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

Work Package 2: Evaluation

D2.2 Final Evaluation Report

V1.0

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MyHealth Consortium

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The partners in this project are:

Participant Nº	Participant Legal Name	Country	Partner's Acronym
1	*Fundacio Hospital Universitari Vall d'Hebron- Institut de recerca*	*ES*	*VHIR*
2	*Institute Catala de la Salut– Hospital Universitari Vall d'Hebron*	*ES*	*ICS*
3	*Syn Eirmos NGO of Social Solidarity Astiki Etairia E*	*EL*	*SYN-EIRMOS*
4	*Migrantas e.V.*	*DE*	*Migrantas*
5	*Consonant*	*UK*	*Consonant*
6	*European Institute of Women's Health, CLG*	*IE*	*EIWH*
7	*University of Greenwich*	*UK*	*UoG*
8	*Asserta Global Healthcare Solutions*	*ES*	*Asserta*
9	*Fakultni Nemocnice U SV. Anny V Brne*	*CZ*	*FNUSA*
10	*Regione.Emilia-Romagna- Agenzia Sanitaria e Sociale Regionale*	*IT*	*RER*
11	*Hospital Charité, Universitaetsmedizin Berlin*	*DE*	*CHARITE*

A brief description for every partner site is outlined in Annex 1.

Abbreviations

CHAFEA	EU Consumers, Health, Agriculture and Food Executive Agency
EC	European Commission
FGs	Focus groups
FGDs	Focus groups discussions
GBV	Gender-based violence
GDPR	General Data Protection Regulation
GP	General Practitioner
HIV	Human immunodeficiency virus
ID	infectious diseases
IDIs	Individual in-depth interviews
ICT	Information and communications technology
IQR	interquartile range
LTBI	latent tuberculosis infection
MyHealth:	Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance
NCD	Non-communicable diseases
PHC	Primary Health Care
SAMM	Severe Acute Maternal Morbidity
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UM	Unaccompanied Minor
UNICEF	United Nations Children's Fund
VMR	Vulnerable Migrants and Refugees
WGIHB	Work Group on International Health in Barcelona
WHO	World Health Organization
WP	Workpackage
WUM	Women and unaccompanied minors

MyHealth Glossary

Asylum seeker	A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.[1]
Chronic disease	No uniform definition of chronic disease exists. Some sources use the term interchangeably with non-communicable diseases whereas others include chronic conditions of infectious origin such as HIV or mental illness such as Alzheimer. [2]
Community	The condition of sharing or having certain attitudes and interests in common.[3]
Community activity	For MyHealth project: A pursuit of civic responsibility and of wanting or feeling to do something to support one another and/or the wider society.
Community Health agent	Community health agents are those who work in communities to strengthen the links between the community and health services, usually not certified and outside of national healthcare services. This also includes non-health agents who work on the social determinants of health such as housing, inequalities, education, employment or the environment.[4]
Community involvement	For MyHealth project: The process of engaging in discussion and collaboration with community members.
Community participation	For MyHealth project: a meaningful active involvement of community members in the design, development, implementation, delivery, as well as evaluation of health services".
Country of origin	The country that is a source of migratory flows (legal or illegal).[1]
Country of transit	The country through which migratory flows (independent of administrative status) move.[1]
Family doctor	The family doctor (FD) is the gatekeeper of the Primary Health Care system. His/her role is to control the entry of people into the healthcare system, to avoid unnecessary use, duplication and coordination of referrals to specialized health care.[5]
General practitioner	General practitioner (GP) treats all common medical conditions and refer patients to hospitals and other medical services for urgent and specialized

	treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.[6]
Health	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[7]
Health champions	People who, with training and support, voluntarily bring in their ability to relate to people and their own life experience to transform health and wellbeing in their communities.[8]
Health education	Health education is any combination of learning experiences designed to help individuals, groups, and communities improve their health, by increasing their knowledge or influencing their attitudes.[9]
Health Needs	For the MyHealth project: Deficiencies in health perceived by stakeholders that require some intervention. The perceptions could be similar or different between them.
Health promotion	Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual 7 behaviour towards a wide range of social and environmental interventions. [10]
Hospital Health Care	For MyHealth project: The term refers to the healthcare structure where patients are treated for more complex or rare diseases that could not be managed by Primary Health Care.
Host Country	The EU Member State/country in which a third-country national / non-national takes up residence.[11]
Immigrant	In the EU context, a person who establishes their usual residence in the territory of an EU Member State for a period that is, or is expected to be, of at least 12 months, having previously been usually resident in another EU Member State or a third country.[11] Any 3rd country national without an EU/EEA passport arriving in the EU.
Infectious, or communicable diseases	Defined as an illness caused by a specific infectious agent or its toxic product that results from transmission of that agent or its products from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate environment.[12]
Integration	As a state where an individual can maintain his or her own cultural identity while at the same time becomes an active participant in the host culture.[13]
International Health	This term refers to a systematic consideration of all the factors that affect the health of human population (genetic, cultural, natural environment,

	political, economic, migration and violence). This term is historically related to tropical diseases, sanitation, water, malnutrition, mother and child health; however, many organizations includes a broader range of subjects as chronic diseases.[14] For MyHealth project, international health includes those infectious diseases, non-communicable diseases and mental health disorders connected to migratory movements, cultural or genetic aspects.
Irregular (administrative) migrant	Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal administrative status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation).[1]
Learning Alliance	Innovative methodology seeking to re-think the utilisation, appropriation and impact of research outcomes in the health services area in more integrated ways. Formally defined, it is "a series of connected multi-stakeholder platforms or networks (practitioner, researchers, policy-makers, service users) at different institutional levels (local, national) involved in two basic tasks: knowledge innovation and its scaling up." [15]
Mediator	A person who usually belongs to the immigrant community or is familiar with the cultural aspects of that immigrant community, translate (if necessary, adapt the information), and facilitate liaison between two entities, for example, a hospital/institution and a service user.
Mental health	Mental health is defined by WHO as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.[16]
Migrant	At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without the intervention of an external compelling factor. This term, therefore, applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family.[1]
Migrant worker	A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.[1]

Migration	A process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants.[1]
Minor	In a legal context and in contrast to a child, a person who, according to the law of their respective country, is under the age of majority, i.e. is not yet entitled to exercise specific civil and political rights.[11]
MyHealth	A transnational project co-funded by the health programme of the European Union to develop and implement models of health network to reach out to migrants and Ethnic minorities, in particular women and unaccompanied minors.
Network	A group or system of interconnected people, institutions or things.[3]
Non-communicable diseases	Non-communicable diseases (NCDs), also known as chronic diseases, tend to be of a long duration and are the result of a combination of genetic, physiological, environmental and 9behavioural factors. The major types include cardiovascular diseases, cancer, chronic pulmonary disease, and diabetes.[17]
Pictograms	Pictograms are the visual language of Migrantas. Their simple, universally understandable images stir emotions: people from different backgrounds recognize themselves in the representations, while others gain new insights or modify their own perspectives.
Pilot	For MyHealth project: is a test of a tool/method/instrument before introducing it more widely.
Primary Health Care	Primary healthcare is an essential part of healthcare based on practical, scientific and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation. It is also made possible because the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. [18]
Refugee	A person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR's mandate, and/or in national legislation.[19]
Social determinants of heath	The social determinants of health are the conditions in which people are born, grow, live, work and age.[20]

Specialized professionals	For MyHealth project: These health professionals are trained to manage more complex or rare diseases (usually at Hospital Health Care settings) that could not be managed by primary healthcare professionals.
Screening	Screening is defined as the presumptive identification of unrecognized disease in an apparently healthy, asymptomatic population by means of tests, examinations or other procedures that can be applied rapidly and easily to the target population.[21]
Stakeholder	For MyHealth project: A person, group or organization that has interest or concern in the project. The general categorisation used in the project for grouping stakeholders included: public sector, civil society, and the private sector.
Third-country national (TCN)	Any person who is not a citizen of the European Union within the meaning of Art. 20(1) of TFEU and who is not a person enjoying the European Union right to free movement, as defined in Art. 2(5) of the Regulation (EU) 2016/399 (Schengen Borders Code).[11]
Tool	For MyHealth project: is an instrument (leaflet, training, game, workshop, network...) or methodology that aids in accomplishing a particular objective or task.
Trafficking in persons	The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person havin control over another person, for the purpose of exploitation. [1]
Translator	A person who provides translation services, which can be professional or informal (such as family members).
Unaccompanied minor	A minor who arrives on the territory of an EU Member unaccompanied by the adult responsible for them by law or by the practice of the EU Member State concerned, and for as long as they are not effectively taken into the care of such a person; or who is left unaccompanied after they have entered the territory of the EU Member State.[11]
Undocumented migrant	See irregular migrant.
Vulnerable migrants (or migrants in	There is no internationally recognized definition. IOM proposes a model that defines vulnerability within a migration context as the diminished capacity of an individual or group to resist, cope with, or recover from

vulnerable situations)	violence, exploitation, abuse, and violation(s) of their rights. It is determined by the presence, absence, and interaction of factors and circumstances that (a) increase the risk of, and exposure to, or (b) protect against, violence, exploitation, abuse, and rights violations .[22]

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OVERVIEW ON THE INTERLINKAGES BETWEEN WORK PACKAGES WITHIN MYHEALTH PROJECT

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

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

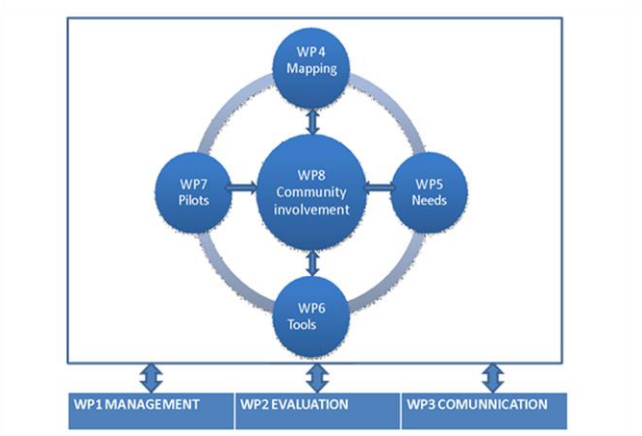


Figure 1: Structure of MyHealth Project and connections among its WPs

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

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

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

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

- ✓ *D3.1 Dissemination package*

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

- ✓ *D4.1 Data collection tool and protocol to gather reference sites, projects and ICT tools dealing with migrant population*

- ✓ *D4.2 Interactive map available online with the different exposed components (country health facts, reference sites, the available ICT tools, etc) and existing initiatives*

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

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

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

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

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

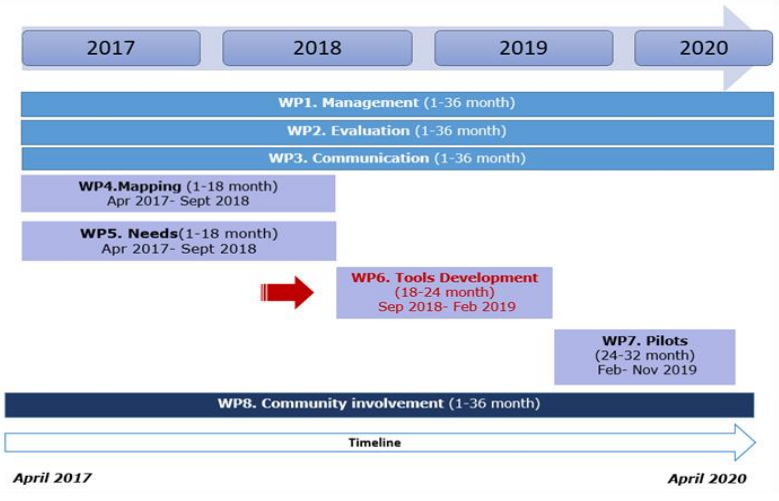
- ✓ *D7.1 Report on Economic analysis of comparative models*
- ✓ *D7.2 Evaluation report of the models*

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

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

Where are we? *The present report corresponds to* **WP6 Tools development.**

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



USER GUIDE

The present report consists of four chapters:

Chapter 1 provides the general context of My Health as a research project by presenting its background, main objectives-outputs and work packages, aim and criteria of the final report (D2.2) as per the Evaluation Plan, deliverables and milestones (MS6), the methods used for this evaluation and the team collaborating in the elaboration of the report.

Chapter 2 discusses and responds to the five evaluation questions MyHealth outlined in its evaluation plan in month 4th. They are respectively: i) how did MyHealth face the main obstacles identified and solved? ii) how have both MyHealth outputs and outcomes improved the health situation of unaccompanied children and women? iii) what are the main criteria emerging from MyHealth regarding quality, effectiveness and sustainability when working with VMR, particularly WUM? iv) to what extent has the use of some components of the LA methodology contributed to the learning and strengthening of the impact of MyHealth as seen by the stakeholders? And finally, v) were expected outputs and outcomes of MyHealth achieved by June 2020? Why, or why not?

Chapter 3 discusses the overall evaluation of MyHealth according to its relevance as a project, its efficiency, effectiveness, impact and sustainability.

Chapter 4 provides a general conclusion to the report and includes a list of recommendations according to methodology, policy, women and unaccompanied minors (WUM), health promotion, EU projects on VMR-WUM, EU administrative procedures and dissemination.

The report is complemented with eight annexes.

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Executive Summary

This final evaluation report, as per the list of deliverables (D2.2) of the Work Package 2 Evaluation of MyHealth, aims to elaborate a summative evaluation of MyHealth achievements as per its aim, objectives and workpackages: http://www.healthonthemove.net/es/workpackage/ http://www.healthonthemove.net/project/objectives/

Specifically, this report is pursuing the following three aims:

- Assess if the general and specific objectives of MyHealth have been achieved
- Assess if MyHealth outcomes meet the needs of the target groups VMR-WUM (Vulnerable migrants and women and minors)
- Assess the contribution of the Learning Alliance (LA) methodology

Thus, in order to achieve the above aims, the report focuses on -answering five questions approved in the Evaluation Plan: http://www.healthonthemove.net/wp-content/uploads/2019/05/D2.1-Evaluation-Plan.pdf They are:

- How were the main obstacles faced by MyHealth identified and solved?
- How have both MyHealth outputs and outcomes improved the health situation of unaccompanied children and women?
- What are the main criteria emerging from MyHealth regarding quality, effectiveness and sustainability when working with VMR-WUM, particularly and women and unaccompanied children (WUM)?
- To what extent has the use of some components of the LA methodology contributed to the learning and strengthening of the impact of MyHealth as seen by the stakeholders?
- Were expected outputs and outcomes of MyHealth achieved by June 2020? Why, or why not?

Additionally, the report answers general questions related to four assessment criteria following international criteria as recommended by the United Nations System, The European Commission and the Organization for Economic Cooperation and Development. They are:

- Relevance – Were the project and its objectives relevant? Did MyHealth identify the main problems and needs of the VMR-WUM regarding their health matters?
- Efficiency – Were MyHealth outputs delivered with quality, quantity and on time?
- Effectiveness – Were MyHealth benefits achieved acknowledged by the stakeholders? Has MyHealth made a difference?

- Impact and sustainability – are MyHealth outputs and outcomes going to have immediate, midterm and long- term effects?

By reviewing most of MyHealth documents, conducting three field visits and gathering qualitative (16 individual and group interviews) and quantitative data (three surveys) and analysing data thematically and statistically from October 2019 till June 2020, this summative evaluation presents the overall results. These are globally represented in table 1 below according to the rating provided by the all MyHealth consortium and other stakeholders, and between the two main phases of the project (April 2017-September 2018 and September 2018-June 2020) comprising 39 months the project lasted.

Table 1. MyHealth Final Evaluation -- Rating of achievements

Up to May 2020	Up to September 2018

Rating Workpackages	Highly Satisfactory	Satisfactory	Less than satisfactory	Highly unsatisfactory
1. Interactive **mapping** (Sep 2018)				
1. (May 2020)				
2. **Needs assessment** VMR and health professionals (Sep 2018)				
2. (May 2020)				
3. List **of current health problems** (Sept 2018)				
3. (May 2020)				

4. Health Interventions – **TOOLS** (May 2020)				
5. ICT-based **platform** (May 2020)				
6. Implement the defined strategies and models in **PILOTS** (May 2020)				
7. A model for community participation (Sep 2018)				
7. (May 2020)				
8. Implementation of a wide-ranging and sound strategy for managing and communicating MyHealth results including the LA methodology (Sep 2018)				
8. (May 2020).				

MyHealth summative evaluation evidences a rating between satisfactory and highly satisfactory. Its outputs, outcomes, and deliverables were met and achieved. Its cost-benefit analysis is positive and shows high productivity. Despite initial obstacles and inherent challenges given the project's scale and its diversity, the project was successfully implemented using two innovative components: community engagement and the LA methodology. It produced useful tools and knowledge accessible to all stakeholders -including migrants and VMR-WUM in order to impact positively their health conditions. WUM were the targeted group. Lessons learnt and recommendations that emerged from this project should be applicable, replicable and sustainable within the EU context.

Even though the main implementation of the project was not done during the COVID-19- pandemic, the knowledge, results and recommendations that emerged from MyHealth become especially significant for (i) policy and health plans formulation within the EU during COVID-19, and (ii) for solving the vulnerabilities that MyHealth has identified as experienced by VRM-WUM.

The main take-away from MyHealth can be summed up as the urgent need to address VMR – specially WUM health needs by taking into account their diversity, and different economic, social and cultural conditions. Special emphasis was given to mental health needs that tend to be dismissed by health providers. -In order to successfully do so in the EU context, a comprehensive LA should be implemented where not only the public sector, but key actors such as organized civil society groups, academia and even the private sector, are consulted and invited to actively contribute in this process. Unless a wide bottom-up community participation process is energised around this issue, partial, incomplete and ineffective interventions will be perpetuated. MyHealth has shown that it can be achieved in a successful way, despite complexity and challenges, by offering concrete examples of good practices, lessons learnt and recommendations made to achieve this aim. This is especially important during the current COVID-19- pandemic when the vulnerability of migrants –WUM have increased given their lack of access to health facilities, their high mobility, exposure to public spaces and proper connectivity as well as day-to-day practices (e.g. informal jobs in populated spaces and crowed living spaces). An overwhelming concluding and urgent recommendation that emerges from this summative evaluation is that MyHealth needs to make an effort to inform the network of 408 identified stakeholders and others about the knowledge platform, tool and resources available on the MyHealth website. In the current context of COVID-19, all these resources could help many health organisations and institutions in Europe as well as professionals and migrants.

1. Project Background

1.1. MyHealth

MyHealth was a 39-month initiative supported by the European Union's health programme (April 2017–June 2020) with the aim of improving the health care access of VMRs newly arrived in Europe. To achieve this aim the project would develop and implement models based on the know how of a European multidisciplinary network. MyHealth focused particularly on WUM newly arrived in Europe (less than five years). The multidisciplinary network implementing the project comprised seven countries: the Czech Republic, Germany, Greece, Ireland, Italy, Spain and the United Kingdom and was conducted in 11 organisational settings: **research hospitals** (Fundacio Hospital Universitari Vall d'Hebron – Institut de Recerca, Fakultni Ultni Nemocine U SV Anny V Brno, Hospital Charité, Universitaetsmedizin Berlin), **health institutes and government agencies** (Institut Catala De La Salut– Hospital Universitari Vall d'Hebron, Regione Emilia-Romagna- Agenzia Sanitaria e Sociale Regionale); **non-governmental organisations** (Syn Eirmos NGO of Social Solidarity Astiki Etairia E, Migrantas, Consonant (ex-the Migrants' Resource Centre), European Institute of Women's Health); a private company (Asserta Global Healthcare Solutions); and **a university** (University of Greenwich) (see annex 1).

The network members used seven EU languages (Catalan, Czech, English, German, Greek, Italian and Spanish) plus the migrants' languages such as Urdu, Parsi and Swahili. Furthermore, most of the partners implementing the project were migrants themselves. Thus, it is important to state at the outset that all of the above elements combined to add several layers of complexity to the MyHealth.

MyHealth's primary outcomes expected to consolidate a European network through a Learning Alliance approach (Moreno-Leguizamon et al., 2015; Smith and Moreno-Leguizamon, 2018; Moreno-Leguizamon, 2018). This involved including all network actors in improving the general health situation of VRMs-WUM. Besides the network MyHealth expected to produce the following objectives/outputs:

i) A representative report on immigrants' and refugees' perceptions of their health priorities and needs consisting of two parts: the first is the report as such and the second details the methodological approach. The reports were posted on the project's website in the last quarter of 2019 and made available to anybody interested: http://www.healthonthemove.net/workpackage/w5/

ii) A digital and interactive map of health and WUM-VRM in Europe, including reference sites, health, legal and organisational details. The map is also

available on the project's website and in May 2020 the countries and stakeholders of Mighealthcare project were added.

iii) Knowledge of the main issues for VRM-WUM concerning mental health, infectious diseases and non-communicable diseases: http://www.healthonthemove.net/workpackage/w5/

iv) appropriate screening and treatment strategies for the three key areas in primary health care based on community health strategies.

v) A versatile ICT-based platform on WUM-VRM health, including the interactive map, general information, contact, and health apps.

vi) Recommendations and a set of innovative tools oriented towards provision of health services to VMR-WUM.

