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

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Manuscripts

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3 1 **Intersectoral and integrated approaches in achieving the right to health**
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5 2 **for refugees upon resettlement: A scoping review**
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10 4 Shirley Ho*¹ email: shirleyyingho@gmail.com
11 5 Dena Javadi ¹ email: javadid@who.int
12 6 Sara Causevic^{2,3} email: sara.causevic@ki.se
13 7 Etienne V. Langlois¹ email: langloise@who.int
14 8 Peter Friberg^{2,5} email: peter.friberg@mednet.gu.se
15 9 Goran Tomson^{2,4} email: Goran.Tomson@ki.se
16
17 10

18 11 ¹ Alliance for Health Policy and Systems Research, World Health Organization, Avenue Appia 20, 1211 Geneva,
19 12 Switzerland

20 13 ² Swedish Institute for Global Health Transformation, SIGHT, Royal Swedish Academy of Science, Stockholm,
21 14 Sweden

22 15 ³ Global and Sexual Health, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden

23 16 ⁴ Medical Management Centre, Department of Learning, Informatics, Management, Ethics (LIME), Karolinska
24 17 Institutet, Stockholm, Sweden

25 18 ⁵ Institute of Medicine, Sahlgrenska Academy at Gothenburg university and Sahlgrenska university hospital
26 19
27 20
28

29 21 ***Corresponding Author:**

30 22 Shirley Ho, shirleyyingho@gmail.com

31 23 Alliance for Health Policy and Systems Research, World Health Organization
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35 25 **Keywords:** intersectoral, right to health, access, refugees, integration, resettlement
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3 28 **ABSTRACT (300/300)**
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5 29 **Background:** Better understanding, documentation, and evaluation of different refugee health
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7 30 interventions, and their means of health system integration and intersectoral collaboration are needed

8
9 31 **Objectives:** Explore the barriers and facilitators to the integration of health services for refugees; the
10
11 32 process and actors involved; and the extent to which intersectoral approaches are leveraged to
12
13 33 protect refugees' right to health on resettlement

14 34 **Design:** Scoping Review

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16 35 **Methods:** A search of articles from 2000 onward was done in MEDLINE, Web of Science, Global
17
18 36 Health, and PsycInfo Embase. Two frameworks were applied in our analysis, the "Framework for
19
20 37 analyzing integration of targeted health interventions in systems", and "Health in All Policies"
21
22 38 framework for country action. A comprehensive description of the methods is included in our
23
24 39 published protocol.

25 40 **Results:** Limited evidence was found overall. 6,117 papers were identified, only 18 studies met
26
27 41 the inclusion criteria. Successful strategies to address refugee health included: networks of
28
29 42 service delivery combining existing public and private services; system navigators; host
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31 43 community engagement to reduce stigma; translation services; legislative support; appropriate
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33 44 funding models; and alternative models of care for women and children. Facilitators in
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35 45 implementation included: communication of program availability; training for providers;
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37 46 colocation of services; transportation services to enhance access; clear role definitions; and
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39 47 innovation in financing. Barriers included: lack of a participatory approach; stigma leading to
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41 48 underuse of services; insufficient resources for providers; absence of financing models; unclear
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43 49 roles and insufficient coordination of inter professional teams; low availability and use of data;
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45 50 and turf wars across governance stakeholders.

46
47 51 **Conclusion:** Key policy insights include: improving coordination between existing programmes
48
49 52 through financing stronger data collection and referral systems, supporting colocation of services;
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51 53 establishing formal system navigator roles that connect all relevant services; engaging host
52
53 54 communities to reduce stigma; establishing formal translation and transport services to improve
54
55 55 access; and establishing training and providers' resources.

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59 57 **Registration:** Registered on Open Science Framework at <https://osf.io/gt9ck/>
60

58 **Strengths and limitations of this study**

- 59 • Our study uses a systematic approach by using two frameworks for integration and
60 intersectoral action, the “Framework for analyzing integration of targeted health
61 interventions in systems”, and “Health in All Policies” framework for country action to
62 develop a strong evidence base in understanding the processes and actors involved
- 63 • The lack of evidence on intersectoral and integrated approaches from low-income and
64 middle-income countries may impact the generalizability of the findings
- 65 • Our findings can be applied for policy and action aiming to enhance the integration of
66 refugee health services within health systems and multisectoral collaboration, and
67 identifying research needs to advance the right to health for refugees.

68 **INTRODUCTION**

69 Upholding the right to health is a fundamental challenge for governments worldwide,
70 particularly when providing services to vulnerable or hard to reach populations such as refugees.
71 The Office of the United Nations High Commission for Human Rights (OHCHR) identifies the
72 right to health as a fundamental part of human rights, first articulated in the 1946 Constitution of
73 the World Health Organization (WHO).¹ Entitlements under the right to health include universal
74 health coverage – now a target under Sustainable Development Goal (SDG) 3 – broadly covering
75 access to preventative and curative services, essential medicines, timely basic health services,
76 health-related education, participation in health-related decision making at both national and
77 community levels, as well as financial protection.^{1,2} Especially relevant to the plight of refugees,
78 the right to health includes non-discrimination whereby health services, commodities and
79 facilities must be provided to all without any discrimination. Lastly, these health services must

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3 80 be accessible, medically and culturally appropriate, available in adequate amount and quality,
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5 81 which includes having a trained health workforce, safe products and adequate sanitation.²
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8 82 Different in definition from the term “migrant,” “refugees” are those fleeing armed
9
10 83 conflict or persecution as defined by the 1951 Refugee Convention which also identifies their
11
12 84 basic rights, specifically that refugees should not be returned to situations that are deemed a
13
14 85 threat to their life or freedom.³ A key distinction is that refugee rights are not only a matter of
15
16 86 national legislation, but also of international law.⁴ Despite these legal protections, refugees face
17
18 87 many challenges in accessing health services, especially more vulnerable groups like women and
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20 88 children.⁵ Many states explicitly exclude refugees from the level of protection afforded to their
21
22 89 citizens, instead choosing to offer “essential care” or “emergency health care,” which is
23
24 90 differentially defined across countries.⁶ The Committee on the Elimination of Racial
25
26 91 Discrimination, and the Committee on Economic, Social and Cultural Rights, both include
27
28 92 general comments that hold States accountable to “the right of non-citizens to an adequate
29
30 93 standard of physical and mental health by, inter alia, refraining from denying or limiting their
31
32 94 access to preventive, curative and palliative health services”.⁷ The increasing number of refugees
33
34 95 over the past years makes the realization and protection of these rights both a legal, ethical and a
35
36 96 logistical challenge.⁵ In addition, the boundaries of the right to health have expanded due to
37
38 97 increased understanding of social determinants of health and the health impacts of the lived
39
40 98 environment.^{8,9} Refugees face challenges in navigating health, legal, education, housing, social
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42 99 protection and employment services, which further threatens their quality of life and health
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44 100 status.¹⁰ A lack of coordination and integration across these services undermines their
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46 101 effectiveness.¹¹
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3 102 Much like the shift from the more vertical approaches of the millennium development
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5 103 goals (MDGs) towards the more integrated SDGs, the protection of the right to health calls for an
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7 104 intersectoral approach whereby health is applied to all policies for all people.¹² Therefore, for
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9
10 105 states to effectively protect the right to health for refugees there is a need to work across sectors
11
12 106 and disciplines to better integrate targeted programmes and initiatives, thereby improving
13
14 107 standards of care during resettlement. Some evidence exists that supporting collaboration and
15
16 108 coordination across social services for refugees improves the effectiveness and quality of care
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18 109 received.¹⁰ Many fragmented psychosocial programmes exist across sectors to attempt to address
19
20 110 the unique challenges faced by refugees but these are largely unevaluated and lack
21
22 111 sustainability.^{13,14} Better understanding, documentation, evaluation and reporting of the dynamic
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24 112 nature of different interventions, and their means of health system integration and intersectoral
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26 113 collaboration, are necessary to ensure that lessons learned are implemented in the design of
27
28 114 future policies and programmes.

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33 115 Therefore, we conducted a scoping review that describes the process and actors involved
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35 116 in protecting refugee health; the barriers and facilitators to health promotion services for
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37 117 refugees; and the extent to which intersectoral approaches and integration of services are
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39 118 leveraged to protect refugees' right to health upon resettlement. We focused on the specific
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41 119 research questions:

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44 120 (1) What are the barriers and facilitators in integrating targeted services for refugees within
45
46 121 existing health systems?
47
48 122 (2) What strategies are involved in addressing refugees' right to health upon resettlement?
49
50 123 (3) To what extent are intersectoral approaches used to protect refugees' right to health,
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52 124 particularly in women and children?
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125 **METHODS**

126 **Study Design**

127 We selected the scoping review method because we were interested in mapping the concepts
128 relevant to the complex nature of this topic, the changing global landscape around it, and the
129 emerging and diverse knowledge-base, which makes the method well-matched to our research
130 objectives.^{15,16} We drafted a scoping review protocol following the methods outlined by the
131 Joanna Briggs Institute Methods Manual for scoping reviews.¹⁷ Our protocol was registered with
132 the Open Science Framework,¹⁸ and published in BMJ Open.¹⁹ Since our full methods are
133 available in the published protocol, a summary is provided below.

134 **Information sources and search strategy**

135 A search of articles from 2000 onward was done by two experienced librarians at Karolinska
136 Institutet in the following electronic databases: MEDLINE, Web of Science, Global Health, and
137 PsycInfo Embase. See Appendix I for the comprehensive search strategy.

138 **Eligibility criteria**

139 **Population:** Refugees as defined as per the 1951 Refugee Convention³

140 **Intervention:** A programme, approach or technical innovation that aims to protect refugees' right
141 to health, including interventions aimed at addressing the social determinants of health.
142 Interventions outside of the health sector that affect health were included.

143 **Comparators:** This component was not necessary as the focus was on gauging the state of
144 evidence.

145 **Outcomes:** Eligible studies and papers include those discussing plans for action, strategies,
146 barriers, facilitators or outcomes using an intersectoral approach.

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3 147 **Exclusion criteria:** Papers published in language other than English were excluded. Other
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5 148 categories of migrants were not included as their legal entitlements are different to those of
6
7 149 refugees which are protected under international law. If the studies did not display some level of
8
9 150 integration nor intersectorality, they were not assessed further.²⁰ Studies or commentaries that
10
11 151 solely discuss theories and conceptual models were excluded. Implementation research and
12
13 152 operations research studies were eligible as well as studies or reports outlining stakeholder
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15 153 experiences and plans.

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19 154 **Time period:** Only studies from 2000 onward have been included, making the study period range
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21 155 over 17 years.

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24 156 **Setting:** Eligible studies are set in countries receiving refugees and asylum seekers (who may
25
26 157 eventually qualify for refugee status) and serving as hosts for resettlement.

27 28 29 158 **Frameworks to address research questions**

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31 159 Two published frameworks were used in our analysis the first to understand integration of health
32
33 160 services within health systems and the second to analyze intersectoral approaches to support
34
35 161 these services. The first is a framework by Atun et al (2010)²¹ for analyzing integration of
36
37 162 targeted health interventions in health systems, where integration is defined as “the extent,
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39 163 pattern, and rate of adoption and eventual assimilation of health interventions into each of the
40
41 164 critical functions of a health system”.²¹ Elements in this framework include (i) governance, (ii)
42
43 165 financing, (iii) planning, (iv) service delivery, (v) monitoring and evaluation (M&E), and (vi)
44
45 166 demand generation.²¹ The framework for integration was also used to assess the process, and
46
47 167 actors involved in integration.²⁰

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52 168 The second framework applied is that of the Health in All Policies (HiAP) framework for
53
54 169 country action. HiAP is defined as a way for countries to protect population health through “an

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3 170 approach to public policies across sectors that systematically takes into account the health
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5 171 implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve
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7 172 population health and health equity".²² The HiAP framework for action involves six components
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9
10 173 including: i) establish the need and priorities for HiAP, ii) frame planned action, iii) identify
11
12 174 supportive structures and policies, iv) facilitate assessment and engagement, v) ensure
13
14 175 monitoring and evaluation, and vi) build capacity.²² These six components, adapted to refugee
15
16 176 needs, were used in the review to frame barriers and facilitators in integrating refugee services
17
18 177 through intersectoral collaboration.

178 **Data Abstraction**

179 A data abstraction chart was developed based on two frameworks. The chart was tested by two
180 researchers and revised as appropriate. The revised chart was used by two reserachers to abstract
181 descriptive and qualitative data as relevant to elements of the two frameworks used. Abstracted
182 data was used to draw conclusions based on thematic analysis and repeating trends in qualitative
183 results.

184 **RESULTS**

185 Of the 6,117 records identified through the search strategy, 1302 were screened after removing
186 duplicates, 1141 were excluded based on selection criteria, 131 full texts were assessed, with
187 references of 15 selected articles screened for inclusion criteria a total 18 studies were included
188 in our review (see figure 1). Five studies were programmes or interventions carried out in the
189 United States of America (USA), one in Australia, two in Canada, one in Ethiopia and Uganda,
190 and one in each of Italy, Lebanon, Mexico, the Netherlands, New Zealand, Spain and the United
191 Kingdom (UK) (See table 1). Six were interventions at the district/local level, four at a broader
192 regional level and five at the national level. The interventions outlined in the included studies

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3 193 addressed mostly all genders and all age ranges with the exception of six that targeted vulnerable
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5 194 groups: two study on mothers and children;^{23,24} one on the elderly;²⁵ one on students;²⁶ and two
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7 195 on women and girls.^{27,28} Interventions targeting women and children in particular used
8
9 196 alternative models of care such as mobile health clinics,^{27,28} and school-based interventions.^{23,26}
10
11 197 Seven studies applied qualitative approaches (primarily in-depth interviews) for evaluation,^{26–32}
12
13 198 four studies used survey tools or standardized assessment tools;^{24,25,33,34} four studies used
14
15 199 descriptive and routine data;^{23,35–37} and three studies were mainly descriptive analysis reporting
16
17 200 on and looking at the outcomes of case examples and policies.^{38–40}
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22 201 Each of the interventions and summarized barriers and facilitators are described in Table
23
24 202 2. In terms of stakeholders involved, studies did not always report on the parties involved in
25
26 203 governance, financing, planning, service delivery, monitoring and evaluation or demand
27
28 204 generation (elements drawn from the integration framework by Atun et al (2010)²¹). Where they
29
30 205 were mentioned, stakeholders responsible for governance of interventions addressing refugee
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32 206 health included primary care centres,^{34,36} municipal government,^{29,37} departments of social
33
34 207 services and/or public health,^{29,35} central services responsible for coordination of refugee services
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36 208 and provision of assistance to local services,^{33,34} national governments,^{30,31} and international
37
38 209 bodies.²⁷ Stakeholders responsible for health financing included individual fundraising by
39
40 210 service providers,^{30,32} government,^{29,30,34,37,40} and international bodies or donors.^{27,35,36,40}
41
42 211 Programme and policy planning stakeholders included national government,^{30,37,40} departments
43
44 212 of social services and/or public health,^{26,29,35} central services responsible for coordination of
45
46 213 refugee services and provision of assistance to local services,^{28,33,34} researchers,^{23,25,29,35,36} service
47
48 214 providers,^{26,27,34,36} and international bodies or donors.^{27,35,40} Service delivery stakeholders
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50 215 included government departments of social services and/or public health,^{26,29,32,35,37–40} networks
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3 216 of local service providers in health, education, socialization, translation and/or
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5 217 employment,^{23,30,33,35} healthcare providers,^{26,32,34,36,37} central services responsible for
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7 218 coordination of refugee services and provision of assistance to local services,^{31,33,34} community
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9 219 health workers,²⁵ and international bodies.^{27,40} Stakeholders responsible for monitoring and
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11 220 evaluation were seldom explicitly mentioned. For demand generation, stakeholders included
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13 221 central services responsible for coordination of refugee services and provision of assistance to
14
15 222 local services,³⁴ local media in the language of the target population,³⁵ community leaders and/or
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17 223 community health workers,^{25,27,30,31} home health outreach services,^{27,30} and healthcare
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19 224 providers.^{32,36}

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24 225 Enabling strategies to address refugee health identified in this review include establishing
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26 226 networks of service delivery through a combination of existing public and private services,
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28 227 establishing a system navigator role, engaging host communities to reduce stigma, ensuring
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30 228 availability of translation services, outreach, advocacy and legislative support, and appropriate
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32 229 funding models. Table 3 highlights the studies that address each of these strategies. In Italy for
33
34 230 example, networks were promoted among private and public authorities and service providers,
35
36 231 including health, employment, vocational training and continuing education services.³³ In this
37
38 232 model, users move through the pathways of integration and can receive support for any
39
40 233 combination of health needs, access to education, housing support, and legal assistance.³³
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42 234 Collaborative design and delivery of services was also demonstrated in Australia with support
43
44 235 from multidisciplinary, intersectoral teams, but a lack of funding presented barriers to success for
45
46 236 this initiative.²⁶ Similarly in the USA, the “Bridge Project” faced funding barriers for
47
48 237 coordination of care despite seeing promising results from use of a system navigator – or primary
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50 238 care nurse “bridge” – to coordinate primary care and mental health care services.³⁶ A network of
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3 239 “gateway services” was also tested in Canada using a “Reception House” model.³⁴ These
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5 240 services are characterized by being person-centred, interprofessional, communication-focused,
6
7 241 and comprehensive across the continuum of care.³⁴ Relationship-management between
8
9 242 Reception House and health professionals, translation services, and social services is a key
10
11 243 component for success.³⁴ Input from international medical graduates in training also supports this
12
13 244 work by enhancing culturally appropriate service delivery by this network of partners.³⁴ Striking
14
15 245 a balance between providing tailored, culturally-appropriate care and integrating health and
16
17 246 social services for refugees into existing services in the host community can be especially
18
19 247 challenging. Policy reviews suggest that taking a “one-policy, one-level, one-outcome” approach
20
21 248 or focusing refugee management under one ministry is not sufficient in addressing the wide
22
23 249 range of challenges that both host and refugee communities are facing as a result of the current
24
25 250 political climate.^{39,40} The Ethiopian government for example reorganized ministries to
26
27 251 incorporate refugee management into existing portfolios rather than one refugee-specific one,
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29 252 moving refugee assistance programs out of camps and promoting more collaboration across
30
31 253 government and non-governmental programs.⁴⁰

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33 254 Facilitators identified in implementing these strategies include strong communication of
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35 255 program availability, tools and training for providers, colocation of services, transportation
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37 256 services to enhance access, clear role definitions, interprofessional team and relationship
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39 257 management across providers, innovation in budget and financing, and coordinated refugee-
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41 258 specific policies.

