BMJ Open

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

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2019-029407
Article Type:	Research
Date Submitted by the Author:	25-Jan-2019
Complete List of Authors:	Ho, Shirley; World Health Organization, Javadi, Dena; World Health Organization Causevic, Sara Langlois, Etienne V.; WHO Friberg, Peter; Medicine, Clinical Physiology Tomson, Göran ; Karolinska Institutet
Keywords:	intersectoral, right to health, access, refugees, integration, resettlement

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

Shirley Ho*[1] email: shirleyyingho@gmail.com
Dena Javadi [1] email: javadid@who.int
Sara Causevic[2,3] email: sara.causevic@ki.se
Etienne V. Langlois[1] email: langloise@who.int
Peter Friberg[2,5] email: peter.friberg@mednet.gu.se
Goran Tomson[2,4] email: Goran.Tomson@ki.se

[1] Alliance for Health Policy and Systems Research, World Health Organization, Avenue Appia 20, 1211 Geneva, Switzerland
[2] Swedish Institute for Global Health Transformation, SIGHT, Royal Swedish Academy of Science, Stockholm, Sweden
[3] Global and Sexual Health, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden
[4.] Medical Management Centre, Department of Learning, Informatics, Management, Ethics (LIME), Karolinska Institutet, Stockholm, Sweden
[5.] Institute of Medicine, Sahlgrenska Academy at Gothenburg university and Sahlgrenska university hospital

***Corresponding Author:**
Shirley Ho, shirleyyingho@gmail.com
Alliance for Health Policy and Systems Research, World Health Organization

Keywords: intersectoral, right to health, access, refugees, integration, resettlement

Word count: 4,115

ABSTRACT (300/300)

Background: Better understanding, documentation, and evaluation of different refugee health interventions, and their means of health system integration and intersectoral collaboration are needed

Objectives: Explore the barriers and facilitators to the integration of health services for refugees; the process and actors involved; and the extent to which intersectoral approaches are leveraged to protect refugees' right to health on resettlement

Design: Scoping Review

Methods: A search of articles from 2000 onward was done in MEDLINE, Web of Science, Global Health, and PsycInfo Embase. Two frameworks were applied in our analysis, the "Framework for analyzing integration of targeted health interventions in systems", and "Health in All Policies" framework for country action. A comprehensive description of the methods is included in our published protocol.

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

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

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

Strengths and limitations of this study

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

INTRODUCTION

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

be accessible, medically and culturally appropriate, available in adequate amount and quality, which includes having a trained health workforce, safe products and adequate sanitation.[2]

Different in definition from the term "migrant," "refugees" are those fleeing armed conflict or persecution as defined by the 1951 Refugee Convention which also identifies their basic rights, specifically that refugees should not be returned to situations that are deemed a threat to their life or freedom.[3] A key distinction is that refugee rights are not only a matter of national legislation, but also of international law.[4] Despite these legal protections, refugees face many challenges in accessing health services, especially more vulnerable groups like women and children.[5] Many states explicitly exclude refugees from the level of protection afforded to their citizens, instead choosing to offer "essential care" or "emergency health care," which is differentially defined across countries.[6] The Committee on the Elimination of Racial Discrimination, and the Committee on Economic, Social and Cultural Rights, both include general comments that hold States accountable to "the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services".[7] The increasing number of refugees over the past years makes the realization and protection of these rights both a legal, ethical and a logistical challenge.[5] In addition, the boundaries of the right to health have expanded due to increased understanding of social determinants of health and the health impacts of the lived environment.[8,9] Refugees face challenges in navigating health, legal, education, housing, social protection and employment services, which further threatens their quality of life and health status.[10] A lack of coordination and integration across these services undermines their effectiveness.[11]

Much like the shift from the more vertical approaches of the millennium development goals (MDGs) towards the more integrated SDGs, the protection of the right to health calls for an intersectoral approach whereby health is applied to all policies for all people.[12] Therefore, for states to effectively protect the right to health for refugees there is a need to work across sectors and disciplines to better integrate targeted programmes and initiatives, thereby improving standards of care during resettlement. Some evidence exists that supporting collaboration and coordination across social services for refugees improves the effectiveness and quality of care received.[10] Many fragmented psychosocial programmes exist across sectors to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability.[13,14] Better understanding, documentation, evaluation and reporting of the dynamic nature of different interventions, and their means of health system integration and intersectoral collaboration, are necessary to ensure that lessons learned are implemented in the design of future policies and programmes.

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

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

(2) What strategies are involved in addressing refugees' right to health upon resettlement?

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

METHODS

Study Design

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

Information sources and search strategy

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

Eligibility criteria

Population: Refugees as defined as per the 1951 Refugee Convention[3]

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

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

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

Exclusion criteria: Papers published in language other than English were excluded. Other categories of migrants were not included as their legal entitlements are different to those of refugees which are protected under international law. If the studies did not display some level of integration nor intersectorality, they were not assessed further.[20] Studies or commentaries that solely discuss theories and conceptual models were excluded. Implementation research and operations research studies were eligible as well as studies or reports outlining stakeholder experiences and plans.

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

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

Frameworks to address research questions

Two published frameworks were used in our analysis the first to understand integration of health services within health systems and the second to analyze intersectoral approaches to support these services. The first is a framework by Atun et al (2010)[21] for analyzing integration of targeted health interventions in health systems, where integration is defined as "the extent, pattern, and rate of adoption and eventual assimilation of health interventions into each of the critical functions of a health system".[21] Elements in this framework include (i) governance, (ii) financing, (iii) planning, (iv) service delivery, (v) monitoring and evaluation (M&E), and (vi) demand generation.[21] The framework for integration was also used to assess the process, and actors involved in integration.[20]

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

approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".[22] The HiAP framework for action involves six components including: i) establish the need and priorities for HiAP, ii) frame planned action, iii) identify supportive structures and policies, iv) facilitate assessment and engagement, v) ensure monitoring and evaluation, and vi) build capacity.[22] These six components, adapted to refugee needs, were used in the review to frame barriers and facilitators in integrating refugee services through intersectoral collaboration.

Data Abstraction

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

RESULTS

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

addressed mostly all genders and all age ranges with the exception of six that targeted vulnerable groups: two study on mothers and children;[23,24] one on the elderly;[25] one on students;[26] and two on women and girls.[27,28] Interventions targeting women and children in particular used alternative models of care such as mobile health clinics,[27,28] and school-based interventions.[23,26] Seven studies applied qualitative approaches (primarily in-depth interviews) for evaluation,[26–32] four studies used survey tools or standardized assessment tools;[24,25,33,34] four studies used descriptive and routine data;[23,35–37] and three studies were mainly descriptive analysis reporting on and looking at the outcomes of case examples and policies.[38–40]

Each of the interventions and summarized barriers and facilitators are described in Table 2. In terms of stakeholders involved, studies did not always report on the parties involved in governance, financing, planning, service delivery, monitoring and evaluation or demand generation (elements drawn from the integration framework by Atun et al (2010)[21]). Where they were mentioned, stakeholders responsible for governance of interventions addressing refugee health included primary care centres,[34,36] municipal government,[29,37] departments of social services and/or public health,[29,35] central services responsible for coordination of refugee services and provision of assistance to local services,[33,34] national governments,[30,31] and international bodies.[27] Stakeholders responsible for health financing included individual fundraising by service providers;[30,32] government,[29,30,34,37,40] and international bodies or donors.[27,35,36,40] Programme and policy planning stakeholders included national government,[30,37,40] departments of social services and/or public health,[26,29,35] central services responsible for coordination of refugee services and provision of assistance to local services,[28,33,34] researchers,[23,25,29,35,36] service providers,[26,27,34,36] and international bodies or donors.[27,35,40] Service delivery stakeholders included government departments of social services and/or public health,[26,29,32,35,37–40] networks

of local service providers in health, education, socialization, translation and/or employment,[23,30,33,35] healthcare providers,[26,32,34,36,37] central services responsible for coordination of refugee services and provision of assistance to local services,[31,33,34] community health workers,[25] and international bodies.[27,40] Stakeholders responsible for monitoring and evaluation were seldom explicitly mentioned. For demand generation, stakeholders included central services responsible for coordination of refugee services and provision of assistance to local services,[34] local media in the language of the target population,[35] community leaders and/or community health workers,[25,27,30,31] home health outreach services,[27,30] and healthcare providers.[32,36]

Enabling strategies to address refugee health identified in this review include establishing networks of service delivery through a combination of existing public and private services, establishing a system navigator role, engaging host communities to reduce stigma, ensuring availability of translation services, outreach, advocacy and legislative support, and appropriate funding models. Table 3 highlights the studies that address each of these strategies. In Italy for example, networks were promoted among private and public authorities and service providers, including health, employment, vocational training and continuing education services.[33] In this model, users move through the pathways of integration and can receive support for any combination of health needs, access to education, housing support, and legal assistance.[33] Collaborative design and delivery of services was also demonstrated in Australia with support from multidisciplinary, intersectoral teams, but a lack of funding presented barriers to success for this initiative.[26] Similarly in the USA, the "Bridge Project" faced funding barriers for coordination of care despite seeing promising results from use of a system navigator – or primary care nurse "bridge" – to coordinate primary care and mental health care services.[36] A network of

"gateway services" was also tested in Canada using a "Reception House" model.[34] These services are characterized by being person-centred, interprofessional, communication-focused, and comprehensive across the continuum of care.[34] Relationship-management between Reception House and health professionals, translation services, and social services is a key component for success.[34] Input from international medical graduates in training also supports this work by enhancing culturally appropriate service delivery by this network of partners.[34] Striking a balance between providing tailored, culturally-appropriate care and integrating health and social services for refugees into existing services in the host community can be especially challenging. Policy reviews suggest that taking a "one-policy, one-level, one-outcome" approach or focusing refugee management under one ministry is not sufficient in addressing the wide range of challenges that both host and refugee communities are facing as a result of the current political climate.[39,40] The Ethiopian government for example reorganized ministries to incorporate refugee management into existing portfolios rather than one refugee-specific one, moving refugee assistance programs out of camps and promoting more collaboration across government and non-governmental programs.[40]

Facilitators idenitified in implementing these strategies include strong communication of program availability, tools and training for providers, colocation of services, transportation services to enhance access, clear role definitions, interprofessional team and relationship management across providers, innovation in budget and financing, and coordinated refugee-specific policies.