1.2. MyHealth objectives/outputs and work packages

Table 2: Objectives and work packages

Objectives	**Work Packages (WP)** **http://www.healthonthemove.net/workpackage/**
1. Develop an interactive map of the central health issues, main actors/stakeholders, reference sites dealing with WUM-VRM legal/organisational aspects of health systems in the countries involved, and the ICT tools made available.	4 Mapping http://www.healthonthemove.net/
2. Conduct a pilot survey on current health status and concerns of VMR and health practitioners in Barcelona, Berlin and Brno.	5 Needs http://www.healthonthemove.net/workpackage/w5/
3. Define more clearly the current health problems of migrants treated by health services in Barcelona, Berlin and Brno.	
4. Define and develop health intervention strategies in mental health, communicable and non-communicable diseases based on a community health approach.	

5. Develop an ICT-based platform to support new tools, enhance health application developments and health information.	6 Tools http://www.healthonthemove.net/workpackage/w6/
6. Implement the pilot strategies and models in the Barcelona, Berlin and Brno hospitals.	7 Pilots http://www.healthonthemove.net/workpackage/w7/
7. Ensure training and involvement of all key actors in the health system value chain (from users to management).	8 Community involvement http://www.healthonthemove.net/workpackage/w8/
8. Ensure sound management and communication strategy for MyHealth.	1, 2, 3 Management, Evaluation and Communication http://www.healthonthemove.net/workpackage/w1/ http://www.healthonthemove.net/workpackage/w2/ http://www.healthonthemove.net/workpackage/w3/

1.3. Aim and criteria of the final report (D2.2) as per the Evaluation Plan, deliverables and milestones (MS6)

Table 3: List of Deliverables

Deliverable Number	Deliverable Title	Lead beneficiary	Type	Dissemination level	Due Date in months
D2.1	Evaluation Plan	7- UoG	Report	Public	4
D2.2	Interim (18) and Final (36) Evaluation reports	7- UoG	Report	Public	39

Table 4: Schedule of Relevant Milestones

Milestone number	Milestone title	Lead benefiaciary	Due date (in months)	Means of Verification
MS5	Evaluation Plan	7 -UoG	4	Roadmap that identifies objectives and goals for setting up a timeline for evaluation activities
MS6	Interim (18) and Final (39) Evaluation	7 -UoG	39	Documental progress reports focused on potentially critical points

The aim of this final report was to elaborate a summative evaluation of MyHealth achievements as per the objectives and work packages illustrated table 1 above, more specifically focusing on the following aims:

- Assess if the MyHealth general and specific objectives have been achieved.
- Assess if MyHealth's outcomes meet the needs of the target groups (VMR-WUM).
- Assess the contribution of the LA methodology.

Thus, in order to achieve the aims, the report focuses on the first instance on answering the five questions below which were approved in the Evaluation Plan in Month 4 http://www.healthonthemove.net/wp-content/uploads/2019/05/D2.1-Evaluation-Plan.pdf

These questions are:

- How were the main obstacles faced by MyHealth identified and solved?
- How have both MyHealth outputs and outcomes improved the health situation of WUM?
- What are the main criteria emerging from MyHealth regarding quality, effectiveness and sustainability when working with VMR-WUM, particularly and women and unaccompanied children (WUM)?
- To what extent has the use of some components of the LA methodology contributed to the learning and strengthening of the impact of MyHealth as seen by the stakeholders?
- Were expected outputs and outcomes of MyHealth achieved by June 2020? Why, or why not?

In a complementary way the report also answers questions related to the international assessment criteria as suggested by the United Nations System, The European Commission and the Organization for Economic Cooperation and Development. They are

- Relevance – Were the project and its objectives relevant? Did MyHealth identify the main problems and needs of the VMR-WUM-regarding their health matters?
- Efficiency – Were MyHealth outputs delivered with quality, quantity and on time? Were there any unforeseen results?
- Effectiveness – Do the stakeholders consider that the benefits from MyHealth have been achieved and the project has made a difference?
- Impact and sustainability – are MyHealth outputs and outcomes going to have immediate, midterm and long- term effects?

The set of questions above are deemed important because they illustrate the strengths and weaknesses of MyHealth as a complex project.

1.4. Interim evaluation methods

This final report has reviewed, gathered, and analysed internal and external information and data from a variety of sources of data. The most significant are:

- Review of Documents: all MyHealth documents and reports produced up to May 2020 (see annex 2);
- Field Visits: Visit to Barcelona (November 2019), Berlin (February 2020) and Athens (February 2020).
- Quantitative data of three surveys/questionnaires distributed to:
  - i) MyHealth work-package leaders.
  - ii) MyHealth implementing partners and
  - iii) External stakeholders

Participants completed tailored online evaluation questionnaires, designed in Qualtrics software (Qualtrics, Provo, UT) (see annexes 3, 4 and 5). The online questionnaires were piloted prior to the data collection and tested and were available on iPhones, androids, desktops using different software and hardware configurations. The questionnaires were distributed via email using a URL link or a quick response (QR) code. Reminder emails were sent weekly (a total of three reminders after the initial email invitation). The questionnaire to the partners responsible for implementing MyHealth used the

same Likert scale (from highly satisfied to highly unsatisfied) from the Interim report in order to contrast those two periods in terms of meeting the project's objectives.

- The MyHealth workpackge leader's questionnaire included a total of 44 questions and was written in English. Eleven MyHealth workpackage leaders and co-leaders from the eight work-packages responded to this questionnaire and it ran during March 2020.
- Leaders were asked about their satisfaction regarding their project solving strategy on a 6-point Likert scale (e.g. extremely satisfied, very satisfied, satisfied, neither satisfied nor dissatisfied, moderately dissatisfied or dissatisfied). They also answered whether the challenges they faced were anticipated, not anticipated or both and whether they would have solved the challenges differently (yes/no). Additional open-ended questions allowed a free-text entry and offered the responders an opportunity to expand on their answers by providing details on what they would have done differently and why. They also provided examples of anticipated and non-anticipated challenges.
- The MyHealth implementation partners questionnaire included a total of 26 open-ended questions in English and included a set of specific questions for each of the eight MyHealth's objectives. 15 individuals of the consortium partners out of 19 responded to the questionnaire and it was administered during March 2020.
- Participants were asked to rate the overall performance of each objective on a 4-point Likert scale (from highly satisfied to highly unsatisfied) and how well challenges in delivering the objectives were solved (from extremely well to not well at all). They were also asked to rate how much they agree or disagree on a 7-point Likert scale on nine statements related to the project (for example, whether MyHealth outputs and objectives were achieved; the extent to which MyHealth outputs and outcomes improved the health of vulnerable migrant women and unaccompanied children, and whether MyHealth is influencing European policies).
- The MyHealth external stakeholders' questionnaire was available in Spanish, English, Greek and Italian. 37 external stakeholders responded out of 52 that opened the link to the questionnaire which was run from March 2020 until 5th June 2020. COVID-19 could have been an influence in the low number of responses unfortunately here.

- It included a brief study description, an informed consent form, five open and 22 close-ended questions. The closed questions assessed their awareness of Myhealth outputs (e.g. interactive maps, website, tools, etc.), their interest in knowing more about the project outcomes and how useful the outcomes were (ranging from extremely useful to not at all useful).

- Descriptive statistics were used to look at the general distributions and quality of the data collected. Likert ordinal scale data were displayed in bar charts.
- Qualitative data complemented the data collected for this final report. This comprised individual or group interviews with 16 MyHealth implementers and supplemented by interaction with migrants in the field visit to Barcelona as well as a street visit to the posters displayed by MyHealth as part of its public campaign in Berlin led by Migrantas (see list is annex 6).
- Thematic analysis was applied to the qualitative data gathered.

1.5. Final Report Evaluation authorship

The final evaluation task was led and coordinated by Dr Carlos Moreno-Leguizamon, work-package two leaders from the University of Greenwich, Faculty of Education and Health, School of Human Sciences with the collaboration and input from the following experts who also revised the final report :

- Dr. Marcela Tovar-Restrepo – Evaluation of gender perspectives and Learning Alliance methodology (Barnard College- Columbia University New York).
- Dr. David Smith- Evaluation of methodological aspects related to the Learning Alliance and quality assurance (Anglia Ruskin University, UK).
- Dr. Amanda R A Adegboye and Dr. Carina Vieira Teixeira – Questionnaire design and analysis of quantitative results (University of Greenwich, Faculty of Health and Education, School of Human Sciences).
- Dr. Erika Kalocsányiová - Associate in qualitative analysis, transcription and report formatting (University of Greenwich, Institute of Lifecourse Development).
- Charles Oham –consultant assessing the feasibility of MyHealth's continuation as a social enterprise in the future as part of its sustainability (University of Greenwich, Faculty of Education and Health, School of Human Sciences).

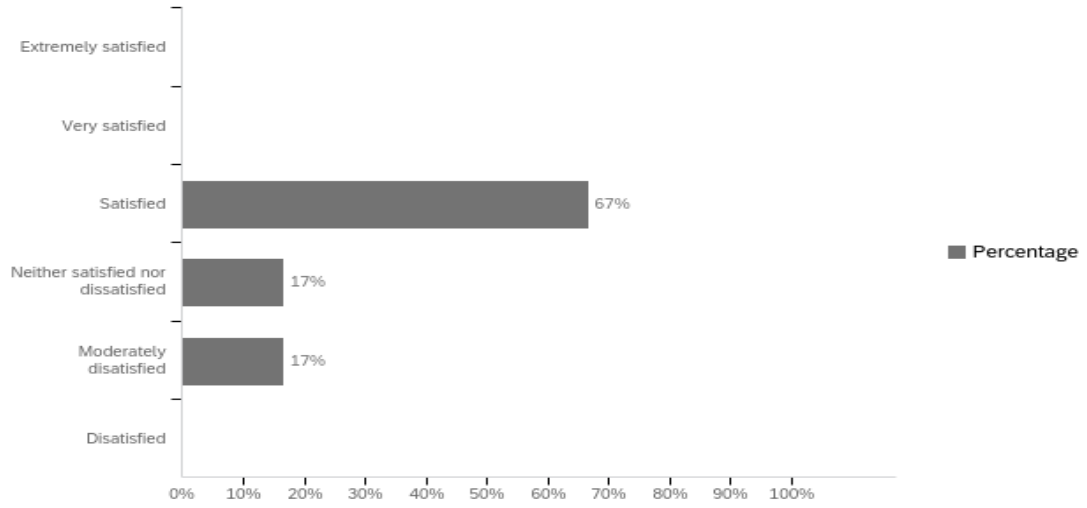
2. MyHealth Evaluation Questions

2.1. How were the main obstacles faced by MyHealth identified and solved?

In order to identify the perceived obstacles faced by MyHealth and how they were solved during the implementation of the project, quantitative data was collected from work-package leaders through one of the surveys as well as via qualitative data using structured interviews to implementing partners and work-package leaders. In general, the results both at the level of project objectives as related to work-packages and concerning the overall project were satisfactory.

Obstacles and problem solving as per objectives-workpackages

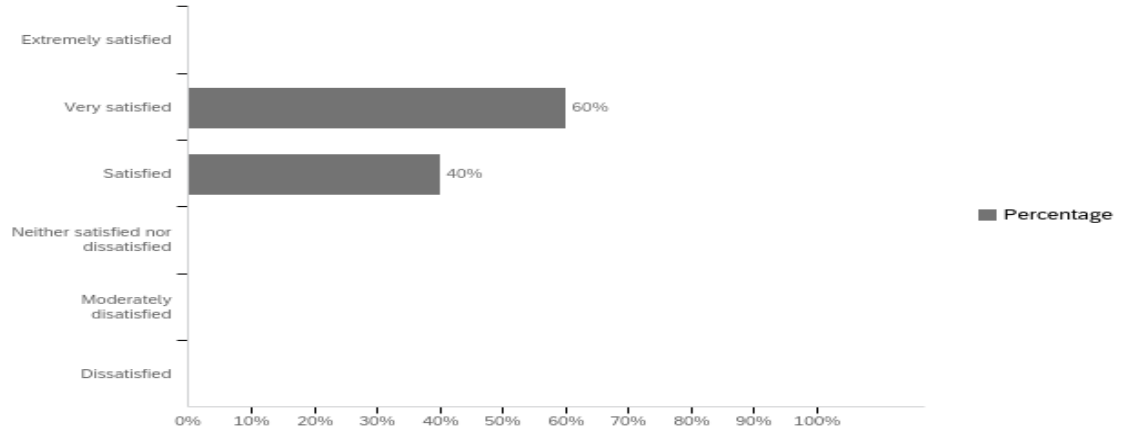
Q. Are you satisfied with the outcome of MyHealth problem-solving strategy for Objective 1 (Mapping)?



In relation to Objective 1 (mapping) around 67% of work-package leaders said they were satisfied while 34% were either moderately dissatisfied or neither satisfied nor dissatisfied (n=6). Most (87%) said they would have solved objective one's challenges differently. When asked about what they would have done differently, the leaders mentioned that they would try to find out about similar initiatives to learn how similar challenges could be solved. They also mentioned that more thorough deliberation from the outset of the project was needed including more reflection on the total cost of a mapping exercise. Leaders also mentioned that one type of questionnaire would be

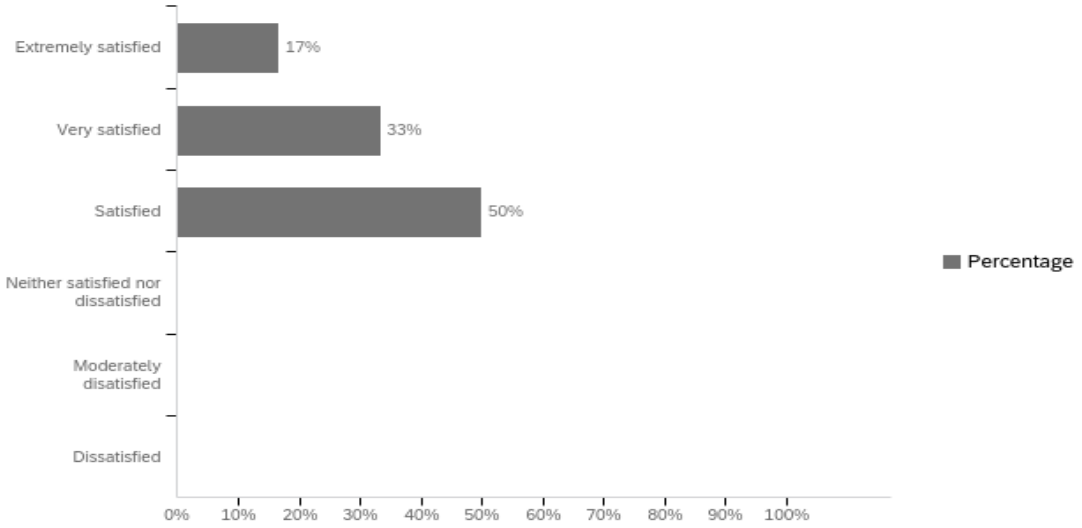
preferable to several questionnaires throughout the project. Finally, one leader also mentioned that one-to-one communication with partners in every country should have been implemented. In addition, 67% (4 out of 6) said some challenges they faced were anticipated and some challenges were not anticipated. Around one-third (33%) of leaders stated that all the challenges they faced were not anticipated. Anticipated challenges included: time consumed by stakeholders completing the survey, low response rates to different questionnaires circulated, high cost of the mapping and use of the Learning Alliance methodological approach. Non-anticipated challenges included the long-winded institutional processes for securing agreement to complete the survey, the need to provide micromanagement and constant supervision of the consortium partners and delays constructing the online map.

Q. Are you satisfied with the outcome of MyHealth's problem-solving strategy for Objectives 2 and 3 (e.g. Health Needs)?



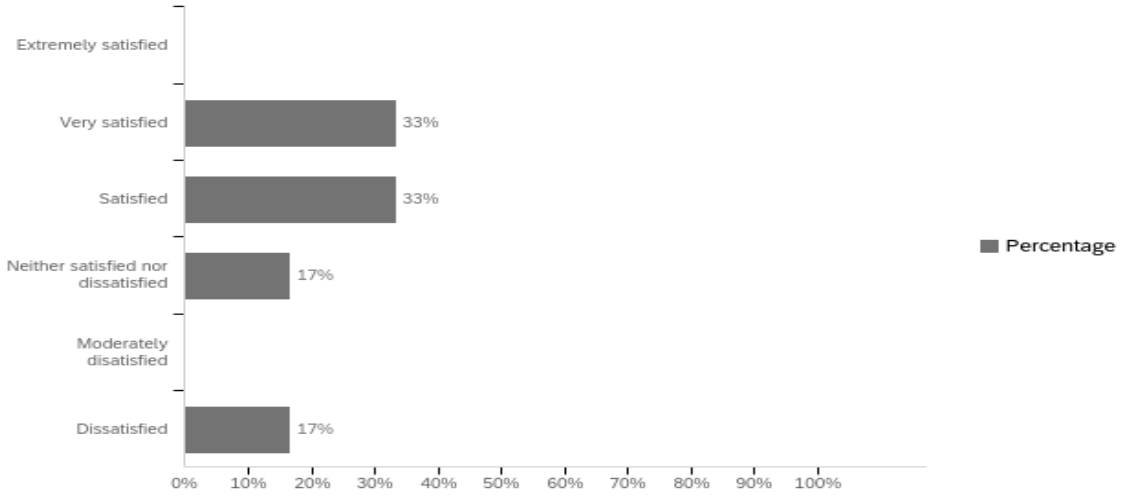
In relation to Objectives 2 and 3 (health needs), all leaders who responded to the question (n=5) said they were either very satisfied or satisfied. When asked to reflect on whether they would have solved the challenges differently 40% said 'yes'. Those who responded in the affirmative justified their answer by mentioning that they would improve supervision and ensure that focus groups and individual interviews were carried out consistently in all sites. One leader also mentioned that survey dissemination needed improvement taking into account the disproportional replies (for example 220 responses in Barcelona and an average of 20 in each of the other sites). Another leader mentioned that the planned sample size was too small to allow for inferences. Some 40% of the leaders said these challenges were anticipated, 20% said they were not anticipated and 40% said both (anticipated and non-anticipated). Examples of anticipated challenges given by leaders were lack of time to engage with project participants for long periods and difficulties engaging with unaccompanied minors.

Q. Are you satisfied with the outcome of MyHealth's problem-solving strategy for Objective 4 (e.g. TOOLS)?



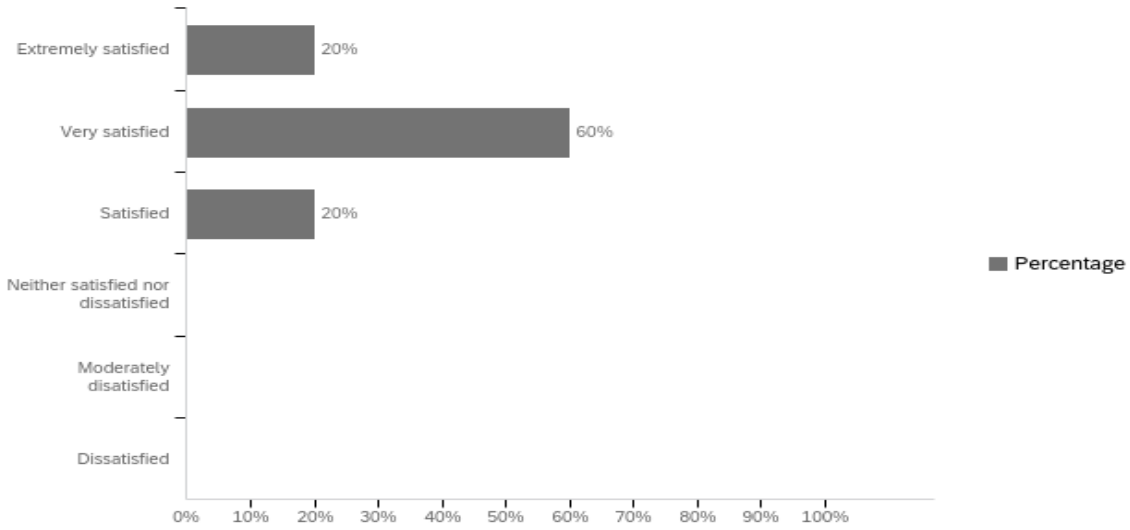
Regarding Objective 4 (Tools), all leaders who responded to the question (n=6) were extremely satisfied, very satisfied or satisfied with the outcome of the problem-solving strategy and only 17% would have solved the challenges differently. 75% of the leaders said the challenges were both anticipated and non-anticipated while 25% said the challenges were anticipated. Anticipated challenges mentioned by the leaders included a lack of time of participants and internal team issues. Difficulties enrolling minors and different communication strategies among partners were the non-anticipated challenges for Objective 4 mentioned by leaders.