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43 259 Barriers articulated include lack of a participatory approach, poor communication leading
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45 260 to stigma and underuse of services, insufficient resources given to providers, absence of
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47 261 financing model, unclear roles and insufficient coordination of interprofessional teams,
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3 262 exclusionary refugee policies, low availability and use of data, and turf wars across governance
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5 263 stakeholders. Table 4 highlights the studies that expand on these themes as barriers or
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8 264 facilitators.

9 10 265 **DISCUSSION**

11
12 266 The findings from the existing but scarce literature highlight that important factors in facilitating
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14 267 intersectoral collaboration and the successful integration of refugee services within existing
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16 268 health systems include: the coordination of existing public and private services, appropriate
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19 269 funding models, a systems navigator role, referral systems and colocation of services, advocacy
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21 270 and legislative support and alternate models of care for vulnerable women and children. These
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23
24 271 are discussed further below.

25 26 272 **Coordination of Existing Public and Private Services**

27
28 273 A networked approach to service delivery during the initial reception of refugees can often
29
30 274 mitigate some of the challenges faced by refugee communities. Some examples of coordination
31
32
33 275 of services were seen in Italy,³³ Australia,²⁶ the US,³⁶ and Canada.³⁴ In Canada where a network
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35 276 of “gateway services” was tested using the “Reception House” model it successfully provided
36
37
38 277 responsive and culturally sensitive primary care.³⁴ By partnering community and translation
39
40 278 services, as well as health care providers with the Reception House, it decreased wait times and
41
42 279 improved health care access through referrals and coordination of services.³⁴

43 44 280 **Appropriate Funding Models for Integrated Services**

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47 281 This was not explicitly studied in the literature, however international bodies dealing with
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49 282 refugee care have previously been reluctant to invest their efforts in what is perceived as
50
51 283 “unstable environments” created with integration.⁴⁰ Furthermore, a lack of data on the specific
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54 284 needs of refugee subgroups (such as women and children) once the delivery of care is integrated

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3 285 may mean that they are not sufficiently prioritized in local strategic health goals.³⁰ Where needs
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5 286 and special services are not prioritized, financing is not provided for more innovative structures
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7 287 within existing primary care or social systems which threaten their sustainability. It is therefore
8
9
10 288 necessary for planners, implementers and evaluators of integrated health and social services to
11
12 289 understand the different needs of their host and refugee community users clearly and to ensure
13
14 290 that an investment case is made for the bolstered services such as system navigation, translation,
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16
17 291 provider training, outreach or colocation.³⁶
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19 292 **System Navigator Role**

20
21 293 Integration works through establishing relationships across networks of local stakeholders and
22
23 294 service providers. To coordinate this effectively, a system navigator role can be established – the
24
25 295 evidence suggests that this role is most effective in the early stage of resettlement.³⁴ The system
26
27 296 navigation role can be played by an organization or by people within the existing health or social
28
29 297 systems. It connects incoming refugees to timely, culturally-appropriate care in the community
30
31 298 without creating parallel structures that either threaten host communities or further stigmatize
32
33 299 refugees.^{29,34} This is further strengthened when providers have access to the knowledge, tools
34
35 300 and training needed to address the specific needs of refugees, including the more vulnerable
36
37 301 (e.g., the elderly, women, and children). Providers should understand the context in which they
38
39 302 work and the available features and services, user needs, and legislation as it relates to
40
41 303 refugees.³³ Those playing a coordination or system navigation role should also be able to build
42
43 304 strong networks with allied specialists, identify appropriate resources and reach out to users.^{33,34}
44
45 305 The challenge here however is that integrating refugee care may eliminate some determination
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47 306 procedures, potentially undermining the protection mandate and underestimate the tailored needs
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49 307 of refugees dealing with significant trauma.⁴⁰
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308 **Advocacy and Legislative Support**

309 Exclusionary immigration policies can play a significant role in marginalization and
310 discrimination against refugee communities leading to low health seeking behaviors and use of
311 available integrated or intersectoral services.³⁹ Effective advocacy needs to target the policy-
312 making levels in order to counteract the negative impacts of exclusionary policies. Advocacy by
313 health care providers can be effective at the institutional level to push for better allocation of
314 services and funding.³⁰ A multipronged approach may be necessary to continue to advocate for
315 the right to health for refugees by addressing legal challenges, establishing timely and accurate
316 data and information systems to capture needs, creating health promoting environments,
317 investing in person-centred, culturally-appropriate and easily accessible services, and evaluating
318 coordination and service delivery efforts. Engaging policy makers in knowledge translation and
319 evidence-informed decision-making is one way to effectively advocate and provide legislative
320 support in refugee health. In Lebanon for example, where there are huge challenges in meeting
321 the health needs of a large Syrian refugee population, researchers engaged policy-makers in
322 knowledge production (i.e research priority-setting), translation and uptake activities.⁴¹ This
323 ultimately led to the hiring of a refugee health coordinator by the Lebanese Ministry of Public
324 Health. The refugee health coordinator role was created to support intersectoral collaboration,
325 assisting in strategic planning and implementation of action plans to respond to the health needs
326 of Syrian refugees including helping with the development of refugee health information systems
327 at the Ministry of Public Health.⁴¹ The UCL-Lancet Commission on Migration and Health
328 supports knowledge translation by bringing together academics, policymakers, and health system
329 experts to take an inter-disciplinary approach to reviewing evidence, develop policy

330 recommendations and disseminate these findings globally amongst policymakers and
331 institutions.⁴²

332 **Alternative Models of Care to Reach Vulnerable Women and Children**

333 Looking at the studies that reported targeted interventions for women and children, alternative
334 models of care were used. This included mobile health clinics, and programs linked to schools to
335 support screening and active case finding. These services reported to reduce barriers to access of
336 essential health services, increase detection of health conditions, and improve coordination of
337 care, and reduced feelings of social isolation.^{26,27} This suggests that flexible service delivery and
338 innovation in mode of delivery may need to be considered when attempting to reach at risk
339 refugee groups.

340 **Limitations and Future Directions**

341 The main purpose of our reviews was to gather available data and point to further research
342 questions that can be derived from our results. Our review was limited by the scarcity of research
343 in this area. Due to the paucity of evidence on evaluation of practical intersectoral interventions,
344 all relevant studies were included; therefore, quality and rigor may vary. Some key programmes
345 and approaches may be missing due to interventions occurring at individual level instead of at
346 the systems level as well as not having been published in academic literature. Individual health
347 providers or organizations will navigate barriers in health systems through tacit and experiential
348 knowledge that is often not documented. Data will be further amplified by conducting key
349 informant interviews in selected countries.

350 As others have noted, the literature on intersectoral collaboration disproportionately
351 focuses on high-income countries.⁴³ It is therefore no surprise that the evidence for this review
352 largely came from high-income countries with only two studies conducted in upper-middle

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3 353 income and two in low-income countries. This may affect the generalizability of the findings
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5 354 reported here as low-income and middle-income countries have greater coordination challenges
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8 355 to overcome due to fragmented systems and weak governance.⁴⁴ Additionally, according to the
9
10 356 latest report on the UN Refugee Agency, approximately 85% of refugees are hosted in
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12 357 developing nations.⁴⁵ More evidence and special consideration is needed in these contexts with
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15 358 respect to refugee health particularly for those most at risk such as women, children and the
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17 359 elderly.

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19 360 Although there exists reaffirmed enthusiasm in intersectoral approaches to achieving
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21 361 global health agendas such as the SDGs, it has been found that the lack of quality evidence
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23 362 represents a key barrier to evidence-informed decision-making for the development of cross-
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25 363 cutting policies and governance required for sustained intersectoral collaboration.⁴³ Most of what
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27 364 has been written have not been grounded in relevant theories or frameworks.⁴⁴ This pattern of a
28
29 365 dearth of evidence was seen in our review, while the challenges in meeting the health needs of
30
31 366 refugees are well documented, paradoxically we found little research on effective intersectoral
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33 367 and integrated approaches in meeting these needs. Our use of the combined frameworks is a step
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35 368 forward in addressing the gap in this essential evidence base. Current gaps in knowledge
36
37 369 represents an untapped potential for improvements to financial and human resource efficiency in
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39 370 health systems. Generating high quality data in health systems and policy research for migrant
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41 371 health and on intersectoral approaches to health has been identified as a research priority.^{43,46}
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43 372 Given the limited evidence we found in our scoping review the momentum for continued
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45 373 research should be sustained.

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3 376 **CONCLUSION**
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5 377 Refugees face individual, institutional, and system level barriers in access to health care and to
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7 378 provide adequate health services to this vulnerable population, gathering more evidence on
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10 379 effective integrated and intersectoral approaches is a priority. This scoping review has
11
12 380 highlighted an important gap in the evidence on integration of services and intersectoral
13
14 381 approaches in serving vulnerable refugee populations.
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17 382 From the available evidence, the following are key policy insights and enablers towards
18
19 383 greater integration of services and/or inter-sectoral collaboration:
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- 21 384 1) Improving coordination between existing programmes through financing stronger data
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23 385 and referral systems, supporting colocation of services, and formalizing system navigator
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25 386 positions to manage coordination activities
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27
28 387 2) Incentivizing health and social service authorities to establish formal system navigator
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30 388 roles that connect all relevant services – provision of information technology tools can
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32 389 help support this function and better manage the network of available programmes
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35 390 3) Engaging host communities to enhance understanding, to reduce stigma, and to create an
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37 391 enabling environment for policies that protect refugees and their rights to social
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39 392 determinants of health
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42 393 4) Communicating the availability of programmes and services through cultural mediators
43
44 394 and establishing formal translation and transport services to improve access
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46
47 395 5) Establishing training and resources for providers to a) better understand the needs of
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49 396 refugee communities, b) be aware of available and relevant services for referral across
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51 397 sectors, and c) more efficiently manage cases.
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3 398 These recommendations are based on consistent facilitators and barriers identified across studies
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5 399 included in this review. They form critical starting points in leveraging integrated services and/or
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7
8 400 intersectoral approaches to better serve refugees while promoting efficiency in health systems.
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10 401 **ETHICS APPROVAL**

11
12 402 Ethics approval was not required for this scoping review as human subjects are not involved.
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14

15 403 **AUTHOR'S CONTRIBUTIONS**

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17
18 404 GT together with librarians at Karolinska Institutet identified databases and planned the literature
19
20 405 search. SH & DJ drafted the paper and incorporated co-author feedback, SH & DJ abstracted data
21
22 406 from peer-reviewed literature. SC, EVL, GT and PF provided critical feedback and comments on
23
24 407 the manuscript. SC and SH acted as secondary reviewers.
25
26

27 408

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31
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33
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37
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39
40

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42
43 415 None.
44

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542 **APPENDIX I**543 **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/

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. ((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.

25. or/18-24

26. 6 and 17 and 25

27. Remove duplicates from 26

28. limit 27 to yr="2000 -Current"

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2. Web of Science (Thomson Reuter)

Date of Search: 2016-11-03
Number of hits: 1.166
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*)

#7 #6 OR #5

#8 #7 AND #4 AND #1

#9 Timespan: 2000-2016.

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548

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3. Global Health (Ovid)

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

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*)).ti,ab.
10. or/8-9
11. exp disparity/
12. exp discrimination/
13. human rights/
14. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab.
15. (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.
16. or/11-15
17. 6 and 10 and 16
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.
18. or/13-17

19. 4 and 12 and 18
20. limit 19 to yr="2000 -Current"

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Figure 1. Review Flowchart

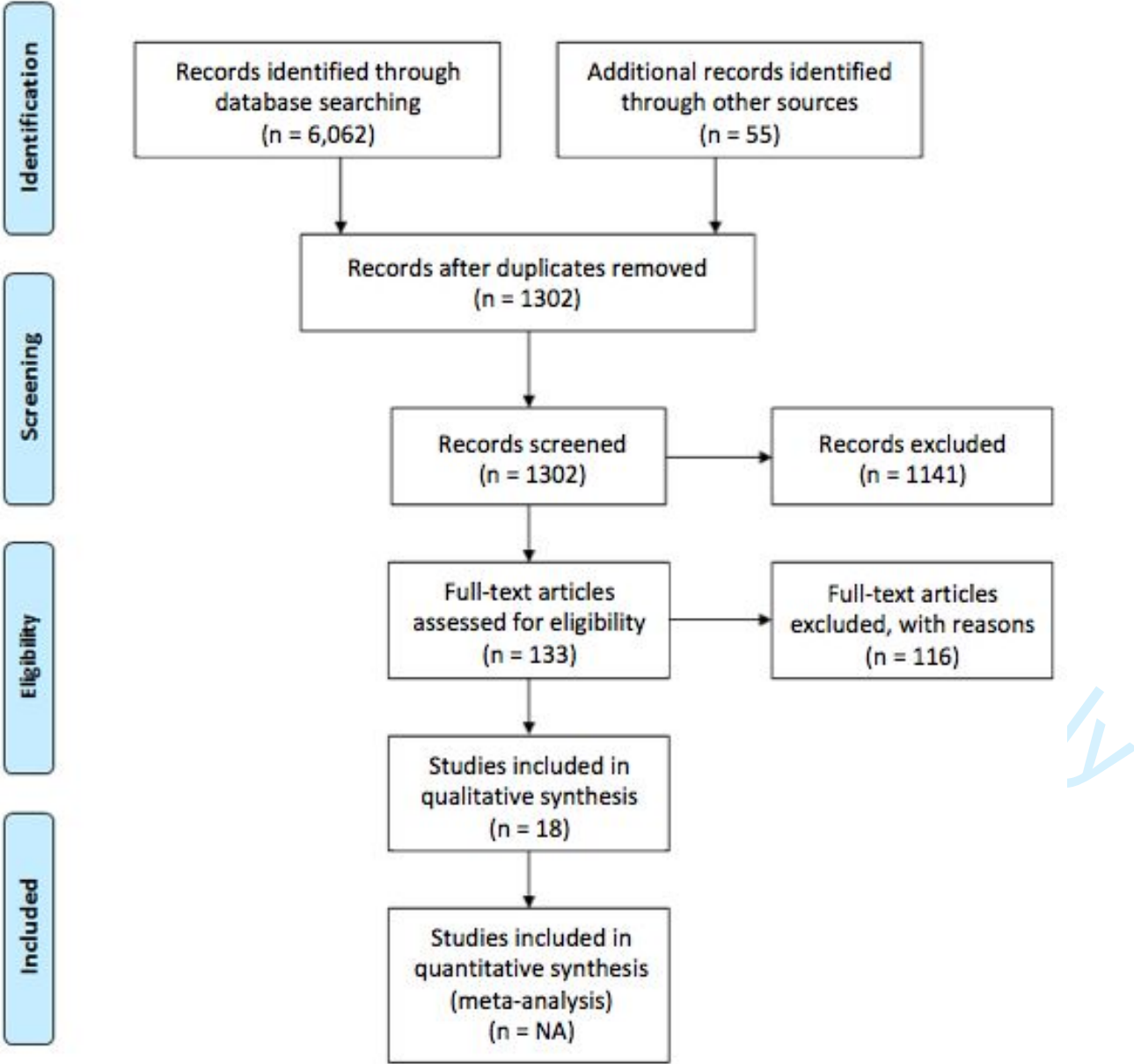


Table 1. Countries represented in Included Studies

Country	Count
Australia	2
Canada	2
Ethiopia & Uganda	1
Italy	1
Lebanon	1
Mexico	1
Netherlands	1
New Zealand	1
Spain	1
UK	1
USA	5
Grand Total	18

Table 2. Summary of included studies

Author	Year	Title	Intervention	Barriers	Facilitators	Country
Calvo et al	2014	The Effect of Universal Service Delivery on the Integration of Moroccan Immigrants in Spain: A Case Study from an Anti-Oppressive Perspective	Addressing stigma & host community perceptions; system navigator (intercultural mediator)	Minimal involvement of target community in design of program; considerations of forced assimilation through integration	Decreased prejudice due to increased contact between host and immigrant communities; clear communication to host community around allocation of resources thereby reducing perceived threat of competition	Spain
Catarci	2012	Conceptions and Strategies for User Integration across Refugee Services in Italy	Integrated reception of refugees and asylum seekers (network of hospitals and health services, public employment services, vocational training and continuing education agencies, etc.)	Service coordinators lack tools to support integrated services; lack of continuity between theory and practice in continuing education support	Service coordinators with access to continuing education were more likely to report adequate support; continuing education with intimate knowledge of the context, user needs, and legislation related to refugee inclusion; coordinators should also have a solid network and an ability to distinguish between resources	Italy
Cowell et al	2009	Clinical Trial Outcomes of the Mexican American Problem Solving Program (MAPS)	A cognitively based problem solving program delivered on linked home visits to mothers and after school program classes to children	Difficulty managing case load by school nurse of home visits and classes	Communication and engagement with the community; partnership with the school	USA
Geltman et al	2005	A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees	Public-private partnerships using a preferred provider network model for conducting refugee health screening	Lack of appropriate funding model leading to delays in health screening	Funding streams approved allowed procurement of services; network of providers created; dedicated training of physicians within the network	USA