Barriers articulated include lack of a participatory approach, poor communication leading to stigma and underuse of services, insufficient resources given to providers, absence of financing model, unclear roles and insufficient coordination of interprofessional teams,

exclusionary refugee policies, low availability and use of data, and turf wars across governance stakeholders. Table 4 highlights the studies that expand on these themes as barriers or facilitators.

DISCUSSION

The findings from the existing but scarce literature highlight that important factors in facilitating intersectoral collaboration and the successful integration of refugee services within existing health systems include: the coordination of existing public and private services, appropriate funding models, a systems navigator role, referral systems and colocation of services, advocacy and legislative support and alternate models of care for vultnerable women and children. These are discussed further below.

Coordination of Existing Public and Private Services

A networked approach to service delivery during the initial reception of refugees can often mitigate some of the challenges faced by refugee communities. Some examples of coordination of services were seen in Italy,[33] Australia,[26] the US,[36] and Canada.[34] In Canada where a network of "gateway services" was tested using the "Reception House" model it successfully provided responsive and culturally sensitive primary care.[34] By partnering community and translation services, as well as health care providers with the Reception House, it decreased wait times and improved health care access through referrals and coordination of services.[34]

Appropriate Funding Models for Integrated Services

This was not explicitly studied in the literature, however international bodies dealing with refugee care have previously been reluctant to invest their efforts in what is perceived as "unstable environments" created with integration.[40] Furthermore, a lack of data on the specific needs of refugee subgroups (such as women and children) once the delivery of care is integrated

may mean that they are not sufficiently prioritized in local strategic health goals.[30] Where needs and special services are not prioritized, financing is not provided for more innovative structures within existing primary care or social systems which threaten their sustainability. It is therefore necessary for planners, implementers and evaluators of integrated health and social services to understand the different needs of their host and refugee community users clearly and to ensure that an investment case is made for the bolstered services such as system navigation, translation, provider training, outreach or colocation.[36]

System Navigator Role

Integration works through establishing relationships across networks of local stakeholders and service providers. To coordinate this effectively, a system navigator role can be established – the evidence suggests that this role is most effective in the early stage of resettlement.[34] The system navigation role can be played by an organization or by people within the existing health or social systems. It connects incoming refugees to timely, culturally-appropriate care in the community without creating parallel structures that either threaten host communities or further stigmatize refugees.[29,34] This is further strengthened when providers have access to the knowledge, tools and training needed to address the specific needs of refugees, including the more vulnerable (e.g., the elderly, women, and children). Providers should understand the context in which they work and the available features and services, user needs, and legislation as it relates to refugees.[33] Those playing a coordination or system navigation role should also be able to build strong networks with allied specialists, identify appropriate resources and reach out to users.[33,34] The challenge here however is that integrating refugee care may eliminate some determination procedures, potentially undermining the protection mandate and underestimate the tailored needs of refugees dealing with significant trauma.[40]

Advocacy and Legislative Support

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

recommendations and disseminate these findings globally amongst policymakers and institutions.[42]

Alternative Models of Care to Reach Vulnerable Women and Children

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

Limitations and Future Directions

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

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

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

Although there exists reaffirmed enthusiasm in intersectoral approaches to achieving global health agendas such as the SDGs, it has been found that the lack of quality evidence represents a key barrier to evidence-informed decision-making for the development of cross-cutting policies and governance required for sustained intersectoral collaboration.[43] Most of what has been written have not been grounded in relevant theories or frameworks.[44] This pattern of a dearth of evidence was seen in our review, while the challenges in meeting the health needs of refugees are well documented, paradoxically we found little research on effective intersectoral and integrated approaches in meeting these needs. Our use of the combined frameworks is a step forward in addressing the gap in this essential evidence base. Current gaps in knowledge represents an untapped potential for improvements to financial and human resource efficiency in health systems. Generating high quality data in health systems and policy research for migrant health and on intersectoral approaches to health has been identified as a research priority.[43,46] Given the limited evidence we found in our scoping review the momentum for continued research should be sustained.

CONCLUSION

Refugees face individual, instititutional, and system level barriers in access to health care and to provide adequate health services to this vulnerable population, gathering more evidence on effective integrated and intersectoral approaches is a priority. This scoping review has highlighted an important gap in the evidence on integration of services and intersectoral approaches in serving vulnerable refugee populations.

From the available evidence, the following are key policy insights and enablers towards greater integration of services and/or inter-sectoral collaboration:

1) Improving coordination between existing programmes through financing stronger data and referral systems, supporting colocation of services, and formalizing system navigator positions to manage coordination activities
2) Incentivizing health and social service authorities to establish formal system navigator roles that connect all relevant services – provision of information technology tools can help support this function and better manage the network of available programmes
3) Engaging host communities to enhance understanding, to reduce stigma, and to create an enabling environment for policies that protect refugees and their rights to social determinants of health
4) Communicating the availability of programmes and services through cultural mediators and establishing formal translation and transport services to improve access
5) Establishing training and resources for providers to a) better understand the needs of refugee communities, b) be aware of available and relevant services for referral across sectors, and c) more efficiently manage cases.

These recommendations are based on consistent facilitators and barriers identified across studies included in this review. They form critical starting points in leveraging integrated services and/or intersectoral approaches to better serve refugees while promoting efficiency in health systems.

ETHICS APPROVAL

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

AUTHOR'S CONTRIBUTIONS

GT together with librarians at Karolinska Institutet identified databases and planned the literature search. SH & DJ drafted the paper and incorporated co-author feedback, SH & DJ abstracted data from peer-reviewed literature. SC, EVL, GT and PF provided critical feedback and comments on the manuscript. SC and SH acted as secondary reviewers.

ACKNOWLEDGMENTS

The authors would like to thank Karolinska Institutet librarians, Magdalena Svanberg and Gun Brit Knutssön, for their contributions, specifically in running the search and identifying appropriate databases. We are also grateful to WHO Euro for their discussions and suggestions in the early stages of this project.

COMPETING INTERESTS

None.

FUNDING STATEMENT

No funding was obtained for this project. In-kind time contributions from staff at the Alliance for Health Policy and Systems Research and SIGHT have made this possible.

REFERENCES

1 OHCHR. The Right to Health. Geneva, Switzerland, 2008.

2 Tangcharoensathien V, Mills A, Palu T. Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. *BMC Med* 2015; **13**: 101.

3 UNHCR. Convention and Protocol relating to the status of refugees. Geneva, Switzerland, 2010.

4 UNHCR. UNHCR viewpoint: 'Refugee' or 'migrant' – Which is right? Geneva, Switzerland, 2016.

5 Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. *Lancet* 2013; **381**: 1235–45.

6 Council for the EU. Council Directive 2003/9/EC of 27 January 2003 Laying Down Minimum Standards for the Reception of Asylum Seekers in Member States. *Off J Eur Union 2003* 2003; : L 31/18.

7 OHCHR. General Recommendation 30. Discrimination against non-citizens. Geneva, Switzerland, 2004.

8 Jackson-Bowers, Eleanor, Cheng I-H. Meeting the primary health care needs of refugees and asylum seekers. *Res Roundup* 2010.

9 WHO. Advancing the right to health: the vital role of law. Geneva, Switzerland, 2017.

10 Joshi C, Russell G, Cheng I-H, *et al.* A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *Int J Equity Health* 2013; **12**: 88.

11 Citizenship AGD of I and. Fact sheet 60 - Australia's refugee and humanitarian program. 2012.

12 UN. Integrated Approaches to Sustainable Development Planning and Implementation. New York, USA, 2015.

13 Kett ME. Internally Displaced Peoples in Bosnia-Herzegovina: Impacts of Long-term Displacement on Health and Well-being. *Med Confl Surviv* 2005; **21**: 199–215.

14 Patel N, Kellezi B, Williams AC de C. Psychological, social and welfare interventions for psychological health and well-being of torture survivors. *Cochrane Database Syst Rev* 2014; published online Nov 11. DOI:10.1002/14651858.CD009317.pub2.

15 Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc*

Res Methodol 2005; **8**: 19–32.

16 Tricco AC, Lillie E, Zarin W, *et al.* A scoping review on the conduct and reporting of scoping reviews. *BMC Med Res Methodol* 2016; **16**: 15.

17 Peters MDJ, Godfrey CM, Khalil H, McInerney P, Parker D, Baldini Soares C. The Joanna Briggs Institute Reviewers' Manual: Methodology for JBI Scoping Review. Adelaide, Australia, 2015.

18 Center for Open Science. Open Science Framework. https://osf.io/.

19 Javadi D, Langlois E V., Ho S, Friberg P, Tomson G. Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: a scoping review protocol. *BMJ Open* 2017; **7**. DOI:10.1136/bmjopen-2017-016638.

20 Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy Plan* 2008; **23**: 308–17.

21 Atun R, de Jongh T, Secci F, Ohiri K, Adeyi O. Integration of targeted health interventions into health systems: a conceptual framework for analysis. *Health Policy Plan* 2010; **25**: 104–11.

22 WHO. Health in All Policies: Framework for Country Action. Geneva, Switzerland, 2014.

23 McNaughton DB, Hindin P, Guerrero Y. Directions for Refining a School Nursing Intervention for Mexican Immigrant Families. *J Sch Nurs* 2010; **26**: 430–5.

24 Cowell JM, McNaughton D, Ailey S, Gross D, Fogg L. Clinical Trial Outcomes of the Mexican American Problem Solving Program (MAPS). *Hisp Heal Care Int* 2009; **7**: 178–89.

25 Verhagen I, Ros WJ, Steunenberg B, de Wit NJ. Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention programme in the Netherlands. *BMC Public Health* 2013; **13**: 227.

26 Woodland L, Kang M, Elliot C, Perry A, Eagar S, Zwi K. Evaluation of a school screening programme for young people from refugee backgrounds. *J Paediatr Child Health* 2016; **52**: 72–9.

27 Lilleston P, Winograd L, Ahmed S, *et al.* Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon. *Health Policy Plan* 2018; published online June 13. DOI:10.1093/heapol/czy050.

28 Guruge S, Hunter J, Barker K, McNally MJ, Magalhães L. Immigrant women's

experiences of receiving care in a mobile health clinic. *J Adv Nurs* 2010; **66**: 350–9.

29 Calvo R, Rojas V, Waters MC. The Effect of Universal Service Delivery on the Integration of Moroccan Immigrants in Spain: A Case Study from an Anti-Oppressive Perspective. *Br J Soc Work* 2014; **44**: i123–39.