Q. Are you satisfied with the outcome of MyHealth's problem-solving strategy for Objective 5 (ICT Platform)?



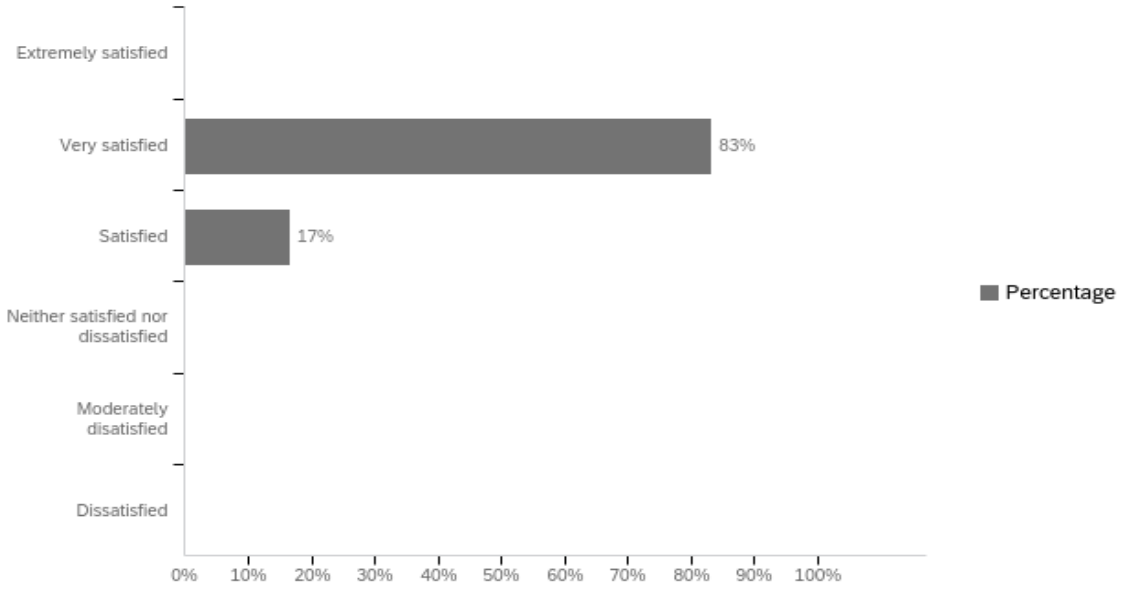
Regarding Objective 5, of the leaders who responded 34% were either dissatisfied or neither satisfied nor dissatisfied with the outcome of MyHealth's problem-solving strategy (ICT platform). Around 66% of the leaders said they were very satisfied or satisfied while 20% would have solved the challenges differently. Approximately 33% of the leaders said the challenges were anticipated while 67% said the challenges were anticipated and non-anticipated. An insufficient budget was an anticipated challenge while a non-anticipated challenge was the difficulty of designing an ICT tool that was interculturally competent for all migrants in Europe.

Q. Are you satisfied with the outcome of MyHealth's problem-solving strategy for Objective 6 (e.g. PILOTS)?



Regarding objective 6 (pilots) all the leaders who responded to the question (n= 5) were either satisfied, very satisfied or extremely satisfied. All the leaders said they would not have solved the challenges differently. 67% of the leaders who responded said the challenges were both anticipated and non-anticipated, while 33% said the challenges were anticipated. Anticipated challenges included lack of time of project participants to wait for a higher number of VMRs and an insufficient timeframe for piloting the tools. Difficulties enrolling minors was a non-anticipated challenge for some leaders while one mentioned that although similar needs were found in different countries, solutions varied which was a non-anticipated challenge.

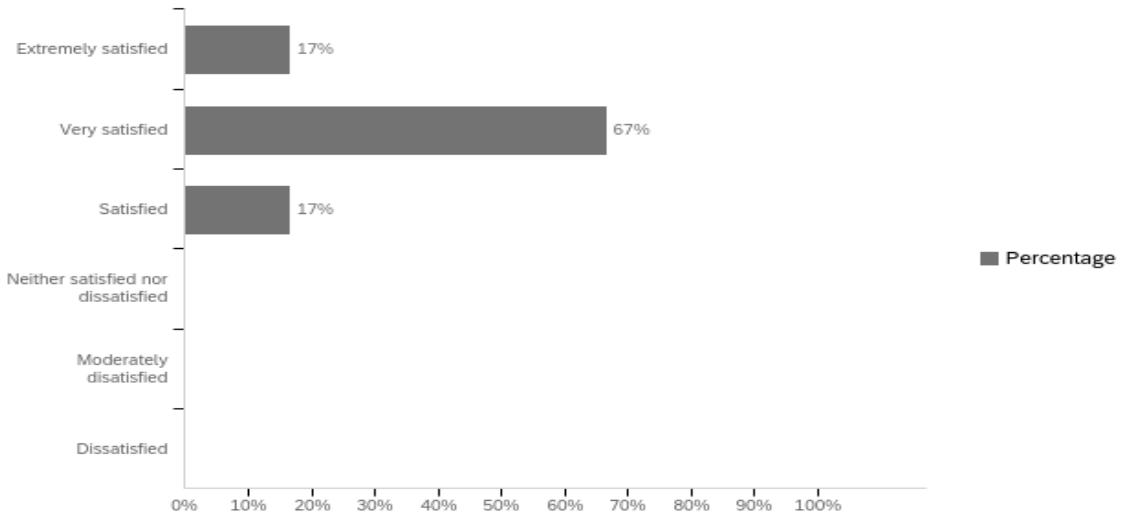
Q. Are you satisfied with the outcome of MyHealth's problem-solving strategy for Objective 7 (Community Development)?



Regarding objective 7 (community development) all leaders said they were satisfied or very satisfied (n=6) and only one of the leaders said they would have solved the challenges differently. For example, giving partners more time to share their successes with community involvement with other participants earlier in the project. According to this leader, this would likely have had a cascade effect, prompting partners to think of new ways to promote community involvement.

75% of the leaders said the challenges were both anticipated and non-anticipated while 25% said the challenges were all anticipated. The lack of time of project participants and VMRS was an unanticipated challenge mentioned by leaders. One leader based in London, said she would not be able to offer their networks and local resources to partners in other European cities noting that "this is due to the nature of community development work which relies so much on local knowledge, networks and resources". Non-anticipated challenges included difficulties involving minors or the more vulnerable in the project since they have other priorities, and the many different cultural backgrounds among migrants. Another leader said that participation by service users at its most meaningful level could take more time to build and develop than that of engaging professionals. According to this leader, "this may be because service users engage in community participation on a voluntary basis, on top of their other priorities, whereas professionals are sometimes able to participate as part of their professional roles, or can be flexible with their professional duties to accommodate for volunteering".

Q. Are you satisfied with the outcome of MyHealth's problem-solving strategy for Objective 8 (Management, Communication and Evaluation)?



Finally, all leaders (n=6) said they were either satisfied, very satisfied or extremely satisfied with the outcome of MyHealth's problem-solving strategy for Objective 8 (management, communication and evaluation). The majority (83%) said they would not have solved the challenges differently while the leader who said he would have solved the challenges differently said he would better define at the beginning what project management comprised of specifically. He/she also said they would better define the tasks and specify the partner responsible for each workpackage. Three-quarters of the leaders (n=3) said the challenges were both anticipated and non-anticipated, while one leader said the challenges were all anticipated. The anticipated challenges mentioned were: different health systems, policies, organisational and working cultures in the different project locations as well as the complexity of working where several different languages were used. The non-anticipated challenges were the substantial cultural differences across European health systems and reaching the project's target population VMR-WUM.

Overall, besides the satisfaction of MyHealth leaders with their various problem-solving strategies to obstacles faced what is interesting here is that they thought in general that most of the problems faced were on the anticipated side rather than the unanticipated. Similarly, the results show that the activities of the objectives implemented in the second part of the project tend to be better rated than the ones implemented in the first 18 months. The project in its first part therefore was not as cohesive as it was in the second part.

Obstacles and problem solving for the whole project as per implanting partners

The list below, are both the obstacles and the strategies to resolve them mentioned by the implementing partners

- MyHealth European Network: Some obstacles were related to the compliance burden imposed by the GDPR and the information overload on social media. GDPR has the potential to ensure better user protection, however, its application to the MyHealth Project has made outreach and dissemination efforts more challenging, resource-intensive, and costly. MyHealth overcame the main GDPR related obstacles that came into effect at the end of the year of implementation by making consortium partners aware of the main issues through regular discussions.
- Overall, it was difficult to guarantee and promote the free participation of unaccompanied minors. In WP6, only two out of the four study sites (Athens and Berlin) received access to unaccompanied minors, based on their established networks in Athens and Berlin. To tackle this issue, the Barcelona site invited young VMRs in their late teens/early twenties (19-23), referred to as ex-minors to participate for instance in the Metaplans sessions.
- There were some obstacles establishing criteria for eligible and ineligible tools for the MyHealth Repository Toolbox, e.g. materials from a heterogeneous group of professionals, source and reliability of the tools, duplicate contents and excessive use of categories. Prior to publication, each tool was sent to an internal committee for assessment depending on the subject area. User feedback, ratings and comments were also used to improve the service and interface.
- Recruiting participants from among newly arrived vulnerable WUM and particularly community involvement was complicated. It required a variety of methods specific to the research locations, dedicated safeguarding considerations and development of partnerships with entities responsible for the welfare and care of UM specifically. Most of the MyHealth partners worked firstly with migrants who had been in the countries for longer periods of time and/or who had contact with newly arrived members of migrant communities. Some of the migrants were health professionals themselves and were thus ideal candidates for engaging in community participation. The number of activities with WUM increased over time across partnerships.
- Community Involvement took a longer time to take off as not all MyHealth partners knew how to integrate it within the project. To tackle this, training on the fundamentals of community development was provided to all partners. Pointers were given on communication tools and channels, networking, and

effective ways of showcasing the practicality of community engagement The compiled materials were converted into a health-educative learning suitcase which provided guidance to all actors involved in healthcare, from management to service users. http://www.healthonthemove.net/wp-content/uploads/2020/05/HEALTH-EDUCATIVE-SUITCASE-v.12-w-DISCLAIMER-1.pdf

- All MyHealth implementers hinted at obstacles and limitations related to language. The cost, role and influence of translators as well as issues of access, power, and language bias require an active and careful consideration from the research design to the dissemination of tools/results.
- Different understandings and definitions about issues related to migration were addressed by creating a dictionary of standardised definitions of key terms such as: VMR - Vulnerable Migrants and Refugees.
- Difficulties reaching out to targeted groups given the different legislation and prerequisites for working with WUM groups in each country (e.g. victims of sexual trafficking) presented some obstacles. Context specific and tailor-made interventions were designed as a solution for engaging with these groups.
- The various languages and the number of countries involved in the project were challenging. For example, the needs-assessment was difficult given very different local realities. Also, some views expressed by health professionals in the interviews and focus-group discussions could be considered as borderline racist. This was difficult to address, but the team members shared concerns and learned from other contexts and partners on how they deal with complexities and difficulties. The Learning Alliance was a very good response to this challenge.
- Coordinating diverse partners and actors as well as different profiles of the people (e.g. different institutions, countries, languages, different minorities in the countries, different experience in managing European funds) and the workflow were important challenges. Some partners needed daily micromanaging while for others a few interactions were enough. Improving communication channels solved this: on top of the 6-monthly assemblies there were monthly coordination calls and scientific calls plus weekly or daily emails. For some partners this resulted in e-mail overload so to tackle this, the coordinating team tried to categorise information and group content into longer emails to reduce the volume of emails.
- Different partner's expectations and in-built capacities were important obstacles (e.g. small NGOs such as Migrantas needed a lot of assistance with finances). The

project addressed this and built consensus about project management among consortium partners and facilitated the operation of all partners.

- The decision-making structures were confusing at the outset. In response to this challenge, a management guide that outlined the roles, expectations and responsibilities was produced to tackle these issues, and the workflow improved.
- Mainstreaming Community Involvement and the Learning Alliance methodology was not undertaken until the second year due to a lack of explicit instructions and knowledge about these components. This omission was specifically addressed by different activities (e.g. at the LA workshop in Berlin and making it explicit how activities such as piloting, the Metaplan and needs assessment all qualify as community activities) were very useful and consequent improvements were made.
- Resources and budget constraints especially with information technology (e.g. The map's allocated budget was EU 5000 but realistically it was EU 30K– 40K) which was inadequate. To cope with these obstacles the team invested additional time and resources in making the map more accessible and user-friendly.
- Time pressure and delays were challenges that generated extension requests from the partners for research activities and information gathering. Asking for time-extensions (e.g. as in the COVID-19-situation) in advance to be compliant with the deadlines set by the Commission solved these challenges.
- Report's formats and templates – the table of required contents for the deliverables from the EU Commission created difficulties for organising the reports without repetition, but consistently and coherently. The templates do not allow for any flexibility. To tackle this unlike in many other institutions training was offered pro-actively, on how to complete the financial reporting forms. Further, the coordination team offered extra help to some partners (e.g. Migrantas) and created an internal calendar. One suggestion for the Commission is to provide training on how to fill out their templates/forms. The identified obstacles have to do with the inherent complexities of MyHealth's diverse nature, its large scale and the administrative procedures involved in it. All these obstacles were spotted and solved in a timely matter after discussion among all the partners which enabled them to reach a consensus or solution. These obstacles did not prevent the project from achieving its objectives. On the contrary, obstacles worked as incentives to share and learn about different contextual situations and needs experienced by different stakeholders.

Furthermore, finding collective solutions in a collaborative way reinforced the spirit of the LA.

2.2. How both MyHealth outputs and outcomes have improved the health situation of unaccompanied children and women?

WUM newly arrived in Europe (less than 5 years) were defined as the target group for the MyHealth project given their particularly vulnerable conditions. Despite the heterogeneity and intersectional differences among the target group they were all directly and indirectly impacted by the project improving their access to health information and resources. Also, in contrast to the first 18 months in which MyHealth was working with all migrants that engaged in the activities, in the second part the emphasis was focused more on WUM following a critical review of the interim report.

The approach used by MyHealth partners to reach the target group involved networking with different external stakeholders such as NGOs or Foundations and public entities such as settlement centres for unaccompanied minors that focused their activities on VMR, supported in most cases by the health community workers. To reach out, MyHealth used the sound expertise of consortium members and a targeted dissemination strategy along with the community work package. More specifically, for UM MyHealth implemented activities in Athens, Barcelona and Berlin. In Brno meanwhile, activities with UM were not implemented as it was found that this was not an issue in this site. To include women, MyHealth implemented the needs, tools and pilots in Athens, Barcelona, Berlin, Brno and London.

According to both the qualitative and quantitative findings MyHealth implementing partners reported that the following outcomes were achieved:

- Design of a multilingual, online, interactive map through which unaccompanied children and women, as well as other end-users, can locate health and social care providers, integration support services, shelters and essential goods, legal assistance and educational activities (e.g. language courses) in their vicinities.
- Creation of open, easy-to-read summaries of migrant health policies and provisions across six EU Member States (Czech Republic, Germany, Greece, Italy, Ireland, Spain) and the UK, including but not limited to information about key legal and organisational aspects such as health entitlements of refugees, asylum seekers and migrants in irregular situations, fees, registration documents and procedures; emergency, national and regional contact points. Emphasis was made on WUM health conditions, especially pre and postnatal care in the case of pregnant women.

- Generation of an overview of the most common health problems among VMR (latent tuberculosis infection, viral hepatitis, HIV, mental health disorders), as well as the major barriers this population faces in accessing and using health care services. MyHealth has communicated research priorities and assisted health care professionals along with European and state-level policymakers in the creation of targeted health education and provision especially for WUM-VMR. The special conditions of the target group became visible and MyHealth considered how educational strategies and health problem identification need to be tailor-made for these two groups.
- MyHealth made visible the strong links between migrants' health and their overall life situation, e.g. poor housing, un-or under-employment, lack of local language fluency, uncertain determination of asylum claims and social isolation. Enabling VMRs to access more social prescribing is suggested and should be a new item on the agenda of researchers and policymakers.
- The project demonstrated evidence that healthcare professionals are not prepared to tackle the specific needs of VMRs given their unique experiences (e.g. traumas), but also as a result of insufficient language (mediation) support and lack of sensitivity to both cultural difference and gender issues.
- The project launched the MyHealth European Network for professionals on Facebook to share and discuss tools and initiatives that can improve the provision of healthcare for VMR, including unaccompanied children and women: https://www.facebook.com/MyHealthEU
- Outlined a strategy proposal on the "The Report on Defined Models and Consequent Tools" to identify and train experts in international health among primary health care professionals (PHC), and to improve the communication channels between PHC and hospital health care (HHC).
- A working group on International Health was formed in 2017. This sought to improve the quality of health care for immigrants residing in Barcelona specifically.
- Proposed tools (videos, for example) to tackle the difficulties newly arrived VMRs face in accessing and participating in health care. These included host-community related solutions such as administrative facilitation, promotion of community-based activities, and training packages for health professionals on intercultural competencies. In addition, VMR-related solutions such as active language learning, help-seeking behaviour, and pro-activeness in networking

with the local community were developed. https://www.youtube.com/watch?v=CDNlqTAbZmA&feature=emb_title

- Created an interactive, open repository of current tools aimed at people professionally related to VMR - directly or indirectly - as final users. For example: *"The protocol to prevent women's genital mutilation"* or the "*The Australian Refugee Health Practice Guide"* that targets children and adolescents. These tools can be used by doctors, nurses and other primary care providers to inform refugees and people seeking asylum on-arrival about health care services. http://www.healthonthemove.net/knowledgebase/

- Generated research about ICT tools that support migrant health service users and professionals working with them. A Guide for ICT Tools was developed with input from the community. The top-rated tools received the "Community-approved" logo and were further disseminated through digital platforms

- Developed and implemented pilot interventions at four sites (Athens, Barcelona, Berlin and Brno) including a training workshop for cooperation between cultural mediators and health/mental health professionals working with VMR (Athens), a participatory educational intervention with unaccompanied minors (Athens), seminars for Somali women about FGM and help-seeking behaviour (Berlin), a role-play with professional health care staff to create awareness about social and health challenges faced by VMR (Barcelona), a video to empower the Latin American community in the administrative procedures for obtaining the Catalan health card (Barcelona); training in intercultural competence for health care professionals in an interdisciplinary out-patient clinic for infectious diseases (Berlin) and workshops for foreigners (the name given to VMRs in the Czech Republic) and integration service providers (Brno). Additionally, a directory of doctors with foreign language capabilities was created and published (Berlin). http://www.healthonthemove.net/knowledgebase/healthcare-guide-for-non-eu-foreigners-in-brno-arabic-czech-english-russian/

  http://www.healthonthemove.net/ca/knowledgebase_category/myhealth-piloted-tools/

- The illustrative statements below in table 5 from some migrants in Barcelona, for example, assessing the video on obtaining the Catalan health card. This was gathered while one of the field visits for the final evaluation of MyHealth.

Table 5: Migrants assessment of the Catalan Health Card

Users:	Users:

The first respondent (male) had some prior knowledge on the topic; however, he learned about the numbers to contact outpatient clinics (ambulatorio). The second respondent (female) felt it right for all people to have a health card and to be attended by health services. The third respondent (female) saw the activity as informative and educational. She offered an example: when she received her health card, she did not pay much attention to the contact numbers, but the video reminded her to. Thanks to the visual medium she will remember the information better. She also appreciates the project's effort to reach immigrants, as in her view there is a lack of information and many immigrants spend months in the country without having a health card. She wishes she had the same information on arrival. She had learned about the health card by word of mouth. Both the first and third participants consider the video useful. The third participant stresses again the benefits of having learned about the numbers to call.	The first respondent (male) was not aware of the health card's existence prior to the video. He learned that -to obtain a health card, he needs to present his passport and registration certificate (certificado de empadronamiento); - everybody has the right to access emergency services in his or her state; - and, everybody who is registered, regular or irregular migrant , has the right to a health card. He considers the activity/information useful, but he wishes for it to be accessible earlier on, i.e. upon or even prior to arrival. He has been in [Catalunya] for a year and did not know about the health card. It would have been much better to know this earlier. The second respondent (woman) learned about the numbers that can be contacted, and the services that can be accessed with a health card. She was not aware of these previously. She found the activity useful, but she also thinks that the information should be more accessible, including for those who cannot read, or speak languages other than Spanish.
Users : The respondent (male) considers the project very important for immigrants arriving from Latin America and Africa. He notes that many immigrants, already living in Catalunya, lack information about the health card. He sees the information as useful and will circulate it to family and friends.	Users: The first respondent (woman) learned that - one needed to be registered (tener el padrón) in order to obtain a health card, - in case one has children, which she does not, every family member needs his or her own card. The second respondent (woman) aligned herself with the first respondent in learning about the importance of being empadronado for obtaining a health card. She has two children living in Catalunya (and a third one in Peru) with both having their own health cards. Both considered the information useful for their lives in Catalunya. The first respondent considers it essential as one can never know when he/she will need emergency care. She also wishes there will be more events like this, to learn about other things as in Catalunya 'everything is different'. The interview concluded with a brief exchange about the centre where the activity took place and its importance for the respondents.

User:
The respondent (woman) learned that all residents of Catalunya have a right to a health card. She had some prior knowledge of this, but after the viewing, she felt more reassured about her knowledge. She described the video as educational and illustrative. Her doubts have been answered by it: for example, she learned that even people who are not registered (yet) can go to certain entities and institutions to resolve their situation. She saw the information as very useful, educational and accessible to all levels.

