are largely unevaluated and face challenges to sustainability. This scoping review will summarize lessons learned from these programmes by exploring barriers and facilitators to the integration of health services for refugees; the content, process and actors involved in protecting refugee health; and the extent to which intersectoral approaches are leveraged to protect refugees' right to health upon resettlement, especially for vulnerable groups such as women and children.
- This study will be limited by the quality of the literature on health care programs for refugees and protection of their right to health.

INTRODUCTION

The Office of the United Nations High Commission for Human Rights (OHCHR) identifies the right to the enjoyment of the highest attainable standard of physical and mental health as a fundamental part of human rights, first articulated in the 1946 Constitution of the World Health Organization (WHO).[1] While the right to health includes access to health care and the hard infrastructure associated with that – such as hospitals and ambulances – it also includes the underlying determinants of health including, safe drinking water, adequate sanitation, safe food, adequate nutrition and housing, healthy working and environmental conditions, health related education and information, and gender equality.[1] Freedoms which protect individuals from non-consensual medical treatment, torture and other degrading treatment are also included in this definition. Furthermore, entitlements under the right to health include universal health coverage – now a target under Sustainable Development Goal 3 – broadly covering access to preventive and curative services, essential medicines, timely basic health services, health related education, and participation in health related decision making at both national and community levels.[1,2] Especially relevant to the plight of refugees, the right to health includes non-discrimination whereby health services, goods and facilities must be provided to all without any discrimination. Lastly, these health services must be available in sufficient quantity, accessible, medically and

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72 culturally acceptable, and of good quality, which includes having a trained health workforce, safe
73 products and adequate sanitation.[2]
74 The influx of refugees over the last few years makes the realization of these rights a legal and
75 logistical challenge.[3,4] Different in definition from the term "migrant," "refugees" are those
76 fleeing armed conflict or persecution as defined by the 1951 Refugee Convention which also
77 identifies their basic rights, specifically that refugees should not be returned to situations that are
78 deemed a threat to their life or freedom.[5] A key distinction is that refugee rights are not only a
79 matter of national legislation, but also of international law.[6] Despite these legal protections,
80 refugees face many challenges in accessing health services, especially more vulnerable groups
81 like women and children.[3,4] Many states explicitly exclude refugees from the level of protection
82 afforded to their citizens, instead choosing to offer "essential care" or "emergency health care,"
83 which is differentially defined across countries.[7] The Committee on the Elimination of Racial
84 Discrimination, and the Committee on Economic, Social and Cultural Rights, both include
85 general comments that hold States accountable to "the right of non-citizens to an adequate
86 standard of physical and mental health by, inter alia, refraining from denying or limiting their
87 access to preventive, curative and palliative health services."[8]
88 However, the capacity of States to truly protect these rights is limited.[9] As the boundaries of the
89 right to health have expanded due to increased understanding of social determinants of health
90 and the health impacts of the lived environment, legal frameworks have been insufficient in
91 ensuring the protection of these rights.[10,11] Refugees are not only more likely to have poorer
92 health during resettlement, but they also face challenges in navigating legal, education, health,
93 housing and employment services, which further threatens their quality of life and health status.[12]
94 A lack of coordination and integration across these services undermines service effectiveness.[13]

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Much like the shift from the more vertical approaches of the millennium development goals (MDGs) towards the more integrated sustainable development goals (SDGs), the protection of the right to health too calls for an intersectoral approach whereby health is applied to all policies for all people.[14] Therefore, for states to effectively protect the right to health for refugees there is a need to work across sectors and disciplines to better integrate targeted programmes and initiatives, thereby improving standards of care during resettlement. Evidence exists that supporting collaboration and coordination across social services improves the quality of care received and its effectiveness.[12] Furthermore, the refugee sub-population is diverse and requires extraneous considerations in ensuring the right to health, not only as compared to the general population, but also within the sub-population itself. Many fragmented psychosocial programmes exist to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability.[15,16] Better understanding, documentation, and reporting of the dynamic nature of such interventions and their means of health system integration and intersectoral collaboration, are necessary to ensure that lessons learned are communicated and implemented in the design of future policies and programmes. This would promote continuity of care, people-centred care, and sustainability of health and social services for refugees. Therefore, we aim to conduct a scoping review to explore barriers and facilitators to integrated health services for refugees; the content, process and actors involved in protecting refugee health; and the extent to which intersectoral approaches are leveraged to protect refugees' right to health upon resettlement. This paper will outline the protocol for this review. The specific research questions for the review will be as follows:

(1) What are the barriers and facilitators (context) in integrating targeted services for refugees within existing systems?

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(2) What strategies (content, process, and actors) are involved in addressing refugees' right to health upon resettlement?

(3) To what extent are intersectoral approaches used to protect refugees' right to health, particularly in women and children?