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2	Guruge et al	2010	Immigrant women's experiences of receiving care in a mobile health clinic	Mobile health clinic for reproductive health services for immigrant women	Lack of awareness of available services and navigating health systems; language barrier; fear of deportation leading to lack of use of services	Colocation of services due to the mobile nature of the clinic	Canada
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10	Kim et al	2002	Primary health care for Korean immigrants: sustaining a culturally sensitive model	Translation support; integrated health and social care; mental health support; bilingual advanced nurse practitioner and community advocate serve as system navigators	Budgetary restrictions; existing restrictions in the roles that nurses can play in outreach	Effective communication around availability of new program; effective communication to announce new outreach and navigation role; efforts to build consensus and coherence across interprofessional teams; clear articulation of the role of advance nurse practitioners and their complementary role	USA
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18	Lilleston et al	2018	Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon	GBV mobile support service, providing safe spaces, community outreach, psychosocial support activities, safe legal and medical referrals, survivor-centred approach, adherence to confidentiality, and access to face-to-face and phone-based case management	Trust-building is a key element and so constant mobility of target audience presented a challenge as did referral of services as quality medical and legal services were not always safe or available	Integration of legal and medical teams in mobile GBV support teams; community mobilizers/system navigator role is a key function	Lebanon
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28	Macfarlane et al.	2009	Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England	Translation support	Use of unpaid interpreters from patients' social networks is complex; only one accredited course for professional interpreters; use of professional interpreters patchy due to low quality and institutional challenges in their acquisition	In England where there is a policy to use language services (Race Equality Policy), there is more use than in Ireland but implementation remains poor	UK
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34	McMurray et al.	2013	Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada	Translation support; integrated health and social care; Gateway services and system navigators	Shortage of primary care physicians which is the gateway; bureaucracy when billing Canada's Interim Federal Health Program (IFHP) that provides coverage for health care costs until provincial health insurance is available	Relationships between local physician community and case workers (navigators); timely transfer of records; ongoing consultations post-transfer	Canada
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2	McNaughton et al.	2010	Directions for Refining a School Nursing Intervention for Mexican Immigrant Families	Active case finding and problem solving through education system (school nurses); translation support	Schools with no existing nursing outreach program were difficult to start at	Nursing role was recognized and accepted by immigrant communities; schools that had a nursing program already could expand it to active case finding with immigrant families	Mexico
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7	Mortensen	2011	Public Health System Responsiveness To Refugee Groups In New Zealand: Activation From The Bottom Up	Physician-driven needs-based programs in primary care	Mismatch between policies at national vs local level; lack of demographic data; no long-term planning or projected needs; low linkages between district health branch, public health offices, and NGOs; low health literacy due to lack of translated materials	Quota refugees have same access to services as host communities; local action activated by physicians and community leaders led to more coverage and higher quality services in specific areas that had more advocacy	New Zealand
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16	Philbin	2018	State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States	Policies to address social and legal determinants of health as they relate to immigrant populations	Exclusionary policies affect social determinants of health, especially in mixed status families; families unwilling to participate in social programs due to fear and confusion over entitlements; structural racism; restrictions in accessing education and employment; low mobility and relocation to remote areas with low availability of integrated social services.	Elimination of waiting period in several states for access to medicaid regardless of immigration status; extra funding to federally qualified health centres	USA
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25	Stewart et al.	2008	Multicultural Meanings of Social Support among Immigrants and Refugees	Policies to address social and legal determinants of health as they relate to immigrant populations; social networking	Inadequate financial and human resources, limited agency mandates, ineffective collaboration with other sectors, and low staff morale; collaboration impeded by the volume of organizations involved	Existing networks of longer term immigrants were supportive in overcoming access barriers	Canada
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30	Tuepker et al.,	2009	Evaluating integrated healthcare for refugees and hosts in an African context	Integrating host and refugee healthcare by reorganizing ministries to incorporate refugee services into existing portfolios rather than under one ministry	Lack of evidence on the added value of integrated care; concern around minimizing exceptional status of refugees; no legal obligation to provide integrated care; turf wars across organizations and sectors	Funding streams from international organizations to national health services	Ethiopia & Uganda
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36	Verhagen et al	2013	Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention programme in the Netherlands	Use of ethnically similar CHWs to deliver health and social care; active case finding; community-driven problem solving with oversight by CHWs	Lack of participation by target community in culturally-sensitive design; limited knowledge by target community around availability of services	Use of ethnically-similar CHWs	Netherlands
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2	Woodland et al	2016	Evaluation of a school screening programme for young people from refugee backgrounds	Active case finding and problem solving through education system (school nurses); translation support	Poor integration of multiple service providers; lack of funding	Integration within the school; informal communication between clinicians and the school	Australia
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6	Woodland et al.	2010	Health service delivery for newly arrived refugee children: A framework for good practice	Comprehensive, colocated screening services; partnerships between community and health services (refugee health nurse as system navigator); transportation services to access centres; specific training provided to physicians and other care providers, including referral pathways; Pharmaceutical benefit scheme addressing refugee needs	Lack of coordinated policy for all categories of refugees and asylum seekers; administrative burden of PHC coordination; lack of information for managing conditions specific or prominent to refugees	Family-based services (colocation to address family needs); refugee health nurses (system navigators) decrease administrative burden of coordination; consumer participation and consultation; colocation of screening services ; transportation support for getting to services; strong health information systems; data and consultations used to inform the direction of intersectoral collaboration and nature of partnerships between health and community service providers	Australia
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19	Yeung et al	2004	Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans	Specific training provided to physicians and other care providers; mental health support (colocation of mental health services); primary care nurse as a bridge/ system navigator for referrals;	Funding for coordination outside purview of essential services; lack of knowledge on culturally-appropriate mental health services	Co-location of primary care and mental health services; designated staff as the bridge; training of service providers	USA
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Table 3. Enabling strategies present across studies

Strategy	Studies						
Host community engagement	Calvo et al						
System navigation	Calvo et al	Kim et al	McMurray et al	Woodland et al, 2010	Yeung et al	Lilleston et al	
Integrated health and social services through networked approach	Catarci	Kim et al	McMurray et al	Yeung et al			
Translation support	Kim et al	MacFarlane et al	McMurray et al	McNaughton et al	Woodland et al 2016	Cowell et al	Guruge et al
Active case finding/Outreach	McNaughton et al	Verhagen et al	Woodland et al 2016	Guruge et al			
Refugee-specific service delivery and access to health and social networks	Mortensen	Philbin et al	Stewart et al	Verhagen et al			
Legislative support	Philbin et al	Tuepker et al	Woodland et al, 2010	Geltman et al			
Changes in funding modalities	Tuepker et al						

Table 4. Barriers & Facilitators Commonly Discussed Across Studies

Elements	Element present as barrier	Element present as facilitator
Community engagement	Calvo et al; Verhagen et al	Kim et al; Mortensen; McMurray et al ; Cowell et al
Communication between host and refugee communities		Calvo et al; Woodland et al, 2016
Tools/training for service providers to support integrated services	Catarci; MacFarlane et al; Woodland et al, 2010	Woodland et al, 2010; Yeung et al ; Geltman et al
Colocation of services		Woodland et al, 2010; Yeung et al; Lilleston et al ; Guruge et al
Transportation		Woodland et al, 2010
Networks between providers		Catarci; Stewart et al; Geltman et al
Budget/Appropriate Funding Streams	Kim et al; McMurray et al; Stewart et al	Philbin; Tuepker et al; Geltman et al
Role definitions	Kim et al	McNaughton et al; Lilleston et al; Yeung et al
Interprofessional team management	Stewart et al; Woodland et al, 2016	Kim et al
Refugee-specific policies	Mortensen; Philbin; Tuepker et al; Woodland et al, 2010; Lilleston et al	MacFarlane et al; Philbin
Data	Mortensen; Tuepker et al	
Organizational turf	Stewart et al; Tuepker et al	

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	p. 1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	p. 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	p. 5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	p. 5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	p. 2 Registered on Open Science Framework https://osf.io/gt9ck/
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	p. 6
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	p. 23-26
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	p. 23-26
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	p. 6-7
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	p. 8
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	p. 6-8
Critical appraisal	12	If done, provide a rationale for conducting a	p. 15



SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
of individual sources of evidence§		critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	p. 8
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	p. 7
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	p. 8-9
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	p. 15
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	p. 9-11, tables 2-4
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	p. 8-9; table 2-4
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	p. 12-16
Limitations	20	Discuss the limitations of the scoping review process.	p. 15-26
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	p. 16-17
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	p. 18

JB1 = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med.* ;169:467–473. doi: 10.7326/M18-0850

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BMJ Open

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

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Manuscript ID	bmjopen-2019-029407.R1
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Date Submitted by the Author:	19-Mar-2019
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Primary Subject Heading:	Global health
Secondary Subject Heading:	Health policy, Public health
Keywords:	intersectoral, right to health, access, refugees, integration, resettlement

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3 1 **Intersectoral and integrated approaches in achieving the right to health**
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5 2 **for refugees upon resettlement: A scoping review**
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10 4 Shirley Ho*¹ email: shirley.ho@jhu.edu
11 5 Dena Javadi ¹ email: javadid@who.int
12 6 Sara Causevic^{2,3} email: sara.causevic@ki.se
13 7 Etienne V. Langlois¹ email: langloise@who.int
14 8 Peter Friberg^{2,5} email: peter.friberg@mednet.gu.se
15 9 Goran Tomson^{2,4} email: goran.tomson@ki.se
16
17 10

18 11 ¹ Alliance for Health Policy and Systems Research, World Health Organization, Avenue Appia 20, 1211 Geneva, Switzerland
19 12

20 13 ² Swedish Institute for Global Health Transformation, SIGHT, Royal Swedish Academy of Science, Stockholm, Sweden
21 14

22 15 ³ Global and Sexual Health, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden

23 16 ⁴ Medical Management Centre, Department of Learning, Informatics, Management, Ethics (LIME), Karolinska Institutet, Stockholm, Sweden
24 17

25 18 ⁵ Institute of Medicine, Sahlgrenska Academy at Gothenburg University and Sahlgrenska University Hospital
26 19
27 20
28

29 21 ***Corresponding Author:**

30 22 Shirley Ho, shirley.ho@jhu.edu

31 23 Alliance for Health Policy and Systems Research, World Health Organization
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35 25 **Keywords:** intersectoral, right to health, access, refugees, integration, resettlement
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3 28 **ABSTRACT (285/300)**
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5 29 **Background:** Better understanding, documentation, and evaluation of different refugee health
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7 30 interventions, and their means of health system integration and intersectoral collaboration are needed
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9 31 **Objectives:** Explore the barriers and facilitators to the integration of health services for refugees; the
10
11 32 processes involved; and the different stakeholders engaged in leveraging intersectoral approaches to
12
13 33 protect refugees' right to health on resettlement

14 34 **Design:** Scoping review

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16 35 **Methods:** A search of articles from 2000 onward was done in MEDLINE, Web of Science, Global
17
18 36 Health, and PsycInfo Embase. Two frameworks were applied in our analysis, the "Framework for
19
20 37 analyzing integration of targeted health interventions in systems", and "Health in All Policies"
21
22 38 framework for country action. A comprehensive description of the methods is included in our
23
24 39 published protocol.

25 40 **Results:** 6,117 papers were identified, only 18 studies met the inclusion criteria. Facilitators in
26
27 41 implementation included: training for providers; colocation of services; transportation services to
28
29 42 enhance access; clear role definitions; and appropriate budget allocation and financing. Barriers
30
31 43 included: lack of a participatory approach; insufficient resources for providers; absence of
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33 44 financing; unclear roles and insufficient coordination of interprofessional teams; low availability
34
35 45 and use of data; and turf wars across governance stakeholders. Successful strategies to address
36
37 46 refugee health included: networks of service delivery combining existing public and private
38
39 47 services; system navigators; host community engagement to reduce stigma; translation services;
40
41 48 legislative support; and alternative models of care for women and children.

42 49 **Conclusion:** Limited evidence was found overall. Further research on intersectoral approaches is
43
44 50 needed. Key policy insights gained from barriers and facilitators reported in available studies
45
46 51 include: improving coordination between existing programs; supporting colocation of services;
47
48 52 establishing formal system navigator roles that connect relevant programs; establishing formal
49
50 53 translation services to improve access; and establishing training and resources for providers.
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55 55 **Registration:** Registered on Open Science Framework at <https://osf.io/gt9ck/>
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58 **Strengths and limitations of this study**

- 59 • Our study uses a systematic approach by using two frameworks, the “Framework for
60 analyzing integration of targeted health interventions in systems”, and “Health in All
61 Policies” framework for country action to develop a strong evidence base in
62 understanding the processes and actors involved in integration and intersectoral action
- 63 • Our findings can be applied for policy and action aiming to enhance the integration of
64 refugee health services within health systems, and identifying research needs to advance
65 the right to health for refugees
- 66 • The lack of evidence on intersectoral and integrated approaches from low-income and
67 middle-income countries may impact the generalizability of the findings

68 **INTRODUCTION**

69 Upholding the right to health is a fundamental challenge for governments worldwide,
70 particularly when providing services to vulnerable or hard to reach populations such as refugees.
71 The Office of the United Nations High Commission for Human Rights (OHCHR) identifies the
72 right to health as a fundamental part of human rights, first articulated in the 1946 Constitution of
73 the World Health Organization (WHO).¹ Entitlements under the right to health include universal
74 health coverage – now a target under Sustainable Development Goal (SDG) 3 – broadly covering
75 access to preventative and curative services, essential medicines, timely basic health services,
76 health-related education, participation in health-related decision making at both national and
77 community levels, as well as financial protection.^{1,2} Especially relevant to the plight of refugees,
78 the right to health includes non-discrimination whereby health services, commodities and
79 facilities must be provided to all without any discrimination. Lastly, these health services must

1
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3 80 be accessible, medically and culturally appropriate, available in adequate amount and quality,
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5 81 which includes having a trained health workforce, safe products and sanitation.²
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8 82 “Refugees” are individuals fleeing armed conflict or persecution as defined by the 1951
9
10 83 Refugee Convention which also identifies their basic rights, specifically that refugees should not
11
12 84 be returned to situations that are deemed a threat to their life or freedom.³ A key distinction of
13
14 85 refugee rights is that they are not only a matter of national legislation, but also of international
15
16 86 law.⁴ Despite these legal protections, refugees face many challenges in accessing health services,
17
18 87 especially more vulnerable groups like women and children.⁵ Many states explicitly exclude
19
20 88 refugees from the level of protection afforded to their citizens, instead choosing to offer
21
22 89 “essential care” or “emergency health care,” which is differentially defined across countries.⁶
23
24 90 The Committee on the Elimination of Racial Discrimination, and the Committee on Economic,
25
26 91 Social and Cultural Rights, both include general statements that hold States accountable to “the
27
28 92 right of non-citizens to an adequate standard of physical and mental health by, inter alia,
29
30 93 refraining from denying or limiting their access to preventive, curative and palliative health
31
32 94 services”.⁷ The increasing number of refugees over the past years makes the realization and
33
34 95 protection of these rights both a legal, ethical and a logistical challenge.⁵ In addition, the
35
36 96 boundaries of the right to health have expanded due to increased understanding of social
37
38 97 determinants of health and the health impacts of the lived environment.^{8,9} Refugees face
39
40 98 challenges in navigating health, legal, education, housing, social protection and employment
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42 99 services, which further threatens their quality of life and health status.¹⁰ Therefore, a lack of
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44 100 coordination and integration across these services undermines their effectiveness.¹¹
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51 101 Much like the shift from the more vertical approaches of the millennium development
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53 102 goals (MDGs) towards the more integrated SDGs, the protection of the right to health calls for an
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3 103 intersectoral approach whereby health is applied to all policies for all people.¹² As such, for
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5 104 states to effectively protect the right to health for refugees there is a need to work across sectors
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8 105 and disciplines to better integrate targeted programs and initiatives, thereby improving standards
9
10 106 of care during resettlement. Some evidence exists that supporting collaboration and coordination
11
12 107 across social services for refugees improves the effectiveness and quality of care received.¹⁰
13
14 108 Many fragmented psychosocial programs exist across sectors to attempt to address the unique
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17 109 challenges faced by refugees but these are largely unevaluated and lack sustainability.^{13,14} Better
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19 110 understanding, documentation, evaluation and reporting of the dynamic nature of different
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21 111 interventions, and their means of health system integration and intersectoral collaboration, are
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24 112 necessary to ensure that lessons learned are implemented in the design of future policies and
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26 113 programs.