- MyHealth improved evidence and measures of subjective and objective knowledge of, self-confidence and efficacy in cooperating with cultural mediators/professionals servicing VMR, accessing healthcare services, seeking professional help (e.g. victims of FGM), or obtaining a Catalan health card, as evidenced by the post-intervention questionnaires and discussions. The pilots also increased awareness about health disparities, migrants' rights and entitlements, racial, ethnic and cultural stereotypes, and the importance of cultural competency training for health professionals.
- The project raised consciousness among health care providers about the need of network coordination and dissemination of good practices that would impact indirectly on the target group.

Finally, it is important to highlight two important positive outcomes specially designed for WUM:

Participatory educative interventions for unaccompanied minors with or without shelter, implemented in Athens-Greece. Despite the small number of participants: 9 in total, aged 11 to 21 years (average age 16 years +/- 3) all Afghani males who arrived between 2018 and 2019, which reported important qualitative results. This educative initiative trained UMs as peer educators on healthcare services and access to healthcare. These peer educators would act as multipliers especially among UMs without shelter. The main topics addressed were homeless youngsters that do not have access to social services, the sense of disengagement and exclusion especially from healthcare systems, and basic information about health emergencies. This intervention proved UM's agency and abilities to participate as active health promoters among their peers, disseminate information and gain a sense of belonging through health services. The need for a better procedure of assigning homeless UM in the shelters became evident, as well as the need to provide information about health care services to homeless UM.

In Berlin, the educational workshop to empower women as part of the pilots had 14 participating Somali women who voiced their concerns regarding the difficulties that female refugees encounter regarding health care access. A lack of knowledge regarding female genital mutilation (FGM), birth obstetrics, and language barriers were the central

themes. Many female Somalis asked in face-to-face talks for more knowledge and information on FGM, expressed their concerns about mental health care for women who had experienced FGM, and requested that information about FGM in birth obstetrics be improved. Additionally, this intervention worked towards reducing cultural, language, and other barriers to the health care system for female refugees and improved their knowledge and help-seeking behaviour. The workshop was well received with a large majority of positive ratings on all indices. This means it was seen as informative, personally relevant, useful and empowering given the health and cultural alternatives and perspectives shared by, and with, women.

Main Limitations:

Even though there were no negative impacts reported by unaccompanied children and women, several limitations and barriers to working with this target group were expressed by MyHealth implementing partners. These included:

- Existing legal restrictions limiting the involvement of UM in different contexts and countries' legislation that prevents easy access of the researchers to them.
- Limited time frame to address the existing complexities involved in the work with this target two groups such as cultural background, subjective experiences, linguistic barriers, age-related aspects and needs.
- Inadequate capacity of partners to guarantee the sustainability of this work by partners.
- Difficulties implementing a more participatory research and a lack of special protocols and guidelines for working with WUM. Most partners use traditional health research models without a gender and/or intersectional lens.

Overall, outcomes and outputs from MyHealth did improve WUM health status not only by identifying their specific contextual needs in selected sites, but also by empowering them in different aspects such as: training to become health multipliers (UM); increased knowledge about procedures and available tools to access health services (women), making health providers aware of needs, dynamics and methodologies to socialize WUM health situations, needs and expectations and giving voice to unheard VMR-WUM. These findings have short- and long-term positive impacts in the targeted group's health conditions.

2.3. What are the main criteria emerging from MyHealth regarding quality, effectiveness and sustainability when working with VMR, particularly WUM?

Quality, effectiveness and sustainability are the main evaluation criteria that the interim and final evaluation reports included. Nonetheless, attention was given to capturing how these criteria emerged through the implementation and evaluation processes of MyHealth specifically in regard to its main target group VMR-WUM by attempting to answer the following questions:

- **Quality:** are implementing partner's networks addressing migrants –especially VMRs' health issues and needs in an effective way? Are MyHealth tools assisting project beneficiaries? Is MyHealth helping migrants – especially VMR-WUM to reach health care services?

- **Effectiveness:** are the potential benefits of MyHealth being recognised? Is MyHealth going to make a difference?

- **Impact and sustainability**: are MyHealth outputs and outcomes going to have a long-term effect (see impact and sustainability in the next Chapter 3)?

Findings

The following actions and findings emerged as key components that improved the quality and effectiveness of MyHealth and that can contribute to the success of future health interventions targeting VMR-WUM:

Quality

- Direct work and involvement with VMR-WUM was undertaken challenging pre-existing assumptions about their needs and interests. Interventions and activities were adapted for the public and targeted groups such as UMs.

- A flexible and adapted research methodology was implemented to work with VMR social groups. Qualitative and participatory research techniques allowed the project to capture the complexities and nuances that are at stake when working with these groups. For example: mobility and connectivity dynamics that rule VMR life practices.

- A shared methodology among different research sites that comprised different countries, health systems and languages using standardised procedures in terms of the interviews, questionnaires and focus group discussions. This ensured consistent results that could be compared and evaluated.

- The need to improved cross-national data and information accessibility across the EU was documented, especially regarding migrant health rights and services in order to compare, track and improve facilities
- Significant differences in the entitlement, organisation and provision of health benefits and services to VMR-WUM across the EU were identified. This provided stakeholders with a better understanding of how to improve their plans and policies targeting this group.
- Health promotion tools were developed which were systematically informed by inputs from professionals, VMR-WUM and members of VMR-WUM host communities. This approach proved to be efficient and successful. Communities can to a great extent keep the project alive by passing down information about the tools by word of mouth, and through health champions such as children's active participation.
- Coordinated work among different stakeholders proved to be efficient and effective under the Learning Alliance model. Outcomes focused on i) the processes of participation, ii) partnerships between unlikely actors (e.g. ESOL teachers and health service providers), iii) new strategies for bringing together health service users with hospital management and researchers as well as other multidisciplinary and multi-sectorial stakeholders.
- Incentives like monetary remuneration, opportunities for CV building, or travel to partner conferences and meetings were identified as potential strategies to put different stakeholders on a level playing field to tackle the main challenges faced by VMR-WUM. Embracing the knowledge and expertise owned by migrant communities and remunerating it is essential. Research funding should be allocated to VMR-WUM for this purpose.
- The need for an intersectional approach taking into account age, gender, cultural, and linguistic differences when identifying health needs and providing services, was documented and evidenced. For example, one of pilot interventions implemented in Berlin with Somali women.
- Specific health conditions affecting women and minors were documented. Many minors have experienced physical violence, suffered genital mutilation, have an unreliable vaccination status and present distinct clinical problems. MyHealth provided ample proof that an optimal evidence-based approach is not only important but fundamental for this vulnerable population.

- The development of a trusting relationship with women and especially with UM is of great value for the effectiveness of educational interventions, especially in terms of participation, stability, consistency and motivation as evidenced by the pilot in Athens. It is important for unaccompanied minors to express their needs and concerns, but also to be equipped with capabilities to adopt a leading role in participatory interventions rather than remaining as subjects of those interventions.
- FGM should be an essential part of cultural competence training for mental health professionals and, potentially, other health practitioners. Particularly, it is important that they are aware of trauma-related disorders after FGM. Working with women with FGM requires that any interpreter also possesses knowledge of FGM, and that counselling and treatment options are offered. The demand for contact with experts amongst the Somali women was very high, with a lot of individual consultation sought (Berlin intervention).
- Mental health was identified as a key factor that is frequently undermined and invisible given the prejudices surrounding it. Professionals and VMR might not be aware or sensitised about it because of cultural differences and/or the migrants' age, (e.g. minors might find it more difficult to conceptualise mental health and relate it to their own experience.)

Effectiveness:

- All of MyHealth's goals, objectives and planned activities were met and accomplished. The project was successful in producing the entire desired results.
- As seen in table 1 the results reflect mainly highly satisfactory scores and satisfactory scores. And less satisfactory results were reported by some respondents of all three surveys.
- The Mid-term report was highly useful in indicating aspects that could be slightly modified and/or enforced such as focusing much more on VRM: WUM. Such observations were seriously considered and changes were implemented with positive results.

Limitations:

- It was challenging to ensure GDPR compliance due to the lack of advice available from the data protection officer and the legal departments.
- Identified needs were defined based on the migrants the project was able to access. Even though some needs are generalisable to VMRs, there might be

additional needs that the project failed to map (e.g. victims of sexual abuse, of slavery).

- Some study (Burns, F.M., et al 2007) shows that VMRs do not use healthcare services until after 5-6 years in the country on average. Therefore, recruitment and outreach activities at hospital sites might not be the best sites for reaching all the VMRs particularly those recently arrived.
- Further projects/research is needed from a medical humanities perspective into doctor-patient communication, not only for VMRs or migrants, but also regards the general population.
- Rigid institutional structures can become an obstacle to guaranteeing the sustainability of MyHealth's positive results. This can be addressed by enhancing the partner institutions' understanding of community development and engagement great potentials, but whether this awareness can translate into sustainable practice given these inflexible institutional structures and processes remains a question.
- The financial sustainability of the project and its results remain a difficult question especially in times of COVID-19. Even though this pandemic is a novel scenario when working with migrants, partners and stakeholders need to attract private sponsors, engage local authorities and apply for funding to continue pursuing their work.

Overall, the three evaluation criteria: quality, effectiveness and sustainability (in Chapter 3) which emerged while implementing MyHealth were thought of and met with relative success. The main remaining challenges continue to be the financial sustainability of the project and its future impact of most of the significant achievements. In addition, the failure to mainstream migrants' health needs, particularly with regards to WUM into health protocols, national plans and policies remains a major barrier to sustainability.

2.4. To what extent the use of some components of the LA methodology has contributed to the learning and strengthening of the impact of MyHealth as seen by the stakeholders?

The LA Methodology was the main strategy of MyHealth by seeking to re-think the utilisation, appropriation and impact of research outcomes in the health services area in more integrated ways. Formally defined, it is *"a series of connected multi-stakeholder platforms or networks (practitioner, researchers, policy-makers, service users) at different institutional levels (local, national) involved in two basic tasks: knowledge*

innovation and its scaling up."[1] Furthermore, it was expected that LA would contribute to strengthening the learning and network capacity of stakeholders with regards to the participation of migrants and refugees by ensuring their inclusion and participation whenever possible.

In general, partner's evaluation of the LA component was positive and ranged between highly satisfactory and satisfactory with 73% agreeing and 13 % of the 15 implementing partners strongly agreeing that this methodology had had positive outcomes for the project through contributing to the learning and strengthening the impact of my MyHealth.

Even though initially as reported in the mid-term review of the MyHealth project, partners considered that the LA methodology was unclear regarding its role in the project, the final evaluation reported better results as described above. The LA training workshop in Berlin in 2018 was a turning point where three key elements for improving the use of the LA approach became clear: i) The need for a checklist outlining a more strategic engagement with local stakeholder analysis; ii) The need to document and evaluate all activities being implemented in terms of research, dissemination and community; and iii) the need to capture the learning experienced by people participating in MyHealth according to their roles.

As a result, Barcelona, Berlin, Brno, Emilia Romagna, London and Athens were more active in capitalising on their previous work and consolidating their local LAs within their existing networks. [2] Table 6 shows the evolution of these sites over time showing the stakeholders' progress in terms of their forms of engagement and their roles when participating in MyHealth activities. This documentation was done more rigorously in the second phase of the project.

Table 6: MyHealth: Cumulative Stakeholder Analysis

[1] See project's glossary
[2] Interim Evaluation Report, 2018, pg. 30-31

JUNE 2019		NOVEMBER 2019			MAY 2020		
Stakeholders & Sites	**Engagement**	**Stakeholders & Sites**	**Engagement**	**Roles**	**Stakeholders & Sites**	**Engagement***	**Roles**
Athens/Greece Total = 34		**Athens/Greece Total = 44**			**Athens/Greece Total = 45**		
Civil Society = 31 Public Sector = 2 Private Sector = 1	Dissemination and Research	Civil Society = 41 Public Sector = 2 Private Sector = 1	Comm Involvement = 4 Dissemination = 34 Research = 3 Mapping = 3	Service Providers = 38 Policy Makers = 6	Civil Society = 41 Public Sector = 3 Private Sector = 1	Comm Involvement = 4 Dissemination = 35 Research = 3 Mapping = 3	Service Providers = 36 Policy Makers = 6 Collaborators = 2 Researchers/Org = 1
Germany/Berlin/Migrantas = 21		**Germany/Berlin/Migrantas Total = 20**			**Germany/Berlin/Migrantas Total = 20**		
Civil Society = 21 Public Sector = 2 Private Sector = 1	Community Involvement	Civil Society = 20	Comm Involvement = 20	Collaborators = 20	Civil Society = 20	Comm Involvement = 20	Collaborators = 20
Germany/Berlin/Charitee = 13		**Germany/Berlin/Charitee Total = 55**			**Germany/Berlin/Charitee Total = 53**		
Civil Society = 9 Public Sector = 4 Private Sector = 0	Community Involvement Dissemination and Research	Civil Society = 17 Public Sector = 38 Private Sector = 0	Comm Involvement = 17 Dissemination = 23 Research = 25 Mapping = 17	Service Providers = 28 Policy Makers = 2 Collaborators = 14 Researchers/Org = 8 Service users = 3	Civil Society = 17 Public Sector = 36 Private Sector = 0	Comm Involvement = 16 Dissemination = 22 Research = 16 Mapping = 17	Service Providers = 26 Policy Makers = 2 Collaborators = 14 Researchers/Org = 8 Service users = 3
Czech Republic/Brno/FNUSA = 17		**Czech Republic/Brno/FNUSA Total = 19**			**Czech Republic/Brno/FNUSA Total = 17**		
Civil Society = 7 Public Sector = 8 Private Sector = 2	Community Involvement Dissemination and Research	Civil Society = 7 Public Sector = 8 Private Sector = 2	Comm Involvement = 6 Dissemination = 2 Research = 14	Service Providers = 9 Policy Makers = 5 Collaborators = 1 Researchers/Org = 3 Associates = 1	Civil Society = 7 Public Sector = 8 Private Sector = 2	Comm Involvement = 6 Dissemination = 1 Research = 14	Service Providers = 8 Policy Makers = 4 Collaborators = 1 Researchers/Org = 3 Associates = 1
Spain/Barcelona/VHIR = 187		**Spain/Barcelona/VHIR Total = 223**			**Spain/Barcelona/VHIR Total = 219**		
Civil Society = 27 Public Sector = 132?134? Private Sector = 11	Community Involvement Dissemination and Research	Civil Society = 35 Public Sector = 165 Private Sector = 12 N Identified = 11	Comm Involvement = 131 Dissemination = 3 Research = 29 Mapping = 21	Service Providers = 144 Policy Makers/Bodies = 22 Collaborators = 1 Researchers/Org = 19 Associates = 19 Media = 1 MyHealth = 1	Civil Society = 33 Public Sector = 163 Private Sector = 12 N Identified = 11	Comm Involvement = 128 Dissemination = 2 Research = 14 Mapping = 20	Service Providers = 145 Policy Makers/Bodies = 22 Collaborators = 1 Researchers/Org = 19 Associates = 19 Media = 1 MyHealth = 1 N Identified = 11
TOTAL = 272							
		London Consonant/UoG = 20			**London Consonant/UoG = 21**		
		Civil Society = 15 Public Sector = 0 Private Sector = 5	Comm Involvement = 20	Service Providers = 2 Policy Makers/Bodies = 1 Collaborators = 11 Researchers/Org = 0 Associates = 4	Civil Society = 15 Public Sector = 1 Private Sector = 5	Comm Involvement = 20	Service Providers = 2 Policy Makers/Bodies = 1 Collaborators = 13 Researchers/Org = 1 Associates = 4
		Regione Emilia Romagna = 34			**Regione Emilia Romagna = 33****		
		Civil Society = 12 Public Sector = 22 Private Sector = 0	Mapping = 30 Dissemination = 3	Service Providers = 32 Policy Makers/Bodies = 2	Civil Society = 12 Public Sector = 21 Private Sector = 0	Dissemination = 3 Mapping = 31	Service Providers = 32 Policy Makers/Bodies = 1
		TOTAL = 415			**TOTAL = 408**		

As table 6 above shows from June 2019 to May 2020, there was a steady documentation and an increase of total stakeholders' participation in the MyHealth project from 272 to 408 stakeholders at the end of the project after cleaning the data and eliminating stakeholders who were repeated in the data. These 408 stakeholders came respectively from the public sector (232), civil society (145) and the private sector (20). The tendency to engage with stakeholders with similar profiles as the implementing partner was noted in the monthly meetings as well as low levels of engagement with dissimilar stakeholders for example, those from the private sector. There was a serious attempt in the final year of the project to increase stakeholder engagement from the private sector. According to MyHealth partners, they felt that in this project they engaged with a broader range of stakeholders than usual and felt that this has been useful, and enriching.

The 408 stakeholders engaged in all the activities that MyHealth implemented during the three years but particularly during the second part of the project, which was the phase when the documentation was implemented more systematically with the tracker. In order of significance, the activities documented that stakeholders took part in were first, community involvement (194 stakeholders); second, mapping (73 stakeholders); third, dissemination (63 stakeholders); and fourth, research activities (47 stakeholders). Some 33 of the stakeholders did not identify the activities in which they participated. As table 6 shows by documenting the activities through the tracker designed in the context of the LA, the community involvement component was emphasised and not just MyHealth research activities. Consortium partners considered that everybody's work had been at the same level without significant differences due to profession/academics/practitioner which is often the case during some research projects.

Regarding stakeholders' roles when participating in MyHealth activities as per the LA methodology and their corresponding learning the seven most substantial these were: service providers (249), collaborators (51), policymakers (36), researchers (32), associates (24), service users (3), media (1), No answer (12). Overall all implementing partners thought that learning occurred by working with different partners and found it reassuring that they were already implementing many elements of an LA without the name things as such.

Consortium partners reported the following positive results and learning outcomes from the LA methodology:

- It allowed VMR participation where their views and concerns were taken into account giving value to their voice.
- The LA methodology enhanced package leaders' ownership of the activities and promoted the formulation of new initiatives.
- Promoted an interdisciplinary approach to MyHealth objectives.
- Strengthened team-building strategies among health professionals, academics and service users to discuss, brainstorm, problem-solve, develop and deliver training as in the case of work-package 8.
- Improved inputs of all actors involved in the health management chain – from users to managers on more equal terms. Those with non-health professional backgrounds appreciated having an environment which enabled them to contribute.

- It changed attitudes and dispositions of health professionals who were open and willing to sit back, listen and absorb rather than being the ones who share knowledge and expertise.
- Created a more democratic, fairer environment that benefited from a broader range of expertise and knowledge sources. Everybody worked at the same level and no distinctions were made between academics and practitioners.
- The LA increased stakeholders' networks and allowed implementers to become conscious of the existing networks among the stakeholders.
- Illustrated the different and specific local realities, difficulties and solutions that each site faced and resolved by coming up with collaborative and consensual solutions.
- Increased diversity by bringing together people interested in the same issues with different expertise and perspectives. This enriched the quality and breadth of discussions around MyHealth.
- Improved partner's support and exchange of ideas.
- Helped in conceptualising activities and components that were already being implemented.

Partners reported the following negative results and learning outcomes from the LA methodology:

- Lack of clarity about its implementation during the initial phase of the project (general observation).
- VMRs were not included in the decision-making processes as project-team members, parts of the general assembly or as specialists in IT etc. That is, there was a lack of involvement beyond consultation.
- Lack of time to properly document further activities and their results as a component of the LA methodology.

Next steps - Suggestions

Partners made the following suggestions to build on the LA's achievements:

- MyHealth as an International LA:

Partners envisioned MyHealth as an international LA focused around the words illustrated on Figure 2.

Figure 2: MyHealth suggestion for a vision as an International Learning Alliance

Some names for an international MyHealth LA were suggested:

- Healthcare Access for Immigrants (HAFI)
- EULAMH (European Learning Alliance for Migrants Health)
- MigRefHealth Learning Alliance
- MyHealth Alliance
- Include VMRs in decision-making processes as project-team members, parts of the general assembly and as IT specialists etc (Eva)

Despite initial operational misunderstandings, most elements of the LA component were achieved in a satisfactory way according to the partner's feedback. Most successful LA elements: involvement and participation of different stakeholders through coordinated activities such as mapping, research, dissemination and community activities. Elements with satisfactory implementation included proper documentation of activities in a more consistent and rigorous way. It is important to highlight that this component brought to the front the diverse perspectives and sources of knowledge of different stakeholders thus improving the democratic and participatory character of the project. Importantly this approach also inspired partners to envision ways to collectively build on the project's results in the future.

2.5. Have expected outputs and outcomes of MyHealth been achieved by April 2020? Why, or why not?

Both the project outputs and outcomes were achieved by June 2020. Their accomplishment was the result of: i) steady commitment of all partners, stakeholders and actors who took part in the project from beginning to end, ii) systematic and efficient coordination and follow-up of the different tasks to be accomplished by the project; iii) equitable distribution of workload and responsibilities among implementing partners; iv) collective feedback and sharing of local achievements and obstacles; vi) good logistic organisation of meetings such as the coordination and scientific meetings (one each month); General Assemblies (one every six months); Board of Directors and Sub-committee meetings and particularly stakeholder presentations before different audiences in several EU countries; vii) The project had a significant proportion of migrants both as participants and as stakeholders.