METHODS

Study Design

This study will be conducted using the scoping review methodology as described by the Joanna Briggs Institute Methods Manual for scoping reviews.[17] Scoping reviews are used to map key concepts in an area to identify the scope of practice, working definitions, conceptual boundaries, and the types of evidence available. We opted for a scoping review due to the complex nature of this topic, the changing global landscape around it, and the insufficient evidence base to support effective decision making.[18]

The five stages outlined in a methodological framework for scoping studies are as follows: i) identify the research question, ii) identify relevant studies, iii) study selection, iv) charting the data, and v) collating, summarising and reporting results.[18]

Protocol

The Preferred Reporting Items for Systematic Reviews and Meta-analysis for Protocols (PRISMA-P) checklist were used in drafting this protocol.[19]

Frameworks to address research questions

While some evidence suggests that improved collaboration and coordination across social sectors can contribute to enhancing refugee health, there remains a need for a stronger evidence base on the context, processes and actors involved in protecting refugees' right to health upon resettlement.[12] Therefore, the research questions identified for this scoping review focus on

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integration and use of intersectoral approaches to address the complex needs of this vulnerable population. Two frameworks are being used concurrently in order to comprehensively identify barriers, facilitators, processes, and actors involved at various stages in programme planning and implementation. The first is a framework for analyzing integration of targeted health interventions in systems, where integration is defined as "the extent, pattern, and rate of adoption and eventual assimilation of health interventions into each of the critical functions of a health system."[20] Elements in this framework include (i) governance, (ii) financing, (iii) planning, (iv) service delivery, (v) monitoring and evaluation (M&E), and (vi) demand generation.[20] To be considered integrated, a health system intervention needs to fulfill certain requirements across these six areas as defined by the framework.[20] We define an intervention here as *changes in service delivery, organizational models, process modification, or new technologies.* To satisfy governance needs for integration, governance and regulatory mechanisms for the intervention match those of the general health system.[20] For financing, full integration has occurred when funding is incurred from national or regional budgets.[20] In planning – which constitutes needs assessment, priority setting and resource allocation – full integration occurs when the same institutions and stakeholders are involved as those planning general health/ other social systems.[20] If service delivery is the responsibility of general staff embedded in the system, the intervention is considered integrated.[20] Similarly, if monitoring and evaluation was conducted by those with overall M&E responsibility, then the intervention is considered integrated.[20] Finally, demand generation is seen as integrated where services were promoted and incentivized by general staff within the existing system.[20]

The second framework applied is that of the Health in All Policies (HiAP) framework for country action. HiAP is defined as a way for countries to protect population health through "an

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approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."[21] HiAP can be a powerful tool for enhancing accountability and safeguarding against distortions imposed by deleterious commercial and political interests. HiAP is in line with the human rights principles of legitimacy, protected by national and international law, accountability of governments to people, transparency of decision making, participation of the wider society, sustainability of policies to meet current needs without compromising future ones, and collaboration across sectors and levels of government.[11,21] The HiAP framework for action involves six components including: i) establish the need and priorities for HiAP, ii) frame planned action, iii) identify supportive structures and policies, iv) facilitate assessment and engagement, v) ensure monitoring and evaluation, and vi) build capacity.[21] These six components, adapted to refugee needs, will be used in the scoping review to frame barriers and facilitators in integrating refugee services across sectors through intersectoral collaboration. The framework for integration will then be used to assess the extent to which provisions for protecting refugees' right to health are integrated into existing social systems, and the content, process, and actors involved in integration.[22]

Identifying relevant studies

Population: Eligible studies and papers will include those targeting refugees and asylum-seekers as previously defined. We are not including other categories of migrants as their legal entitlements are different to those of refugees which are protected under international law.

Intervention: Eligible studies and papers will describe a programme, approach or technical innovation that aims to protect refugees' right to health, including interventions aimed at addressing the social determinants of health. Interventions outside of the health sector that affect

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health will be included. If the studies do not display some level of integration or intersectorality, based on the frameworks for integration and HiAP, they will not be assessed further.[20,21] This will be determined using a data abstraction chart where the key elements of the two frameworks will be laid out and contrasted against the studies found.

Comparators: Eligible studies and papers do not necessarily have to display a comparator as this scoping review is meant to gauge the state of the evidence. Where comparators exist, any types are relevant for inclusion, for example those comparing a parallel approach to service provision for refugees versus an integrated approach.

Outcomes: Eligible studies and papers will include those discussing plans for action, strategies, barriers, facilitators or outcomes in integrating refugee health using an integrated or intersectoral approach. Studies or commentaries that solely discuss theories and conceptual models will be excluded.

Study design: Qualitative, quantitative, and mixed methods will be eligible for inclusion. Experimental designing including randomized controlled trials, non-randomized controlled trials and quasi-experimental models will be included, as well as observation and qualitative studies including cohort, cross sectional, case series, ethnographic, interview/based, and focus-group discussion based studies. Grey literature that explores plans, strategies, barriers, facilitators or outcomes of refugee health, as well as implementation research and operations research studies will also be included. Studies or report outlining stakeholder experiences and plans will also be included as case studies.

Time period: In order to ensure relevance, only studies from 2000 onward (search completed May 8th 2017) have been included, making the study period range over 16 years. It is estimated that the review will be completed by January 2018.

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210 ***Setting:*** Eligible studies will be set in countries receiving refugees and asylum seekers (who may
211 eventually qualify for refugee status) and serving as hosts for resettlement.

212 **Information sources and search strategy**

213 Based on the study team's concepts for the review, an experienced team of librarians from
214 Karolinska Institutet have conducted a search of articles from 2000 to May 2017 in the following
215 electronic databases: MEDLINE, Web of Science, Global Health, and PsycInfo Embase. The
216 three concepts used to create the search strategy includede: i) refugees and asylum-seekers; ii)
217 type of service provision (health sector service delivery, intersectoral approaches, partnerships,
218 integration); and iii) health equity, human rights and social determinants of health. See appendix
219 I for search strategy.

220 The search of the peer-reviewed literature will be supplemented by a search of grey literature
221 through government websites, particularly governments of countries that receive the highest
222 refugee burden, reports from multi-nationals and non-governmental organizations, conference
223 abstracts, dissertations, and news articles. Any additional report and articles will be identified by
224 reaching out to relevant stakeholders in the authors' professional networks, including those
225 involved in the European refugee response.