30 Mortensen A. Public health system responsiveness to refugee groups in New Zealand: activation from the bottom up. *Soc Policy J New Zeal* 2011.

31 Stewart M, Anderson J, Beiser M, *et al.* Multicultural Meanings of Social Support among Immigrants and Refugees. *Int Migr* 2008; **46**: 123–59.

32 MacFarlane A, Singleton C, Green E. Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England. *Health Policy (New York)* 2009; **92**: 203–10.

33 Catarci M. Conceptions and Strategies for User Integration across Refugee Services in Italy. *J Educ Cult Psychol Stud* 2012.

34 McMurray J, Breward K, Breward M, Alder R, Arya N. Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada. *J Immigr Minor Heal* 2014; **16**: 576–85.

35 Kim MJ, Cho H-I, Cheon-Klessig YS, Gerace LM, Camilleri DD. Primary health care for Korean immigrants: sustaining a culturally sensitive model. *Public Health Nurs* 2002; **19**: 191–200.

36 Yeung A, Kung WW, Chung H, *et al.* Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *Gen Hosp Psychiatry* 2004; **26**: 256–60.

37 Geltman PL, Cochran J. A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees. *Am J Public Health* 2005; **95**: 196–9.

38 Woodland L, Burgner D, Paxton G, Zwi K. Health service delivery for newly arrived refugee children: A framework for good practice. *J Paediatr Child Health* 2010; **46**: 560–7.

39 Philbin MM, Flake M, Hatzenbuehler ML, Hirsch JS. State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Soc Sci Med* 2018; **199**: 29–38.

40 Tuepker A, Chi C. Evaluating integrated healthcare for refugees and hosts in an African context. *Heal Econ Policy Law* 2009; **4**: 159.

41 Langlois E V., Daniels K, Akl EA. Evidence synthesis for health policy and systems: a

methods guide. Geneva, Switzerland, 2018.

42 The UCL-Lancet Commission on Migration and Health. UCL-Lancet Commission on Migration and Health. 2018.

43 Glandon D, Meghani A, Jessani N, Qiu M, Bennett S. Identifying health policy and systems research priorities on multisectoral collaboration for health in low-income and middle-income countries. *BMJ Glob Heal* 2018; **3**: e000970.

44 Bennett S, Glandon D, Rasanathan K. Governing multisectoral action for health in low-income and middle-income countries: unpacking the problem and rising to the challenge. *BMJ Glob Heal* 2018; **3**: e000880.

45 UNHCR. Global Trends Forced Displacement in 2017. Geneva, Switzerland, 2018 https://www.unhcr.org/5b27be547.pdf.

46 Abubakar I, Aldridge RW, Devakumar D, *et al.* The UCL–Lancet Commission on Migration and Health: the health of a world on the move. *Lancet* 2018; **392**: 2606–54.

APPENDIX I

1. Medline (Ovid)

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

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

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

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.

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"

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"

Figure 1. Review Flowchart

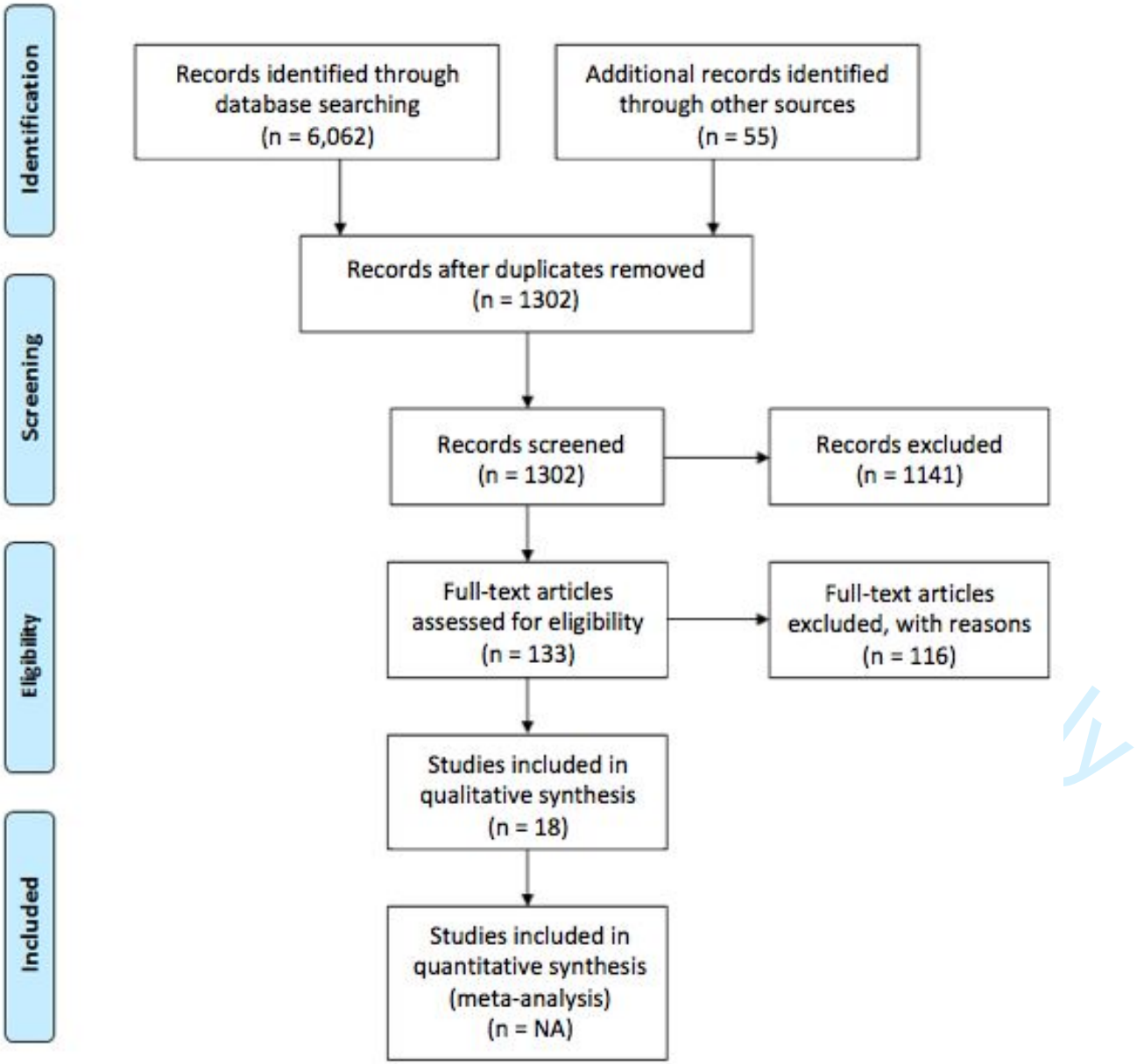


Table 1. Countries represented in Included Studies

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 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
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

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
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
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
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
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

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
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
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
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
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
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

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
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
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

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

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

BMJ Open

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

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2019-029407.R1
Article Type:	Research
Date Submitted by the Author:	19-Mar-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

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

Shirley Ho*[1] email: shirley.ho@jhu.edu
Dena Javadi [1] email: javadid@who.int
Sara Causevic[2,3] email: sara.causevic@ki.se
Etienne V. Langlois[1] email: langloise@who.int
Peter Friberg[2,5] email: peter.friberg@mednet.gu.se
Goran Tomson[2,4] email: goran.tomson@ki.se

[1] Alliance for Health Policy and Systems Research, World Health Organization, Avenue Appia 20, 1211 Geneva, Switzerland
[2] Swedish Institute for Global Health Transformation, SIGHT, Royal Swedish Academy of Science, Stockholm, Sweden
[3] Global and Sexual Health, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden
[4.] Medical Management Centre, Department of Learning, Informatics, Management, Ethics (LIME), Karolinska Institutet, Stockholm, Sweden
[5.] Institute of Medicine, Sahlgrenska Academy at Gothenburg University and Sahlgrenska University Hospital

***Corresponding Author:**
Shirley Ho, shirley.ho@jhu.edu
Alliance for Health Policy and Systems Research, World Health Organization

Keywords: intersectoral, right to health, access, refugees, integration, resettlement

Word count: 3,989

ABSTRACT (285/300)

Background: Better understanding, documentation, and evaluation of different refugee health interventions, and their means of health system integration and intersectoral collaboration are needed

Objectives: Explore the barriers and facilitators to the integration of health services for refugees; the processes involved; and the different stakeholders engaged in levaraging intersectoral approaches to protect refugees' right to health on resettlement

Design: Scoping review

Methods: A search of articles from 2000 onward was done in MEDLINE, Web of Science, Global Health, and PsycInfo Embase. Two frameworks were applied in our analysis, the "Framework for analyzing integration of targeted health interventions in systems", and "Health in All Policies" framework for country action. A comprehensive description of the methods is included in our published protocol.

Results: 6,117 papers were identified, only 18 studies met the inclusion criteria. Facilitators in implementation included: training for providers; colocation of services; transportation services to enhance access; clear role definitions; and appropriate budget allocation and financing. Barriers included: lack of a participatory approach; insufficient resources for providers; absence of financing; unclear roles and insufficient coordination of interprofessional teams; low availability and use of data; and turf wars across governance stakeholders. Successful strategies to address refugee health included: networks of service delivery combining existing public and private services; system navigators; host community engagement to reduce stigma; translation services; legislative support; and alternative models of care for women and children.