Outputs/Outcomes' Achievements:

- The interactive map features 1,132 hits by June 25 2020 without counting Mighealthcare. To continue receiving input, the mapping questionnaires will also be distributed through various platforms and communication channels in the future (newsletters, social media, MyHealth website etc.). The map will remain active for a minimum 2 years after the project's completion, ensuring a continuous update and dissemination of the information (WP4).
- MyHealth yielded considerable and relevant knowledge and insights about the health needs and challenges faced by professionals working and serving migrant and refugee populations. Many of the findings are context-specific according to their locality and have methodological limitations (e.g. sample size, access to internet by VMR, different language and literacy skills in the VMR cohort) making generalisation difficult. Nevertheless, there were several important themes and issues common to all participating partners and stakeholders such as vulnerability to legal status (refugee and residence) housing, jobs, and health issues; the latter, in some cases, not seen or perceived as urgent or important. The project has produced significant and pertinent results to inform health policy, plans and interventions for engaging and working with this population (W5).
- Since its creation, the European MyHealth Network has increased its community of professionals and regular users of the online tools (see annex 7 page 127 for numbers).

- The Metaplan methodology (14 sessions at four sites) allowed a bottom-to-top approach to tools development with participants and project stakeholders who are the actual tool's users informing the methodology. The outcomes and recommended solutions represent the opinions of the target populations. Despite the fact that these perspectives are important, it would had been beneficial to also involve members of the general public as key informants (WP6).
- MyHealth Repository Toolbox: until March 2020, MyHealth had gathered 139 tools, including infographic material for migrants, scientific papers concerning infectious diseases and mental health, social content, games and online applications for those wishing to improve their knowledge or to propose awareness-raising activities about VMR-WUM. Materials are accessible in various languages, and there is no registration required to access the contents. From March 2019, when the MyHealth consortium started uploading the first tools, the page has received 38.069 page views(see annex 7 page 127)
- All planned interventions were successfully conducted, recruiting 244 VMRs across all sites therefore exceeding MyHealth's initial target of 200 VMRs. Additionally, 175 professionals were recruited for the interventions. Overall, the pilots met their individual objectives and were rated positively (WP7).
- The economic aspects were also assessed showing that overall, the pilots are sustainable and transferable to other contexts. Two were rated as more costly, but in terms of their impact and benefits they too came out as cost-effective. For some pilots - e.g. the training for cooperation between cultural mediators and health/ mental health professionals working with VMR - a small charge could be considered in the future to cover part of the expenses (WP7).
- By May 2020, MyHealth partners had delivered 103 community involvement activities across six European sites (Brno, Barcelona, Berlin, Athens, London, Regione Emilia-Romagna). They established collaborations between different stakeholders that will hopefully outlive the project, such as the Steering Group on Health and Well-Being and the Peer 2 Peer Training for Unaccompanied Minors in Athens. Community involvement also supported the development of the Learning Alliance and vice versa (WP8).

Limitations:

- Some of the initially planned outputs such as the interactive map, were incorrectly budgeted from the outset. This despite the fact that this work was being led by only one partner from the private sector. Strategies to overcome budget difficulties were not set in place by this private sector partner.
- Research and training implementation and evaluation activities lacked a control group and the sample size was too small to make more accurate data comparisons. For future research and training development, a larger sample size coupled with a set of objective questions comprehensively assessing training knowledge (supported by subject-matched self-efficacy and subjective knowledge questions) is recommended.
- MyHealth did not directly assess the pilots' impact on health care access, the quality of care, cooperation, help-seeking behaviours etc. These would require greater longitudinal assessment.

Implementing Partners' observations:

- Some partners reported survey fatigue and observed that completing survey requirements absorbed a significant part of their working hours.
- The project was overambitious given the existing complexities of working with WUM and with a range of conditions including infectious and non-communicable diseases and mental health.
- Despite the great contribution of having a diverse group of partners in the consortium sometimes this same diversity made it difficult to reach common understandings of tasks, roles as well as communication.
- Most of MyHealth outputs and outcomes target health professionals, social workers and are not oriented directly and immediately to migrants.
- It was difficult to reach the specific vulnerable group the project members originally had in mind. MyHealth was a health project, rather than a community project which would have allowed for bringing in perspectives from education, employment, housing and other sectors relevant for understanding migrant health.

3. MyHealth Overall Evaluation

3.1. MyHealth Relevance

MyHealth results are highly relevant for the EU participating countries, especially in the context of the current COVID-19 health emergency. The project's planning, design and implementation highlight the relationship between the problems issues faced by vulnerable migrants when accessing health services and health providers' ability to respond adequately to those problems. Even though the projects' main implementation was undertaken prior to the COVID-19 pandemic, the knowledge, results and recommendations generated from MyHealth become especially significant for policy and formulation of health-plans. At the same time as COVID-19 is exacerbating the health vulnerabilities facing VRM, MyHealth has created a useful knowledge base and a range of tools for UMW-VMR, professionals and others who are currently working or who will be working with them in future.

The final evaluation of MyHealth showed that the consortium considered the eight objectives of the project to be realistic and achievable, despite some challenges that were overcome particularly during the project's second phase (September 2018-June 2020). The second phase (April 2017-September 2018) was more organic, integrated and fluid than the first phase and when challenges and obstacles were identified, the team solved them in a satisfactory manner (see Chapter 2.1 in this report). For example, certain issues were raised in the first phase such as the lack of clarity between the meaning and role of mapping; uncertainty surrounding the final destination of the qualitative ad quantitative data regarding health needs and the community strategy and LA. These challenges were resolved in the second phase.

The innovative character of some activities and the lack of familiarity among partners with those activities in the first phase explains the lack of clarity expressed by the MyHealth consortium in the first phase. Paradoxically, in the second phase, this perception also shows the project's role in bridging innovation and new participatory methodologies where diversity was present at all levels (e.g. linguistic, gender, age and ethnic diversity among others). In the second phase, the project made a consistent effort to include unheard voices for example WUM. As a result, their health needs became visible and shared among key health stakeholders such as professionals, practitioners, civil society organisations, and even private sector groups that work with VMR and migrants in general. In that sense, the learning alliance methodology and community approach demonstrated success in facilitating the development of the tools and the pilots assessed under workpackages six and seven.

A crucial criterion when assessing the relevance of this project are its beneficiaries. In this regard, MyHealth made strenuous efforts to engage with vulnerable migrants who have arrived in Europe in the last five years with a particular focus on WUM. Nonetheless, as discussed, this approach faced challenges that differed between the project's two phases. In contrast to the first phase when engaging with and including WUM was a major challenge by the second phase the project was more directly inclusive of WUM-VMR, for example in work done with tools and pilots in Athens and Berlin. Some lessons learnt in these two sites were that:

- a project involving unaccompanied minors should ideally be exclusively focused on them and led by those social care stakeholders and authorities who work with these minors and who therefore have enough experience and time to comprehend their realities more closely.
- regarding women, it is vital that health providers receive adequate training in cultural differences and their specific needs about their reproductive and sexual rights.
- mental health issues associated with earlier experiences of both WUM-VMR should be addressed in an equal manner.

MyHealth's process, output and outcome indicators show that over the 39 months the project has made a highly satisfactory effort to meet and document the projects activities according to the indicators under each objective. The specific results regarding the indicators can be reviewed in annex 7. Thus, overall, the project's goals and objectives were met or surpassed. Elements of the project requiring attention at some point in the project were satisfactorily met in the second phase.

3.2. MyHealth Efficiency

Table 1 in the executive summary illustrates the comparative representation of what the group of individuals (workpackage leaders, implementing consortium and external stakeholders) consulted for the final evaluation of MyHealth, consider it has achieved in terms of quality, quantity and timeliness regarding objectives-outputs.

Table 1. MyHealth FinalEvaluation -- Rating of achievements

Up to May 2020	Up to September 2018

Rating Objectives	Highly Satisfactory	Satisfactory	Less than satisfactory	Highly unsatisfactory
1. Interactive **mapping** (Sep 2018)				
1. (May 2020)				
2. **Need assessment** VMR and health professionals (Sep 2018)				
2. (May 2020)				
3. List **of current health problems** (Sept 2018)				
3. (May 2020)				
4. Health Interventions –**TOOLS** (May 2020)				
5. ICT-based **platform** (May 2020)				
6. Implement the defined strategies and models in **PILOTS** (May 2020)				
7. A model for community participation				

(Sep 2018)				
7. (May 2020)				
8. Implementation of a wide-ranging and sound strategy managing and communicating MyHealth results including the Learning Alliance methodology (Sep 2018)				
8. (May 2020).				

1. Interactive mapping: all parties consulted for the final evaluation found this useful and satisfactory. Over half (53%) thought that MyHealth is finishing having produced a comprehensive that is user-friendly. The 47% who did not agree considered that VMRs are more likely to go to more generic applications such as Google maps where the information is not tailored for them. Some individuals were critical of the time that it took to develop the map. As this was one of the first activities to be completed, they felt this affected the overall confidence of the project in its first year. Contrasting the quality rating given between the two phases of the project, this moved from less than satisfactory in the first phase to satisfactory at the end of the project. However, in terms of time it was not very efficient. Of all MyHealth's outputs and outcomes, the map has been the most contentious as the rating table above demonstrates. A lesson learnt is that an IT specialist needs to be fully involved from the planning stage to consider all the technical and financial aspects of a complex tool like this one. http://www.healthonthemove.net/workpackage/w4/

2. Needs assessment: The majority of respondents (71%) to the final evaluation considered that the achievement under this objective-output was satisfactory with 21% rating the achievement as highly satisfactory. Similarly, half of the respondents thought that the challenges MyHealth faced when delivering the health needs reports were solved collaboratively by all consortium members. After the publication of the reports had been approved by the EU around October 2018 the project achieved a good level of dissemination as confirmed by the number of new visitors to 591 the website by 7,591

by June 30,2020. Nonetheless comparing the assessment of phases one and two means that besides disseminating outputs and findings on the health needs of UMV-VMR via the project's website elements of the report will potentially make a very high-quality academic publications. http://www.healthonthemove.net/workpackage/w5/

3. List of current health problems: The results to this indicator were the same as above with 71% and 21% of respondents considering that the achievement under this objective-output was satisfactory or highly satisfactory respectively. What is particularly significant is that during the second phase, the project created the screening strategy for mental health disorders and infectious diseases in primary health care. This indeed should help currently in the COVID-19crisis not only in Spain but also in other parts of Europe, if other stakeholders wish to adapt the strategy that Spain has created.

4. Health Interventions–Tools: This workpackage tasks had not commenced by September 2018, so cannot be compared with the phase one of the projects. More than half of respondents (64%) and a further third (29%) believed that the objectives were achieved in either a satisfactory or a highly satisfactory manner. The most significant achievement under this objective-output was the gathering of high-quality data through the 14 Metaplans, which were carried out across four MyHealth sites. This allowed the project members to validate the results from the health needs analysis using in-depth, community and participatory methods. This also allowed the project to collect first-hand the experiences and views of VMR including WUM regarding solutions related to their health care needs. At the same time, health professionals underlined the importance of overcoming barriers associated with legal entitlements and administrative protocols. The consortium's capacity building in community participation was very visible in the Metaplans and in the selection of tools to be piloted. Furthermore, the European Network led on Facebook by MyHealth as a platform for exchange and communication among and between professionals and migrants/refugees has acquired added significance and importance during the COVID-19 pandemic.

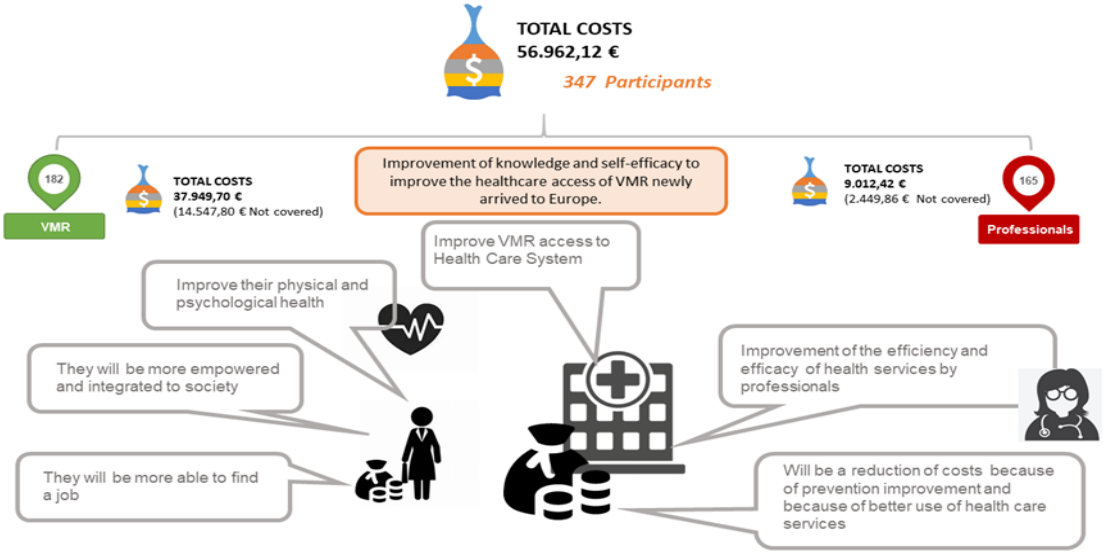
5. ICT-based platform: Likewise, this work-package had not yet started in September 2018, so cannot be compared with the first phase of the project. The various parties consulted for the final evaluation found the work under this objective-output satisfactory (86%) and highly satisfactory (7%). Similarly, 86% of respondents deemed that MyHealth is delivering an ICT-based platform that is comprehensive and informative as against 14% who thought that this was not the case. Some of the latter responses relate to the fact the platform is more oriented towards health professional and similar actors rather than the VMR-WUM as such. Others thought that the interface could be improved and expressed a wish that the platform will continuously be updated in the future. Along with the map, this is one of the objectives-outputs that has been

contentious within MyHealth. The quality and quantity of the tool in the ICT platform is good as is the efficiency with which it was created during the second phase.

6. Implement the defined strategies and models in pilots: All respondents were of the view that achievements under this output were met to a satisfactory or highly satisfactory way which was divided equally. Similarly, 60% and 20% respectively of the ones who responded satisfactory and highly satisfactory thought that the challenges MyHealth faced delivering the health pilots were solved collaboratively by all consortium members. The pilot was an objective-output of the second phase of the project and one of the last to be implemented. It recruited 231 VRMs in Athens, Barcelona and Berlin, therefore, exceeding the initial target of 200. Additionally, 165 professionals were recruited throughout the interventions. This objective-output of MyHealth along with the tools piloting of the tools selected by the UMW-VMR and professionals went through cost-effective impact evaluation. This indicated that the value for money of the piloted interventions could and should be transferrable to other cultural contexts. The following excerpt and pictogram from the D7.2 Evaluation report is significant as it allows consideration of rigorous evidence of MyHealth's impact:

"The economic results demonstrate that the 9 pilots could potentially be sustainable and easily implemented in a future project to maximize their social impact around Europe. The pictogram below reflects the positive economic effects of the 9 implemented pilots performed during the MyHealth project. A total of 56.962,12€ were invested in these interventions performed over 419 participants (244 VMR and 175 professionals) to increase their knowledge and self-efficacy and directly improve the health access of VMR newly arrived to Europe. These direct outcomes imply indirect outcomes for the economy such as: reduction of costs due to improvements in health prevention and higher efficiency on the use of healthcare services. Moreover, improved care and knowledge among professionals on VMRs translates into higher integration rates to hosting societies and accordingly higher probability to find a job" (p.162)

Figure 3: Economic Pictogram of Pilots



7. A model for community participation: Over half (57%) of the respondents to the final evaluation considered that the achievement under this objective-output was satisfactory with 36% rating them as highly satisfactory. Similarly, 60% of respondents thought that the challenges MyHealth faced delivering community development were solved collaboratively within the consortium. Contrasting the assessment of the first and second phases of this objective-output, this one improved significantly from satisfactory to highly satisfactory. As pointed out in the interim report community participation was one of the central innovative components of MyHeath and this approach proved highly challenging at the beginning, as not all partners knew how it fit within the overall project. The highly satisfactory rating demonstrates the capacity building and the learning the consortium partners experienced with this objective-output. One of the main findings of MyHealth is the central importance of the participatory approach when working on health issues with VMR-WUM. So, it was the creation of tools such as those included in the health educative suitcase. http://www.healthonthemove.net/wp-content/uploads/2020/05/HEALTH-EDUCATIVE-SUITCASE-v.12-w-DISCLAIMER-1.pdf

8. Implementation of a wide-ranging and sound strategy for managing and communicating MyHealth results including the Learning Alliance methodology: respondents rated the management, communication and learning alliance activities under this objective-output as highly satisfactory or satisfactory at 69% and 31% respectively. Comparing the two phases, this is an objective whose rating improved over the two phases of the project. Concerns about the project's managerial structure and

lines of command between a hierarchical or horizontal structure were reported in the interim report. These issues were solved during the second part of the project contributing to MyHealth's excellent flow in implementing the activities during the second phase. The manager of the project has been excellent at "keeping us all on our toes" when it came to the delivery, quality and timeliness of MyHealth's deliverables. So it was the scientific director of MyHealth during the second phase of the project.

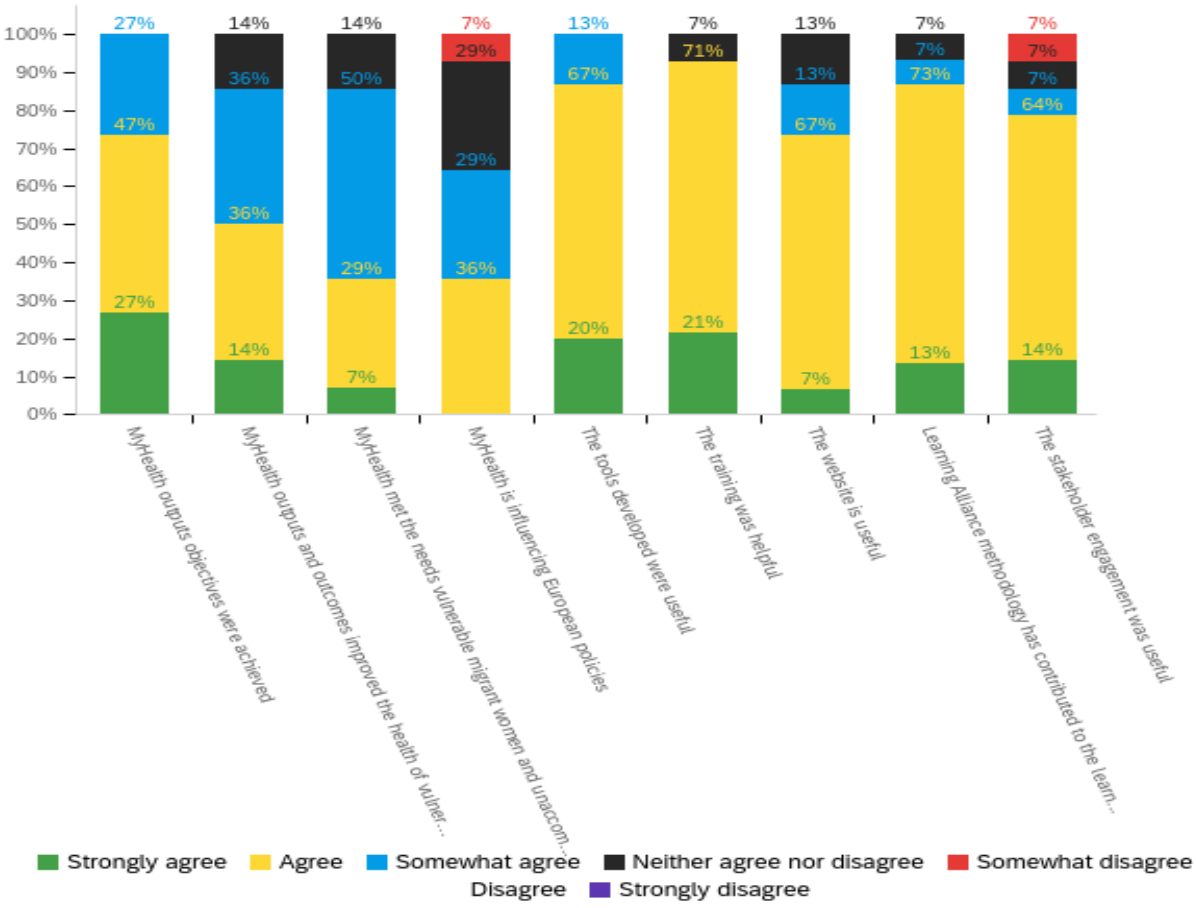
Regarding the communication work package, this along management and the LA were all transversal to MyHealth and as such, integrated from the beginning of the project. By month 4th there was a communication plan outlining how the results of the project were going to be communicated to the stakeholders, including their engagement and what type of activities will be the main ones oriented to disseminate the mains results. Some thinking was given to tailor messages to the different audiences at local, national and European level, including Brussels.