226 **Study selection process**

227 Search results will be cleaned for duplicates and uploaded to an excel document, which will be
228 used for screening using the eligibility criteria described above.

229 Two members of the study team will screen results based on the screening tool discussed. Inter-
230 rater reliability will be assessed based on a set of 100 initial screens, and adjustments and
231 clarifications to the screening tool will be made if reliability is not as high as desired (above
232 80%). Once a set of included studies and papers are identified, two reviewers will independently

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233 conduct a full-text screen in order to apply the aforementioned frameworks for integration and
234 intersectorality (HiAP). Eligible studies will be those displaying integration or intersectorality,
235 defined as satisfying at least 2 of the 6 elements in either one of the integration or HiAP
236 frameworks. A third reviewer has been identified in the event of disagreement between the two
237 reviewers. This will be followed by data abstraction, using a form derived from the two
238 framework, from the finalized set.

239 **Data abstraction and charting process**

240 General data collected will include study design, setting, and journal discipline. Demographic
241 data collected will include context, target study group (gender, age, ethnic background), number
242 of participants, economy status of setting based on World Bank classifications, and level of the
243 health system where applicable (community, district, regional, etc.). Intervention-specific data
244 collected will include the type of intervention (behavioural, medical, social), the social
245 determinant of health being addressed (WHO commission on social determinants of health
246 framework)[23], the primary sector(s) involved (health, education, law enforcement, housing, etc.),
247 duration, resources, funding source, and conceptual framework applied if any. Outcome data
248 collected will include barriers, facilitators, strategies, plans, qualitative findings from interviews
249 and focus groups, and any unintended consequences. In the final set of included studies – those
250 displaying some level of integration or intersectorality – key elements will be charted according
251 to the two frameworks described above.[18,20,21] Data will be charted to include types of
252 stakeholders involved in (i) governance, (ii) financing, (iii) planning, (iv) service delivery, (v)
253 monitoring and evaluation (M&E), and (vi) demand generation.[20] This will assess the extent of
254 integration while data charted against the six components of the HiAP framework will assess the

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intersectoral potential of the intervention. Two members of the study team will code studies on NVivo software[24] using a coding guide based on the two frameworks used for the review.

The data abstraction form will be tested by both reviewers using 5 studies. Where there is a sufficient level of agreement across reviewers (above 80%), data abstraction will continue as designed. If agreement falls below the required range, the data abstraction form will be clarified. As this is a scoping review, meta-analysis will not be conducted.

Risk of bias assessment

In line with the manual used to design this scoping review, risk of bias assessments will not be conducted.[17]

Results

Frequency tables will be used to describe included studies quantitatively while narratives will be used to describe interventions, barriers, facilitators, and other qualitative outcomes. Stakeholders will be presented based on the combined integration and HiAP frameworks, with their roles and involvement in the studies outlined. If a sufficiently diverse range of studies are identified, stratification by health system level (community, district, region) and country economy status will be done.

Charted data will be mapped out into subcategories to allow for a narrative description of barriers and facilitators, including barriers specific to vulnerable groups (women, children, torture survivors, those with disabilities, etc.). New themes will be added where necessary and elements of integration and/or intersectorality that are more or less prevalent across included studies will be highlighted. Finally, context, content, process and actors will be mapped based on charted data in accordance with the Walt Policy Triangle.[22] Vulnerabilities of specific groups such as women and children will be highlighted.

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DISCUSSION

Implications

This scoping review will identify programmes, approaches and interventions both within and outside the health sector that promote and protect refugees' right to health directly or indirectly through social determinants of health. To support country-level decision making and resettlement efforts, this review will provide an understanding of the extent of integration and intersectoral collaboration currently reported in this area, barriers and facilitators to provision of such services and their integration, and key stakeholders involved as well as those often missing. Findings will be shared with WHO colleagues working in this area, the Alliance for Health Policy and Systems Research contacts, and a network of policy makers who will in turn share with their national and local networks. Other expected outputs include an improved understanding of contextual factors that are necessary in supporting the right to health for refugees as well as a narrative exploration of whether intersectoral collaboration and the idea of "Health in All Policies" (HiAP) also works to protect and promote the health of persons outside of the traditional definitions of citizenry. These discussions will stimulate dialogue on how receiving countries can strengthen the resilience of their social systems to enhance their capacity for effective resettlement and improved health outcomes in their refugee populations.

Ethics and Dissemination

In addition to the study team's respective networks, this review will also be disseminated at relevant conferences, meetings, and communities of practice focused on enhancing use of evidence in policy making. A brief of key learnings will be created to support evidence-informed decision making in this area.

Ethics approval is not required for this scoping review as human subjects are not involved.

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AUTHOR'S CONTRIBUTIONS

DJ drafted the paper and will be acting as primary reviewer, EVL, SH, PF, and GT provided feedback and comments. SH and EVL will be acting as secondary reviewers. PF and GT, of SIGHT will be providing continued support and connecting to relevant actors working in this area.