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

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

Strengths and limitations of this study

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

INTRODUCTION

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

be accessible, medically and culturally appropriate, available in adequate amount and quality, which includes having a trained health workforce, safe products and sanitation.[2]

"Refugees" are individuals fleeing armed conflict or persecution as defined by the 1951 Refugee Convention which also identifies their basic rights, specifically that refugees should not be returned to situations that are deemed a threat to their life or freedom.[3] A key distinction of refugee rights is that they are not only a matter of national legislation, but also of international law.[4] Despite these legal protections, refugees face many challenges in accessing health services, especially more vulnerable groups like women and children.[5] Many states explicitly exclude refugees from the level of protection afforded to their citizens, instead choosing to offer "essential care" or "emergency health care," which is differentially defined across countries.[6] The Committee on the Elimination of Racial Discrimination, and the Committee on Economic, Social and Cultural Rights, both include general statements that hold States accountable to "the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services".[7] The increasing number of refugees over the past years makes the realization and protection of these rights both a legal, ethical and a logistical challenge.[5] In addition, the boundaries of the right to health have expanded due to increased understanding of social determinants of health and the health impacts of the lived environment.[8,9] Refugees face challenges in navigating health, legal, education, housing, social protection and employment services, which further threatens their quality of life and health status.[10] Therefore, a lack of coordination and integration across these services undermines their effectiveness.[11]

Much like the shift from the more vertical approaches of the millennium development goals (MDGs) towards the more integrated SDGs, the protection of the right to health calls for an

intersectoral approach whereby health is applied to all policies for all people.[12] As such, for states to effectively protect the right to health for refugees there is a need to work across sectors and disciplines to better integrate targeted programs and initiatives, thereby improving standards of care during resettlement. Some evidence exists that supporting collaboration and coordination across social services for refugees improves the effectiveness and quality of care received.[10] Many fragmented psychosocial programs exist across sectors to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability.[13,14] Better understanding, documentation, evaluation and reporting of the dynamic nature of different interventions, and their means of health system integration and intersectoral collaboration, are necessary to ensure that lessons learned are implemented in the design of future policies and programs.

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

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

(2) What strategies are involved in addressing refugees' right to health upon resettlement?

(3) Which stakeholders are involved in leveraging intersectoral approaches to protect refugees' right to health?

METHODS

Study Design

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

Information Sources and Search Strategy

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

Eligibility Criteria

Population: Refugees as defined by the 1951 Refugee Convention[3]

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

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

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

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

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

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

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

Frameworks to Address Research Questions

Two published frameworks were used in our analysis to understand integration of health services within health systems and to analyze intersectoral approaches to support these services. The first framework by Atun et al (2010)[21], is a tool for analyzing integration of targeted health interventions in health systems, where integration is defined as "the extent, pattern, and rate of adoption and eventual assimilation of health interventions into each of the critical functions of a health system".[21] The framework for integration was also used to assess the process, and actors involved in integration.[20]

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

account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".[22] Components of this framework, adapted to refugee needs, were used in the review to frame barriers and facilitators in integrating refugee services through intersectoral collaboration.

Data Abstraction

A data abstraction chart was developed based on the two frameworks used in this study. The chart was tested by two researchers and revised as appropriate. The revised chart was used by the same researchers to abstract descriptive and qualitative data as relevant to the elements of the frameworks used. Elements included in the chart were: intervention description; barriers and facilitators; contextual details; target population; type of evaluation; outcomes; stakeholder involvement in governance, financing, planning, service delivery, monitoring and evaluation, and engagement. Deductive reasoning was used to identify barriers and facilitators in intersectoral collaboration for refugee health. Open coding was applied to visualize themes across interventions as well as barriers and facilitators.[23] Axial coding was applied to then draw connections to enabling strategies for intersectoral collaboration.[23] General conclusions were drawn based on these themes, leading to suggestions for strengthening programs and policies.

Patient and Public Involvement

There was no patient or public involvement required in conducting this scoping review.

RESULTS

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

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

Catarci[34]	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[25]	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
Geltman et al[38]	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
Guruge et al[29]	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
Kim et al[36]	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

Lilleston et al[28]	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 al[33]	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 al[35]	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 al[24]	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
Mortensen[31]	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

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
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
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
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
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

Woodland et al[39]	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
Yeung et al[37]	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

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

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

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

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]	

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

authorities and service providers, including health, employment, vocational training and continuing education services.[34] In this model, users moved through the pathways of integration and can receive support for any combination of health needs, access to education, housing support, and legal assistance.[34] Collaborative design and delivery of services was also demonstrated in Australia with support from multidisciplinary, intersectoral teams, but a lack of funding presented barriers to the potential success of this initiative.[27] Similarly in the USA, the "Bridge Project" faced insufficient funding in the coordination of care despite seeing promising results from use of a system navigator – or primary care nurse "bridge" – to connect primary care and mental health care services.[37] A network of "gateway services" was also tested in Canada using a "Reception House" model.[35] These services are characterized by being person-centred, interprofessional, communication-focused, and comprehensive across the continuum of care.[35] Relationship-management between the Reception House, health professionals, translation services, and social services was acknowledge as a key component for success.[35] Input from international medical graduates in training also supported this work by enhancing culturally appropriate service delivery by this network of partners.[35]

Striking a balance between providing tailored, culturally-appropriate care and integrating health and social services for refugees into existing services in the host community can be especially challenging. Policy reviews suggest that taking a "one-policy, one-level, one-outcome" approach or focusing refugee management under one ministry is not sufficient in addressing the wide range of obstacles that both host and refugee communities are facing as a result of the current political climate.[40,41] The Ethiopian government for example had success in reorganizing ministries to incorporate refugee management into existing portfolios rather than a

refugee-specific one, moving refugee assistance programs out of camps and promoting more collaboration across government and non-governmental programs.[41]

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]						

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

fundraising by service providers,[31,33] government,[30,31,35,38,41] and international bodies or donors.[28,36,37,41] Program and policy planning stakeholders encompassed national governments,[31,38,41] departments of social services and/or public health,[27,30,36] central services responsible for coordination of refugee services and provision of assistance to local services,[29,34,35] researchers,[24,26,30,36,37] service providers,[27,28,35,37] and international bodies or donors.[28,36,41] Service delivery stakeholders included national departments of social services and/or public health,[27,30,33,36,38–41] networks of local service providers in health, education, socialization, translation and/or employment,[24,31,34,36] healthcare providers,[27,33,35,37,38] central services responsible for coordination of refugee services and provision of assistance to local services,[32,34,35] community health workers,[26] and international bodies.[28,41] Stakeholders responsible for monitoring and evaluation were seldom explicitly mentioned. For demand generation, stakeholders included central services responsible for the coordination of refugee services and provision of assistance to local services,[35] local media in the language of the target population,[36] community leaders and/or community health workers,[26,28,31,32] home health outreach services,[28,31] and healthcare providers.[33,37]

DISCUSSION

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

Coordination of Existing Public and Private Services

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

Introduction of a System Navigator Role

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

system navigation role should also be able to build strong networks with allied specialists, identify appropriate resources and reach out to users.[34,35] The risk here however is that integrating refugee care may eliminate some determination procedures, potentially undermining the protection mandate and underestimate the tailored needs of refugees dealing with significant trauma.[41] Future research on the required competencies of the system navigator role is required to ensure that appropriate professionals are recruited and trained.

Advocacy and Legislative Support

Exclusionary immigration policies can play a considerable role in marginalization and discrimination against refugee communities leading to decreased health seeking behaviors and use of available integrated or intersectoral services.[40] Effective advocacy needs to target the policy-making levels in order to counteract the negative impacts of exclusionary policies. Advocacy by health care providers can be influential at the institutional level to push for better allocation of services and funding.[31] A multipronged approach may be necessary to continue to advocate for the right to health for refugees by addressing legal challenges, establishing timely and accurate data and information systems to capture needs, creating health promoting environments, investing in person-centred, culturally-appropriate and easily accessible services, and evaluating coordination and service delivery efforts. Engaging policy makers in knowledge translation and evidence-informed decision-making is one way to effectively advocate and provide legislative support in refugee health. In Lebanon for example, where there are huge demands in meeting the health needs of a large Syrian refugee population, researchers engaged policy-makers in knowledge production (i.e. research priority-setting), translation and uptake activities.[42] This ultimately led to the hiring of a refugee health coordinator by the Lebanese Ministry of Public Health. The refugee health coordinator role functioned to support intersectoral

collaboration, assisting in strategic planning and implementation of action plans to respond to the health needs of Syrian refugees including helping with the development of refugee health information systems at the Ministry of Public Health.[42] The UCL-Lancet Commission on Migration and Health also supports knowledge translation by bringing together academics, policymakers, and health system experts to take an inter-disciplinary approach to reviewing evidence, develop policy recommendations and disseminate these findings globally amongst policymakers and institutions.[43]

Alternative Models of Care to Reach Vulnerable Women and Children

Among the studies that reported targeted interventions for women and children, alternative models of care were used. This included mobile health clinics, and programs linked to schools to support screening and active case finding. These alternate models increased accessibility of essential health services, increase detection of health conditions, and improve coordination of care, and reduced feelings of social isolation.[27,28] This suggests that flexible service delivery and innovation in mode of delivery should be considered when attempting to reach at risk refugee groups. Better collection and use of evidence on the needs of vulnerable refugee subgroups and how to target them are essential next steps to design appropriate service delivery models.

Policy Insights

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

1) Strengthening the coordination between existing programs through financing stronger referral systems and colocation of services
2) Incentivizing health and social service authorities to establish and finance formal system navigator roles that connect all relevant services – provision of information technology tools can help support this function and better manage the network of available programs
3) Engaging host communities to enhance understanding, reduce stigma, and to create an enabling environment for policies that protect refugees and their rights to social determinants of health
4) Communicating the availability of programs and services through cultural mediators and establishing formal translation and transport services to improve access
5) Establishing training and resources for providers to a) better understand the needs of refugee communities, b) be aware of available and relevant services for referral across sectors, and c) more efficiently manage cases

Limitations and Future Directions

Our review was limited by the scarcity of evidence in this area. Due to this, all relevant studies were included, therefore, quality and rigor may vary. Some key programs and approaches may be missing due to interventions occurring at the individual level instead of at the systems level, as well as not having been published in academic literature**.** Individual health providers or organizations will navigate barriers in health systems through tacit and experiential knowledge that is often not documented. Data will be further amplified by conducting key informant interviews in selected countries.

As others have noted, the literature on intersectoral collaboration disproportionately focuses on high-income countries.[44] It is therefore no surprise that the evidence for this review

largely came from high-income countries with only two studies conducted in upper-middle income and two in low-income countries. This may affect the generalizability of the findings reported here as low-income and middle-income countries have greater coordination challenges to overcome due to fragmented systems and weak governance.[45] Additionally, according to the latest report on the UN Refugee Agency, approximately 85% of refugees are hosted in developing nations.[46] More evidence and special consideration is needed in these contexts with respect to refugee health, particularly for those most at risk subgroups such as women, children and the elderly.