A vital and innovative practice that emerged quite early in the project proposed by EIWH and artistically designed by Migrants was the elaboration of pictograms as a tool to start to translate research findings and other messages into practice. All partners supported the creation of a pictogram as a corporate logo to be included in all the materials of the project (leaflets, press releases, presentations, bags, newsletters, laymen's report and Powtoon video maker). There was always the effort to write materials in simple and concise English and translated into local languages by partners. The enormous amount of materials elaborated by MyHealth are reported in the indicator tables of the final technical report and annex 7. So, it is the number of dissemination events in which MyHelath was involved or was presented as a project.

3.3. MyHealth Effectiveness

The aim concerning effectiveness is to assess if, on the whole, the desired results of MyHealth have been achieved. Table 7 below illustrates graphically what the respondents thought in terms of strongly agreeing or strongly disagreeing how well MyHealth completed the activities:

Table 7: MyHealth effectiveness



In general, respondents strongly agreed, agreed or somewhat agreed that the desired results of MyHealth were achieved concerning i) its objectives-outputs; ii) improving the health of VMR-WUM; iii) meeting their health-related needs; iv) developing useful tools and training including the website; and finally v) contributing to learning and impact by using the LA methodology. However, some respondents disagreed that stakeholder engagement was useful or that MyHealth is currently influencing European health policies and approaches for working with the target population.

3.4. Impact and Sustainability

Various activities have been implemented contributing to the mid or long-term sustainable effects of MyHealth project. The exploitation resources report details what the consortium members thought could be the future potential of the project (see exploitation resources report).

In the context of the final evaluation, respondents stated that they would like to be involved should MyHealth become a social enterprise/consultancy company. In this regard, a colleague at the University of Greenwich who has expertise in social enterprise

presented to the consortium and prepared a report (annex 8) detailing the possibilities of My health becoming a social enterprise. Once the consortium had all the detailed information they opted not to become either a social enterprise or a company but to adopt a more flexible arrangement and to continue collaborating institutionally as opportunities arise.

Brainstorming about MyHealth impacts for WUM these were i) direct and ii) indirect:

i) Direct impacts: derived from immediate project results and the research activated during the second part of the project (i.e. Needs, Tools and Pilots). For example: direct contact with women who freely expressed health needs and concerns, making evident the importance of designing separate and particular tools/spaces only for them (i.e. Berlin workshop) – for example having separate interventions destined to work ONLY with women about gendered violence, sexual and reproductive health and rights.
In the case of UM, a small but meaningful group of children and adolescents were trained in health issues and became potential active multipliers among their peers. This is evidence of the need for more inclusive and participatory approaches that consult them as equal stakeholders and partners in any intervention.

Finally, health professionals' and partners' skills for working with migrants using a gender-based and intersectional approach were improved.

ii) Indirect impacts: were identified as mid-long-term effects through the ICT platform, website, and all printed materials related to the WP Tools. Access to key information and health resources and strengthening networks involving different stakeholders and partners such as civil society groups are the two main visible impacts.

Refining the MyHealth impacts in a list for VMR-WUM, MyHealth consortium, policymakers and the public in general in the mid and long term the project identified the ones shown in table 8.

Table 8: MyHealth Impacts

For migrants/VRM-WUM:	MyHealth Consortium partners
Some migrants' experience with health services provision has improved. Outcomes for patients or related groups have improved in terms of their relation to providers who better understand their	Practices have changed, and new methods have been adopted (e.g. community approach or LA) by individuals, partners and stakeholders through the provision of training and participation in the project.

social contexts, cultural and intersectional needs now, and the potential solutions of migrants and VMR.	
Implementing Partners' new health guidelines and community involvement have made them aware of the need of care provided to VMR-WUM within a more comprehensive and engaging environment.	Stakeholders and partners are able to adapt to the increasing presence of migrants in their locales enabling health professionals' development.
Increased participation of health stakeholders who have not had their voices heard (e.g. WUM who have experienced FGM).	Professional methods, ideas and ethics have been influenced by the project's formulation, implementation and evaluation process.
Innovative models such as the LA methodology has made evident the diversity of experiences, perspectives and complex needs among the chain of stakeholders, including VMR-WUM.	Partners' and stakeholders' interest and engagement in research has been stimulated through results obtained about assessment of health needs, tools, pilots) of VMR-WUM.
	Research recommendations were considered by partners to modify and innovate their practices and interventions in hospital for example.
For policy makers and the public in general:	
Evidence is available to policymakers to mainstream VRM-WUM needs into EU and national policies, plans and legislation.	
Health planning activities and awareness have been influenced by research results provided by the project (e.g. campaigns run by Migrantas (Berlin)).	
Public awareness of migrant's health risks concerning enhanced health problems and disease prevention.	
Generate new ways of thinking (mindset) that influence creative practices and partners' outreach.	

Sustainability:

The *"MyHealth Exploitation Plan"* identified key elements for the project's sustainability building on the results and findings of: Pilots, Repository Toolbox, Workshops, Publications/papers and the interactive map. The main potential financial sources were identified as: Private foundations/entities, Private companies (IT agencies), Public entities/voluntary/charity organisations.

The following actions and findings emerged as additional key components that improved and can improve further the sustainability of MyHealth in the future:

- Sustainability is higher when working with communities due to their involvement and commitment beyond projects and deadlines, for example: i) running community activities between two and three organisations added to sustainability; ii) the continued use of the ICT platform and tools by migrants.

- VMR-WUM and professionals' empowerment guarantees sustainability. Building on MyHealth results these two stakeholders will play a fundamental role in the project's sustainability.
- Having "social mediators": agents mediating among migrant communities satisfied sustainability requirements. In other words, migrants who are bilingual and can help/train/translate contents to others that do not speak the host country's language were crucial. For example: training UM to become multipliers among their peers.
- Changing institutions and not only individuals should help to the long-term sustainability of MyHealth by orienting and training actors such as: health provision centres, NGOs or academia on migrants and VMR-WUM specific needs.
- Research outcomes and findings of MyHealth created sufficient evidence/research/expertise and a new understanding about the migrant and VMR-WUM health problematic from a holistic view.
- Cultural competency was made visible as a crucial factor, especially when working with health professionals and health providers. The consortium and its stakeholders can provide/offer training services to other parties.
- Having the consortium become a social enterprise for research, training and capacity building was an initiative explored during the final meeting which took place in Athens in 2020. Even though it was decided not to create a new entity, partners identified their comparative advantages for guaranteeing mid-long-term sustainability. These are the principals tasks discussed : i) Continuing research on crucial aspects such as migrants' mental health (Berlin); ii) Continued dissemination of successful strategies (Berlin: Migrantas); iii) Persist with running activities with UM by formulating new projects (Athens); iv) continue community outreach and activities (Barcelona); v) implement cultural competency skills within health provision centres (Barcelona); vi) explore internal changes to the organisational structure of some health systems (London); vii) enforce and promote the use of tools and instruments such as the interactive map and the materials/booklet presenting key issues of health provision and migrants in health centres (Brno/Bologna).

4. Conclusion and Recommendations from MyHealth

4.1. The Conclusion from MyHealth

The qualitative and quantitative insights discussed in this report indicate that in terms of MyHealth's relevance, efficiency, effectiveness, impact and sustainability demonstrate the objectives-outputs and outcomes were met or surpassed satisfactorily. Solutions to the different challenges and obstacles that arise during the project's implementation were overcome in a timely manner by the MyHealth consortium. The project had an innovative and participatory character based on LA methodology that brought multiple stakeholders and key actors together to address health and migrants' needs within the EU. Even though MyHealth was not initially designed following a traditional "research-action" framework, significant and numerous practical interventions and actions of a participatory style were undertaken by all partners across the seven countries. This occurred despite significant challenges accessing and engaging within the project's first phase. From a cost-effective perspective, the project met most of the required numbers assigned through all processes, outcomes and outcome indicators showing satisfactory levels of productivity (see annex 7). Furthermore, MyHealth partners added extra value to the project by investing more time and resources when required in order to achieve MyHealth's overarching aim: to improve the healthcare access of vulnerable immigrants and refugees (VMR-WUM) newly arrived in Europe. To achieve this, it would develop and implement a participatory model based on the expertise and know-how of a European wide multidisciplinary network.

The results from MyHealth have produced crucial knowledge, insights and recommendations surrounding how to identify and attend to the health needs and challenges that VMR especially WUM face upon arrival and then during their first few years after arriving in the EU. The diverse perspectives and inclusion of what are usually marginalised voices (e.g. unaccompanied minor) contributed importantly in the co-production of knowledge. Consequently, their physical and their mental health needs were made explicit and shared with key health who work with VMR and migrants in general. By adopting an intersectional perspective, the project sought to integrate diversity and social differences along multidimensional dimensions (e.g. language, age, ethnicity and cultural backgrounds and gender as related to the access and provision of health services). Despite the intrinsic complexity and challenges present when trying to coordinate and articulate such diversity it proved to be constructive, novel and enriching for all participants.

Objectives-outputs and outcomes did impact and will impact further on migrant health conditions and relations with health systems. Not only direct impacts were reported

among VRM (e.g. generating health multipliers among UM or identifying specific gender needs and cultural challenges) but also among health professionals and practitioners (e.g. in Barcelona VHIR/ICS, Charité, (Berlin), Brno (FNUSA) teams). Furthermore. direct impacts emerging from My Health were noted by NGOs working with migrants (e.g. Migrantas (Berlin), Consonant (London) and SYN-EIRMOS in Greece) local authorities (e.g. Emilia Romagna) along with academic impact (Greenwich University). A comprehensive strategy to disseminate results was set in place to inform health policy makers, health commissioners, think-tanks, advocacy organisations (EIWH), civil society and community organisations and importantly the migrants themselves. Specific recommendations addressing different health provision aspects to migrants were delivered throughout the project and are part of the deliverables of which this report is also one element. Rigorous monitoring and evaluation of management was performed throughout the project's implementation. These allowed those responsible for implementing the activities and interventions to redirect their actions when needed and actively participate in a learning and self-reflective process to improve their practices and service.

The main message from MyHealth can be summed up as the urgent need to address VMR – especially women's and unaccompanied minors' health needs by taking into account their diversity, and their different economic, social and personal conditions. Special emphasis was made on mental health needs as these often tend to be dismissed by health providers. In order to successfully do so in the EU context, a comprehensive LA should be implemented where public sector representatives in addition to other key actors such as organised civil society groups, academic and the private sector are consulted and invited to actively contribute in this process. Unless a wide-ranging bottom-up community participation process is facilitated with a core focus on migrant's health needs then the cycle of partial, incomplete and ineffective interventions will be perpetuated. MyHealth has shown that such a model can be successfully implemented. This is particularly important during the current COVID-19 pandemic when the vulnerability of migrants –has increased given the lack of access to health facilities experienced by many along with their high levels of mobility, exposure, connectivity and day-to-day practices (e.g. informal jobs in populated spaces, crowed living spaces etc).

4.2. Recommendations

4.2.1. Methodological recommendations

European projects like MyHealth which are comprised of partners and stakeholders in different EU member states are by their very nature complex in their organisational and

communicative structures. Thus, in order to avoid misunderstandings and attend to the inherent challenges of such diversity, sufficient time and attention should be allocated at the beginning of the project to ensure that all parties have understood their role and responsibilities in the project. There should be a collective consensus and clarity about the terminology being used between partners this last point being particularly critical given the linguistic diversity of participants and stakeholders.

We recommend replication and scaling up of the LA ensuring the active participation of all the health provision actors involved with refugees and vulnerable migrants. This must include: public sector (EU/national/local level authorities), NGOs, CBOs and private sector entities. The LA will guarantee: i) a proper flow of information between actors; ii) active bottom-up and top-down participation of the key actors; iii) documentation of the LA processes; iv) monitoring and evaluation; and v) dissemination of findings.

We further recommend mainstreaming the intersectional perspective –making especial emphasis on gender, age, nationality, religion, ableism and social class differences within and between different cultural/ national population at all project stages: formulation, implementation, monitoring and evaluation and results dissemination.

Select pilot experiences and interventions to identify weakness, strengths and the most appropriate tools (including economic impact) at different scales and which engage all stakeholders.

Budgets – especially the IT budget must be planned with adequate resources and allow for potential changes and adaptations based on the particular needs of different partners and contexts (i.e. The map, the Repository Toolbox)

Use social media and visually appealing methods such as street posters and pictograms to disseminate information about health provision services in strategic sites where migrants live and undertake their daily activities.

Health providers should have intercultural competence training to raise awareness of language and other intercultural elements such as health beliefs and practices which play a significant role in shaping health service access for migrants.

4.2.2. Policy Formulation Recommendations

At an EU wide level, the health systems and regulations for the target population– especially UMW-VMR – should be standardised.

Provisional challenges such as data sharing and the impact of EU data protection laws when creating EU networks with partners/stakeholders needs to be addressed.

Establish systematic informative sessions for health and public health system bureaucrats in order to ensure that institutions are up to date concerning current laws, policies and procedures regarding UMW-VMR access to health.

Promote the presence of health bi-lingual/multilingual workers in public health institutions according to the more prevalent migrant languages/nationalities attending health centres. Given language barriers this would be a significant advance in the delivery of more effective health services to VMR=WUM.

Create communication channels among health professionals, civil servants (from the public health sector) and policy makers in order to share common knowledge and best practice concerning meeting the health needs of VMR-wum and expedite the delivery of health services.

Mainstream an intersectional perspective making emphasis on gender, age, nationality, ableism, class and religion, to identify targeted groups' health needs and interests. Mainstream such perspective into health policy including programmes.

Improve data collection processes about the main health issues among VMR desegregating the information on gender, age, religion and nationality basis.

Consider mental health issues being equally as important as physical health in policies for social development; work for policies encouraging equity in access to and provision of treatment.

Allocate sufficient resources to raise awareness of mental health issues for all minority groups that is cognizant of their needs and obligations as part of health information strategies of communication.

Inform mental health services about specialised services available for all minority groups.

Take into account socio-demographic factors including housing and employment and their impact on the physical and mental health needs of all minority groups.

Prioritise funding for cultural research ensuring that quantitative and qualitative research on etiological factors, interventions and outcomes are promoted as a prerequisite for setting up services.

Research dealing with the health-related needs of minority groups should be encouraged and appropriately funded in an open-access manner.

Encourage cross-national exchange, provide mechanisms to aid collaboration, and promote intercultural competency training for key stakeholders like policymakers and senior stakeholders.

Take concrete steps to combat discrimination and facilitate the employment of migrants, supporting immigrants trained abroad to overcome bureaucratic and regulatory hurdles in having their training and qualifications recognised once in the EU.

4.2.3. Recommendations related to WUM

Projects and interventions targeting UM should be designed and formulated taking into account the legal requirements of the authorities who manage UM in each country/city to work with this social group.

The role of gender must be taken into account when identifying needs and designing interventions for WUM and an awareness of cultural sensitivities.

Even though male and female refugees both appreciate collective activities around health services provision, it is advisable to create individual space and situations where men and women can separately address personal/particular health conditions and circumstances. Project and health teams shall have a gender balance in terms of personnel.

Multilingual health care information should be available to VMR. This can be done using social media, booklets or posting posters at health care centres or sites visited by targeted groups such as NGOs or places of worship.

Run separate and specific activities for women and UM by trained health practitioners and providers with the appropriate cultural competence skills.

4.2.4. Recommendations regarding health promotion

Provide accessible information on the health care systems of host countries and how to access them to recently arrived migrants.
Tackle racial and patriarchal prejudices against migrants in the host community when running health promotion activities or providing health services.

Invest time and resources on dissemination activities about health services for target groups among VMR-WUM in community centres, places of worship, NGOs working with this population and on public transport systems commonly used by VMR.

Improve funding/incentives available for migrant community-based organisations' (CBOs) participation in health provision activities. Incentives could be monetary, vouchers, volunteer banking vouchers, opportunities to travel to partner conferences and meetings, opportunities for curriculum vitae building and providing employment related skills and references.

Promote migrant platforms/groups that can reach out to health service providers including policy makers to inform them about their needs and challenges.

Promote intercultural competence among health professionals through different types of intervention such as: i) empathy evoking tools (i.e. gamification tools), ii) regular sessions to inform and keep professionals updated on the general challenges that migrants face and their specific health needs, and iv) focus groups and conferences where migrants (recent and long stay) are the main actors delivering these sessions.

4.2.5. Projects targeting VMR-WUM within EU context

Inclusion of migrants´ associations and policy makers in the partnership of future projects targeting migrants.

Secure resources to continuously update the mapping tool of available resources across the EU and the repository of available tools, and for developing new tools.

The tools facilitating intercultural work with migrants in the EU need to be continuously updated and/or resources to develop new ones, based on the changing needs of the target population in highly evolving EU contexts need to be made available.
Living conditions (legal status, work, housing and education) are some of the most critical concerns for newly arrived migrants in Europe rather than health issues as such. However, this hierarchy needs to be challenged. The fact that some of them do not perceive their health and wellbeing as a priority is risky for them and expensive later for health systems and societies.

Bottom-up participatory methodologies are the most effective methods in the planning and development of tools and activities for vulnerable migrants. The LA methodology should be upscaled as a model to all other health stakeholders that work with migrant's projects.

The use of sustainable and flexible health promotion activities (i.e. responsive to particular needs) to promote community involvement (both host community and vulnerable migrants) should be encouraged to ensure that different actors take ownership of the project.

A “One-model fits all” approach targeting VMR-WUM across different EU contexts is not recommended. Specific sending and host countries’ realities and challenges experienced by migrants and VRM-WUM should inform health provision interventions within the project.

Encourage community involvement as both a strategy and a tool to identify and respond to needs of VMR-WUM.

Guarantee neutral spaces for trust building processes with migrants and VMR-WUM in order to dismantle negative racist beliefs held by some institutions such as the police, health and social services or hospitals.

4.2.6. Administrative procedures within the EU Commission

Procedures and formats for reporting evaluation and monitoring results could be simplified and made less unwieldy.

Allow enough time to manage and coordinate contextual differences among the stakeholders –especially partners and implementers during the early phases of the project. Investing time and effort to this in the early phase of such projects would guarantee a smother and more effective project implementation in the long run.

Demonstrate greater flexibility when budgets need to be re-assessed and modified.

4.2.7. Dissemination Strategy

Continue disseminating results to healthcare professionals, academics in health and social sciences, migrant organisations, policymakers, the public health community, NGOs, civil societies, scientific and the lay media.

Define the strategy for using results by policymakers and regulators and for the production of recommendations on engaging Vulnerable Migrants and Refugees in their health needs with particular focus on women and unaccompanied minors.

Continue disseminating results to refugee and migrants’ community organisations.

Strategically plan the dissemination and translation of findings into practice, programming and policy.

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Annex 1: Description of MyHealth Partners

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

Vall d'Hebron
Institut de Recerca
VHIR

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

2. Institut Català de la Salut

Institut Català de la Salut
Programa de salut internacional
Barcelona

With a staff of over 38,000 professionals, the Catalan Health Institute is the public health service largest in Catalonia and provides health care to nearly six million users across the country. It currently manages eight hospitals (Vall d'Hebron, Bellvitge Trias, Arnau de

Vilanova in Lleida, Tarragona Joan XXIII, Josep Trueta in Girona, Verge de la Cinta de Tortosa Viladecans) and 287 primary care teams, three of which through a partnership with the Hospital Clínic of Barcelona and a quarter with another partnership with the city of Castelldefels.

3. Syn-eirnos

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

4. Migrantas

migrantas

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

5. Consonant

consonant

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

6. EIWH

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

7. The University of Greenwich

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

8. Asserta

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

9. FNUSA-ICRC

St. Anne´s University Hospital Brno – International Clinical Research Centre (FNUSA-ICRC) is an emerging centre of excellence in the European Research Area. It is an innovative science and research centre and a top-quality public healthcare centre

focusing on prevention, early detection and treatment primarily of cardiovascular and neurological diseases. ICRC has almost ten years of successful cooperation between St. Anne´s University Hospital Brno and the Mayo Clinic in Rochester, Minnesota (USA).