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COMPETING INTERESTS AND FUNDING STATEMENT

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Appendix I

1. Medline(Ovid)

Date of Search: 5 May 2017 Number of hits: 2,766 Comments:	Field labels: .tw,kf. = title, abstract, keyword exp/ = MeSH, exploded / = MeSH, not exploded adj3 = within two words

1. Refugees/
2. exp "Emigrants and Immigrants"/
3. "Emigration and Immigration"/
4. "Transients and Migrants"/
5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).tw,kf.
6. or/1-5

7. Delivery of Health Care/
8. Health Services Accessibility/
9. Patient Acceptance of Health Care/
10. "Health Services Needs and Demand"/
11. Quality of Health Care/
12. Interinstitutional Relations/
13. Interdepartmental Relations/
14. Public-Private Sector Partnerships/
15. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).tw,kf.
16. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).tw,kf.
17. or/7-16

18. Healthcare Disparities/
19. Social Determinants of Health/
20. Health Status Disparities/
21. Health Equity/
22. exp Human Rights/
23. Community Integration/
24. Acculturation/
25. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).tw,kf.
26. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).tw,kf.
27. (acculturat* or assimilat* or integration).tw,kf.

28. or/18-27

29. 6 and 17 and 28

30. remove duplicates from 29

31. limit 30 to yr="2000 -Current"

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2. Web of Science (Thomson Reuter)

Date of Search: 8 May 2017 Number of hits: 1,727 Comments:	Field labels: TOPIC = title, abstract, keywords NEAR/3 = within 3 words

#1 TOPIC: (refugee* or immigra* or migrat* or migrant* or asylum* or transient*)

#2 TOPIC: (("health care" or healthcare or "health service*") NEAR/3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization))

#3 TOPIC: ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) NEAR/3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*))

#4 #3 OR #2

#5 TOPIC: ((health or "health care" or healthcare or "health service*") NEAR/3 (situation or difference*))

#6 TOPIC: (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or "human right*" or "civil right*" or "citizen* right*" or "social right*" or injustice* or discrimination* or determinant* or disadvantage* or vulnerab* or acculturat* or assmilat* or integration)

#7 #6 OR #5

#8 #7 AND #4 AND #1

#9 Timespan: 2000-2017.

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3. Global Health (Ovid)

Date of Search: 8 May 2017 Number of hits: 667 Comments:	Field labels: .ab,ti. = title, abstract exp/ =thesaurus term, exploded / = thesaurus term, not exploded adj3 = within two words

1. refugees/
2. immigrants/
3. migrants/
4. immigration/
5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).ab,ti.
6. or/1-5

7. health care utilization/
8. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).ab,ti.
9. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).ab,ti.
10. or/7-9

11. exp disparity/
12. exp discrimination/
13. human rights/
14. cultural integration/
15. social integration/
16. acculturation/
17. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab.
18. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).ti,ab.
19. (acculturat* or assimilat* or integration).ti,ab.
20. or/11-19

21. 6 and 10 and 20

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4. PsycInfo (OVID)

Date of Search: 8 May 2017 Number of hits: 902 Comments:	Field labels: .ti,ab,id. = title, abstract, keyword exp/ = subject heading, exploded / = subject heading, not exploded adj3 = within two words

1. exp Human Migration/
2. Immigration/
3. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).ti,ab,id.
4. or/1-3

5. Health Care Delivery/
6. Health Care Utilization/
7. Health Care Seeking Behavior/
8. Health Service Needs/
9. "Quality of Care"/
10. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).ti,ab,id.
11. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).ti,ab,id.

12. or/5-11
13. Health Disparities/
14. Social Equality/
15. exp Human Rights/
16. exp Social integration/
17. Assimilation/
18. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab,id.
19. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or human right* or civil right* or citizen* right* or social right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).ti,ab,id.
20. (acculturat* or assimilat* or integration).ti,ab,id.
21. or/13-20

22. 4 and 12 and 21
23. limit 22 to yr="2000 -Current"

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PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol*

Section and topic	Item No	Checklist item	Page
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a protocol of a systematic review	1, 2
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	NA
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	Registered on Open Science Framework at https://osf.io/gt9ck/
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	13
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	NA
Support:			
Sources	5a	Indicate sources of financial or other support for the review	NA
Sponsor	5b	Provide name for the review funder and/or sponsor	NA
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	14
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	4-5
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	5-6
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	8-10
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	9

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Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	9-10; 16-20
Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	10-11
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	10
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	11
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	11
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	11-12
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	NA
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	12
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2, Kendall's τ)	12
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	12
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	12
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	12
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	NA

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1):g7647.

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BMJ Open

Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: A scoping review Protocol

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Primary Subject Heading:	Health services research
Secondary Subject Heading:	Ethics, Global health, Health policy, Public health, Qualitative research
Keywords:	intersectoral, refugees, human rights, integration, resettlement

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Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: A scoping review Protocol

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Word count: 3,150

Keywords: intersectoral, human rights, access, refugees, integration, resettlement

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23 **ABSTRACT**

24 **Introduction:** Global insecurity and climate change are exacerbating the need for improved
25 management of refugee resettlement services. International standards hold states responsible for
26 the protection of the right of non-citizens to an adequate standard of physical and mental health,
27 while recognizing the importance of social determinants of health. However, programmes to
28 protect refugees' right to health often lack coordination and monitoring. This paper describes the
29 protocol for a scoping review to explore barriers and facilitators to the integration of health
30 services for refugees; the content, process and actors involved in protecting refugee health; and
31 the extent to which intersectoral approaches are leveraged to protect refugees' right to health
32 upon resettlement, especially for vulnerable groups such as women and children.

33 **Methods and analysis:** Peer reviewed (through four databases including Medline, Web of
34 Science, Global Health, and PsycInfo) and grey literature were searched to identify programmes
35 and interventions designed to promote refugee health in receiving countries. Two reviewers will
36 screen articles and abstract data. Two frameworks for integration and intersectoral action will be
37 applied to understand how and why certain approaches work while others do not and to identify
38 the actors involved in achieving success at different levels of integration as defined by these
39 frameworks.