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28 114 Therefore, we conducted a scoping review that describes the barriers and facilitators to
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31 115 integrated health services for refugees; the process involved in protecting refugee health; and the
32
33 116 different stakeholders engaged in leveraging intersectoral approaches to protect refugees' right to
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35 117 health on resettlement. We focused on three specific research questions:

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38 118 (1) What are the barriers and facilitators in integrating targeted services for refugees within
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40 119 existing health systems?
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42 120 (2) What strategies are involved in addressing refugees' right to health upon resettlement?
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45 121 (3) Which stakeholders are involved in leveraging intersectoral approaches to protect
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47 122 refugees' right to health?
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126 **METHODS**

127 **Study Design**

128 We selected the scoping review method as we were interested in mapping the concepts relevant
129 to the complex nature of this topic, the changing global landscape around it, and the emerging
130 and diverse knowledge-base, which makes the method well-matched to our research
131 objectives.^{15,16} We drafted a scoping review protocol following the methods outlined by the
132 Joanna Briggs Institute Methods Manual for scoping reviews.¹⁷ Our protocol was registered with
133 the Open Science Framework,¹⁸ and published in BMJ Open.¹⁹ Since our full methods are
134 available in the published protocol, a summary is provided below.¹⁹

135 **Information Sources and Search Strategy**

136 A search of articles was done by two experienced librarians at the Karolinska Institutet using the
137 following electronic databases: MEDLINE, Web of Science, Global Health, and PsycInfo
138 Embase. See Appendix I for the comprehensive search strategy.

139 **Eligibility Criteria**

140 **Population:** Refugees as defined by the 1951 Refugee Convention³

141 **Intervention:** A program, approach or technical innovation that aims to protect refugees' right to
142 health, including interventions aimed at addressing the social determinants of health.
143 Interventions outside of the health sector that affect health were included.

144 **Comparators:** This component was not necessary as the focus was on gauging the state of
145 evidence.

146 **Outcomes:** Eligible studies and papers include those discussing plans for action, strategies,
147 barriers, facilitators or outcomes using an intersectoral approach.

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3 148 **Types of Studies Included:** Randomized control trials, pre-post design evaluations, qualitative
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5 149 evaluations, and economic evaluations were included. Further, implementation research and
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7 150 operations research studies were eligible for inclusion, as well as studies or reports outlining
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9 151 stakeholder experiences and plans.

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12 152 **Exclusion Criteria:** Papers published in a language other than English were excluded. Other
13
14 153 categories of migrants were not included as their legal entitlements are different to those of
15
16 154 refugees which are protected under international law. If the studies did not display some level of
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18 155 integration nor intersectorality, they were not assessed further.²⁰ Studies or commentaries that
19
20 156 solely discuss theories and conceptual models were excluded.

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23 157 **Time Period:** Only studies from 2000 onward have been included.

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26 158 **Setting:** Eligible studies are set in countries receiving refugees and asylum seekers (who may
27
28 159 eventually qualify for refugee status) and serving as hosts for resettlement.

30 31 160 **Frameworks to Address Research Questions**

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34 161 Two published frameworks were used in our analysis to understand integration of health services
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36 162 within health systems and to analyze intersectoral approaches to support these services. The first
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38 163 framework by Atun et al (2010)²¹, is a tool for analyzing integration of targeted health
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40 164 interventions in health systems, where integration is defined as “the extent, pattern, and rate of
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42 165 adoption and eventual assimilation of health interventions into each of the critical functions of a
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44 166 health system”.²¹ The framework for integration was also used to assess the process, and actors
45
46 167 involved in integration.²⁰

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49
50 168 The second framework applied in our analysis is that of the Health in All Policies (HiAP)
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52 169 framework for country action. HiAP is defined as a way for countries to protect population
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54 170 health through “an approach to public policies across sectors that systematically takes into

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3 171 account the health implications of decisions, seeks synergies, and avoids harmful health impacts
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5 172 in order to improve population health and health equity".²² Components of this framework,
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7 173 adapted to refugee needs, were used in the review to frame barriers and facilitators in integrating
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9 174 refugee services through intersectoral collaboration.

12 175 **Data Abstraction**

14 176 A data abstraction chart was developed based on the two frameworks used in this study. The
15
16 177 chart was tested by two researchers and revised as appropriate. The revised chart was used by the
17
18 178 same researchers to abstract descriptive and qualitative data as relevant to the elements of the
19
20 179 frameworks used. Elements included in the chart were: intervention description; barriers and
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22 180 facilitators; contextual details; target population; type of evaluation; outcomes; stakeholder
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24 181 involvement in governance, financing, planning, service delivery, monitoring and evaluation,
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26 182 and engagement. Deductive reasoning was used to identify barriers and facilitators in
27
28 183 intersectoral collaboration for refugee health. Open coding was applied to visualize themes
29
30 184 across interventions as well as barriers and facilitators.²³ Axial coding was applied to then draw
31
32 185 connections to enabling strategies for intersectoral collaboration.²³ General conclusions were
33
34 186 drawn based on these themes, leading to suggestions for strengthening programs and policies.

39 187 **Patient and Public Involvement**

40 188 There was no patient or public involvement required in conducting this scoping review.
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194 RESULTS

195 Of the 6,117 records identified through the search strategy, 1302 abstracts were screened after
 196 removing duplicates. 1141 were excluded based on exclusion criteria described above as
 197 assessed by two independent reviewers, 131 full texts were assessed, with the references of 15
 198 selected articles additionally screened for inclusion criteria, a total of 18 studies were included in
 199 our review (see Figure 1). Five studies were programs or interventions carried out in the United
 200 States of America (USA), one in Australia, two in Canada, one in Ethiopia and Uganda, and one
 201 in each of the following: Italy, Lebanon, Mexico, the Netherlands, New Zealand, Spain and the
 202 United Kingdom (UK) (See Table 1). Six studies were interventions at the district/local level,
 203 four at a broader regional level and five at the national level. The interventions outlined in the
 204 included studies addressed mostly all genders and all age ranges with the exception of six that
 205 targeted vulnerable groups: two studies on mothers and children;^{24,25} one on the elderly;²⁶ one on
 206 students;²⁷ and two on women and girls.^{28,29} Interventions targeting women and children in
 207 particular used alternative models of care such as mobile health clinics,^{28,29} and school-based
 208 interventions.^{24,27} Seven studies applied qualitative approaches (primarily in-depth interviews)
 209 for evaluation,^{27–33} four studies used survey tools or standardized assessment tools;^{25,26,34,35} four
 210 studies used descriptive and routine data;^{24,36–38} and three studies were mainly descriptive
 211 analysis reporting on and looking at the outcomes of case examples and policies.^{39–41}

212 **Table 1. Summary of Included Studies**

Author	Year	Title	Intervention	Barriers	Facilitators	Country
Calvo et al ³⁰	2014	The Effect of Universal Service Delivery on the Integration of Moroccan Immigrants in Spain: A Case Study from an Anti-Oppressive Perspective	Addressing stigma & host community perceptions; system navigator (intercultural mediator)	Minimal involvement of target community in design of program; considerations of forced assimilation through integration	Decreased prejudice due to increased contact between host and immigrant communities; clear communication to host community around allocation of resources thereby reducing perceived threat of competition	Spain

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3	Catarci³⁴	2012	Conceptions and Strategies for User Integration across Refugee Services in Italy	Integrated reception of refugees and asylum seekers (network of hospitals and health services, public employment services, vocational training and continuing education agencies, etc.)	Service coordinators lack tools to support integrated services; lack of continuity between theory and practice in continuing education support	Service coordinators with access to continuing education were more likely to report adequate support; continuing education with intimate knowledge of the context, user needs, and legislation related to refugee inclusion; coordinators should also have a solid network and an ability to distinguish between resources	Italy
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17	Cowell et al²⁵	2009	Clinical Trail Outcomes of the Mexican American Problem Solving Program (MAPS)	A cognitively based problem solving program delivered on linked home visits to mothers and after school program classes to children	Difficulty managing case load by school nurse of home visits and classes	Communication and engagement with the community; partnership with the school	USA
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25	Geltman et al³⁸	2005	A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees	Public-private partnerships using a preferred provider network model for conducting refugee health screening	Lack of appropriate funding model leading to delays in health screening	Funding streams approved allowed procurement of services; network of providers created; dedicated training of physicians within the network	USA
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33	Guruge et al²⁹	2010	Immigrant women's experiences of receiving care in a mobile health clinic	Mobile health clinic for reproductive health services for immigrant women	Lack of awareness of available services and navigating health systems; language barrier; fear of deportation leading to lack of use of services	Colocation of services due to the mobile nature of the clinic	Canada
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41	Kim et al³⁶	2002	Primary health care for Korean immigrants: sustaining a culturally sensitive model	Translation support; integrated health and social care; mental health support; bilingual advanced nurse practitioner and community advocate serve as system navigators	Budgetary restrictions; existing restrictions in the roles that nurses can play in outreach	Effective communication around availability of new program; effective communication to announce new outreach and navigation role; efforts to build consensus and coherence across interprofessional teams; clear articulation of the role of advance nurse practitioners and their complementary role	USA
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Lilleston et al²⁸	2018	Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon	GBV mobile support service, providing safe spaces, community outreach, psychosocial support activities, safe legal and medical referrals, survivor-approach, adherence to confidentiality, and access to face-to-face and phone-based case management	Trust-building is a key element and so constant mobility of target audience presented a challenge as did referral of services as quality medical and legal services were not always safe or available	Integration of legal and medical teams in mobile GBV support teams; community mobilizers/system navigator role is a key function	Lebanon
Macfarlane et al³³	2009	Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England	Translation support	Use of unpaid interpreters from patients' social networks is complex; only one accredited course for professional interpreters; use of professional interpreters patchy due to low quality and institutional challenges in their acquisition	In England where there is a policy to use language services (Race Equality Policy), there is more use than in Ireland but implementation remains poor	UK
McMurray et al³⁵	2014	Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada	Translation support; integrated health and social care; Gateway services and system navigators	Shortage of primary care physicians which is the gateway; bureaucracy when billing Canada's Interim Federal Health Program (IFHP) that provides coverage for health care costs until provincial health insurance is available	Relationships between local physician community and case workers (navigators); timely transfer of records; ongoing consultations post-transfer	Canada
McNaughton et al²⁴	2010	Directions for Refining a School Nursing Intervention for Mexican Immigrant Families	Active case finding and problem solving through education system (school nurses); translation support	Schools with no existing nursing outreach program were difficult to start at	Nursing role was recognized and accepted by immigrant communities; schools that had a nursing program already could expand it to active case finding with immigrant families	Mexico
Mortensen³¹	2011	Public Health System Responsiveness To Refugee Groups In New Zealand: Activation From The Bottom Up	Physician-driven needs-based programs in primary care	Mismatch between policies at national vs. local level; lack of demographic data; no long-term planning or projected needs; low linkages between district health branch, public health offices, and NGOs; low health literacy due to lack of translated materials	Quota refugees have same access to services as host communities; local action activated by physicians and community leaders led to more coverage and higher quality services in specific areas that had more advocacy	New Zealand

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3	Philbin et al ⁴⁰	2018	State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States	Policies to address social and legal determinants of health as they relate to immigrant populations	Exclusionary policies affect social determinants of health, especially in mixed status families; families unwilling to participate in social programs due to fear and confusion over entitlements; structural racism; restrictions in accessing education and employment; low mobility and relocation to remote areas with low availability of integrated social services.	Elimination of waiting period in several states for access to Medicaid regardless of immigration status; extra funding to federally qualified health centres	USA
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19	Stewart et al ³²	2008	Multicultural Meanings of Social Support among Immigrants and Refugees	Policies to address social and legal determinants of health as they relate to immigrant populations; social networking	Inadequate financial and human resources, limited agency mandates, ineffective collaboration with other sectors, and low staff morale; collaboration impeded by the volume of organizations involved	Existing networks of longer term immigrants were supportive in overcoming access barriers	Canada
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29	Tuepker et al ⁴¹	2009	Evaluating integrated healthcare for refugees and hosts in an African context	Integrating host and refugee healthcare by reorganizing ministries to incorporate refugee services into existing portfolios rather than under one ministry	Lack of evidence on the added value of integrated care; concern around minimizing exceptional status of refugees; no legal obligation to provide integrated care; turf wars across organizations and sectors	Funding streams from international organizations to national health services	Ethiopia & Uganda
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40	Verhagen et al ²⁶	2013	Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention program in the Netherlands	Use of ethnically similar CHWs to deliver health and social care; active case finding; community-driven problem solving with oversight by CHWs	Lack of participation by target community in culturally-sensitive design; limited knowledge by target community around availability of services	Use of ethnically-similar CHWs	Netherlands
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50	Woodland et al ²⁷	2016	Evaluation of a school screening program for young people from refugee backgrounds	Active case finding and problem solving through education system (school nurses); translation support	Poor integration of multiple service providers; lack of funding	Integration within the school; informal communication between clinicians and the school	Australia
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3	Woodland et al³⁹	2010	Health service delivery for newly arrived refugee children: A framework for good practice	Comprehensive, screening services; partnerships between community and health services (refugee health nurse as system navigator); transportation services to access centres; specific training provided to physicians and other care providers, including referral pathways; Pharmaceutical benefit scheme addressing refugee needs	Lack of coordinated policy for all categories of refugees and asylum seekers; administrative burden of PHC coordination; lack of information for managing conditions specific or prominent to refugees	Family-based services (colocation to address family needs); refugee health nurses (system navigators) decrease administrative burden of coordination; consumer participation and consultation; colocation of screening services ; transportation support for getting to services; strong health information systems; data and consultations used to inform the direction of intersectoral collaboration and nature of partnerships between health and community service providers	Australia
23	Yeung et al³⁷	2004	Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans	Specific training provided to physicians and other care providers; mental health support (colocation of mental health services); primary care nurse as a bridge/ system navigator for referrals;	Funding for coordination outside purview of essential services; lack of knowledge on culturally-appropriate mental health services	Co-location of primary care and mental health services; designated staff as the bridge; training of service providers	USA

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214 To respond to research question 1, each of the interventions and summarized barriers and
 215 facilitators are described in Table 1 and grouped by common themes in Table 2. Findings are
 216 summarized in this section. Common facilitators identified in programs and approaches to
 217 protect refugee health through intersectoral approaches and integration of services include:
 218 strong communication of program availability, tools and training for providers, colocation of
 219 services, transportation services to enhance access, clear role definitions, interprofessional team
 220 and relationship management across providers, appropriate allocation of budget and financing,
 221 and coordinated refugee-specific policies.

222 Barriers articulated include: lack of a participatory approach, poor communication
 223 leading to stigma and underuse of services, insufficient resources given to providers, absence of

224 financing, unclear roles and insufficient coordination of interprofessional teams, exclusionary
 225 refugee policies, low availability and use of data, and turf wars across governance stakeholders.
 226 Table 2 highlights the studies that expand on these themes as barriers or facilitators.

227 **Table 2. Barriers & Facilitators Commonly Discussed Across Studies**

Elements	Element present as barrier	Element present as facilitator
Community engagement	Calvo et al; ³⁰ Verhagen et al ²⁶	Kim et al; ³⁶ Mortensen; ³¹ McMurray et al; ³⁵ Cowell et al ²⁵
Communication between host and refugee communities		Calvo et al; ³⁰ Woodland et al, 2016 ²⁷
Tools/Training for service providers to support integrated services	Catarci; ³⁴ MacFarlane et al; ³³ Woodland et al, 2010 ³⁹	Woodland et al, 2010; ³⁹ Yeung et al; ³⁷ Geltman et al ³⁸
Colocation of services		Woodland et al, 2010; ³⁹ Yeung et al; ³⁷ Lilleston et al; ²⁸ Guruge et al ²⁹
Transportation		Woodland et al, 2010 ³⁹
Networks between providers		Catarci; ³⁴ Stewart et al; ³² Geltman et al ³⁸
Budget/Appropriate funding streams	Kim et al; ³⁶ McMurray et al; ³⁵ Stewart et al ³²	Philbin; ⁴⁰ Tuepker et al; ⁴¹ Geltman et al ³⁸
Role definitions	Kim et al ³⁶	McNaughton et al; ²⁴ Lilleston et al; ²⁸ Yeung et al ³⁷
Interprofessional team management	Stewart et al; ³² Woodland et al, 2016 ²⁷	Kim et al ³⁶
Refugee-specific policies	Mortensen; ³¹ Philbin; ⁴⁰ Tuepker et al; ⁴¹ Woodland et al, 2010; ³⁹ Lilleston et al ²⁸	MacFarlane et al; ³³ Philbin ⁴⁰
Data	Mortensen; ³¹ Tuepker et al ⁴¹	
Organizational turf	Stewart et al; ³² Tuepker et al ⁴¹	

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 229 To respond to research question 2, this section will summarize common themes identified
 230 as enabling strategies that support intersectoral collaboration to promote refugee health.
 231 Strategies identified in this review include: establishing networks of service delivery through a
 232 combination of existing public and private services, establishing a system navigator role,
 233 engaging host communities to reduce stigma, ensuring availability of translation services,
 234 outreach, and advocacy and legislative support. Table 3 highlights the studies that address each
 235 of these strategies. In Italy for example, networks were promoted among private and public

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3 236 authorities and service providers, including health, employment, vocational training and
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5 237 continuing education services.³⁴ In this model, users moved through the pathways of integration
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7 238 and can receive support for any combination of health needs, access to education, housing
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9 239 support, and legal assistance.³⁴ Collaborative design and delivery of services was also
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11 240 demonstrated in Australia with support from multidisciplinary, intersectoral teams, but a lack of
12
13 241 funding presented barriers to the potential success of this initiative.²⁷ Similarly in the USA, the
14
15 242 “Bridge Project” faced insufficient funding in the coordination of care despite seeing promising
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17 243 results from use of a system navigator – or primary care nurse “bridge” – to connect primary care
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19 244 and mental health care services.³⁷ A network of “gateway services” was also tested in Canada
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21 245 using a “Reception House” model.³⁵ These services are characterized by being person-centred,
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23 246 interprofessional, communication-focused, and comprehensive across the continuum of care.³⁵
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25 247 Relationship-management between the Reception House, health professionals, translation
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27 248 services, and social services was acknowledge as a key component for success.³⁵ Input from
28
29 249 international medical graduates in training also supported this work by enhancing culturally
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31 250 appropriate service delivery by this network of partners.³⁵