Although there exists reaffirmed enthusiasm in intersectoral approaches to achieving global health agendas such as the SDGs, it has been found that the lack of quality evidence represents an essential hurdle to evidence-informed decision-making for the development of cross-cutting policies and governance required for sustained intersectoral collaboration.[44] This pattern of a dearth of evidence was seen in our review. Additionally, most of what has been written has not been grounded in relevant theories or frameworks.[45] Our use of frameworks to structure our analysis is a step forward in addressing this issue. Generating high quality data in health systems and policy research for migrant health and on intersectoral approaches has been identified as a research priority.[44,47] Future research should therefore also consider the structured evaluation of evidence through a frameworked approach.

CONCLUSION

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

priority. This scoping review has highlighted important gaps in current knowledge and made suggestions for future research relevant to key themes.

Our findings indicate that policies aiming at integrating services and fostering intersectoral action should consider system-level approaches such as the colocation of services, transportation support, and establishing system navigator roles. Communication challenges due to language barriers should also be addressed with a view of providing culturally-sensitive programs. There is also a need to strengthen the capacities of frontline providers and managers, to improve their knowledge of available services as well as their ability to provide care to specialized vulnerable groups such as refugees. Engaging host communities around a human rights-focused strategy to the health of refugees is also fundamental to address discrimination and stigma. Current gaps in knowledge found in our study represent an untapped potential for improvements to financial and human resource efficiency in health systems. Given the limited evidence we found in our scoping review, the momentum for continued research should be sustained.

ETHICS APPROVAL

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

AUTHOR'S CONTRIBUTIONS

GT together with librarians at Karolinska Institutet identified databases and planned the literature search. SH & DJ drafted the paper and incorporated co-author feedback, SH & DJ abstracted data from peer-reviewed literature. SC, EVL, GT and PF provided critical feedback and comments on the manuscript. SC and SH acted as secondary reviewers.

ACKNOWLEDGMENTS

The authors would like to thank Karolinska Institutet librarians, Magdalena Svanberg and Gun Brit Knutssön, for their contributions, specifically in running the search and identifying appropriate databases. We are also grateful to WHO Euro for their discussions and suggestions in the early stages of this project.

DATA AVAILABILITY STATEMENT

No data are available.

COMPETING INTERESTS

None.

FUNDING STATEMENT

No funding was obtained for this project. In-kind time contributions from staff at the Alliance for Health Policy and Systems Research and SIGHT have made this possible.

REFERENCES

1 OHCHR. The Right to Health. Geneva, Switzerland, 2008.
2 Tangcharoensathien V, Mills A, Palu T. Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. *BMC Med* 2015; **13**: 101.
3 UNHCR. Convention and Protocol relating to the status of refugees. Geneva, Switzerland, 2010.
4 UNHCR. UNHCR viewpoint: 'Refugee' or 'migrant' – Which is right? Geneva, Switzerland, 2016.
5 Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. *Lancet* 2013; **381**: 1235–45.
6 Council for the EU. Council Directive 2003/9/EC of 27 January 2003 Laying Down Minimum Standards for the Reception of Asylum Seekers in Member States. *Off J Eur Union 2003* 2003; : L 31/18.
7 OHCHR. General Recommendation 30. Discrimination against non-citizens. Geneva, Switzerland, 2004.
8 Jackson-Bowers, Eleanor, Cheng I-H. Meeting the primary health care needs of refugees and asylum seekers. *Res Roundup* 2010.
9 WHO. Advancing the right to health: the vital role of law. Geneva, Switzerland, 2017.
10 Joshi C, Russell G, Cheng I-H, *et al.* A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *Int J Equity Health* 2013; **12**: 88.
11 Citizenship AGD of I and. Fact sheet 60 - Australia's refugee and humanitarian program. 2012.

12 UN. Integrated Approaches to Sustainable Development Planning and Implementation. New York, USA, 2015.

13 Kett ME. Internally Displaced Peoples in Bosnia-Herzegovina: Impacts of Long-term Displacement on Health and Well-being. *Med Confl Surviv* 2005; **21**: 199–215.

14 Patel N, Kellezi B, Williams AC de C. Psychological, social and welfare interventions for psychological health and well-being of torture survivors. *Cochrane Database Syst Rev* 2014; published online Nov 11. DOI:10.1002/14651858.CD009317.pub2.

15 Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005; **8**: 19–32.

16 Tricco AC, Lillie E, Zarin W, *et al.* A scoping review on the conduct and reporting of scoping reviews. *BMC Med Res Methodol* 2016; **16**: 15.

17 Peters MDJ, Godfrey CM, Khalil H, McInerney P, Parker D, Baldini Soares C. The Joanna Briggs Institute Reviewers' Manual: Methodology for JBI Scoping Review. Adelaide, Australia, 2015.

18 Center for Open Science. Open Science Framework. https://osf.io/.

19 Javadi D, Langlois E V., Ho S, Friberg P, Tomson G. Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: a scoping review protocol. *BMJ Open* 2017; **7**. DOI:10.1136/bmjopen-2017-016638.

20 Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy Plan* 2008; **23**: 308–17.

21 Atun R, de Jongh T, Secci F, Ohiri K, Adeyi O. Integration of targeted health interventions into health systems: a conceptual framework for analysis. *Health Policy Plan* 2010; **25**: 104–11.

22 WHO. Health in All Policies: Framework for Country Action. Geneva, Switzerland, 2014.

23 Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol* 2008; **8**: 45.

24 McNaughton DB, Hindin P, Guerrero Y. Directions for Refining a School Nursing Intervention for Mexican Immigrant Families. *J Sch Nurs* 2010; **26**: 430–5.

25 Cowell JM, McNaughton D, Ailey S, Gross D, Fogg L. Clinical Trial Outcomes of the Mexican American Problem Solving Program (MAPS). *Hisp Heal Care Int* 2009; **7**: 178–89.

26 Verhagen I, Ros WJ, Steunenberg B, de Wit NJ. Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention programme in the Netherlands. *BMC Public Health* 2013; **13**: 227.

27 Woodland L, Kang M, Elliot C, Perry A, Eagar S, Zwi K. Evaluation of a school screening programme for young people from refugee backgrounds. *J Paediatr Child Health* 2016; **52**: 72–9.

28 Lilleston P, Winograd L, Ahmed S, *et al.* Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon. *Health Policy Plan* 2018; published online June 13. DOI:10.1093/heapol/czy050.

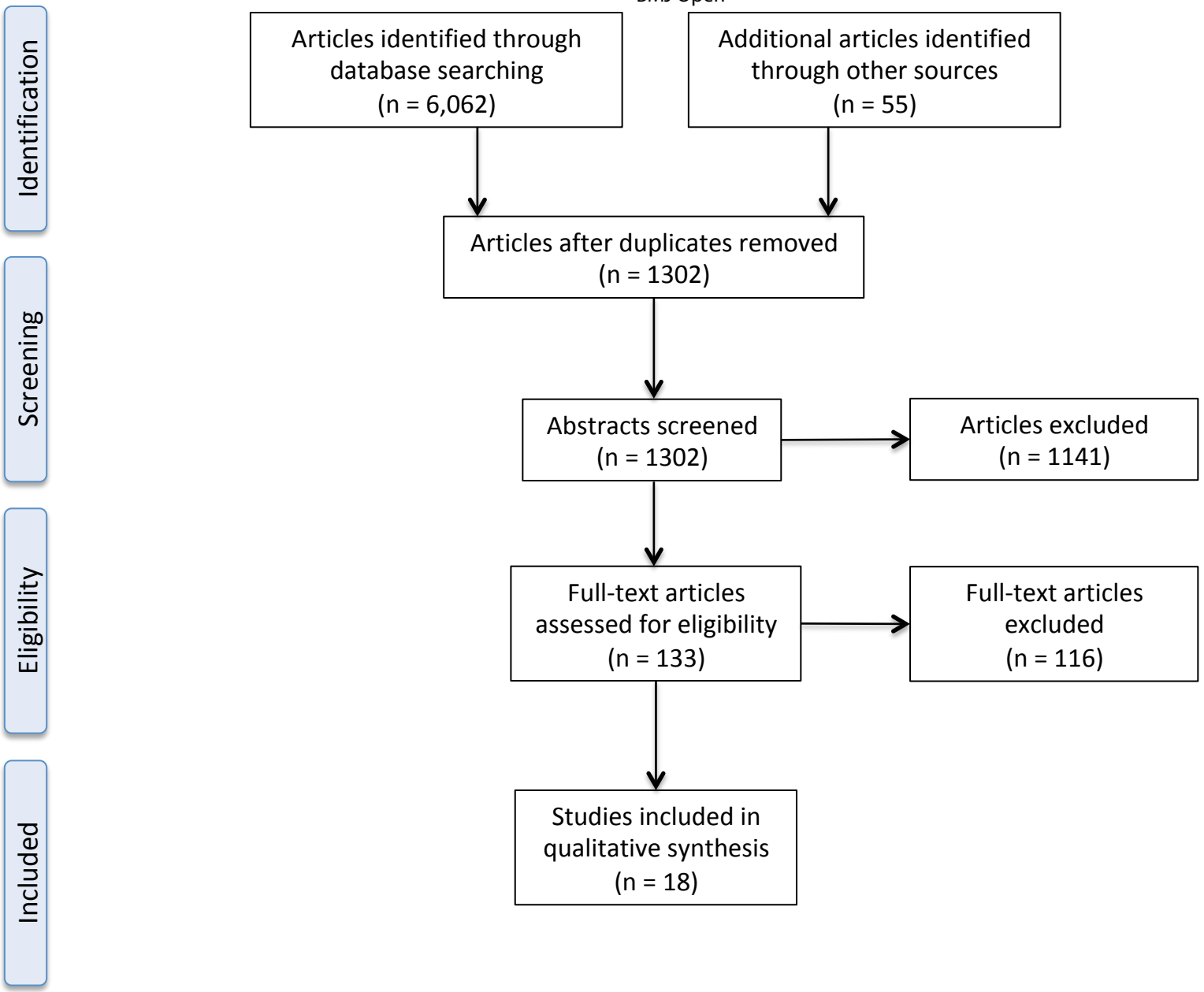
29 Guruge S, Hunter J, Barker K, McNally MJ, Magalhães L. Immigrant women's experiences of receiving care in a mobile health clinic. *J Adv Nurs* 2010; **66**: 350–9.