40 **Ethics & dissemination:** Findings from the scoping review will be shared in relevant
41 conferences and meetings. A brief will be created with lessons learned from successful
42 programmes to inform decision making in design of refugee programmes and services. Ethical
43 approval is not required as human subjects are not involved.

44 **Registration:** Registered on Open Science Framework at https://osf.io/gt9ck/

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45 **Strengths and Limitations:**

- 46 Many programmes exist to attempt to address the unique challenges faced by refugees 47 but these are largely unevaluated and face challenges to sustainability. This scoping 48 review will summarize lessons learned from these programmes by exploring barriers and 49 facilitators to the integration of health services for refugees; the content, process and 50 actors involved in protecting refugee health; and the extent to which intersectoral 51 approaches are leveraged to protect refugees' right to health upon resettlement, especially 52 for vulnerable groups such as women and children.
- 53 This study will be limited by the quality of the literature on health care programs for 54 refugees and protection of their right to health.

55 **INTRODUCTION**

56 The Office of the United Nations High Commission for Human Rights (OHCHR) identifies the 57 right to the enjoyment of the highest attainable standard of physical and mental health as a 58 fundamental part of human rights, first articulated in the 1946 Constitution of the World Health 59 Organization (WHO).[1] While the right to health includes access to health care and the hard 60 infrastructure associated with that – such as hospitals and ambulances – it also includes the 61 underlying determinants of health including, safe drinking water, adequate sanitation, safe food, 62 adequate nutrition and housing, healthy working and environmental conditions, health related 63 education and information, and gender equality.[1] Freedoms which protect individuals from non-64 consensual medical treatment, torture and other degrading treatment are also included in this 65 definition. Furthermore, entitlements under the right to health include universal health coverage 66 – now a target under Sustainable Development Goal 3 – broadly covering access to preventive 67 and curative services, essential medicines, timely basic health services, health related education, 68 and participation in health related decision making at both national and community levels.[1,2] 69 Especially relevant to the plight of refugees, the right to health includes non-discrimination 70 whereby health services, goods and facilities must be provided to all without any discrimination. 71 Lastly, these health services must be available in sufficient quantity, accessible, medically and

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culturally acceptable, and of good quality, which includes having a trained health workforce, safe products and adequate sanitation.[2]

The influx of refugees over the last few years makes the realization of these rights a legal and logistical challenge.[3,4] Different in definition from the term "migrant," "refugees" are those fleeing armed conflict or persecution as defined by the 1951 Refugee Convention which also identifies their basic rights, specifically that refugees should not be returned to situations that are deemed a threat to their life or freedom.[5] A key distinction is that refugee rights are not only a matter of national legislation, but also of international law.[6] Despite these legal protections, refugees face many challenges in accessing health services, especially more vulnerable groups like women and children.[3,4] Many states explicitly exclude refugees from the level of protection afforded to their citizens, instead choosing to offer "essential care" or "emergency health care," which is differentially defined across countries.[7] The Committee on the Elimination of Racial Discrimination, and the Committee on Economic, Social and Cultural Rights, both include general comments that hold States accountable to "the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services."[8]

However, the capacity of States to truly protect these rights is limited.[9] As the boundaries of the right to health have expanded due to increased understanding of social determinants of health and the health impacts of the lived environment, legal frameworks have been insufficient in ensuring the protection of these rights.[10,11] Refugees are not only more likely to have poorer health during resettlement, but they also face challenges in navigating legal, education, health, housing and employment services, which further threatens their quality of life and health status.[12] A lack of coordination and integration across these services undermines service effectiveness.[13]

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95 Much like the shift from the more vertical approaches of the millennium development goals (MDGs) towards the more integrated sustainable development goals (SDGs), the protection of the right to health too calls for an intersectoral approach whereby health is applied to all policies for all people.[14] Therefore, for states to effectively protect the right to health for refugees there is a need to work across sectors and disciplines to better integrate targeted programmes and initiatives, thereby improving standards of care during resettlement. Evidence exists that supporting collaboration and coordination across social services improves the quality of care received and its effectiveness.[12] Furthermore, the refugee sub-population is diverse and requires extraneous considerations in ensuring the right to health, not only as compared to the general population, but also within the sub-population itself. Many fragmented psychosocial programmes exist to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability.[15,16] Better understanding, documentation, and reporting of the dynamic nature of such interventions and their means of health system integration and intersectoral collaboration, are necessary to ensure that lessons learned are communicated and implemented in the design of future policies and programmes. This would promote continuity of care, people-centred care, and sustainability of health and social services for refugees. Therefore, we aim to conduct a scoping review to explore barriers and facilitators to integrated health services for refugees; the content, process and actors involved in protecting refugee health; and the extent to which intersectoral approaches are leveraged to protect refugees' right to health upon resettlement. This paper will outline the protocol for this review. The specific research questions for the review will be as follows:

116 (1) What are the barriers and facilitators (context) in integrating targeted services for refugees within existing systems?

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(2) What strategies (content, process, and actors) are involved in addressing refugees' right to health upon resettlement?

(3) To what extent are intersectoral approaches used to protect refugees' right to health, particularly in women and children?