32
33 251 Striking a balance between providing tailored, culturally-appropriate care and integrating
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35 252 health and social services for refugees into existing services in the host community can be
36
37 253 especially challenging. Policy reviews suggest that taking a “one-policy, one-level, one-
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39 254 outcome” approach or focusing refugee management under one ministry is not sufficient in
40
41 255 addressing the wide range of obstacles that both host and refugee communities are facing as a
42
43 256 result of the current political climate.^{40,41} The Ethiopian government for example had success in
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45 257 reorganizing ministries to incorporate refugee management into existing portfolios rather than a
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258 refugee-specific one, moving refugee assistance programs out of camps and promoting more
 259 collaboration across government and non-governmental programs.⁴¹

260 **Table 3. Enabling Strategies Present Across Studies**

Strategy	Studies						
Host community engagement	Calvo et al ³⁰						
System navigation	Calvo et al ³⁰	Kim et al ³⁶	McMurray et al ³⁵	Woodland et al, 2010 ³⁹	Yeung et al ³⁷	Lilleston et al ²⁸	
Integrated health and social services through networked approach	Catarci ³⁴	Kim et al ³⁶	McMurray et al ³⁵	Yeung et al ³⁷			
Translation support	Kim et al ³⁶	MacFarlane et al ³³	McMurray et al ³⁵	McNaughton et al ²⁴	Woodland et al, 2016 ²⁷	Cowell et al ²⁵	Guruge et al ²⁹
Active case finding/Outreach	McNaughton et al ²⁴	Verhagen et al ²⁶	Woodland et al, 2016 ²⁷	Guruge et al ²⁹			
Refugee-specific service delivery and access to health and social networks	Mortensen ³¹	Philbin et al ⁴⁰	Stewart et al ³²	Verhagen et al ²⁶			
Legislative support	Philbin et al ⁴⁰	Tuepker et al ⁴¹	Woodland et al, 2010 ³⁹	Geltman et al ³⁸			
Changes in funding modalities	Tuepker et al ⁴¹						

261
 262 In terms of stakeholders involved (research question 3) in implementing, monitoring or
 263 facilitating the aforementioned strategies, studies did not always report on the parties involved in
 264 governance, financing, planning, service delivery, monitoring and evaluation or demand
 265 generation (elements drawn from the integration framework by Atun et al (2010)²¹). Where they
 266 were mentioned, stakeholders responsible for the governance of interventions addressing refugee
 267 health were comprised of primary care centres,^{35,37} municipal governments,^{30,38} departments of
 268 social services and/or public health,^{30,36} central services responsible for coordination of refugee
 269 services and provision of assistance to local services,^{34,35} national governments,^{31,32} and
 270 international bodies.²⁸ Stakeholders responsible for health financing consisted of individual

271 fundraising by service providers,^{31,33} government,^{30,31,35,38,41} and international bodies or
272 donors.^{28,36,37,41} Program and policy planning stakeholders encompassed national
273 governments,^{31,38,41} departments of social services and/or public health,^{27,30,36} central services
274 responsible for coordination of refugee services and provision of assistance to local
275 services,^{29,34,35} researchers,^{24,26,30,36,37} service providers,^{27,28,35,37} and international bodies or
276 donors.^{28,36,41} Service delivery stakeholders included national departments of social services
277 and/or public health,^{27,30,33,36,38-41} networks of local service providers in health, education,
278 socialization, translation and/or employment,^{24,31,34,36} healthcare providers,^{27,33,35,37,38} central
279 services responsible for coordination of refugee services and provision of assistance to local
280 services,^{32,34,35} community health workers,²⁶ and international bodies.^{28,41} Stakeholders
281 responsible for monitoring and evaluation were seldom explicitly mentioned. For demand
282 generation, stakeholders included central services responsible for the coordination of refugee
283 services and provision of assistance to local services,³⁵ local media in the language of the target
284 population,³⁶ community leaders and/or community health workers,^{26,28,31,32} home health
285 outreach services,^{28,31} and healthcare providers.^{33,37}

286 **DISCUSSION**

287 The findings from the existing but scarce literature highlight critical factors necessary in
288 facilitating intersectoral collaboration and the successful integration of refugee services within
289 existing health systems. The three research questions studied demonstrated barriers and
290 facilitators, enabling strategies recorded in the literature, and the stakeholders involved. This
291 section will summarize key themes across these topics and discuss implications for program
292 implementation, policy and future research.

293

294 **Coordination of Existing Public and Private Services**

295 A networked approach to service delivery during the initial reception of refugees can often
296 mitigate some of the difficulties encountered by refugee communities. Some examples of
297 coordination of services were seen in Italy,³⁴ Australia,²⁷ the US,³⁷ and Canada.³⁵ In Canada,
298 where a network of “gateway services” was tested using the “Reception House” model, it
299 successfully provided responsive and culturally sensitive primary care.³⁵ By partnering
300 community and translation services, as well as health care providers with the Reception House, it
301 decreased wait times and improved health care access through referrals and coordination of
302 services.³⁵ Further analysis with costing studies on a tailored package of health services for
303 vulnerable populations could help to support improved financing of efforts at coordination of
304 services across sectors.

305 **Introduction of a System Navigator Role**

306 Integration works through establishing relationships across networks of local stakeholders and
307 service providers. To coordinate this effectively, a system navigator role can be established – the
308 evidence suggests that this role is most effective in the early stage of resettlement.³⁵ The system
309 navigation role can be played by an organization or by people within the existing health or social
310 systems. It connects incoming refugees to timely, culturally-appropriate care in the community
311 without creating parallel structures that either threaten host communities or further stigmatize
312 refugees.^{30,35} The likelihood of success of a system navigator role is further strengthened when
313 providers have access to the knowledge, tools and training needed to address the specific needs
314 of refugees, including the more vulnerable subgroups (e.g., the elderly, women, and children).
315 Providers need to understand the context in which they work and the available features and
316 services, user needs, and legislation as it relates to refugees.³⁴ Those playing a coordination or

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3 317 system navigation role should also be able to build strong networks with allied specialists,
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5 318 identify appropriate resources and reach out to users.^{34,35} The risk here however is that
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7 319 integrating refugee care may eliminate some determination procedures, potentially undermining
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9 320 the protection mandate and underestimate the tailored needs of refugees dealing with significant
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11 321 trauma.⁴¹ Future research on the required competencies of the system navigator role is required
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13 322 to ensure that appropriate professionals are recruited and trained.
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16 17 323 **Advocacy and Legislative Support**

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19 324 Exclusionary immigration policies can play a considerable role in marginalization and
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21 325 discrimination against refugee communities leading to decreased health seeking behaviors and
22
23 326 use of available integrated or intersectoral services.⁴⁰ Effective advocacy needs to target the
24
25 327 policy-making levels in order to counteract the negative impacts of exclusionary policies.
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27 328 Advocacy by health care providers can be influential at the institutional level to push for better
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29 329 allocation of services and funding.³¹ A multipronged approach may be necessary to continue to
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31 330 advocate for the right to health for refugees by addressing legal challenges, establishing timely
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33 331 and accurate data and information systems to capture needs, creating health promoting
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35 332 environments, investing in person-centred, culturally-appropriate and easily accessible services,
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37 333 and evaluating coordination and service delivery efforts. Engaging policy makers in knowledge
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39 334 translation and evidence-informed decision-making is one way to effectively advocate and
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41 335 provide legislative support in refugee health. In Lebanon for example, where there are huge
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43 336 demands in meeting the health needs of a large Syrian refugee population, researchers engaged
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45 337 policy-makers in knowledge production (i.e. research priority-setting), translation and uptake
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47 338 activities.⁴² This ultimately led to the hiring of a refugee health coordinator by the Lebanese
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49 339 Ministry of Public Health. The refugee health coordinator role functioned to support intersectoral
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3 340 collaboration, assisting in strategic planning and implementation of action plans to respond to the
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5 341 health needs of Syrian refugees including helping with the development of refugee health
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7 342 information systems at the Ministry of Public Health.⁴² The UCL-Lancet Commission on
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10 343 Migration and Health also supports knowledge translation by bringing together academics,
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12 344 policymakers, and health system experts to take an inter-disciplinary approach to reviewing
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14 345 evidence, develop policy recommendations and disseminate these findings globally amongst
15
16 346 policymakers and institutions.⁴³

19 347 **Alternative Models of Care to Reach Vulnerable Women and Children**

21 348 Among the studies that reported targeted interventions for women and children, alternative
22
23 349 models of care were used. This included mobile health clinics, and programs linked to schools to
24
25 350 support screening and active case finding. These alternate models increased accessibility of
26
27 351 essential health services, increase detection of health conditions, and improve coordination of
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29 352 care, and reduced feelings of social isolation.^{27,28} This suggests that flexible service delivery and
30
31 353 innovation in mode of delivery should be considered when attempting to reach at risk refugee
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33 354 groups. Better collection and use of evidence on the needs of vulnerable refugee subgroups and
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35 355 how to target them are essential next steps to design appropriate service delivery models.

39 356 **Policy Insights**

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42 357 From the available evidence, the following are policy insights to inform greater integration of
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44 358 services and/or intersectoral collaboration. These recommendations are based on consistent
45
46 359 facilitators and barriers identified across studies included in this review. They are critical starting
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48 360 points in enhancing programs to better serve refugees while promoting efficiency in health
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50 361 systems.

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3 362 1) Strengthening the coordination between existing programs through financing stronger
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5 363 referral systems and colocation of services
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- 8 364 2) Incentivizing health and social service authorities to establish and finance formal system
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10 365 navigator roles that connect all relevant services – provision of information technology
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12 366 tools can help support this function and better manage the network of available programs
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- 15 367 3) Engaging host communities to enhance understanding, reduce stigma, and to create an
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17 368 enabling environment for policies that protect refugees and their rights to social
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19 369 determinants of health
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- 22 370 4) Communicating the availability of programs and services through cultural mediators and
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24 371 establishing formal translation and transport services to improve access
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- 26 372 5) Establishing training and resources for providers to a) better understand the needs of
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28 373 refugee communities, b) be aware of available and relevant services for referral across
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30 374 sectors, and c) more efficiently manage cases
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33 375 **Limitations and Future Directions**

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35 376 Our review was limited by the scarcity of evidence in this area. Due to this, all relevant studies
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37 377 were included, therefore, quality and rigor may vary. Some key programs and approaches may
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39 378 be missing due to interventions occurring at the individual level instead of at the systems level,
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41 379 as well as not having been published in academic literature. Individual health providers or
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43 380 organizations will navigate barriers in health systems through tacit and experiential knowledge
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45 381 that is often not documented. Data will be further amplified by conducting key informant
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47 382 interviews in selected countries.
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51 383 As others have noted, the literature on intersectoral collaboration disproportionately
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53 384 focuses on high-income countries.⁴⁴ It is therefore no surprise that the evidence for this review
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3 385 largely came from high-income countries with only two studies conducted in upper-middle
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5 386 income and two in low-income countries. This may affect the generalizability of the findings
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7 387 reported here as low-income and middle-income countries have greater coordination challenges
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9 388 to overcome due to fragmented systems and weak governance.⁴⁵ Additionally, according to the
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11 389 latest report on the UN Refugee Agency, approximately 85% of refugees are hosted in
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13 390 developing nations.⁴⁶ More evidence and special consideration is needed in these contexts with
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15 391 respect to refugee health, particularly for those most at risk subgroups such as women, children
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17 392 and the elderly.

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21 393 Although there exists reaffirmed enthusiasm in intersectoral approaches to achieving
22
23 394 global health agendas such as the SDGs, it has been found that the lack of quality evidence
24
25 395 represents an essential hurdle to evidence-informed decision-making for the development of
26
27 396 cross-cutting policies and governance required for sustained intersectoral collaboration.⁴⁴ This
28
29 397 pattern of a dearth of evidence was seen in our review. Additionally, most of what has been
30
31 398 written has not been grounded in relevant theories or frameworks.⁴⁵ Our use of frameworks to
32
33 399 structure our analysis is a step forward in addressing this issue. Generating high quality data in
34
35 400 health systems and policy research for migrant health and on intersectoral approaches has been
36
37 401 identified as a research priority.^{44,47} Future research should therefore also consider the structured
38
39 402 evaluation of evidence through a frameworked approach.

403 **CONCLUSION**

404 Refugees experience individual, institutional, and system level obstacles when seeking health
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46 405 care. To ensure adequate health services tailored to this vulnerable population, conducting
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48 406 research and gathering quality evidence on integrated and intersectoral approaches is a top
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3 407 priority. This scoping review has highlighted important gaps in current knowledge and made
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5 408 suggestions for future research relevant to key themes.
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8 409 Our findings indicate that policies aiming at integrating services and fostering
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10 410 intersectoral action should consider system-level approaches such as the colocation of services,
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12 411 transportation support, and establishing system navigator roles. Communication challenges due
13
14 412 to language barriers should also be addressed with a view of providing culturally-sensitive
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16 413 programs. There is also a need to strengthen the capacities of frontline providers and managers,
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18 414 to improve their knowledge of available services as well as their ability to provide care to
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20 415 specialized vulnerable groups such as refugees. Engaging host communities around a human
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22 416 rights-focused strategy to the health of refugees is also fundamental to address discrimination
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24 417 and stigma. Current gaps in knowledge found in our study represent an untapped potential for
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26 418 improvements to financial and human resource efficiency in health systems. Given the limited
27
28 419 evidence we found in our scoping review, the momentum for continued research should be
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30 420 sustained.
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38 422 **ETHICS APPROVAL**

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40 423 Ethics approval was not required for this scoping review as human subjects are not involved.
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43 424 **AUTHOR'S CONTRIBUTIONS**

44
45 425 GT together with librarians at Karolinska Institutet identified databases and planned the literature
46
47 426 search. SH & DJ drafted the paper and incorporated co-author feedback, SH & DJ abstracted data
48
49 427 from peer-reviewed literature. SC, EVL, GT and PF provided critical feedback and comments on
50
51 428 the manuscript. SC and SH acted as secondary reviewers.
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2
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8
9 433 in the early stages of this project.
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15 435 No data are available.

16 17 436 **COMPETING INTERESTS**

18
19 437 None.

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23
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556 **Figure Legend**

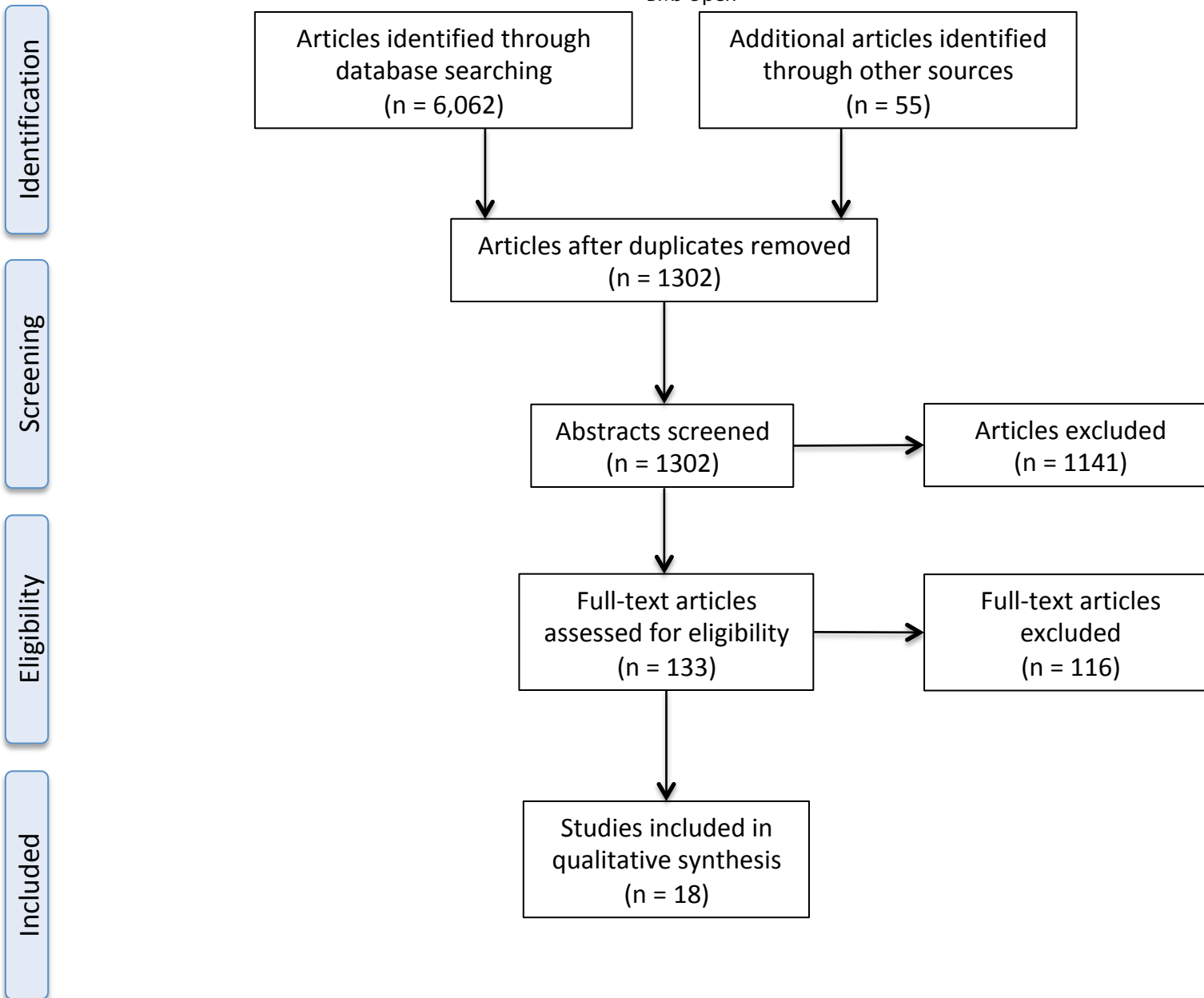
557 **Figure 1: Scoping Review Flowchart**

558 **Table 1: Summary of Included Studies**

559 **Table 2: Barriers and Facilitators Commonly Discussed Across Studies**

560 **Table 3: Enabling Strategies Present Across Studies**

For peer review only



1 APPENDIX I

2 1. Medline (Ovid)

3 Date of Search: 2016-11-03

4 Number of hits: 2019

5 Comments:

6 Field labels:

7 .tw,kf. = title, abstract, keyword

8 exp/ = MeSH, exploded

9 / = MeSH, not exploded

10 adj3 = within two words

11 1. Refugees/

12 2. exp "Emigrants and Immigrants"/

13 3. "Emigration and Immigration"/

14 4. "Transients and Migrants"/

15 5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).tw,kf.