30 Calvo R, Rojas V, Waters MC. The Effect of Universal Service Delivery on the Integration of Moroccan Immigrants in Spain: A Case Study from an Anti-Oppressive

Perspective. *Br J Soc Work* 2014; **44**: i123–39.
31 Mortensen A. Public health system responsiveness to refugee groups in New Zealand: activation from the bottom up. *Soc Policy J New Zeal* 2011.
32 Stewart M, Anderson J, Beiser M, *et al.* Multicultural Meanings of Social Support among Immigrants and Refugees. *Int Migr* 2008; **46**: 123–59.
33 MacFarlane A, Singleton C, Green E. Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England. *Health Policy (New York)* 2009; **92**: 203–10.
34 Catarci M. Conceptions and Strategies for User Integration across Refugee Services in Italy. *J Educ Cult Psychol Stud* 2012.
35 McMurray J, Breward K, Breward M, Alder R, Arya N. Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada. *J Immigr Minor Heal* 2014; **16**: 576–85.
36 Kim MJ, Cho H-I, Cheon-Klessig YS, Gerace LM, Camilleri DD. Primary health care for Korean immigrants: sustaining a culturally sensitive model. *Public Health Nurs*; **19**: 191–200.
37 Yeung A, Kung WW, Chung H, *et al.* Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *Gen Hosp Psychiatry* 2004; **26**: 256–60.
38 Geltman PL, Cochran J. A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees. *Am J Public Health* 2005; **95**: 196–9.
39 Woodland L, Burgner D, Paxton G, Zwi K. Health service delivery for newly arrived refugee children: A framework for good practice. *J Paediatr Child Health* 2010; **46**: 560–7.
40 Philbin MM, Flake M, Hatzenbuehler ML, Hirsch JS. State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Soc Sci Med* 2018; **199**: 29–38.
41 Tuepker A, Chi C. Evaluating integrated healthcare for refugees and hosts in an African context. *Heal Econ Policy Law* 2009; **4**: 159.
42 Langlois E V., Daniels K, Akl EA. Evidence synthesis for health policy and systems: a methods guide. Geneva, Switzerland, 2018.
43 The UCL-Lancet Commission on Migration and Health. UCL-Lancet Commission on Migration and Health. 2018.
44 Glandon D, Meghani A, Jessani N, Qiu M, Bennett S. Identifying health policy and systems research priorities on multisectoral collaboration for health in low-income and middle-income countries. *BMJ Glob Heal* 2018; **3**: e000970.
45 Bennett S, Glandon D, Rasanathan K. Governing multisectoral action for health in low-income and middle-income countries: unpacking the problem and rising to the challenge. *BMJ Glob Heal* 2018; **3**: e000880.
46 UNHCR. Global Trends Forced Displacement in 2017. Geneva, Switzerland, 2018 https://www.unhcr.org/5b27be547.pdf.
47 Abubakar I, Aldridge RW, Devakumar D, *et al.* The UCL–Lancet Commission on Migration and Health: the health of a world on the move. *Lancet* 2018; **392**: 2606–54.

Figure Legend

Figure 1: Scoping Review Flowchart
Table 1: Summary of Included Studies
Table 2: Barriers and Facilitators Commonly Discussed Across Studies
Table 3: Enabling Strategies Present Across Studies


Identification
Screening
Eligibility
Included
Articles identified through database searching (n = 6,062)
Additional articles identified through other sources (n = 55)
Articles after duplicates removed (n = 1302)
Abstracts screened (n = 1302)
Articles excluded (n = 1141)
Full-text articles assessed for eligibility (n = 133)
Full-text articles excluded (n = 116)
Studies included in qualitative synthesis (n = 18)

APPENDIX I

1. Medline (Ovid)

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

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

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

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.

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"

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"

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

BMJ Open

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

Journal:	*BMJ Open*
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

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

Shirley Ho*[1] email: shirley.ho@jhu.edu
Dena Javadi [1] email: javadid@who.int
Sara Causevic[2,3] email: sara.causevic@ki.se
Etienne V. Langlois[1] email: langloise@who.int
Peter Friberg[2,5] email: peter.friberg@mednet.gu.se
Goran Tomson[2,4] email: goran.tomson@ki.se

[1] Alliance for Health Policy and Systems Research, World Health Organization, Avenue Appia 20, 1211 Geneva, Switzerland
[2] Swedish Institute for Global Health Transformation, SIGHT, Royal Swedish Academy of Science, Stockholm, Sweden
[3] Global and Sexual Health, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden
[4.] Medical Management Centre, Department of Learning, Informatics, Management, Ethics (LIME), Karolinska Institutet, Stockholm, Sweden
[5.] Institute of Medicine, Sahlgrenska Academy at Gothenburg University and Sahlgrenska University Hospital

***Corresponding Author:**
Shirley Ho, shirley.ho@jhu.edu
Alliance for Health Policy and Systems Research, World Health Organization

Keywords: intersectoral, right to health, access, refugees, integration, resettlement

Word count: 4,041

ABSTRACT (285/300)

Background: Better understanding, documentation, and evaluation of different refugee health interventions, and their means of health system integration and intersectoral collaboration are needed

Objectives: Explore the barriers and facilitators to the integration of health services for refugees; the processes involved; and the different stakeholders engaged in levaraging intersectoral approaches to protect refugees' right to health on resettlement

Design: Scoping review

Methods: A search of articles from 2000 onward was done in MEDLINE, Web of Science, Global Health, and PsycInfo Embase. Two frameworks were applied in our analysis, the "Framework for analyzing integration of targeted health interventions in systems", and "Health in All Policies" framework for country action. A comprehensive description of the methods is included in our published protocol.

Results: 6,117 papers were identified, only 18 studies met the inclusion criteria. Facilitators in implementation included: training for providers; colocation of services; transportation services to enhance access; clear role definitions; and appropriate budget allocation and financing. Barriers included: lack of a participatory approach; insufficient resources for providers; absence of financing; unclear roles and insufficient coordination of interprofessional teams; low availability and use of data; and turf wars across governance stakeholders. Successful strategies to address refugee health included: networks of service delivery combining existing public and private services; system navigators; host community engagement to reduce stigma; translation services; legislative support; and alternative models of care for women and children.

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

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

Strengths and limitations of this study

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

INTRODUCTION

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

be accessible, medically and culturally appropriate, available in adequate amount and quality, which includes having a trained health workforce, safe products and sanitation.[2]

"Refugees" are individuals fleeing armed conflict or persecution as defined by the 1951 Refugee Convention which also identifies their basic rights, specifically that refugees should not be returned to situations that are deemed a threat to their life or freedom.[3] A key distinction of refugee rights is that they are not only a matter of national legislation, but also of international law.[4] Despite these legal protections, refugees face many challenges in accessing health services, especially more vulnerable groups like women and children.[5] Many states explicitly exclude refugees from the level of protection afforded to their citizens, instead choosing to offer "essential care" or "emergency health care," which is differentially defined across countries.[6] The Committee on the Elimination of Racial Discrimination, and the Committee on Economic, Social and Cultural Rights, both include general statements that hold States accountable to "the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services".[7] The increasing number of refugees over the past years makes the realization and protection of these rights both a legal, ethical and a logistical challenge.[5] In addition, the boundaries of the right to health have expanded due to increased understanding of social determinants of health and the health impacts of the lived environment.[8,9] Refugees face challenges in navigating health, legal, education, housing, social protection and employment services, which further threatens their quality of life and health status.[10] Therefore, a lack of coordination and integration across these services undermines their effectiveness.[11]

Much like the shift from the more vertical approaches of the millennium development goals (MDGs) towards the more integrated SDGs, the protection of the right to health calls for an

intersectoral approach whereby health is applied to all policies for all people.[12] As such, for states to effectively protect the right to health for refugees there is a need to work across sectors and disciplines to better integrate targeted programs and initiatives, thereby improving standards of care during resettlement. Some evidence exists that supporting collaboration and coordination across social services for refugees improves the effectiveness and quality of care received.[10] Many fragmented psychosocial programs exist across sectors to attempt to address the unique challenges faced by refugees but these are largely unevaluated and lack sustainability.[13,14] Better understanding, documentation, evaluation and reporting of the dynamic nature of different interventions, and their means of health system integration and intersectoral collaboration, are necessary to ensure that lessons learned are implemented in the design of future policies and programs.

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

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

(2) What strategies are involved in addressing refugees' right to health upon resettlement?

(3) Which stakeholders are involved in leveraging intersectoral approaches to protect refugees' right to health?

METHODS

Study Design

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

Information Sources and Search Strategy

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

Eligibility Criteria

Population: Refugees as defined by the 1951 Refugee Convention[3]

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

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

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

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

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

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

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

Frameworks to Address Research Questions

Two published frameworks were used in our analysis to understand integration of health services within health systems and to analyze intersectoral approaches to support these services. The first framework by Atun et al (2010)[21], is a tool for analyzing integration of targeted health interventions in health systems, where integration is defined as "the extent, pattern, and rate of adoption and eventual assimilation of health interventions into each of the critical functions of a

health system".[21] The framework for integration was also used to assess the process, and actors involved in integration.[20]

The second framework applied in our analysis is that of the Health in All Policies (HiAP) framework for country action. HiAP is defined as a way for countries to protect population health through "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".[22] Components of this framework, adapted to refugee needs, were used in the review to frame barriers and facilitators in integrating refugee services through intersectoral collaboration.

Data Abstraction

A data abstraction chart was developed based on the two frameworks used in this study. The chart was tested by two researchers and revised as appropriate. The revised chart was used by the same researchers to abstract descriptive and qualitative data as relevant to the elements of the frameworks used. Elements included in the chart were: intervention description; barriers and facilitators; contextual details; target population; type of evaluation; outcomes; stakeholder involvement in governance, financing, planning, service delivery, monitoring and evaluation, and engagement. Deductive reasoning was used to identify barriers and facilitators in intersectoral collaboration for refugee health. Open coding was applied to visualize themes across interventions as well as barriers and facilitators.[23] Axial coding was applied to then draw connections to enabling strategies for intersectoral collaboration.[23] General conclusions were drawn based on these themes, leading to suggestions for strengthening programs and policies.

Patient and Public Involvement

There was no patient or public involvement required in conducting this scoping review.