METHODS

Study Design

This study will be conducted using the scoping review methodology as described by the Joanna Briggs Institute Methods Manual for scoping reviews.[17] Scoping reviews are used to map key concepts in an area to identify the scope of practice, working definitions, conceptual boundaries, and the types of evidence available. We opted for a scoping review due to the complex nature of this topic, the changing global landscape around it, and the insufficient evidence base to support effective decision making.[18]

The five stages outlined in a methodological framework for scoping studies are as follows: i) identify the research question, ii) identify relevant studies, iii) study selection, iv) charting the data, and v) collating, summarising and reporting results.[18]

Protocol

The Preferred Reporting Items for Systematic Reviews and Meta-analysis for Protocols (PRISMA-P) checklist were used in drafting this protocol.[19]

Frameworks to address research questions

While some evidence suggests that improved collaboration and coordination across social sectors can contribute to enhancing refugee health, there remains a need for a stronger evidence base on the context, processes and actors involved in protecting refugees' right to health upon

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141 resettlement.[12] Therefore, the research questions identified for this scoping review focus on
142 integration and use of intersectoral approaches to address the complex needs of this vulnerable
143 population. Two frameworks are being used concurrently in order to comprehensively identify
144 barriers, facilitators, processes, and actors involved at various stages in programme planning and
145 implementation. The first is a framework for analyzing integration of targeted health
146 interventions in systems, where integration is defined as "the extent, pattern, and rate of adoption
147 and eventual assimilation of health interventions into each of the critical functions of a health
148 system."[20] Elements in this framework include (i) governance, (ii) financing, (iii) planning, (iv)
149 service delivery, (v) monitoring and evaluation (M&E), and (vi) demand generation.[20] To be
150 considered integrated, a health intervention needs to fulfill certain requirements across
151 these six areas as defined by the framework.[20] We define an intervention here as *changes in*
152 *service delivery, organizational models, process modification, or new technologies.* To satisfy
153 governance needs for integration, governance and regulatory mechanisms for the intervention
154 match those of the general health system.[20] For financing, full integration has occurred when
155 funding is incurred from national or regional budgets.[20] In planning – which constitutes needs
156 assessment, priority setting and resource allocation – full integration occurs when the same
157 institutions and stakeholders are involved as those planning general health/ other social
158 systems.[20] If service delivery is the responsibility of general staff embedded in the system, the
159 intervention is considered integrated.[20] Similarly, if monitoring and evaluation was conducted by
160 those with overall M&E responsibility, then the intervention is considered integrated.[20] Finally,
161 demand generation is seen as integrated where services were promoted and incentivized by
162 general staff within the existing system.[20]

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The second framework applied is that of the Health in All Policies (HiAP) framework for country action. HiAP is defined as a way for countries to protect population health through "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."[21] HiAP can be a powerful tool for enhancing accountability and safeguarding against distortions imposed by deleterious commercial and political interests. HiAP is in line with the human rights principles of legitimacy, protected by national and international law, accountability of governments to people, transparency of decision making, participation of the wider society, sustainability of policies to meet current needs without compromising future ones, and collaboration across sectors and levels of government.[11,21] The HiAP framework for action involves six components including: i) establish the need and priorities for HiAP, ii) frame planned action, iii) identify supportive structures and policies, iv) facilitate assessment and engagement, v) ensure monitoring and evaluation, and vi) build capacity.[21] These six components, adapted to refugee needs, will be used in the scoping review to frame barriers and facilitators in integrating refugee services across sectors through intersectoral collaboration. The framework for integration will then be used to assess the extent to which provisions for protecting refugees' right to health are integrated into existing social systems, and the content, process, and actors involved in integration.[22]

Identifying relevant studies

Population: Eligible studies and papers will include those targeting refugees and asylum-seekers as previously defined. We are not including other categories of migrants as their legal entitlements are different to those of refugees which are protected under international law. Asylum-seekers have yet to be granted full legal refugee status as their request for sanctuary is

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186 still in process; however, we are including them in this review in order to capture any programs
187 that are also targeting this vulnerable group and reflect on differences in access to health across
188 the two different stages of being granted sanctuary. This is especially relevant due to the scale of
189 the current refugee crisis and the time it takes to be granted refugee status.

190 ***Intervention:*** Eligible studies and papers will describe a programme, approach or technical
191 innovation that aims to protect refugees' right to health, including interventions aimed at
192 addressing the social determinants of health. Interventions outside of the health sector that affect
193 health will be included. If the studies do not display some level of integration or intersectorality,
194 based on the frameworks for integration and HiAP, they will not be assessed further.[20,21] This
195 will be determined using a data abstraction chart where the key elements of the two frameworks
196 will be laid out and contrasted against the studies found.

197 ***Comparators:*** Eligible studies and papers do not necessarily have to display a comparator as this
198 scoping review is meant to gauge the state of the evidence. Where comparators exist, any types
199 are relevant for inclusion, for example those comparing a parallel approach to service provision
200 for refugees versus an integrated approach.

201 ***Outcomes:*** Eligible studies and papers will include those discussing plans for action, strategies,
202 barriers, facilitators or outcomes in integrating refugee health using an integrated or intersectoral
203 approach. Studies or commentaries that solely discuss theories and conceptual models will be
204 excluded.

205 ***Study design:*** Qualitative, quantitative, and mixed methods will be eligible for inclusion.
206 Experimental designing including randomized controlled trials, non-randomized controlled trials
207 and quasi-experimental models will be included, as well as observation and qualitative studies
208 including cohort, cross sectional, case series, ethnographic, interview/based, and focus-group

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discussion based studies. Grey literature that explores plans, strategies, barriers, facilitators or outcomes of refugee health, as well as implementation research and operations research studies will also be included. Studies or report outlining stakeholder experiences and plans will also be included as case studies.

Time period: In order to ensure relevance, only studies from 2000 onward (search completed May 8th 2017) have been included, making the study period range over 16 years. It is estimated that the review will be completed by January 2018.