16 6. or/1-5

17 7. Delivery of Health Care/

18 8. Health Services Accessibility/

19 9. Patient Acceptance of Health Care/

20 10. "Health Services Needs and Demand"/

21 11. Quality of Health Care/

22 12. Interinstitutional Relations/

23 13. Interdepartmental Relations/

24 14. Public-Private Sector Partnerships/

25 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.

26 16. ((multisector* or multi-sector* or intersector* or inter-sector* or crossector* 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.

27 17. or/7-16

28 18. Healthcare Disparities/

29 19. Social Determinants of Health/

30 20. Health Status Disparities/

31 21. Health Equity/

32 22. exp Human Rights/

33 23. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).tw,kf.

34 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.

35 25. or/18-24

36 26. 6 and 17 and 25

37 27. Remove duplicates from 26

28. limit 27 to yr="2000 -Current"

2. Web of Science (Thomson Reuter)

Date of Search: 2016-11-03
 Number of hits: 1.166
 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*)

#7 #6 OR #5

#8 #7 AND #4 AND #1

#9 Timespan: 2000-2016.

8

3. Global Health (Ovid)

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

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*)).ti,ab.
10. or/8-9
11. exp disparity/
12. exp discrimination/
13. human rights/
14. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab.
15. (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.
16. or/11-15
17. 6 and 10 and 16
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.
18. or/13-17

19. 4 and 12 and 18
20. limit 19 to yr="2000 -Current"

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Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	p. 1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	p. 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	p. 5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	p. 5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	p. 2 Registered on Open Science Framework https://osf.io/gt9ck/
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	p. 6-7
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Supplementary File
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Supplementary File
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	p. 6-7
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	p. 8
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	p. 6-8
Critical appraisal	12	If done, provide a rationale for conducting a	p. 21



SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
of individual sources of evidence§		critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	p. 8
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	p. 9
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	p. 7-9
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	p. 21
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	p. 9-17, tables 1-3
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	p. 9-17; tables 1-3
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	p. 17-21
Limitations	20	Discuss the limitations of the scoping review process.	p. 21-22
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	p. 22-23
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	p. 24

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).



From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med.* ;169:467–473. doi: 10.7326/M18-0850

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BMJ Open

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

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-029407.R2
Article Type:	Research
Date Submitted by the Author:	17-May-2019
Complete List of Authors:	Ho, Shirley; World Health Organization, Alliance for Health Policy and Systems Research Javadi, Dena; World Health Organization, Alliance for Health Policy and Systems Research Causevic, Sara; Royal Swedish Academy of Sciences, Swedish Institute for Global Health Transformation; Karolinska Institute, Global and Sexual Health, Department of Public Health Sciences Langlois, Etienne V.; World Health Organization, Alliance for Health Policy and Systems Research Friberg, Peter; Royal Swedish Academy of Sciences, Swedish Institute for Global Health Transformation; Sahlgrenska Academy, Institute of Medicine Tomson, Göran ; Royal Swedish Academy of Sciences, Swedish Institute for Global Health Transformation; Karolinska Institute, Medical Management Centre, Department of Learning, Informatics, Management, Ethics
Primary Subject Heading:	Global health
Secondary Subject Heading:	Health policy, Public health
Keywords:	intersectoral, right to health, access, refugees, integration, resettlement

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Manuscripts

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2
3 1 **Intersectoral and integrated approaches in achieving the right to health**
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10 4 Shirley Ho*¹ email: shirley.ho@jhu.edu
11 5 Dena Javadi ¹ email: javadid@who.int
12 6 Sara Causevic^{2,3} email: sara.causevic@ki.se
13 7 Etienne V. Langlois¹ email: langloise@who.int
14 8 Peter Friberg^{2,5} email: peter.friberg@mednet.gu.se
15 9 Goran Tomson^{2,4} email: goran.tomson@ki.se
16
17 10

18 11 ¹ Alliance for Health Policy and Systems Research, World Health Organization, Avenue Appia 20, 1211 Geneva,
19 12 Switzerland

20 13 ² Swedish Institute for Global Health Transformation, SIGHT, Royal Swedish Academy of Science, Stockholm,
21 14 Sweden

22 15 ³ Global and Sexual Health, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden

23 16 ⁴ Medical Management Centre, Department of Learning, Informatics, Management, Ethics (LIME), Karolinska
24 17 Institutet, Stockholm, Sweden

25 18 ⁵ Institute of Medicine, Sahlgrenska Academy at Gothenburg University and Sahlgrenska University Hospital
26 19
27 20

28
29 21 ***Corresponding Author:**

30 22 Shirley Ho, shirley.ho@jhu.edu

31 23 Alliance for Health Policy and Systems Research, World Health Organization
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35 25 **Keywords:** intersectoral, right to health, access, refugees, integration, resettlement
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39 27 Word count: 4,041
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3 28 **ABSTRACT (285/300)**
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5 29 **Background:** Better understanding, documentation, and evaluation of different refugee health
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7 30 interventions, and their means of health system integration and intersectoral collaboration are needed

8
9 31 **Objectives:** Explore the barriers and facilitators to the integration of health services for refugees; the
10
11 32 processes involved; and the different stakeholders engaged in leveraging intersectoral approaches to
12
13 33 protect refugees' right to health on resettlement

14 34 **Design:** Scoping review

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16 35 **Methods:** A search of articles from 2000 onward was done in MEDLINE, Web of Science, Global
17
18 36 Health, and PsycInfo Embase. Two frameworks were applied in our analysis, the "Framework for
19
20 37 analyzing integration of targeted health interventions in systems", and "Health in All Policies"
21
22 38 framework for country action. A comprehensive description of the methods is included in our
23
24 39 published protocol.

25 40 **Results:** 6,117 papers were identified, only 18 studies met the inclusion criteria. Facilitators in
26
27 41 implementation included: training for providers; colocation of services; transportation services to
28
29 42 enhance access; clear role definitions; and appropriate budget allocation and financing. Barriers
30
31 43 included: lack of a participatory approach; insufficient resources for providers; absence of
32
33 44 financing; unclear roles and insufficient coordination of interprofessional teams; low availability
34
35 45 and use of data; and turf wars across governance stakeholders. Successful strategies to address
36
37 46 refugee health included: networks of service delivery combining existing public and private
38
39 47 services; system navigators; host community engagement to reduce stigma; translation services;
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41 48 legislative support; and alternative models of care for women and children.

42 49 **Conclusion:** Limited evidence was found overall. Further research on intersectoral approaches is
43
44 50 needed. Key policy insights gained from barriers and facilitators reported in available studies
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46 51 include: improving coordination between existing programs; supporting colocation of services;
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48 52 establishing formal system navigator roles that connect relevant programs; establishing formal
49
50 53 translation services to improve access; and establishing training and resources for providers.

51 54
52 55 **Registration:** Registered on Open Science Framework at <https://osf.io/gt9ck/>
53
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58 **Strengths and limitations of this study**

- 59 • Our study uses a systematic approach by using two frameworks, the “Framework for
60 analyzing integration of targeted health interventions in systems”, and “Health in All
61 Policies” framework for country action to develop a strong evidence base in
62 understanding the processes and actors involved in integration and intersectoral action
- 63 • Our findings can be applied for policy and action aiming to enhance the integration of
64 refugee health services within health systems, and identifying research needs to advance
65 the right to health for refugees
- 66 • The lack of evidence on intersectoral and integrated approaches from low-income and
67 middle-income countries may impact the generalizability of the findings

68 **INTRODUCTION**

69 Upholding the right to health is a fundamental challenge for governments worldwide,
70 particularly when providing services to vulnerable or hard to reach populations such as refugees.
71 The Office of the United Nations High Commission for Human Rights (OHCHR) identifies the
72 right to health as a fundamental part of human rights, first articulated in the 1946 Constitution of
73 the World Health Organization (WHO).¹ Entitlements under the right to health include universal
74 health coverage – now a target under Sustainable Development Goal (SDG) 3 – broadly covering
75 access to preventative and curative services, essential medicines, timely basic health services,
76 health-related education, participation in health-related decision making at both national and
77 community levels, as well as financial protection.^{1,2} Especially relevant to the plight of refugees,
78 the right to health includes non-discrimination whereby health services, commodities and
79 facilities must be provided to all without any discrimination. Lastly, these health services must

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3 80 be accessible, medically and culturally appropriate, available in adequate amount and quality,
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5 81 which includes having a trained health workforce, safe products and sanitation.²
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8 82 “Refugees” are individuals fleeing armed conflict or persecution as defined by the 1951
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10 83 Refugee Convention which also identifies their basic rights, specifically that refugees should not
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12 84 be returned to situations that are deemed a threat to their life or freedom.³ A key distinction of
13
14 85 refugee rights is that they are not only a matter of national legislation, but also of international
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16 86 law.⁴ Despite these legal protections, refugees face many challenges in accessing health services,
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18 87 especially more vulnerable groups like women and children.⁵ Many states explicitly exclude
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20 88 refugees from the level of protection afforded to their citizens, instead choosing to offer
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22 89 “essential care” or “emergency health care,” which is differentially defined across countries.⁶
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24 90 The Committee on the Elimination of Racial Discrimination, and the Committee on Economic,
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26 91 Social and Cultural Rights, both include general statements that hold States accountable to “the
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28 92 right of non-citizens to an adequate standard of physical and mental health by, inter alia,
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30 93 refraining from denying or limiting their access to preventive, curative and palliative health
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32 94 services”.⁷ The increasing number of refugees over the past years makes the realization and
33
34 95 protection of these rights both a legal, ethical and a logistical challenge.⁵ In addition, the
35
36 96 boundaries of the right to health have expanded due to increased understanding of social
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38 97 determinants of health and the health impacts of the lived environment.^{8,9} Refugees face
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40 98 challenges in navigating health, legal, education, housing, social protection and employment
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42 99 services, which further threatens their quality of life and health status.¹⁰ Therefore, a lack of
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44 100 coordination and integration across these services undermines their effectiveness.¹¹
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51 101 Much like the shift from the more vertical approaches of the millennium development
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53 102 goals (MDGs) towards the more integrated SDGs, the protection of the right to health calls for an
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3 103 intersectoral approach whereby health is applied to all policies for all people.¹² As such, for
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5 104 states to effectively protect the right to health for refugees there is a need to work across sectors
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8 105 and disciplines to better integrate targeted programs and initiatives, thereby improving standards
9
10 106 of care during resettlement. Some evidence exists that supporting collaboration and coordination
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12 107 across social services for refugees improves the effectiveness and quality of care received.¹⁰
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14 108 Many fragmented psychosocial programs exist across sectors to attempt to address the unique
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17 109 challenges faced by refugees but these are largely unevaluated and lack sustainability.^{13,14} Better
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19 110 understanding, documentation, evaluation and reporting of the dynamic nature of different
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21 111 interventions, and their means of health system integration and intersectoral collaboration, are
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24 112 necessary to ensure that lessons learned are implemented in the design of future policies and
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26 113 programs.

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28 114 Therefore, we conducted a scoping review that describes the barriers and facilitators to
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31 115 integrated health services for refugees; the process involved in protecting refugee health; and the
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33 116 different stakeholders engaged in leveraging intersectoral approaches to protect refugees' right to
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35 117 health on resettlement. We focused on three specific research questions:

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38 118 (1) What are the barriers and facilitators in integrating targeted services for refugees within
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40 119 existing health systems?
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42 120 (2) What strategies are involved in addressing refugees' right to health upon resettlement?
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45 121 (3) Which stakeholders are involved in leveraging intersectoral approaches to protect
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47 122 refugees' right to health?
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126 **METHODS**

127 **Study Design**

128 We selected the scoping review method as we were interested in mapping the concepts relevant
129 to the complex nature of this topic, the changing global landscape around it, and the emerging
130 and diverse knowledge-base, which makes the method well-matched to our research
131 objectives.^{15,16} We drafted a scoping review protocol following the methods outlined by the
132 Joanna Briggs Institute Methods Manual for scoping reviews.¹⁷ Our protocol was registered with
133 the Open Science Framework,¹⁸ and published in BMJ Open.¹⁹ Since our full methods are
134 available in the published protocol, a summary is provided below.¹⁹

135 **Information Sources and Search Strategy**

136 A search of articles was done by two experienced librarians at the Karolinska Institutet using the
137 following electronic databases: MEDLINE, Web of Science, Global Health, and PsycInfo
138 Embase. See Appendix I for the comprehensive search strategy. Search terms included umbrella
139 terms for three topics: refugees (eg. immigrants, migrants, asylum seekers, transients); health and
140 social services (eg. healthcare, patient experience, health services, interdisciplinary, intersectoral
141 collaboration, access to care); and health equity (eg. disparities, social determinants, rights-based
142 approaches). These were combined to comprise the search (detailed search terms in appendix).

143 **Eligibility Criteria**

144 **Population:** Refugees as defined by the 1951 Refugee Convention³

145 **Intervention:** A program, approach or technical innovation that aims to protect refugees' right to
146 health, including interventions aimed at addressing the social determinants of health.
147 Interventions outside of the health sector that affect health were included.

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3 148 **Comparators:** This component was not necessary as the focus was on gauging the state of
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5 149 evidence.

7 150 **Outcomes:** Eligible studies and papers include those discussing plans for action, strategies,
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9 151 barriers, facilitators or outcomes using an intersectoral approach.

12 152 **Types of Studies Included:** Randomized control trials, pre-post design evaluations, qualitative
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14 153 evaluations, and economic evaluations were included. Further, implementation research and
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16 154 operations research studies were eligible for inclusion, as well as studies or reports outlining
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18 155 stakeholder experiences and plans.

21 156 **Exclusion Criteria:** Papers published in a language other than English were excluded. Other
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23 157 categories of migrants were not included as their legal entitlements are different to those of
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25 158 refugees which are protected under international law. If the studies did not display some level of
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27 159 integration nor intersectorality, they were not assessed further.²⁰ Studies or commentaries that
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29 160 solely discuss theories and conceptual models were excluded.

33 161 **Time Period:** Only studies from 2000 onward have been included.

35 162 **Setting:** Eligible studies are set in countries receiving refugees and asylum seekers (who may
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37 163 eventually qualify for refugee status) and serving as hosts for resettlement.