RESULTS

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

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

Catarci[34]	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[25]	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
Geltman et al[38]	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
Guruge et al[29]	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
Kim et al[36]	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

Lilleston et al[28]	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 al[33]	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 al[35]	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 al[24]	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
Mortensen[31]	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

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
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
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
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
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

Woodland et al[39]	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
Yeung et al[37]	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

212

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

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

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]	

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

authorities and service providers, including health, employment, vocational training and continuing education services.[34] In this model, users moved through the pathways of integration and can receive support for any combination of health needs, access to education, housing support, and legal assistance.[34] Collaborative design and delivery of services was also demonstrated in Australia with support from multidisciplinary, intersectoral teams, but a lack of funding presented barriers to the potential success of this initiative.[27] Similarly in the USA, the "Bridge Project" faced insufficient funding in the coordination of care despite seeing promising results from use of a system navigator – or primary care nurse "bridge" – to connect primary care and mental health care services.[37] A network of "gateway services" was also tested in Canada using a "Reception House" model.[35] These services are characterized by being person-centred, interprofessional, communication-focused, and comprehensive across the continuum of care.[35] Relationship-management between the Reception House, health professionals, translation services, and social services was acknowledge as a key component for success.[35] Input from international medical graduates in training also supported this work by enhancing culturally appropriate service delivery by this network of partners.[35]

Striking a balance between providing tailored, culturally-appropriate care and integrating health and social services for refugees into existing services in the host community can be especially challenging. Policy reviews suggest that taking a "one-policy, one-level, one-outcome" approach or focusing refugee management under one ministry is not sufficient in addressing the wide range of obstacles that both host and refugee communities are facing as a result of the current political climate.[40,41] The Ethiopian government for example had success in reorganizing ministries to incorporate refugee management into existing portfolios rather than a

refugee-specific one, moving refugee assistance programs out of camps and promoting more collaboration across government and non-governmental programs.[41]

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]						

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

fundraising by service providers,[31,33] government,[30,31,35,38,41] and international bodies or donors.[28,36,37,41] Program and policy planning stakeholders encompassed national governments,[31,38,41] departments of social services and/or public health,[27,30,36] central services responsible for coordination of refugee services and provision of assistance to local services,[29,34,35] researchers,[24,26,30,36,37] service providers,[27,28,35,37] and international bodies or donors.[28,36,41] Service delivery stakeholders included national departments of social services and/or public health,[27,30,33,36,38–41] networks of local service providers in health, education, socialization, translation and/or employment,[24,31,34,36] healthcare providers,[27,33,35,37,38] central services responsible for coordination of refugee services and provision of assistance to local services,[32,34,35] community health workers,[26] and international bodies.[28,41] Stakeholders responsible for monitoring and evaluation were seldom explicitly mentioned. For demand generation, stakeholders included central services responsible for the coordination of refugee services and provision of assistance to local services,[35] local media in the language of the target population,[36] community leaders and/or community health workers,[26,28,31,32] home health outreach services,[28,31] and healthcare providers.[33,37]

DISCUSSION

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

Coordination of Existing Public and Private Services

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

Introduction of a System Navigator Role

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

system navigation role should also be able to build strong networks with allied specialists, identify appropriate resources and reach out to users.[34,35] The risk here however is that integrating refugee care may eliminate some determination procedures, potentially undermining the protection mandate and underestimate the tailored needs of refugees dealing with significant trauma.[41] Future research on the required competencies of the system navigator role is required to ensure that appropriate professionals are recruited and trained.

Advocacy and Legislative Support

Exclusionary immigration policies can play a considerable role in marginalization and discrimination against refugee communities leading to decreased health seeking behaviors and use of available integrated or intersectoral services.[40] Effective advocacy needs to target the policy-making levels in order to counteract the negative impacts of exclusionary policies. Advocacy by health care providers can be influential at the institutional level to push for better allocation of services and funding.[31] A multipronged approach may be necessary to continue to advocate for the right to health for refugees by addressing legal challenges, establishing timely and accurate data and information systems to capture needs, creating health promoting environments, investing in person-centred, culturally-appropriate and easily accessible services, and evaluating coordination and service delivery efforts. Engaging policy makers in knowledge translation and evidence-informed decision-making is one way to effectively advocate and provide legislative support in refugee health. In Lebanon for example, where there are huge demands in meeting the health needs of a large Syrian refugee population, researchers engaged policy-makers in knowledge production (i.e. research priority-setting), translation and uptake activities.[42] This ultimately led to the hiring of a refugee health coordinator by the Lebanese Ministry of Public Health. The refugee health coordinator role functioned to support intersectoral

collaboration, assisting in strategic planning and implementation of action plans to respond to the health needs of Syrian refugees including helping with the development of refugee health information systems at the Ministry of Public Health.[42] The UCL-Lancet Commission on Migration and Health also supports knowledge translation by bringing together academics, policymakers, and health system experts to take an inter-disciplinary approach to reviewing evidence, develop policy recommendations and disseminate these findings globally amongst policymakers and institutions.[43]

Alternative Models of Care to Reach Vulnerable Women and Children

Among the studies that reported targeted interventions for women and children, alternative models of care were used. This included mobile health clinics, and programs linked to schools to support screening and active case finding. These alternate models increased accessibility of essential health services, increase detection of health conditions, and improve coordination of care, and reduced feelings of social isolation.[27,28] This suggests that flexible service delivery and innovation in mode of delivery should be considered when attempting to reach at risk refugee groups. Better collection and use of evidence on the needs of vulnerable refugee subgroups and how to target them are essential next steps to design appropriate service delivery models.

Policy Insights

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

1) Strengthening the coordination between existing programs through financing stronger referral systems and colocation of services
2) Incentivizing health and social service authorities to establish and finance formal system navigator roles that connect all relevant services – provision of information technology tools can help support this function and better manage the network of available programs
3) Engaging host communities to enhance understanding, reduce stigma, and to create an enabling environment for policies that protect refugees and their rights to social determinants of health
4) Communicating the availability of programs and services through cultural mediators and establishing formal translation and transport services to improve access
5) Establishing training and resources for providers to a) better understand the needs of refugee communities, b) be aware of available and relevant services for referral across sectors, and c) more efficiently manage cases

Limitations and Future Directions

Our review was limited by the scarcity of evidence in this area. Due to this, all relevant studies were included, therefore, quality and rigor may vary. Some key programs and approaches may be missing due to interventions occurring at the individual level instead of at the systems level, as well as not having been published in academic literature**.** Individual health providers or organizations will navigate barriers in health systems through tacit and experiential knowledge that is often not documented. Data will be further amplified by conducting key informant interviews in selected countries.

As others have noted, the literature on intersectoral collaboration disproportionately focuses on high-income countries.[44] It is therefore no surprise that the evidence for this review

largely came from high-income countries with only two studies conducted in upper-middle income and two in low-income countries. This may affect the generalizability of the findings reported here as low-income and middle-income countries have greater coordination challenges to overcome due to fragmented systems and weak governance.[45] Additionally, according to the latest report on the UN Refugee Agency, approximately 85% of refugees are hosted in developing nations.[46] More evidence and special consideration is needed in these contexts with respect to refugee health, particularly for those most at risk subgroups such as women, children and the elderly.

Although there exists reaffirmed enthusiasm in intersectoral approaches to achieving global health agendas such as the SDGs, it has been found that the lack of quality evidence represents an essential hurdle to evidence-informed decision-making for the development of cross-cutting policies and governance required for sustained intersectoral collaboration.[44] This pattern of a dearth of evidence was seen in our review. Additionally, most of what has been written has not been grounded in relevant theories or frameworks.[45] Our use of frameworks to structure our analysis is a step forward in addressing this issue. Generating high quality data in health systems and policy research for migrant health and on intersectoral approaches has been identified as a research priority.[44,47] Future research should therefore also consider the structured evaluation of evidence through a frameworked approach.

CONCLUSION

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

priority. This scoping review has highlighted important gaps in current knowledge and made suggestions for future research relevant to key themes.

Our findings indicate that policies aiming at integrating services and fostering intersectoral action should consider system-level approaches such as the colocation of services, transportation support, and establishing system navigator roles. Communication challenges due to language barriers should also be addressed with a view of providing culturally-sensitive programs. There is also a need to strengthen the capacities of frontline providers and managers, to improve their knowledge of available services as well as their ability to provide care to specialized vulnerable groups such as refugees. Engaging host communities around a human rights-focused strategy to the health of refugees is also fundamental to address discrimination and stigma. Current gaps in knowledge found in our study represent an untapped potential for improvements to financial and human resource efficiency in health systems. Given the limited evidence we found in our scoping review, the momentum for continued research should be sustained.

ETHICS APPROVAL

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

AUTHOR'S CONTRIBUTIONS

GT together with librarians at Karolinska Institutet identified databases and planned the literature search. SH & DJ drafted the paper and incorporated co-author feedback, SH & DJ abstracted data from peer-reviewed literature. SC, EVL, GT and PF provided critical feedback and comments on the manuscript. SC and SH acted as secondary reviewers.

ACKNOWLEDGMENTS

The authors would like to thank Karolinska Institutet librarians, Magdalena Svanberg and Gun Brit Knutssön, for their contributions, specifically in running the search and identifying appropriate databases. We are also grateful to WHO Euro for their discussions and suggestions in the early stages of this project.

DATA AVAILABILITY STATEMENT

No data are available.

COMPETING INTERESTS

None.

FUNDING STATEMENT

No funding was obtained for this project. In-kind time contributions from staff at the Alliance for Health Policy and Systems Research and SIGHT have made this possible.

REFERENCES

1 OHCHR. The Right to Health. Geneva, Switzerland, 2008.
2 Tangcharoensathien V, Mills A, Palu T. Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. *BMC Med* 2015; **13**: 101.
3 UNHCR. Convention and Protocol relating to the status of refugees. Geneva, Switzerland, 2010.
4 UNHCR. UNHCR viewpoint: 'Refugee' or 'migrant' – Which is right? Geneva, Switzerland, 2016.
5 Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. *Lancet* 2013; **381**: 1235–45.
6 Council for the EU. Council Directive 2003/9/EC of 27 January 2003 Laying Down Minimum Standards for the Reception of Asylum Seekers in Member States. *Off J Eur Union 2003* 2003; : L 31/18.
7 OHCHR. General Recommendation 30. Discrimination against non-citizens. Geneva, Switzerland, 2004.
8 Jackson-Bowers, Eleanor, Cheng I-H. Meeting the primary health care needs of refugees and asylum seekers. *Res Roundup* 2010.
9 WHO. Advancing the right to health: the vital role of law. Geneva, Switzerland, 2017.
10 Joshi C, Russell G, Cheng I-H, *et al.* A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *Int J Equity Health* 2013; **12**: 88.