Setting: Eligible studies will be set in countries receiving refugees and asylum seekers (who may eventually qualify for refugee status) and serving as hosts for resettlement.

Information sources and search strategy

Based on the study team's concepts for the review, an experienced team of librarians from Karolinska Institutet have conducted a search of articles from 2000 to May 2017 in the following electronic databases: MEDLINE, Web of Science, Global Health, and PsycInfo Embase. The three concepts used to create the search strategy includede: i) refugees and asylum-seekers; ii) type of service provision (health sector service delivery, intersectoral approaches, partnerships, integration); and iii) health equity, human rights and social determinants of health. See appendix I for search strategy.

The search of the peer-reviewed literature will be supplemented by a search of grey literature through government websites, particularly governments of countries that receive the highest refugee burden, reports from multi-nationals and non-governmental organizations, conference abstracts, dissertations, and news articles. Any additional report and articles will be identified by reaching out to relevant stakeholders in the authors' professional networks, including those involved in the European refugee response.

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232 **Study selection process**

233 Search results will be cleaned for duplicates and uploaded to an excel document, which will be
234 used for screening using the eligibility criteria described above.

235 Two members of the study team will screen results based on the screening tool discussed. Inter-
236 rater reliability will be assessed based on a set of 100 initial screens, and adjustments and
237 clarifications to the screening tool will be made if reliability is not as high as desired (above
238 80%). Once a set of included studies and papers are identified, two reviewers will independently
239 conduct a full-text screen in order to apply the aforementioned frameworks for integration and
240 intersectorality (HiAP). Eligible studies will be those displaying integration or intersectorality,
241 defined as satisfying at least 2 of the 6 elements in either one of the integration or HiAP
242 frameworks. A third reviewer has been identified in the event of disagreement between the two
243 reviewers. This will be followed by data abstraction, using a form derived from the two
244 framework, from the finalized set.

245 **Data abstraction and charting process**

246 General data collected will include study design, setting, and journal discipline. Demographic
247 data collected will include context, target study group (gender, age, ethnic background, status),
248 number of participants, economy status of setting based on World Bank classifications, and level
249 of the health system where applicable (community, district, regional, etc.). Intervention-specific
250 data collected will include the type of intervention (behavioural, medical, social), the social
251 determinant of health being addressed (WHO commission on social determinants of health
252 framework)[23], the primary sector(s) involved (health, education, law enforcement, housing, etc.),
253 duration, resources, funding source, and conceptual framework applied if any. Outcome data
254 collected will include barriers, facilitators, strategies, plans, qualitative findings from interviews

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and focus groups, and any unintended consequences. Programmes and approaches specific to refugees versus asylum seekers will be disaggregated and distinctions highlighted. In the final set of included studies – those displaying some level of integration or intersectorality – key elements will be charted according to the two frameworks described above.[18,20,21] Data will be charted to include types of stakeholders involved in (i) governance, (ii) financing, (iii) planning, (iv) service delivery, (v) monitoring and evaluation (M&E), and (vi) demand generation.[20] This will assess the extent of integration while data charted against the six components of the HiAP framework will assess the intersectoral potential of the intervention. Two members of the study team will code studies on NVivo software[24] using a coding guide based on the two frameworks used for the review.

The data abstraction form will be tested by both reviewers using 5 studies. Where there is a sufficient level of agreement across reviewers (above 80%), data abstraction will continue as designed. If agreement falls below the required range, the data abstraction form will be clarified. As this is a scoping review, meta-analysis will not be conducted.

Risk of bias assessment

In line with the manual used to design this scoping review, risk of bias assessments will not be conducted.[17]

Results

Frequency tables will be used to describe included studies quantitatively while narratives will be used to describe interventions, barriers, facilitators, and other qualitative outcomes. Stakeholders will be presented based on the combined integration and HiAP frameworks, with their roles and involvement in the studies outlined. If a sufficiently diverse range of studies are identified,

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stratification by health system level (community, district, region) and country economy status will be done.

Charted data will be mapped out into subcategories to allow for a narrative description of barriers and facilitators, including barriers specific to vulnerable groups (women, children, torture survivors, those with disabilities, etc.). New themes will be added where necessary and elements of integration and/or intersectorality that are more or less prevalent across included studies will be highlighted. Finally, context, content, process and actors will be mapped based on charted data in accordance with the Walt Policy Triangle.[22] Vulnerabilities of specific groups such as women and children will be highlighted.

DISCUSSION

Implications

This scoping review will identify programmes, approaches and interventions both within and outside the health sector that promote and protect refugees' right to health directly or indirectly through social determinants of health. To support country-level decision making and resettlement efforts, this review will provide an understanding of the extent of integration and intersectoral collaboration currently reported in this area, barriers and facilitators to provision of such services and their integration, and key stakeholders involved as well as those often missing. Findings will be shared with WHO colleagues working in this area, the Alliance for Health Policy and Systems Research contacts, and a network of policy makers who will in turn share with their national and local networks. Other expected outputs include an improved understanding of contextual factors that are necessary in supporting the right to health for refugees as well as a narrative exploration of whether intersectoral collaboration and the idea of "Health in All Policies" (HiAP) also works to protect and promote the health of persons outside of the traditional definitions of citizenry.

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These discussions will stimulate dialogue on how receiving countries can strengthen the resilience of their social systems to enhance their capacity for effective resettlement and improved health outcomes in their refugee populations.

Ethics and Dissemination

In addition to the study team's respective networks, this review will also be disseminated at relevant conferences, meetings, and communities of practice focused on enhancing use of evidence in policy making. A brief of key learnings will be created to support evidence-informed decision making in this area.