41 164 **Frameworks to Address Research Questions**

43 165 Two published frameworks were used in our analysis to understand integration of health services
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45 166 within health systems and to analyze intersectoral approaches to support these services. The first
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47 167 framework by Atun et al (2010)²¹, is a tool for analyzing integration of targeted health
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49 168 interventions in health systems, where integration is defined as “the extent, pattern, and rate of
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51 169 adoption and eventual assimilation of health interventions into each of the critical functions of a
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3 170 health system".²¹ The framework for integration was also used to assess the process, and actors
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5 171 involved in integration.²⁰
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8 172 The second framework applied in our analysis is that of the Health in All Policies (HiAP)
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10 173 framework for country action. HiAP is defined as a way for countries to protect population
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12 174 health through "an approach to public policies across sectors that systematically takes into
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14 175 account the health implications of decisions, seeks synergies, and avoids harmful health impacts
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16 176 in order to improve population health and health equity".²² Components of this framework,
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18 177 adapted to refugee needs, were used in the review to frame barriers and facilitators in integrating
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20 178 refugee services through intersectoral collaboration.
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23 24 179 **Data Abstraction**

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26 180 A data abstraction chart was developed based on the two frameworks used in this study. The
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28 181 chart was tested by two researchers and revised as appropriate. The revised chart was used by the
29
30 182 same researchers to abstract descriptive and qualitative data as relevant to the elements of the
31
32 183 frameworks used. Elements included in the chart were: intervention description; barriers and
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34 184 facilitators; contextual details; target population; type of evaluation; outcomes; stakeholder
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36 185 involvement in governance, financing, planning, service delivery, monitoring and evaluation,
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38 186 and engagement. Deductive reasoning was used to identify barriers and facilitators in
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40 187 intersectoral collaboration for refugee health. Open coding was applied to visualize themes
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42 188 across interventions as well as barriers and facilitators.²³ Axial coding was applied to then draw
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44 189 connections to enabling strategies for intersectoral collaboration.²³ General conclusions were
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46 190 drawn based on these themes, leading to suggestions for strengthening programs and policies.
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51 191 **Patient and Public Involvement**

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54 192 There was no patient or public involvement required in conducting this scoping review.
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193 RESULTS

194 Of the 6,117 records identified through the search strategy, 1302 abstracts were screened after
 195 removing duplicates. 1141 were excluded based on exclusion criteria described above as
 196 assessed by two independent reviewers, 131 full texts were assessed, with the references of 15
 197 selected articles additionally screened for inclusion criteria, a total of 18 studies were included in
 198 our review (see Figure 1). Five studies were programs or interventions carried out in the United
 199 States of America (USA), one in Australia, two in Canada, one in Ethiopia and Uganda, and one
 200 in each of the following: Italy, Lebanon, Mexico, the Netherlands, New Zealand, Spain and the
 201 United Kingdom (UK) (See Table 1). Six studies were interventions at the district/local level,
 202 four at a broader regional level and five at the national level. The interventions outlined in the
 203 included studies addressed mostly all genders and all age ranges with the exception of six that
 204 targeted vulnerable groups: two studies on mothers and children;^{24,25} one on the elderly;²⁶ one on
 205 students;²⁷ and two on women and girls.^{28,29} Interventions targeting women and children in
 206 particular used alternative models of care such as mobile health clinics,^{28,29} and school-based
 207 interventions.^{24,27} Seven studies applied qualitative approaches (primarily in-depth interviews)
 208 for evaluation,^{27–33} four studies used survey tools or standardized assessment tools;^{25,26,34,35} four
 209 studies used descriptive and routine data;^{24,36–38} and three studies were mainly descriptive
 210 analysis reporting on and looking at the outcomes of case examples and policies.^{39–41}

211 **Table 1. Summary of Included Studies**

Author	Year	Title	Intervention	Barriers	Facilitators	Country
Calvo et al ³⁰	2014	The Effect of Universal Service Delivery on the Integration of Moroccan Immigrants in Spain: A Case Study from an Anti-Oppressive Perspective	Addressing stigma & host community perceptions; system navigator (intercultural mediator)	Minimal involvement of target community in design of program; considerations of forced assimilation through integration	Decreased prejudice due to increased contact between host and immigrant communities; clear communication to host community around allocation of resources thereby reducing perceived threat of competition	Spain

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3	Catarci³⁴	2012	Conceptions and Strategies for User Integration across Refugee Services in Italy	Integrated reception of refugees and asylum seekers (network of hospitals and health services, public employment services, vocational training and continuing education agencies, etc.)	Service coordinators lack tools to support integrated services; lack of continuity between theory and practice in continuing education support	Service coordinators with access to continuing education were more likely to report adequate support; continuing education with intimate knowledge of the context, user needs, and legislation related to refugee inclusion; coordinators should also have a solid network and an ability to distinguish between resources	Italy
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17	Cowell et al²⁵	2009	Clinical Trail Outcomes of the Mexican American Problem Solving Program (MAPS)	A cognitively based problem solving program delivered on linked home visits to mothers and after school program classes to children	Difficulty managing case load by school nurse of home visits and classes	Communication and engagement with the community; partnership with the school	USA
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25	Geltman et al³⁸	2005	A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees	Public-private partnerships using a preferred provider network model for conducting refugee health screening	Lack of appropriate funding model leading to delays in health screening	Funding streams approved allowed procurement of services; network of providers created; dedicated training of physicians within the network	USA
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33	Guruge et al²⁹	2010	Immigrant women's experiences of receiving care in a mobile health clinic	Mobile health clinic for reproductive health services for immigrant women	Lack of awareness of available services and navigating health systems; language barrier; fear of deportation leading to lack of use of services	Colocation of services due to the mobile nature of the clinic	Canada
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41	Kim et al³⁶	2002	Primary health care for Korean immigrants: sustaining a culturally sensitive model	Translation support; integrated health and social care; mental health support; bilingual advanced nurse practitioner and community advocate serve as system navigators	Budgetary restrictions; existing restrictions in the roles that nurses can play in outreach	Effective communication around availability of new program; effective communication to announce new outreach and navigation role; efforts to build consensus and coherence across interprofessional teams; clear articulation of the role of advance nurse practitioners and their complementary role	USA
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Lilleston et al²⁸	2018	Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon	GBV mobile support service, providing safe spaces, community outreach, psychosocial support activities, safe legal and medical referrals, survivor-approach, adherence to confidentiality, and access to face-to-face and phone-based case management	Trust-building is a key element and so constant mobility of target audience presented a challenge as did referral of services as quality medical and legal services were not always safe or available	Integration of legal and medical teams in mobile GBV support teams; community mobilizers/system navigator role is a key function	Lebanon
Macfarlane et al³³	2009	Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England	Translation support	Use of unpaid interpreters from patients' social networks is complex; only one accredited course for professional interpreters; use of professional interpreters patchy due to low quality and institutional challenges in their acquisition	In England where there is a policy to use language services (Race Equality Policy), there is more use than in Ireland but implementation remains poor	UK
McMurray et al³⁵	2014	Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada	Translation support; integrated health and social care; Gateway services and system navigators	Shortage of primary care physicians which is the gateway; bureaucracy when billing Canada's Interim Federal Health Program (IFHP) that provides coverage for health care costs until provincial health insurance is available	Relationships between local physician community and case workers (navigators); timely transfer of records; ongoing consultations post-transfer	Canada
McNaughton et al²⁴	2010	Directions for Refining a School Nursing Intervention for Mexican Immigrant Families	Active case finding and problem solving through education system (school nurses); translation support	Schools with no existing nursing outreach program were difficult to start at	Nursing role was recognized and accepted by immigrant communities; schools that had a nursing program already could expand it to active case finding with immigrant families	Mexico
Mortensen³¹	2011	Public Health System Responsiveness To Refugee Groups In New Zealand: Activation From The Bottom Up	Physician-driven needs-based programs in primary care	Mismatch between policies at national vs. local level; lack of demographic data; no long-term planning or projected needs; low linkages between district health branch, public health offices, and NGOs; low health literacy due to lack of translated materials	Quota refugees have same access to services as host communities; local action activated by physicians and community leaders led to more coverage and higher quality services in specific areas that had more advocacy	New Zealand

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3	Philbin et al⁴⁰	2018	State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States	Policies to address social and legal determinants of health as they relate to immigrant populations	Exclusionary policies affect social determinants of health, especially in mixed status families; families unwilling to participate in social programs due to fear and confusion over entitlements; structural racism; restrictions in accessing education and employment; low mobility and relocation to remote areas with low availability of integrated social services.	Elimination of waiting period in several states for access to Medicaid regardless of immigration status; extra funding to federally qualified health centres	USA
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19	Stewart et al³²	2008	Multicultural Meanings of Social Support among Immigrants and Refugees	Policies to address social and legal determinants of health as they relate to immigrant populations; social networking	Inadequate financial and human resources, limited agency mandates, ineffective collaboration with other sectors, and low staff morale; collaboration impeded by the volume of organizations involved	Existing networks of longer term immigrants were supportive in overcoming access barriers	Canada
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29	Tuepker et al⁴¹	2009	Evaluating integrated healthcare for refugees and hosts in an African context	Integrating host and refugee healthcare by reorganizing ministries to incorporate refugee services into existing portfolios rather than under one ministry	Lack of evidence on the added value of integrated care; concern around minimizing exceptional status of refugees; no legal obligation to provide integrated care; turf wars across organizations and sectors	Funding streams from international organizations to national health services	Ethiopia & Uganda
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40	Verhagen et al²⁶	2013	Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention program in the Netherlands	Use of ethnically similar CHWs to deliver health and social care; active case finding; community-driven problem solving with oversight by CHWs	Lack of participation by target community in culturally-sensitive design; limited knowledge by target community around availability of services	Use of ethnically-similar CHWs	Netherlands
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50	Woodland et al²⁷	2016	Evaluation of a school screening program for young people from refugee backgrounds	Active case finding and problem solving through education system (school nurses); translation support	Poor integration of multiple service providers; lack of funding	Integration within the school; informal communication between clinicians and the school	Australia
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3	Woodland et al³⁹	2010	Health service delivery for newly arrived refugee children: A framework for good practice	Comprehensive, screening services; partnerships between community and health services (refugee health nurse as system navigator); transportation services to access centres; specific training provided to physicians and other care providers, including referral pathways; Pharmaceutical benefit scheme addressing refugee needs	Lack of coordinated policy for all categories of refugees and asylum seekers; administrative burden of PHC coordination; lack of information for managing conditions specific or prominent to refugees	Family-based services (colocation to address family needs); refugee health nurses (system navigators) decrease administrative burden of coordination; consumer participation and consultation; colocation of screening services ; transportation support for getting to services; strong health information systems; data and consultations used to inform the direction of intersectoral collaboration and nature of partnerships between health and community service providers	Australia
23	Yeung et al³⁷	2004	Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans	Specific training provided to physicians and other care providers; mental health support (colocation of mental health services); primary care nurse as a bridge/ system navigator for referrals;	Funding for coordination outside purview of essential services; lack of knowledge on culturally-appropriate mental health services	Co-location of primary care and mental health services; designated staff as the bridge; training of service providers	USA

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213 To respond to research question 1, each of the interventions and summarized barriers and
 214 facilitators are described in Table 1 and grouped by common themes in Table 2. Findings are
 215 summarized in this section. Common facilitators identified in programs and approaches to
 216 protect refugee health through intersectoral approaches and integration of services include:
 217 strong communication of program availability, tools and training for providers, colocation of
 218 services, transportation services to enhance access, clear role definitions, interprofessional team
 219 and relationship management across providers, appropriate allocation of budget and financing,
 220 and coordinated refugee-specific policies.

221 Barriers articulated include: lack of a participatory approach, poor communication
 222 leading to stigma and underuse of services, insufficient resources given to providers, absence of

223 financing, unclear roles and insufficient coordination of interprofessional teams, exclusionary
 224 refugee policies, low availability and use of data, and turf wars across governance stakeholders.
 225 Table 2 highlights the studies that expand on these themes as barriers or facilitators.

226 **Table 2. Barriers & Facilitators Commonly Discussed Across Studies**

Elements	Element present as barrier	Element present as facilitator
Community engagement	Calvo et al; ³⁰ Verhagen et al ²⁶	Kim et al; ³⁶ Mortensen; ³¹ McMurray et al; ³⁵ Cowell et al ²⁵
Communication between host and refugee communities		Calvo et al; ³⁰ Woodland et al, 2016 ²⁷
Tools/Training for service providers to support integrated services	Catarci; ³⁴ MacFarlane et al; ³³ Woodland et al, 2010 ³⁹	Woodland et al, 2010; ³⁹ Yeung et al; ³⁷ Geltman et al ³⁸
Colocation of services		Woodland et al, 2010; ³⁹ Yeung et al; ³⁷ Lilleston et al; ²⁸ Guruge et al ²⁹
Transportation		Woodland et al, 2010 ³⁹
Networks between providers		Catarci; ³⁴ Stewart et al; ³² Geltman et al ³⁸
Budget/Appropriate funding streams	Kim et al; ³⁶ McMurray et al; ³⁵ Stewart et al ³²	Philbin; ⁴⁰ Tuepker et al; ⁴¹ Geltman et al ³⁸
Role definitions	Kim et al ³⁶	McNaughton et al; ²⁴ Lilleston et al; ²⁸ Yeung et al ³⁷
Interprofessional team management	Stewart et al; ³² Woodland et al, 2016 ²⁷	Kim et al ³⁶
Refugee-specific policies	Mortensen; ³¹ Philbin; ⁴⁰ Tuepker et al; ⁴¹ Woodland et al, 2010; ³⁹ Lilleston et al ²⁸	MacFarlane et al; ³³ Philbin ⁴⁰
Data	Mortensen; ³¹ Tuepker et al ⁴¹	
Organizational turf	Stewart et al; ³² Tuepker et al ⁴¹	

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 228 To respond to research question 2, this section will summarize common themes identified
 229 as enabling strategies that support intersectoral collaboration to promote refugee health.
 230 Strategies identified in this review include: establishing networks of service delivery through a
 231 combination of existing public and private services, establishing a system navigator role,
 232 engaging host communities to reduce stigma, ensuring availability of translation services,
 233 outreach, and advocacy and legislative support. Table 3 highlights the studies that address each
 234 of these strategies. In Italy for example, networks were promoted among private and public

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3 235 authorities and service providers, including health, employment, vocational training and
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5 236 continuing education services.³⁴ In this model, users moved through the pathways of integration
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7 237 and can receive support for any combination of health needs, access to education, housing
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9 238 support, and legal assistance.³⁴ Collaborative design and delivery of services was also
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11 239 demonstrated in Australia with support from multidisciplinary, intersectoral teams, but a lack of
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13 240 funding presented barriers to the potential success of this initiative.²⁷ Similarly in the USA, the
14
15 241 “Bridge Project” faced insufficient funding in the coordination of care despite seeing promising
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17 242 results from use of a system navigator – or primary care nurse “bridge” – to connect primary care
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19 243 and mental health care services.³⁷ A network of “gateway services” was also tested in Canada
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21 244 using a “Reception House” model.³⁵ These services are characterized by being person-centred,
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23 245 interprofessional, communication-focused, and comprehensive across the continuum of care.³⁵
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25 246 Relationship-management between the Reception House, health professionals, translation
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27 247 services, and social services was acknowledge as a key component for success.³⁵ Input from
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29 248 international medical graduates in training also supported this work by enhancing culturally
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31 249 appropriate service delivery by this network of partners.³⁵
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38 250 Striking a balance between providing tailored, culturally-appropriate care and integrating
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40 251 health and social services for refugees into existing services in the host community can be
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42 252 especially challenging. Policy reviews suggest that taking a “one-policy, one-level, one-
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44 253 outcome” approach or focusing refugee management under one ministry is not sufficient in
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46 254 addressing the wide range of obstacles that both host and refugee communities are facing as a
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48 255 result of the current political climate.^{40,41} The Ethiopian government for example had success in
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50 256 reorganizing ministries to incorporate refugee management into existing portfolios rather than a
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257 refugee-specific one, moving refugee assistance programs out of camps and promoting more
 258 collaboration across government and non-governmental programs.⁴¹

259 **Table 3. Enabling Strategies Present Across Studies**

Strategy	Studies						
Host community engagement	Calvo et al ³⁰						
System navigation	Calvo et al ³⁰	Kim et al ³⁶	McMurray et al ³⁵	Woodland et al, 2010 ³⁹	Yeung et al ³⁷	Lilleston et al ²⁸	
Integrated health and social services through networked approach	Catarci ³⁴	Kim et al ³⁶	McMurray et al ³⁵	Yeung et al ³⁷			
Translation support	Kim et al ³⁶	MacFarlane et al ³³	McMurray et al ³⁵	McNaughton et al ²⁴	Woodland et al, 2016 ²⁷	Cowell et al ²⁵	Guruge et al ²⁹
Active case finding/Outreach	McNaughton et al ²⁴	Verhagen et al ²⁶	Woodland et al, 2016 ²⁷	Guruge et al ²⁹			
Refugee-specific service delivery and access to health and social networks	Mortensen ³¹	Philbin et al ⁴⁰	Stewart et al ³²	Verhagen et al ²⁶			
Legislative support	Philbin et al ⁴⁰	Tuepker et al ⁴¹	Woodland et al, 2010 ³⁹	Geltman et al ³⁸			
Changes in funding modalities	Tuepker et al ⁴¹						

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 261 In terms of stakeholders involved (research question 3) in implementing, monitoring or
 262 facilitating the aforementioned strategies, studies did not always report on the parties involved in
 263 governance, financing, planning, service delivery, monitoring and evaluation or demand
 264 generation (elements drawn from the integration framework by Atun et al (2010)²¹). Where they
 265 were mentioned, stakeholders responsible for the governance of interventions addressing refugee
 266 health were comprised of primary care centres,^{35,37} municipal governments,^{30,38} departments of
 267 social services and/or public health,^{30,36} central services responsible for coordination of refugee
 268 services and provision of assistance to local services,^{34,35} national governments,^{31,32} and
 269 international bodies.²⁸ Stakeholders responsible for health financing consisted of individual

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3 270 fundraising by service providers,^{31,33} government,^{30,31,35,38,41} and international bodies or
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5 271 donors.^{28,36,37,41} Program and policy planning stakeholders encompassed national
6
7 272 governments,^{31,38,41} departments of social services and/or public health,^{27,30,36} central services
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9
10 273 responsible for coordination of refugee services and provision of assistance to local
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12 274 services,^{29,34,35} researchers,^{24,26,30,36,37} service providers,^{27,28,35,37} and international bodies or
13
14 275 donors.^{28,36,41} Service delivery stakeholders included national departments of social services
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16 276 and/or public health,^{27,30,33,36,38-41} networks of local service providers in health, education,
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18 277 socialization, translation and/or employment,^{24,31,34,36} healthcare providers,^{27,33,35,37,38} central
19
20 278 services responsible for coordination of refugee services and provision of assistance to local
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22 279 services,^{32,34,35} community health workers,²⁶ and international bodies.^{28,41} Stakeholders
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24
25 280 responsible for monitoring and evaluation were seldom explicitly mentioned. For demand
26
27 281 generation, stakeholders included central services responsible for the coordination of refugee
28
29 282 services and provision of assistance to local services,³⁵ local media in the language of the target
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31 283 population,³⁶ community leaders and/or community health workers,^{26,28,31,32} home health
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33 284 outreach services,^{28,31} and healthcare providers.^{33,37}

285 **DISCUSSION**

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39 286 The findings from the existing but scarce literature highlight critical factors necessary in
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41 287 facilitating intersectoral collaboration and the successful integration of refugee services within
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43 288 existing health systems. The three research questions studied demonstrated barriers and
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45 289 facilitators, enabling strategies recorded in the literature, and the stakeholders involved. This
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47 290 section will summarize key themes across these topics and discuss implications for program
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49 291 implementation, policy and future research.