11 Citizenship AGD of I and. Fact sheet 60 - Australia's refugee and humanitarian program. 2012.

12 UN. Integrated Approaches to Sustainable Development Planning and Implementation. New York, USA, 2015.

13 Kett ME. Internally Displaced Peoples in Bosnia-Herzegovina: Impacts of Long-term Displacement on Health and Well-being. *Med Confl Surviv* 2005; **21**: 199–215.

14 Patel N, Kellezi B, Williams AC de C. Psychological, social and welfare interventions for psychological health and well-being of torture survivors. *Cochrane Database Syst Rev* 2014; published online Nov 11. DOI:10.1002/14651858.CD009317.pub2.

15 Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005; **8**: 19–32.

16 Tricco AC, Lillie E, Zarin W, *et al.* A scoping review on the conduct and reporting of scoping reviews. *BMC Med Res Methodol* 2016; **16**: 15.

17 Peters MDJ, Godfrey CM, Khalil H, McInerney P, Parker D, Baldini Soares C. The Joanna Briggs Institute Reviewers' Manual: Methodology for JBI Scoping Review. Adelaide, Australia, 2015.

18 Center for Open Science. Open Science Framework. https://osf.io/.

19 Javadi D, Langlois E V., Ho S, Friberg P, Tomson G. Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: a scoping review protocol. *BMJ Open* 2017; **7**. DOI:10.1136/bmjopen-2017-016638.

20 Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy Plan* 2008; **23**: 308–17.

21 Atun R, de Jongh T, Secci F, Ohiri K, Adeyi O. Integration of targeted health interventions into health systems: a conceptual framework for analysis. *Health Policy Plan* 2010; **25**: 104–11.

22 WHO. Health in All Policies: Framework for Country Action. Geneva, Switzerland, 2014.

23 Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol* 2008; **8**: 45.

24 McNaughton DB, Hindin P, Guerrero Y. Directions for Refining a School Nursing Intervention for Mexican Immigrant Families. *J Sch Nurs* 2010; **26**: 430–5.

25 Cowell JM, McNaughton D, Ailey S, Gross D, Fogg L. Clinical Trial Outcomes of the Mexican American Problem Solving Program (MAPS). *Hisp Heal Care Int* 2009; **7**: 178–89.

26 Verhagen I, Ros WJ, Steunenberg B, de Wit NJ. Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention programme in the Netherlands. *BMC Public Health* 2013; **13**: 227.

27 Woodland L, Kang M, Elliot C, Perry A, Eagar S, Zwi K. Evaluation of a school screening programme for young people from refugee backgrounds. *J Paediatr Child Health* 2016; **52**: 72–9.

28 Lilleston P, Winograd L, Ahmed S, *et al.* Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon. *Health Policy Plan* 2018; published online June 13. DOI:10.1093/heapol/czy050.

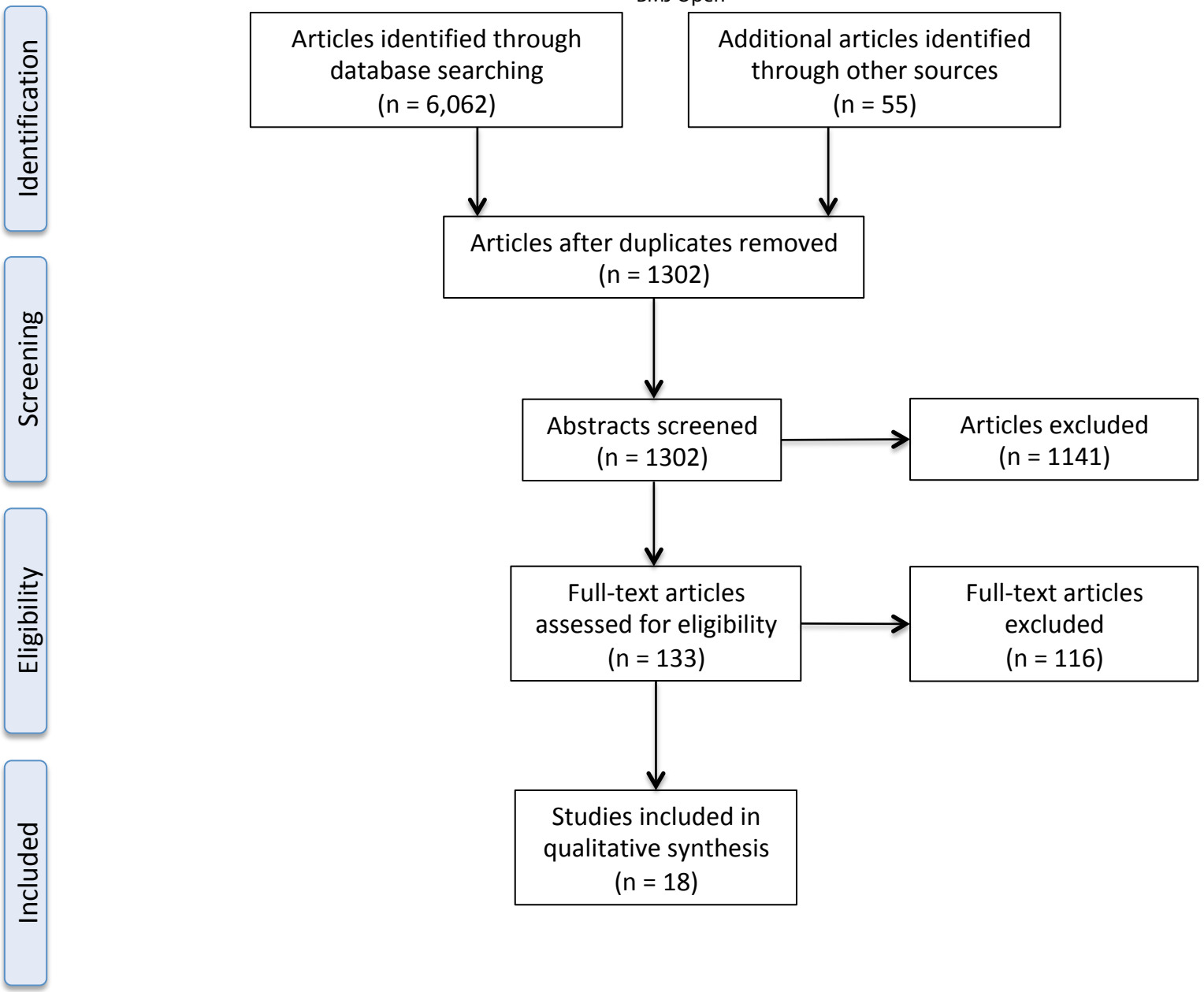
29 Guruge S, Hunter J, Barker K, McNally MJ, Magalhães L. Immigrant women's experiences of receiving care in a mobile health clinic. *J Adv Nurs* 2010; **66**: 350–9.

30 Calvo R, Rojas V, Waters MC. The Effect of Universal Service Delivery on the Integration of Moroccan Immigrants in Spain: A Case Study from an Anti-Oppressive Perspective. *Br J Soc Work* 2014; **44**: i123–39.
31 Mortensen A. Public health system responsiveness to refugee groups in New Zealand: activation from the bottom up. *Soc Policy J New Zeal* 2011.
32 Stewart M, Anderson J, Beiser M, *et al.* Multicultural Meanings of Social Support among Immigrants and Refugees. *Int Migr* 2008; **46**: 123–59.
33 MacFarlane A, Singleton C, Green E. Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England. *Health Policy (New York)* 2009; **92**: 203–10.
34 Catarci M. Conceptions and Strategies for User Integration across Refugee Services in Italy. *J Educ Cult Psychol Stud* 2012.
35 McMurray J, Breward K, Breward M, Alder R, Arya N. Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada. *J Immigr Minor Heal* 2014; **16**: 576–85.
36 Kim MJ, Cho H-I, Cheon-Klessig YS, Gerace LM, Camilleri DD. Primary health care for Korean immigrants: sustaining a culturally sensitive model. *Public Health Nurs*; **19**: 191–200.
37 Yeung A, Kung WW, Chung H, *et al.* Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *Gen Hosp Psychiatry* 2004; **26**: 256–60.
38 Geltman PL, Cochran J. A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees. *Am J Public Health* 2005; **95**: 196–9.
39 Woodland L, Burgner D, Paxton G, Zwi K. Health service delivery for newly arrived refugee children: A framework for good practice. *J Paediatr Child Health* 2010; **46**: 560–7.
40 Philbin MM, Flake M, Hatzenbuehler ML, Hirsch JS. State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Soc Sci Med* 2018; **199**: 29–38.
41 Tuepker A, Chi C. Evaluating integrated healthcare for refugees and hosts in an African context. *Heal Econ Policy Law* 2009; **4**: 159.
42 Langlois E V., Daniels K, Akl EA. Evidence synthesis for health policy and systems: a methods guide. Geneva, Switzerland, 2018.
43 The UCL-Lancet Commission on Migration and Health. UCL-Lancet Commission on Migration and Health. 2018.
44 Glandon D, Meghani A, Jessani N, Qiu M, Bennett S. Identifying health policy and systems research priorities on multisectoral collaboration for health in low-income and middle-income countries. *BMJ Glob Heal* 2018; **3**: e000970.
45 Bennett S, Glandon D, Rasanathan K. Governing multisectoral action for health in low-income and middle-income countries: unpacking the problem and rising to the challenge. *BMJ Glob Heal* 2018; **3**: e000880.
46 UNHCR. Global Trends Forced Displacement in 2017. Geneva, Switzerland, 2018 https://www.unhcr.org/5b27be547.pdf.
47 Abubakar I, Aldridge RW, Devakumar D, *et al.* The UCL–Lancet Commission on Migration and Health: the health of a world on the move. *Lancet* 2018; **392**: 2606–54.

555

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**


Identification
Screening
Eligibility
Included
Articles identified through database searching (n = 6,062)
Additional articles identified through other sources (n = 55)
Articles after duplicates removed (n = 1302)
Abstracts screened (n = 1302)
Articles excluded (n = 1141)
Full-text articles assessed for eligibility (n = 133)
Full-text articles excluded (n = 116)
Studies included in qualitative synthesis (n = 18)

APPENDIX I

1. Medline (Ovid)

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

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

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

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.

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"

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"

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