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

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

11. Charité

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

Annex 2: List of MyHealth documents reviewed

Deliverable	Deliverable name	WP No	Lead	Content specification	Dissemination level	Delivery date
1.1	Interim(18) and final (39) reports	1	1 VHIR	Reports describing activities carried out, milestones and results achieved in the project.	CO	18, 39
2.1	Evaluation plan	2	7 UoG	Plan with the definition of the Evaluation Methodology, schedule and responsables.	PU	4
2.2	Interim and Final Evaluation reports	2	7 UoG	Interim (M18) and Final (M39) Internal assessments for each WP and partner	PU	18, 39
3.1	Dissemination package	3	6 EIWH	Communication and Dissemination Plan (3), Leaflet (3), Web-site (3), Newsletter (12, 24), Layman version of the final report (37)	PU	3, 12, 24, 37
4.1	Data collection tool and protocol	4	10 RER	Report on the development of methodology and construction of tools for the collection of descriptive data on reference sites, projects and ICT for VMR	PU	9

Deliverable	Deliverable name	WP No	Lead	Content specification	Dissemination level	Delivery date
4.2	Interactive map	4	8 Asserta	Interactive map, with main health issues, main actors and stakeholders, reference sites dealing with VRM, legal and organisational aspects of Health systems in the involved countries, and the ICT tools available	PU	39
5.1	Methodological approach for needs assessment in Health access for Migrants and refugees in Europe	5	2 ICS-HUVH	Methodological approach based on focus groups and individual interviews' results for the preparation of online survey	PU	9
5.2	Needs and capacity assessment report	5	8 Asserta	Report with identified needs and potential ICT tools to address migrants, ensuring security, encryption, privacy, etc	PU	18
6.1	Report on defined models and consequent tools	6	2 ICS-HUVH	Report on different strategies for health promotion specifying wich one is more easily able to convey messages acording to social an cultural community	PU	24

Deliverable	Deliverable name	WP No	Lead	Content specification	Dissemination level	Delivery date
6.2	Web platform based tools	6	8 Asserta	Web platform where other professionals can access each of the ideal tools identified for health promotion and screening in every cultural community.	PU	30
7.1	Report on Economic analysis of comparative models	7	8 Asserta	Economic analysis of comparative selected models implemented in the three involved sites (ICS, FNUSA CHARITE)	PU	30
7.2	Evaluation report of the models	7	11 CHARITE	Global evaluation (social, work processes and flows) of the implementation of the selected models implemented in the three involved sites ((ICS, FNUSA CHARITE)	PU	32
8.1	Model for Community Participation	8	2 ICS-HUVH	Plan of the informative sessions translated into the diefferent languages	PU	9
8.2	Final health-educative suitcase for the informative sessions	8	2 ICS-HUVH	Final health-educative suitcase with the materials to ensure training and involvement of all the	PU	37

Deliverable	Deliverable name	WP No	Lead	Content specification	Dissemination level	Delivery date
				key actors in the Health system value chain.		
8.3	Guide for recommendation of ICT solutions for WUM-VRM, design and content of the tools	8	5 MRC	Guide for integration of ICT Solutions for Migrants (informational value, identity-security, integration-mediator capacity) for health literacy (Support ICT tools to enhance health literacy)	PU	37

Annex 3: Survey 1, MyHealth Leaders

English

Informed Consent

Welcome to MyHealth Final Evaluation

To be responded by those individuals or organisations leading the delivery of MyHealth objectives 1, 2, 3, 4, 5, 7 and 8. Please answer questions related to the objectives that you have led.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 1 (Mapping)**?

- Extremely satisfied
- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Moderately disatisfied
- Disatisfied

Thinking back, would you have solved the challenges of **Objective 1** differently?

- Yes
- No

If yes, what would you have done differently?

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The challenges you faced were:

- ○ Anticipated
- ○ Non-anticipated
- ○ Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 2 and 3** (e.g. **Health Needs**)?

- ○ Extremely satisfied
- ○ Very satisfied
- ○ Satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Moderately disatisfied
- ○ Dissatisfied

Thinking back, would you have solved the challenges of **Objective 2 and 3** differently?

- ○ Yes
- ○ No

If yes, what would you have done differently?

The challenges you faced were:

- Anticipated
- Non-anticipated
- Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 4** (e.g. **TOOLS**)?

- Extremely satisfied
- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Moderately disatisfied
- Dissatisfied

Thinking back, would you have solved the challenges of **Objective 4** differently?

- ○ Yes
- ○ No

If yes, what would you have done differently?

The challenges you faced were:

- ○ Anticipated
- ○ Non-anticipated
- ○ Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 5 (ICT Platform)**?

- ○ Extremely satisfied
- ○ Very satisfied
- ○ Satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Moderately disatisfied
- ○ Dissatisfied

Thinking back, would you have solved the challenges of **Objective 5** differently?

- ○ Yes

- ○ No

If yes, what would you have done differently?

The challenges you faced were:

- ○ Anticipated
- ○ Non-anticipated
- ○ Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 6** (e.g. **PILOTS**)?

- ○ Extremely satisfied
- ○ Very satisfied
- ○ Satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Moderately disatisfied
- ○ Dissatisfied

Thinking back, would you have solved the challenges of **Objective 6** differently?

- ○ Yes
- ○ No

If yes, what would you have done differently?

The challenges you faced were:

- Anticipated
- Non-anticipated
- Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 7 (Community Developement)**?

- Extremely satisfied
- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Moderately disatisfied
- Dissatisfied

Thinking back, would you have solved the challenges of **Objective 7** differently?

- Yes
- No

If yes, what would you have done differently?

The challenges you faced were:

- ○ Anticipated
- ○ Non-anticipated
- ○ Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

Are you satisfied with the outcome of MyHealth problem-solving strategy for **Objective 8 Objective 8 (Management, Communication and Evaluation)?**

- ○ Extremely satisfied
- ○ Very satisfied
- ○ Satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Moderately disatisfied
- ○ Dissatisfied

Thinking back, would you have solved the challenges of **Objective 8** differently?

- ○ Yes
- ○ No

If yes, what would you have done differently?

The challenges you faced were:

- ○ Anticipated
- ○ Non-anticipated
- ○ Both

Please provide 1-2 examples of the anticipated challenges you faced.

Please provide 1-2 examples of the non-anticipated challenges you faced.

THANK YOU

AFRIKAANS – dankie
ALBANIAN – faleminderit
ARABIC – shukran
ARMENIAN – Շնորհակալություն / chnorakaloutioun
BOSNIAN – hvala (HVAH-lah)
BULGARIAN – благодаря / blagodaria
CATALAN – gràcies (GRAH-syuhs)
CANTONESE – M̀h'gōi
CROATIAN – hvala (HVAH-lah)
CZECH – děkuji (Dyekooyih)
DANISH – tak (tahg)
DUTCH – dank u
ESTONIAN – tänan (TA-nahn)
FINNISH – kiitos (KEE-tohss)

FRENCH – merci
GERMAN – danke
GREEK – ευχαριστώ (ef-hah-rees-TOH)
HAWAIIAN – mahalo (ma-HA-lo)
HEBREW – תודה. / todah (toh-DAH)
HINDI – dhanyavād / shukriya
HUNGARIAN – köszönöm (KØ-sø-nøm)
ICELANDIC – takk (tahk)
INDONESIAN – terima kasih. (tuh-REE-mah KAH-see)
ITALIAN – grazie (GRAHT-tsyeh)
JAPANESE – arigatô (ah-ree-GAH-toh)
KOREAN – 감사합니다 (gamsahamnida)
LATVIAN – paldies (PUHL-dyehs)
LEBANESE – choukrane
LITHUANIAN – ačiū (AH-choo)
MACEDONIAN – Благодарам / blagodaram (blah-GOH-dah-rahm)
MALAY – terima kasih (TREE-muh KAH-seh)
MALTESE – grazzi (GRUTS-ee)
MANDARIN – Xièxiè
MONGOLIAN – Баярлалаа (bayarlalaa)
NORWEGIAN – takk
POLISH – dziękuję (Jenkoo-yen)
PORTUGUESE – obrigado [masculine] / obrigada [feminine] (oh-bree-GAH-doo / oh-bree-GAH-dah)
ROMANIAN – mulţumesc (mool-tzoo-MESK)
RUSSIAN – спасибо (spuh-SEE-buh)
SERBIAN – хвала / hvala (HVAH-lah)
SLOVAK – Ďakujem (JAH-koo-yehm)
SLOVENIAN – hvala (HVAA-lah)
SPANISH – gracias (GRAH-syahs)
SWEDISH – tack
TAMIL – nandri
THAI – kop khun
TURKISH – teşekkür ederim (teh shek uer eh der eem)
UKRAINIAN – Дякую (DYAH-koo-yoo)
WELSH – diolch (DEE-ol'ch)
YIDDISH – a dank
ZULU – ngiyabonga

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Annex 4: Survey 2, MyHealth Consortium

English

Final Evaluation of MyHealth

Welcome to MyHealth Final Evaluation

Please rate the overall performance of **MyHealth's objective 1**:

Develop a complete interactive map, with main health issues, main actors and stakeholders, reference sites dealing with VRM, legal and organisational aspects of health systems in the involved countries, and the ICT tools available

- Highly satisfactory
- Satisfactory
- Less than satisfactory
- Highly unsatisfactory

Do you consider the MyHealth is ending with a **map** that is comprehensive and user-friendly?

- Yes
- No

Provide reasons why it should or not end with a **user-friendly and comprehensive map**

How well do you think the challenges MyHealth faced delivering the **Objective 1 (Mapping)** were solved by all of us?

- Extremely well

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- Very well
- Moderately well
- Slightly well
- Not well at all

Please rate the overall performance of **MyHealth's objective 2**: To conduct a pilot survey on current health status and concerns (e.g. **Health Needs**) of VMR and health practitioners.

- Highly satisfactory
- Satisfactory
- Less than satisfactory
- Highly unsatisfactory

How well do you think the challenges MyHealth faced delivering the **Objective 2 (e.g. Health Needs)** were solved by all of us?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not well at all

Please rate the overall performance of **MyHealth's objective 3**: To define more clearly the current health problems (**Health Needs**) of migrants.

- Highly satisfied
- Satisfactory
- Less than satisfactory
- Highly unsatisfactory

How well do you think the challenges MyHealth faced delivering the **Objective 3** (**Health Needs**) were solved by all of us?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not well at all

Please rate the overall performance of **MyHealth's objective 4**: Define and develop health intervention strategies in mental health, communicable and non-communicable diseases based on a community health approach. Please remember that the work assessed under this objective is related to workpackge on **Tools** and particularly the metaplans.

- ○ Highly satisfied
- ○ Satisfactory
- ○ Less than satisfactory
- ○ Highly unsatisfactory

How well do you think the challenges MyHealth faced delivering the **Objective 4 (Tools)** were solved by all of us?

- ○ Extremely well
- ○ Very well
- ○ Moderately well
- ○ Slightly well
- ○ Not well at all

Please rate the overall performance of **MyHealth's objective 5**: Develop an **ICT-based platform** to support new tools, enhance health application developments and health information.

- ○ Highly satisfied
- ○ Satisfactory
- ○ Less than satisfactory
- ○ Highly unsatisfactory

Do you consider that MyHealth delivered an **ICT-based platform** which is comprehensive and informative?

- ○ Yes
- ○ No

Provide reasons why it is or not the case

How well do you think the challenges MyHealth faced delivering the **Objective 5 (ICT-based platform)** were solved by all of us?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not well at all

Please rate the overall performance of **MyHealth's objective 6**: Implement the defined strategies and models in pilot over the project's sites. Please remember that the work assessed under this objective is related to the workpackge on **Pilots**.

- Highly satisfied
- Satisfactory
- Less than satisfactory
- Highly unsatisfactory

How well do you think the challenges MyHealth faced delivering the **Objective 6 (Pilots)** were solved by all of us?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not well at all

Please rate the overall performance of **MyHealth's objective 7**: To ensure training and involvement of all key actors in the health system value chain (from users to managers). Please remember that the work assessed under this objective is related to the workpackge **on Community Development.**

- Highly satisfied
- Satisfactory
- Less than satisfactory
- Highly unsatisfactory

How well do you think the challenges MyHealth faced delivering the **Objective 7 (Health Needs)** were solved by all of us?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not well at all

Please rate the overall performance of MyHealth's **objective 8**: Ensure sound management and communication strategy for MyHealth. Please remember that the work assessed under this objective is related to the work packages on **management, communication and evaluation**.

- Highly satisfied
- Satisfactory
- Less than satisfactory
- Highly unsatisfactory

How well do you think the challenges MyHealth faced delivering the **Objective 8 (Management, Communication and Evaluation)** were solved by all of us?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not well at all

Please indicate how much you agree or disagree with the following statements about MyHealth

	Strongly agree	Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Disagree	Strongly disagree
MyHealth outputs objectives were achieved	O	O	O	O	O	O	O
MyHealth outputs and outcomes improved the health of vulnerable migrant women and unaccompanied children	O	O	O	O	O	O	O
MyHealth met the needs vulnerable migrant women and unaccompanied children	O	O	O	O	O	O	O

	Strongly agree	Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Disagree	Strongly disagree
MyHealth is influencing European policies	○	○	○	○	○	○	○
The tools developed were useful	○	○	○	○	○	○	○
The training was helpful	○	○	○	○	○	○	○
The website is useful	○	○	○	○	○	○	○
Learning Alliance methodology has contributed to the learning and strengthen the impact of my MyHealth	○	○	○	○	○	○	○
The stakeholder engagement was useful	○	○	○	○	○	○	○

How useful was the advisory board?

- ○ Extremely useful
- ○ Very useful
- ○ Moderately useful
- ○ Slightly useful
- ○ Not at all useful

If MyHealth decide to become a social enterprise/consultancy company would you be interested in becoming a member?

- ○ Yes
- ○ No

Please mention at least three new things that you have learnt in the last 3 years as part of MyHealth as an International Alliance, if this is the case!

THANK YOU

AFRIKAANS – dankie
ALBANIAN – faleminderit
ARABIC – shukran

ARMENIAN – Շնորհակալություն / chnorakaloutioun
BOSNIAN – hvala (HVAH-lah)
BULGARIAN – благодаря / blagodaria
CATALAN – gràcies (GRAH-syuhs)
CANTONESE – M̀h'gōi
CROATIAN – hvala (HVAH-lah)
CZECH – děkuji (Dyekooyih)
DANISH – tak (tahg)
DUTCH – dank u
ESTONIAN – tänan (TA-nahn)
FINNISH – kiitos (KEE-tohss)
FRENCH – merci
GERMAN – danke
GREEK – ευχαριστώ (ef-hah-rees-TOH)
HAWAIIAN – mahalo (ma-HA-lo)
HEBREW – .תודה / todah (toh-DAH)
HINDI – dhanyavād / shukriya
HUNGARIAN – köszönöm (KØ-sø-nøm)
ICELANDIC – takk (tahk)
INDONESIAN – terima kasih. (tuh-REE-mah KAH-see)
ITALIAN – grazie (GRAHT-tsyeh)
JAPANESE – arigatô (ah-ree-GAH-toh)
KOREAN – 감사합니다 (gamsahamnida)
LATVIAN – paldies (PUHL-dyehs)
LEBANESE – choukrane
LITHUANIAN – ačiū (AH-choo)
MACEDONIAN – Благодарам / blagodaram (blah-GOH-dah-rahm)
MALAY – terima kasih (TREE-muh KAH-seh)
MALTESE – grazzi (GRUTS-ee)
MANDARIN – Xièxiè
MONGOLIAN – Баярлалаа (bayarlalaa)
NORWEGIAN – takk
POLISH – dziękuję (Jenkoo-yen)
PORTUGUESE – obrigado [masculine] / obrigada [feminine] (oh-bree-GAH-doo / oh-bree-GAH-dah)
ROMANIAN – mulţumesc (mool-tzoo-MESK)
RUSSIAN – спасибо (spuh-SEE-buh)
SERBIAN – хвала / hvala (HVAH-lah)
SLOVAK – Ďakujem (JAH-koo-yehm)
SLOVENIAN – hvala (HVAA-lah)
SPANISH – gracias (GRAH-syahs)
SWEDISH – tack
TAMIL – nandri

THAI – kop khun
TURKISH – teşekkür ederim (teh shek uer eh der eem)
UKRAINIAN – Дякую (DYAH-koo-yoo)
WELSH – diolch (DEE-ol'ch)
YIDDISH – a dank
ZULU – ngiyabonga

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Annex 5: Survey 3, External Stakeholders

English (United Kingdom)

Informed Consent

Welcome to the MyHealth Project!

Please help us evaluate the main activities of the MyHealth project in the last **three years** in your role as a stakeholder. We would appreciate if you could respond to this questionnaire to the best of your knowledge. If you know any or all MyHealth activities help us by answering the survey. If you do not know anything about MyHealth, as you go through the survey, you will find links to our website where you can find information about MyHealth activities.

You will be presented with information relevant to MyHealth and asked to answer some questions about it. Please be assured that your responses will be kept completely confidential.

The survey should take you around 10 minutes to complete. Your participation in this survey is voluntary. You have the right to withdraw at any point.

By clicking the button below, you acknowledge that your participation in the survey is voluntary, you are 18 years of age, and that you are aware that you may choose to terminate your participation in the survey at any time and for any reason.

Please note that this survey will be best displayed on a laptop or desktop computer. Some features may be less compatible for use on a mobile device.

Twitter: @MyHealth EU
Website: http://www.healthonthemove.net/

Thank you for accepting to give us your views about MyHealth

- ○ I consent, begin the study
- ○ I do not consent, I do not wish to participate

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Would you identify your organisation as?

- A public sector organisation
- A civil society organisation
- A private sector organisation
- Other

If other, please specify

Please identify your ROLE when interacting with MyHealth?

- Health service provider
- Researcher
- Service user
- Policy maker
- Other

If other, please specify

Please tell us the country you are responding this survey from

Do you identify as:

- Woman
- Man
- Transgender
- Prefer not to say

Do you consider yourself a migrant?

- Yes
- No

Could you describe in a few words the aim of MyHealth?

In the last three years, MyHealth has developed an interactive map on migrant health information resources and tools. Are you aware of its existence on the website of the project?

- Yes
- No

If yes, how do you find the map?

- Extremely useful
- Very useful
- Moderately useful
- Slightly useful
- Not at all useful

If No, would like to see it in the website?
http://www.healthonthemove.net/

- Yes
- No

In the last three years, MyHealth has defined the current health needs of migrants treated in health centres of various European cities. Are you aware of the reports on the website of the project?

- Yes
- No

If yes, how do you find the reports?

- O Extremely useful
- O Very useful
- O Moderately useful
- O Slightly useful
- O Not at all useful

If No, would like to get a copy of the reports in the website of MyHealth?
http://www.healthonthemove.net/workpackage/w5/

- O Yes
- O No

In the last three years, MyHealth has developed an Information and Communication Technology (ICT) based platform to support TOOLS and health information for migrants, health professionals and other stakeholders. Are you aware of the TOOLBOX on the website of the project?

- O Yes
- O No

If yes, how do you find the TOOLBOX?

- O Extremely useful
- O Very useful
- O Moderately useful
- O Slightly useful
- O Not at all useful

If No, would like to see the TOOLBOX on the website?
http://www.healthonthemove.net/knowledgebase/

- O Yes
- O No

In the last three years, MyHealth has created health interventions using a community health approach. Are you aware that the report is on the website of the project?

- O Yes

- ○ No

If yes, how do you find the report?

- ○ Extremely useful
- ○ Very useful
- ○ Moderately useful
- ○ Slightly useful
- ○ Not at all useful

If No, would like to see the report in the website of the project? http://www.healthonthemove.net/workpackage/w8/

- ○ Yes
- ○ No

In the last three years, MyHealth has implemented some pilot programmes to test some of the tools developed. Are you aware of this work?

- ○ Yes
- ○ No

If yes, how do you find this work?

- ○ Extremely useful
- ○ Very useful
- ○ Moderately useful
- ○ Slightly useful
- ○ Not at all useful

If No, would like to know more about this work?

- ○ Yes
- ○ No

In the last three years, MyHealth has developed a European Network of professionals interested in working with migrants on Facebook. Are you aware of the Network?

- Yes
- No

If yes, how do you find this Network

- Extremely useful
- Very useful
- Moderately useful
- Slightly useful
- Not at all useful

If No, would like to know more about this on Facebook?
https://www.facebook.com/pg/MyHealthEU

- Yes
- No

Please could you tell us 3 new things you have learnt from MyHealth in the last three years, if this is the case?

This is the end of the questionnaire.
Thanks for your participation!