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293 **Coordination of Existing Public and Private Services**

294 A networked approach to service delivery during the initial reception of refugees can often
295 mitigate some of the difficulties encountered by refugee communities. Some examples of
296 coordination of services were seen in Italy,³⁴ Australia,²⁷ the US,³⁷ and Canada.³⁵ In Canada,
297 where a network of “gateway services” was tested using the “Reception House” model, it
298 successfully provided responsive and culturally sensitive primary care.³⁵ By partnering
299 community and translation services, as well as health care providers with the Reception House, it
300 decreased wait times and improved health care access through referrals and coordination of
301 services.³⁵ Further analysis with costing studies on a tailored package of health services for
302 vulnerable populations could help to support improved financing of efforts at coordination of
303 services across sectors.

304 **Introduction of a System Navigator Role**

305 Integration works through establishing relationships across networks of local stakeholders and
306 service providers. To coordinate this effectively, a system navigator role can be established – the
307 evidence suggests that this role is most effective in the early stage of resettlement.³⁵ The system
308 navigation role can be played by an organization or by people within the existing health or social
309 systems. It connects incoming refugees to timely, culturally-appropriate care in the community
310 without creating parallel structures that either threaten host communities or further stigmatize
311 refugees.^{30,35} The likelihood of success of a system navigator role is further strengthened when
312 providers have access to the knowledge, tools and training needed to address the specific needs
313 of refugees, including the more vulnerable subgroups (e.g., the elderly, women, and children).
314 Providers need to understand the context in which they work and the available features and
315 services, user needs, and legislation as it relates to refugees.³⁴ Those playing a coordination or

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2
3 316 system navigation role should also be able to build strong networks with allied specialists,
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5 317 identify appropriate resources and reach out to users.^{34,35} The risk here however is that
6
7 318 integrating refugee care may eliminate some determination procedures, potentially undermining
8
9 319 the protection mandate and underestimate the tailored needs of refugees dealing with significant
10
11 320 trauma.⁴¹ Future research on the required competencies of the system navigator role is required
12
13 321 to ensure that appropriate professionals are recruited and trained.
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16 17 322 **Advocacy and Legislative Support**

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19 323 Exclusionary immigration policies can play a considerable role in marginalization and
20
21 324 discrimination against refugee communities leading to decreased health seeking behaviors and
22
23 325 use of available integrated or intersectoral services.⁴⁰ Effective advocacy needs to target the
24
25 326 policy-making levels in order to counteract the negative impacts of exclusionary policies.
26
27 327 Advocacy by health care providers can be influential at the institutional level to push for better
28
29 328 allocation of services and funding.³¹ A multipronged approach may be necessary to continue to
30
31 329 advocate for the right to health for refugees by addressing legal challenges, establishing timely
32
33 330 and accurate data and information systems to capture needs, creating health promoting
34
35 331 environments, investing in person-centred, culturally-appropriate and easily accessible services,
36
37 332 and evaluating coordination and service delivery efforts. Engaging policy makers in knowledge
38
39 333 translation and evidence-informed decision-making is one way to effectively advocate and
40
41 334 provide legislative support in refugee health. In Lebanon for example, where there are huge
42
43 335 demands in meeting the health needs of a large Syrian refugee population, researchers engaged
44
45 336 policy-makers in knowledge production (i.e. research priority-setting), translation and uptake
46
47 337 activities.⁴² This ultimately led to the hiring of a refugee health coordinator by the Lebanese
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49 338 Ministry of Public Health. The refugee health coordinator role functioned to support intersectoral
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3 339 collaboration, assisting in strategic planning and implementation of action plans to respond to the
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5 340 health needs of Syrian refugees including helping with the development of refugee health
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7 341 information systems at the Ministry of Public Health.⁴² The UCL-Lancet Commission on
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9
10 342 Migration and Health also supports knowledge translation by bringing together academics,
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12 343 policymakers, and health system experts to take an inter-disciplinary approach to reviewing
13
14 344 evidence, develop policy recommendations and disseminate these findings globally amongst
15
16 345 policymakers and institutions.⁴³
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19 346 **Alternative Models of Care to Reach Vulnerable Women and Children**

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21 347 Among the studies that reported targeted interventions for women and children, alternative
22
23 348 models of care were used. This included mobile health clinics, and programs linked to schools to
24
25 349 support screening and active case finding. These alternate models increased accessibility of
26
27 350 essential health services, increase detection of health conditions, and improve coordination of
28
29 351 care, and reduced feelings of social isolation.^{27,28} This suggests that flexible service delivery and
30
31 352 innovation in mode of delivery should be considered when attempting to reach at risk refugee
32
33 353 groups. Better collection and use of evidence on the needs of vulnerable refugee subgroups and
34
35 354 how to target them are essential next steps to design appropriate service delivery models.
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40 355 **Policy Insights**

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42 356 From the available evidence, the following are policy insights to inform greater integration of
43
44 357 services and/or intersectoral collaboration. These recommendations are based on consistent
45
46 358 facilitators and barriers identified across studies included in this review. They are critical starting
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48 359 points in enhancing programs to better serve refugees while promoting efficiency in health
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50 360 systems.
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3 361 1) Strengthening the coordination between existing programs through financing stronger
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5 362 referral systems and colocation of services
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- 8 363 2) Incentivizing health and social service authorities to establish and finance formal system
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10 364 navigator roles that connect all relevant services – provision of information technology
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12 365 tools can help support this function and better manage the network of available programs
13
14
- 15 366 3) Engaging host communities to enhance understanding, reduce stigma, and to create an
16
17 367 enabling environment for policies that protect refugees and their rights to social
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19 368 determinants of health
20
- 21 369 4) Communicating the availability of programs and services through cultural mediators and
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23
24 370 establishing formal translation and transport services to improve access
25
- 26 371 5) Establishing training and resources for providers to a) better understand the needs of
27
28 372 refugee communities, b) be aware of available and relevant services for referral across
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30
31 373 sectors, and c) more efficiently manage cases
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33 374 **Limitations and Future Directions**

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35 375 Our review was limited by the scarcity of evidence in this area. Due to this, all relevant studies
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37 376 were included, therefore, quality and rigor may vary. Some key programs and approaches may
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40 377 be missing due to interventions occurring at the individual level instead of at the systems level,
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42 378 as well as not having been published in academic literature. Individual health providers or
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45 379 organizations will navigate barriers in health systems through tacit and experiential knowledge
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47 380 that is often not documented. Data will be further amplified by conducting key informant
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49 381 interviews in selected countries.
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51 382 As others have noted, the literature on intersectoral collaboration disproportionately
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54 383 focuses on high-income countries.⁴⁴ It is therefore no surprise that the evidence for this review
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3 384 largely came from high-income countries with only two studies conducted in upper-middle
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5 385 income and two in low-income countries. This may affect the generalizability of the findings
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7 386 reported here as low-income and middle-income countries have greater coordination challenges
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9 387 to overcome due to fragmented systems and weak governance.⁴⁵ Additionally, according to the
10
11 388 latest report on the UN Refugee Agency, approximately 85% of refugees are hosted in
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13 389 developing nations.⁴⁶ More evidence and special consideration is needed in these contexts with
14
15 390 respect to refugee health, particularly for those most at risk subgroups such as women, children
16
17 391 and the elderly.

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21 392 Although there exists reaffirmed enthusiasm in intersectoral approaches to achieving
22
23 393 global health agendas such as the SDGs, it has been found that the lack of quality evidence
24
25 394 represents an essential hurdle to evidence-informed decision-making for the development of
26
27 395 cross-cutting policies and governance required for sustained intersectoral collaboration.⁴⁴ This
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29 396 pattern of a dearth of evidence was seen in our review. Additionally, most of what has been
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31 397 written has not been grounded in relevant theories or frameworks.⁴⁵ Our use of frameworks to
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33 398 structure our analysis is a step forward in addressing this issue. Generating high quality data in
34
35 399 health systems and policy research for migrant health and on intersectoral approaches has been
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37 400 identified as a research priority.^{44,47} Future research should therefore also consider the structured
38
39 401 evaluation of evidence through a frameworked approach.

402 **CONCLUSION**

403 Refugees experience individual, institutional, and system level obstacles when seeking health
404 care. To ensure adequate health services tailored to this vulnerable population, conducting
405 research and gathering quality evidence on integrated and intersectoral approaches is a top

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3 406 priority. This scoping review has highlighted important gaps in current knowledge and made
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5 407 suggestions for future research relevant to key themes.
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8 408 Our findings indicate that policies aiming at integrating services and fostering
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10 409 intersectoral action should consider system-level approaches such as the colocation of services,
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12 410 transportation support, and establishing system navigator roles. Communication challenges due
13
14 411 to language barriers should also be addressed with a view of providing culturally-sensitive
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16 412 programs. There is also a need to strengthen the capacities of frontline providers and managers,
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18 413 to improve their knowledge of available services as well as their ability to provide care to
19
20 414 specialized vulnerable groups such as refugees. Engaging host communities around a human
21
22 415 rights-focused strategy to the health of refugees is also fundamental to address discrimination
23
24 416 and stigma. Current gaps in knowledge found in our study represent an untapped potential for
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26 417 improvements to financial and human resource efficiency in health systems. Given the limited
27
28 418 evidence we found in our scoping review, the momentum for continued research should be
29
30 419 sustained.
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38 421 **ETHICS APPROVAL**

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40 422 Ethics approval was not required for this scoping review as human subjects are not involved.
41
42

43 423 **AUTHOR'S CONTRIBUTIONS**

44
45 424 GT together with librarians at Karolinska Institutet identified databases and planned the literature
46
47 425 search. SH & DJ drafted the paper and incorporated co-author feedback, SH & DJ abstracted data
48
49 426 from peer-reviewed literature. SC, EVL, GT and PF provided critical feedback and comments on
50
51 427 the manuscript. SC and SH acted as secondary reviewers.
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432 appropriate databases. We are also grateful to WHO Euro for their discussions and suggestions
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434 DATA AVAILABILITY STATEMENT

435 No data are available.

436 COMPETING INTERESTS

437 None.

438 FUNDING STATEMENT

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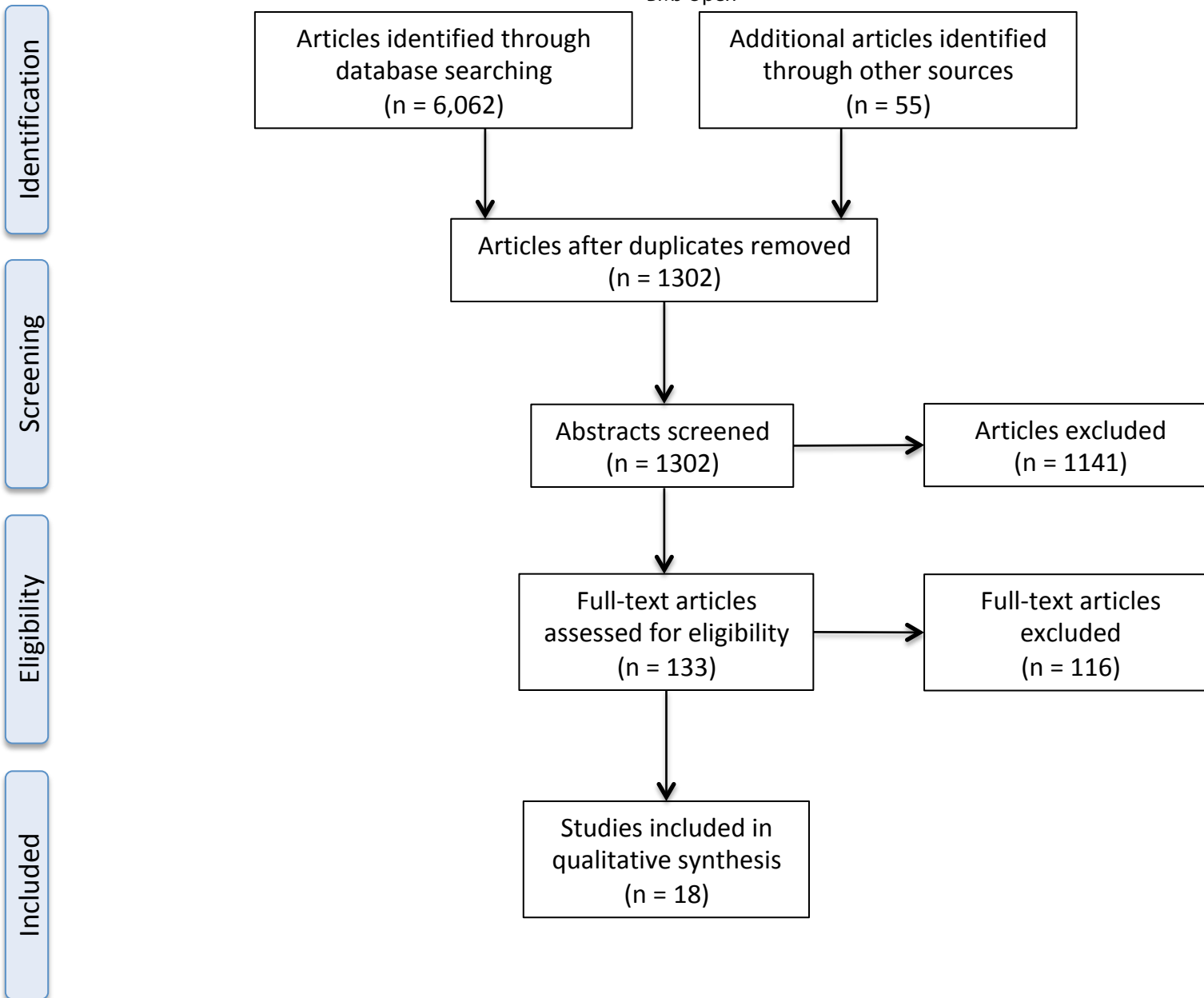
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556 **Figure Legend**

- 557 **Figure 1: Scoping Review Flowchart**
- 558 **Table 1: Summary of Included Studies**
- 559 **Table 2: Barriers and Facilitators Commonly Discussed Across Studies**
- 560 **Table 3: Enabling Strategies Present Across Studies**

For peer review only



1 APPENDIX I

2 1. Medline (Ovid)

3 Date of Search: 2016-11-03

4 Number of hits: 2019

5 Comments:

6 Field labels:

7 .tw,kf. = title, abstract, keyword

8 exp/ = MeSH, exploded

9 / = MeSH, not exploded

10 adj3 = within two words

11 1. Refugees/

12 2. exp "Emigrants and Immigrants"/

13 3. "Emigration and Immigration"/

14 4. "Transients and Migrants"/

15 5. (refugee* or immigra* or migrat* or migrant* or asylum* or transient*).tw,kf.

16 6. or/1-5

17 7. Delivery of Health Care/

18 8. Health Services Accessibility/

19 9. Patient Acceptance of Health Care/

20 10. "Health Services Needs and Demand"/

21 11. Quality of Health Care/

22 12. Interinstitutional Relations/

23 13. Interdepartmental Relations/

24 14. Public-Private Sector Partnerships/

25 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.

26 16. ((multisector* or multi-sector* or intersector* or inter-sector* or crossector* 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.

27 17. or/7-16

28 18. Healthcare Disparities/

29 19. Social Determinants of Health/

30 20. Health Status Disparities/

31 21. Health Equity/

32 22. exp Human Rights/

33 23. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).tw,kf.

34 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.

35 25. or/18-24

36 26. 6 and 17 and 25

37 27. Remove duplicates from 26

28. limit 27 to yr="2000 -Current"

2. Web of Science (Thomson Reuter)

Date of Search: 2016-11-03
 Number of hits: 1.166
 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*)

#7 #6 OR #5

#8 #7 AND #4 AND #1

#9 Timespan: 2000-2016.

8

3. Global Health (Ovid)

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

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*)).ti,ab.
10. or/8-9
11. exp disparity/
12. exp discrimination/
13. human rights/
14. ((health or health care or healthcare or health service*) adj3 (situation or difference*)).ti,ab.
15. (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.
16. or/11-15
17. 6 and 10 and 16
18. limit 17 to yr="2000 -Current"

9

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11

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.
18. or/13-17

19. 4 and 12 and 18
20. limit 19 to yr="2000 -Current"

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Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	p. 1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	p. 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	p. 5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	p. 5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	p. 2 Registered on Open Science Framework https://osf.io/gt9ck/
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	p. 6-7
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Supplementary File
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Supplementary File
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	p. 6-7
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	p. 8
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	p. 6-8
Critical appraisal	12	If done, provide a rationale for conducting a	p. 21



SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
of individual sources of evidence§		critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	p. 8
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	p. 9
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	p. 7-9
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	p. 21
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	p. 9-17, tables 1-3
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	p. 9-17; tables 1-3
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	p. 17-21
Limitations	20	Discuss the limitations of the scoping review process.	p. 21-22
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	p. 22-23
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	p. 24

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).



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3 From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-
4 ScR): Checklist and Explanation. Ann Intern Med. ;169:467–473. doi: 10.7326/M18-0850
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