Ethics approval is not required for this scoping review as human subjects are not involved.

AUTHOR'S CONTRIBUTIONS

DJ drafted the paper and will be acting as primary reviewer, EVL, SH, PF, and GT provided feedback and comments. SH and EVL will be acting as secondary reviewers. PF and GT, of SIGHT will be providing continued support and connecting to relevant actors working in this area.

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COMPETING INTERESTS AND FUNDING STATEMENT

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Appendix I

1. Medline(Ovid)

Date of Search: 5 May 2017 Number of hits: 2,766 Comments:	Field labels: .tw,kf. = title, abstract, keyword exp/ = MeSH, exploded / = MeSH, not exploded adj3 = within two words

1. Refugees/
2. exp "Emigrants and Immigrants"/
3. "Emigration and Immigration"/
4. "Transients and Migrants"/
5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).tw,kf.
6. or/1-5

7. Delivery of Health Care/
8. Health Services Accessibility/
9. Patient Acceptance of Health Care/
10. "Health Services Needs and Demand"/
11. Quality of Health Care/
12. Interinstitutional Relations/
13. Interdepartmental Relations/
14. Public-Private Sector Partnerships/
15. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).tw,kf.
16. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).tw,kf.
17. or/7-16

18. Healthcare Disparities/
19. Social Determinants of Health/
20. Health Status Disparities/
21. Health Equity/
22. exp Human Rights/
23. Community Integration/
24. Acculturation/
25. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).tw,kf.
26. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).tw,kf.
27. (acculturat* or assimilat* or integration).tw,kf.

28. or/18-27

29. 6 and 17 and 28

30. remove duplicates from 29

31. limit 30 to yr="2000 -Current"

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2. Web of Science (Thomson Reuter)

Date of Search: 8 May 2017 Number of hits: 1,727 Comments:	Field labels: TOPIC = title, abstract, keywords NEAR/3 = within 3 words

#1 TOPIC: (refugee* or immigra* or migrat* or migrant* or asylum* or transient*)

#2 TOPIC: (("health care" or healthcare or "health service*") NEAR/3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization))

#3 TOPIC: ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) NEAR/3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*))

#4 #3 OR #2

#5 TOPIC: ((health or "health care" or healthcare or "health service*") NEAR/3 (situation or difference*))

#6 TOPIC: (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or "human right*" or "civil right*" or "citizen* right*" or "social right*" or injustice* or discrimination* or determinant* or disadvantage* or vulnerab* or acculturat* or assmilat* or integration)

#7 #6 OR #5

#8 #7 AND #4 AND #1

#9 Timespan: 2000-2017.

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3. Global Health (Ovid)

Date of Search: 8 May 2017 Number of hits: 667 Comments:	Field labels: .ab,ti. = title, abstract exp/ =thesaurus term, exploded / = thesaurus term, not exploded adj3 = within two words

1. refugees/
2. immigrants/
3. migrants/
4. immigration/
5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).ab,ti.
6. or/1-5

7. health care utilization/
8. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).ab,ti.
9. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).ab,ti.
10. or/7-9

11. exp disparity/
12. exp discrimination/
13. human rights/
14. cultural integration/
15. social integration/
16. acculturation/
17. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab.
18. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).ti,ab.
19. (acculturat* or assimilat* or integration).ti,ab.
20. or/11-19

21. 6 and 10 and 20

22. limit 21 to yr="2000-Current"

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4. PsycInfo (OVID)

Date of Search: 8 May 2017 Number of hits: 902 Comments:	Field labels: .ti,ab,id. = title, abstract, keyword exp/ = subject heading, exploded / = subject heading, not exploded adj3 = within two words

1. exp Human Migration/
2. Immigration/
3. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).ti,ab,id.
4. or/1-3

5. Health Care Delivery/
6. Health Care Utilization/
7. Health Care Seeking Behavior/
8. Health Service Needs/
9. "Quality of Care"/
10. ((health care or healthcare or health service*) adj3 (access* or availab* or barrier* or deliver* or need* or provision* or seeking or quality or utilization)).ti,ab,id.
11. ((multisector* or multi-sector* or intersector* or inter-sector* or crosssector* or cross-sector* or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary or interinstitution* or inter-institution* or interdepartment* or inter-department*) adj3 (analysis or collaborat* or cooperat* or co-operat* or approach* or partnership* or relation*)).ti,ab,id.

12. or/5-11
13. Health Disparities/
14. Social Equality/
15. exp Human Rights/
16. exp Social integration/
17. Assimilation/
18. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab,id.
19. (disparit* or equity or equities or inequity or inequities or equalit* or inequalit* or human right* or civil right* or citizen* right* or social right* or injustice* or discrimination* or determinant* or disadvantage* or vulnerab*).ti,ab,id.
20. (acculturat* or assimilat* or integration).ti,ab,id.
21. or/13-20

22. 4 and 12 and 21
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PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol*

Section and topic	Item No	Checklist item	Page
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a protocol of a systematic review	1, 2
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	NA
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	Registered on Open Science Framework at https://osf.io/gt9ck/
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	13
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	NA
Support:			
Sources	5a	Indicate sources of financial or other support for the review	NA
Sponsor	5b	Provide name for the review funder and/or sponsor	NA
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	14
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	4-5
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	5-6
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	8-10
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	9

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Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	9-10; 16-20
Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	10-11
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	10
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	11
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	11
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	11-12
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	NA
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	12
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2, Kendall's τ)	12
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	12
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	12
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	12
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	NA

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated.** **The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1):g7647.

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