AFRIKAANS – dankie
ALBANIAN – faleminderit
ARABIC – shukran
ARMENIAN – Շնորհակալություն / chnorakaloutioun
BOSNIAN – hvala (HVAH-lah)

BULGARIAN – благодаря / blagodaria
CATALAN – gràcies (GRAH-syuhs)
CANTONESE – M̀h'gōi
CROATIAN – hvala (HVAH-lah)
CZECH – děkuji (Dyekooyih)
DANISH – tak (tahg)
DUTCH – dank u
ESTONIAN – tänan (TA-nahn)
FINNISH – kiitos (KEE-tohss)
FRENCH – merci
GERMAN – danke
GREEK – ευχαριστώ (ef-hah-rees-TOH)
HAWAIIAN – mahalo (ma-HA-lo)
HEBREW – .תודה / todah (toh-DAH)
HINDI – dhanyavād / shukriya
HUNGARIAN – köszönöm (KØ-sø-nøm)
ICELANDIC – takk (tahk)
INDONESIAN – terima kasih. (tuh-REE-mah KAH-see)
ITALIAN – grazie (GRAHT-tsyeh)
JAPANESE – arigatô (ah-ree-GAH-toh)
KOREAN – 감사합니다 (gamsahamnida)
LATVIAN – paldies (PUHL-dyehs)
LEBANESE – choukrane
LITHUANIAN – ačiū (AH-choo)
MACEDONIAN – Благодарам / blagodaram (blah-GOH-dah-rahm)
MALAY – terima kasih (TREE-muh KAH-seh)
MALTESE – grazzi (GRUTS-ee)
MANDARIN – Xièxiè
MONGOLIAN – Баярлалаа (bayarlalaa)
NORWEGIAN – takk
POLISH – dziękuję (Jenkoo-yen)
PORTUGUESE – obrigado [masculine] / obrigada [feminine] (oh-bree-GAH-doo / oh-bree-GAH-dah)
ROMANIAN – mulţumesc (mool-tzoo-MESK)
RUSSIAN – спасибо (spuh-SEE-buh)
SERBIAN – хвала / hvala (HVAH-lah)
SLOVAK – Ďakujem (JAH-koo-yehm)
SLOVENIAN – hvala (HVAA-lah)
SPANISH – gracias (GRAH-syahs)
SWEDISH – tack
TAMIL – nandri
THAI – kop khun
TURKISH – teşekkür ederim (teh shek uer eh der eem)

UKRAINIAN – Дякую (DYAH-koo-yoo)
WELSH – diolch (DEE-ol'ch)
YIDDISH – a dank
ZULU – ngiyabonga

Powered by Qualtrics

Annex 6: List of Interviewees

Participants Nº	*Participant Legal Name*	*Country*	*Partner's Acronym*
1	**Fundacio Hospital Universitari Vall d'Hebron- Institut de recerca** Esperanza Esteban Eva Hajdok	*ES*	*VHIR*
2	**INSTITUT CATALA DE LA SALUT– Hospital Universitari Vall d'Hebron**	*ES*	*ICS*
3	**SYN EIRMOS NGO OF SOCIAL SOLIDARITY ASTIKI ETAIRIA E** Maria Ntetsika Nikos Gionakis	*EL*	*SYN-EIRMO*
4	**MIGRANTAS** Florencia Young Maria Luisa Di Como	*DE*	*Migrantas*
5	**THE MIGRANTS' RESOURCE CENTRE** Sheena Vella Amanuel	*UK*	*MRC*
6	**Asserta Global Healthcare Solutions** Anais Lecorvec Danniela	*ES*	*Asserta*
7	**FAKULTNI NEMOCNICE U SV. ANNY V BRNE** Narine Movsisyan	*CZ*	*FNUSA*
8	**Regione.Emilia-Romagna- Agenzia Sanitaria e Sociale Regionale** Giovanni Ragazzi	*IT*	*RER*
9	**Hospital Charité. UNIVERSITAETSMEDIZIN BERLIN** Meryam Schouler-Ocak James	*DE*	*CHARITE*

Annex 7: Indicators

1. Process evaluation

The following is the process evaluation of the eight objectives of MyHealth up to June 2020 according to Annex 1 of the grant agreement.

Table 9. Process evaluation indicators

Objective	Process indicators	Results-- June 2020
1. Develop a complete interactive map, with the main health issues, main actors and stakeholders, reference sites dealing with VRM, legal and organisational aspects of health systems in the involved countries and the ICT tools available.	Involvement of at least 100 actors and at least 50 sources reviewed.	**Achieved** 104 stakeholders filled up the map form. There are 193 sources reviewed and available in the map: Disaggregated by country Country Resource Bulgaria 4 Czech Republic 10 Cyprus 2 Germany 42 Greece 31 Spain 23 France 7 Ireland 5 Italy 49 Austria 4 UK 14 Luxembourg 1 Netherlands 1
2. To conduct a pilot survey on the current health status and concerns of VMR and health practitioners in Barcelona, Berlin and Brno.	Development of the survey and participation and learning of the various stakeholders.	**Achieved** http://www.healthonthemove.net/wp-content/uploads/2019/05/D5.1-Methodological-approach-for-needs-assessment_compressed.pdf
3. Define more clearly the current health problems of migrants treated in Barcelona, Berlin and Brno.	At least 50 health professionals and stakeholders interviewed, according to diverse professions	**Achieved** http://www.healthonthemove.net/wp-content/uploads/2019/05/D5.2-Needs-and-Capacity-Assessment-Report_compressed.pdf

4. Define and develop health intervention strategies in mental health, communicable and non-communicable diseases based on a community health approach.	At least 15 actors involved in the definition of the strategies in each site/area	**Achieved** Overall, 300 actors were part of the nine tools piloted incorporating a community approach in Athens, Barcelona, Berlin and Brno.
5. Develop an ICT-based platform to support new tools, enhance the development of health applications and information.	Quality and user-friendly platform in at least seven languages.	**Achieved** The whole platform with tools, applications and information is in English. In Catalan, Check, German, Spanish, Greek, Italian and English: • Objectives • MyHealth brochure • Partners • Beneficiaries • Main results are Over half (53%) of all 63 stakeholders consulted for the final evaluation considered MyHealth has produced a comprehensive and user-friendly platform.
6. To implement the defined strategies and models in pilot over the hospitals in Barcelona, Berlin and Brno.	At least one hospital in Barcelona, Berlin and Brno.	**Achieved** Four pilots were adoptable in three hospital across: • Athens, • Barcelona: Val de Hebron Hospital, • Berlin: Charite Hospital, and • Brno: Fakultni Nemocnice U SV. Anny V Brne Methodology and economic analysis http://www.healthonthemove.net/wp-content/uploads/2020/07/D7-1-Report-on-pilot-methodology-and-economic-analysis-methodology_compressed.pdf Evaluation of the models http://www.healthonthemove.net/wp-content/uploads/2020/06/D7.2-Evaluation-report-of-the-models.pdf
7. Ensure training and involvement of all key actors in the health system value chain (from users to management).	At least 10 training sessions and communication events.	**Achieved** There were at least 10 training sessions targeted to users and managers. Overall, 1,306 participants were involved in all these activities, including the 10 training sessions. Other roles besides users and mangers of those participants were:

		VRM (Women only) VRM (Mixed Gender Group) VRM (Minors or Ex-Minors) Civil Society Policy Makers Scientific Community (Higher Education, Research)
8. Ensure a sound management and communication strategy for MyHealth.	At least 20 activities registered in communication and management.	**Achieved** The activities below comprised at least 20 communication and management activities implanted by MyHealth **Elaboration of newsletters**: 2 **Writing of press releases**: 2 **Design and distribution of leaflets**: 2,000 MyHealth "Join us" campaign QCODE flyers distributed + 500 bags advertising MyHealth's website and pictograms printed out and distributed in Athens, Barcelona, Berlin, Bologna, Brno, and London **Tweeter** Over 120 Tweeter followers - Follow us on Twitter @MyHealthEU **Website posts**: Over 12,000 website visits – Visit us on www.healthonthemove.net Over 37,000 website visits **Facebook** Over 290 Facebook followers Over 280 Facebook likes **Congresses** Over 10 Congresses sharing MyHealth project activities **Booklets** Over 3,900 booklets distributed and over 3,500 booklets downloaded of our directory of multilingual medical practices in Berlin **Flyers** 2,000 MyHealth "Join us" campaign QCODE flyers distributed **General Assemblies** 6 general assemblies were implemented during the three years MyHelath lasted.

Overall, the numbers reported as part of the process of monitoring MyHealth are highly satisfactory regarding the different activities performed under each objective. It is suggested that in the future the gender, age, and ethnic background of the various stakeholders

participating in all events of the project should allow having a more detailed picture of whom MyHealth is serving.

2. Output evaluation

Table 10 Output evaluation indicators

Eight Specific Objectives	Output indicators	Results -- June 2020
1. Develop a complete interactive map, with main health issues, main actors and stakeholders, reference sites dealing with VRM, legal and organisational aspects of Health systems in the involved countries, and the ICT tools available.	At least 200 references listed on the map	**Achieved** The total number of references listed on the map were 266 distributed in the following way: 1. Migrant Resources Mapping: Information about key reference sites for migrants. 183 2. Stakeholder Mapping: Information on stakeholders interested in our activities, including MyHealth Project dissemination. 43 3. App/Website/E-tool Mapping: Information about existing e-tools, including apps or websites. 13 4. Current Studies and Projects Mapping: Information about current studies or project activities at community level (Map it now) 17
2. To conduct a pilot survey on current health status and concerns of VMR and health practitioners in Barcelona, Berlin and Brno.	At least 60 surveys completed	**Achieved** The total number of surveys responded and completed were 390, distributed between 101 migrants and 285 professionals.
3. Define more clearly the current health problems of migrants treated in Barcelona, Berlin and Brno.	At least 10 health conditions defined and looked at	**Achieved** The different reports indicated the conditions identified in four MyHealth sites: Athens, Barcelona, Berlin, and Brno as per the list below. However, the prominent condition identified by all was mental health. Also, some conditions were related to the places the migrants come from. That is the poorer the area, the higher the risk of more infection conditions, for example, latent tuberculosis.

		Infectious diseases: • Latent tuberculosis • Viral hepatitis • HIV Non-communicable diseases: • Women: severe acute maternal morbidity • Physical trauma • sexual abuse Unaccompanied minors: • Vaccination • Physical violence • Genital mutilation Mental health of Women: • Insecurity • Rape Mental health of Unaccompanied minors: • Traumatic pre-migration experiences • Separation from family
4. Define and develop health intervention strategies in mental health, communicable and non-communicable diseases based on a community health approach.	Easy to be implemented modular plan in heath institutions	**Achieved** The 14 Metaplans, which were carried out across four MyHealth sites (Athens, Barcelona, Berlin, Brno) decided to pilot nine tools by consensus among all stakeholders for practical reasons in both hospitals and the community. http://www.healthonthemove.net/it/knowledgebase_category/myhealth-piloted-tools/
5. Develop an ICT based platform to support new tools, enhance the development of health applications and health information.	At least 12 relevant inputs per year regarding quantity and diversity of content	**Achieved** The website so far contains inputs from the interactive map, events, news, twitter, the newsletters, the repository tools box, the European network (Facebook) to make it an ongoing appealing site for the last 36 month and the next 24 months. **http://www.healthonthemove.net/it/** **Map--inputs** • Migrant Resources Mapping: Information about key reference sites for migrants. • Stakeholder Mapping: Information on stakeholders interested in our activities, including MyHealth Project dissemination.

		• App/Website/E-tool Mapping: Information about existing e-tools, including apps or websites. • Current Studies and Projects Mapping: Information about current studies or project activities at community level. • Repository Tool Platform: If you want to upload a tool. • List of stakeholders and mapping resources **Repository tools -inputs** • Mental health: 18 articles • Infectious diseases: 13 articles • Education: 73 articles • Women: 11 articles • Minors: 7 articles • ICT tools; 39 articles • MyHelath piloted tools; 8 articles • Users/Migrants: 32 articles • Health access information: 10 articles • Non-communicable diseases: 6 articles **European network in Facebook** • Over 291 Facebook followers + Over 281 Facebook like **Additional inputs** • Directory of multilingual medical practices in Berlin. • 4 videos explaining our results (youtube channel). • Health educative suitcase material and resources (focused on community ones). • Healthcare guide for non- EU foreigners in Brno. **Reports** • Most of the reports submitted by MyHelath and approved by the EC. • Visual infographics based on submitted reports freely downloadable from MyHealth website
6. To implement the defined strategies and models in pilot over the hospitals in Barcelona, Berlin and Brno.	At least one hospital in Barcelona, Berlin and Brno	**Achieved** Of the total of nine tools piloted, the following six were implemented in three hospitals: Barcelona: **Vall D'Hebron Hospital** • Health card • Game Berlin: **Charite Hospital**

<table>
<tr><td></td><td></td><td>

- FGM
- Intercultural Training
- Directory of multilingual medical practices

Brno: Fakultni Nemocnice U SV. Anny V Brne

- Healthcare Guide User for Foreigners in Brno
</td></tr>
<tr><td>7. To ensure training and involvement of all key actors in the health system value chain (from users to management)</td><td>At least 150 participants involved</td><td>Achieved

The numbers below are an overall calculation (including possible overlapping) of the number of participants in the MyHealth activities ranging for plan activities, research activities, to training according to type of participants from the perspective of the community development work-package.

<table>
<tr><td>Activities for</td><td>No of participants</td></tr>
<tr><td>VRM (Women only)</td><td>109</td></tr>
<tr><td>VRM (Mixed Gender Group)</td><td>415</td></tr>
<tr><td>VRM (Minors or Ex-Minors)</td><td>135</td></tr>
<tr><td>Civil Society</td><td>411</td></tr>
<tr><td>Policy Makers</td><td>3</td></tr>
<tr><td>Scientific Community (Higher Education, Research)</td><td>213</td></tr>
<tr><td>Other</td><td>20</td></tr>
<tr><td>Total</td><td>1306</td></tr>
</table>
</td></tr>
<tr><td>8. Ensure a sound management and communication strategy for MyHealth</td><td>At least 150 participants in all events</td><td>Achieved

MyHealth identified a total of 408 stakeholders who participated in all the events of the project. They came respectively from the public sector (232), civil society (145) and the private sector (20).</td></tr>
</table>

In a similar way to the numbers reported as part of the process of monitoring MyHealth, the output indicators are highly satisfactory regarding the different activities performed under each objective up to June 2020.

3. Outcome evaluation

Table 11 Outcome evaluation indicators

Eight Specific Objectives	Outcome indicators	Results -- June 2020

1. Develop a complete interactive map, with main health issues, main actors and stakeholders, reference sites dealing with VRM, legal and organisational aspects of Health systems in the involved countries, and the ICT tools available.	At least 2000 hits on the map by month 36.	**Nearly Achieved** Up to the mid of May 2020 (month 37) there were 1132 hits in the map. + 141 form Mighealthcare
2. To conduct a pilot survey on current health status and concerns of VMR and health practitioners in Barcelona, Berlin and Brno.	Survey analysis report To be completed by the end of the project according to the different pieces of information to be disseminated.	**Achieved** Reports http://www.healthonthemove.net/wp-content/uploads/2019/05/D5.2-Needs-and-Capacity-Assessment-Report_compressed.pdf http://www.healthonthemove.net/wp-content/uploads/2019/05/D5.1-Methodological-approach-for-needs-assessment_compressed.pdf
3. Define more clearly the current health problems of migrants treated in Barcelona, Berlin and Brno.	At least 10 guidelines on how to check and treat health problems developed	**Achieved** http://www.healthonthemove.net/it/knowledgebase_category/guides-education/
4. Define and develop health intervention strategies in mental health, communicable and non-communicable diseases based on a community health approach.	Strategy model positively assessed by Advisory Board and confirmed by Steering Committee (for both quality and adequacy) and dissemination by all partners.	**Achieved** At the General Assembly in Barcelona on the 25th of April 2019, both the Advisory Board and Steering Committee of MyHealth provided the inputs for the project to go ahead implanting the tools (metaplans) and the pilots.
5. Develop an ICT based platform to support new tools, enhance the development of health applications and health information.	At least 2000 hits on the platform and information on the users	**Achieved** MyHealth website contains most of the components created by the project, including the platform. Thus, the analytics show the following figures: **Analytics** Users: 7,478 Number of session per users: 1.67 Avg. session duration: 3’15 New Users: 7,591

		<table><tr><td></td><td></td></tr><tr><td>Sessions</td><td>12,486</td></tr><tr><td>Page views</td><td>30,069</td></tr><tr><td>Pages/session</td><td>3.05</td></tr><tr><td>Returning visitor</td><td>14.3%</td></tr><tr><td>New visitor</td><td>85.7%</td></tr></table> <table><tr><td colspan="2">First three Languages Users</td></tr><tr><td>English US</td><td>2,517 (33.15)</td></tr><tr><td>Español</td><td>1,237 (16.52)</td></tr><tr><td>Deutsch</td><td>701 (9.23%)</td></tr></table>
6. To implement the defined strategies and models in pilot over the hospitals in Barcelona, Berlin and Brno	Improvement of patients' knowledge and health status	**Achieved** All planned interventions implement for the pilots were successfully carried out, recruiting 231 VRMs and 165 professionals across all four sites (Athens, Barcelona, Berlin and Brno) Overall, the assessment of the VMRs in the four sites, including the unaccompanied minors was that MyHealth piloted tools that will improve their knowledge of both health issues and how to access services. For example, table 5 in the final evaluation report illustrates in detail the quotations given the VMRS (patients) about their improvement of knowledge about the Catalan Health Card.
7. To ensure training and involvement of all key actors in the health system value chain (from users to management)	Learning and awareness about health and VMR issues	**Nearly Achieved** Training and other activities exclusively with VMRs Women only =109 + Mix genders = 415 + UM+ExUM = 135 + TOTAL: 659 **Percentages** VRM women only =17% VRM mixed genders = 63% VMR minors and ex-minors= 20% The project developed two evaluation forms for all training sessions. One was with the text and the second one with only images for those migrants that could not read and write. Not all training sessions were evaluated.

8. Ensure a sound management and communication strategy for MyHealth	Level of satisfaction (very satisfied/very unsatisfied) in it the events & At least 10 published articles and media announcements to be completed by the end of the project.	**Achieved** The overall number of responses here come from the answer provided by the three surveys: i) leaders (11) ii) stakeholders (37), and iii) the consortium partners 15) plus (16) interviews. This applies to the 8 objectives. 6 are highly satisfactory and 2 satisfactory. **Highly Satisfactory:** 2. Need assessment VMR and health professionals 3. List of current health problems 4. Health Interventions –TOOLS 6. Implement the defined strategies and models in PILOTS 7. A model for community participation 8. Implementation of a wide-ranging and sound strategy manage and communicating MyHealth results including the Learning Alliance methodology **Satisfactory** 1. Interactive mapping 5. ICT-based platform **Conferences:** Abstract and draft papers were presented over 10 congresses sharing MyHealth project activities. Over 3,900 published booklets distributed and over 3,500 booklets downloaded of our directory of multilingual medical practices in Berlin.

Annex 8: MyHealth as a possible social enterprise

Social Enterprise Sustainability Report for My Health Project

By Charles Oham, MBA, MA, PGCERT. FHEA

Executive Summary

The report explores the future of My Health Project post March 2020 when the EU project comes to an end. It considers social enterprise as an option to sustain and scale the activities of My Health Project.

My Health Project has been successful in developing a range of outcomes which provides the basis for further development and market research for a social enterprise that runs refugee and migrant health intervention for service users and commissioners.

The seven countries linked to this project have an ideal political and social environment that can support the startup of My Health as a social enterprise.

Contents

Background:

My Health-Project, a consortium of 11 organisations in 7 countries, is an EU funded Health Programme (2017-2020). My health aims to enhance the healthcare access of vulnerable immigrants and refugees new in Europe by developing and implementing models based on the know-how of a European multidisciplinary network focusing on women and unaccompanied minors who arrived in Europe.

In three years, My Health has developed the following outcomes:

- An online interactive map
- A pilot survey on current health status and concerns
- A repository of best strategies for health promotion
- Evaluation of the pilot models
- Guide for the integration of ICT solutions for vulnerable immigrants and refugees

These outcomes have given MyHealth the competitive advantage to provide consultancy and health-related interventions for migrants and refugees, especially women and children in Europe. Furthermore, the intellectual property acquired, and the learning can be useful in other continents to address the

challenges faced by refugees and migrants. Scoping the development of new products and services can be gained by applying innovation models (Durkin and Oham, 2016).

Objectives

The objective of this report is to provide strategic advice on the exit strategy of My Health, exploring social entrepreneurship as a route to sustaining the project beyond March 2020.

What is social enterprise?

Social enterprises are business with social objectives whose profits, when realised are ploughed back into the organisation rather than being distributed among shareholders. The profits are used to further the social objectives which could be environmental, health, social, or employment etc. (Oham 2016). A social enterprise is situated in the social economy or not for profit sector made up of charities, voluntary organisations, and cooperatives. Most social enterprises are set up as a result of the market(business), societal(negative attitudes and behaviour of people) and government failure to provide adequate services or bridge the gaps in the provision of services such as access to healthcare by refugees and migrants. An example of a social enterprise could be setting up an advocacy and support centre that supports refugees' access to health and social care services. The Government's health care budget can fund such a social enterprise through a process of commissioning, procurement, contracts or grants. For a social enterprise to access these opportunities, they would have to develop a business plan- vision, mission, objectives, market research, social innovation/USP, marketing strategy, human resources, operations and budgeting -forecasting and breakeven analysis etc.

What are the pros and cons of becoming a social enterprise?

The benefits of social enterprises are the goodwill they receive from stakeholders (people, organisations and governments). This is because of their nonprofit nature (profits do not go to shareholders or owners; instead, it is put back into the social enterprise to further its mission). Social enterprises are highly innovative and resourceful in fulfilling their objectives of tackling critical social needs. They quickly generate income, can raise start-up capital from a range of sources- crowdfunding, grants, social investment and low-interest loans, donations, trading activity (consultancy, training, capacity building, research and development, etc.).

Table 1: Key Social Enterprise Facts in the United Kingdom

- 38% of all Social Enterprises work in the most deprived communities in the UK
- 84% of Social Enterprises have at least one woman on their leadership team
- 59% of Social Enterprises do some business with the Public sector
- 15% of Social Enterprise leaders are from Black Asian or Minority communities
- 28% of Social Enterprise have Black, Asian or Minority directors
- 73% of Social Enterprises earn more than 75% of their income from trading

(Source Social Enterprise Survey UK, 2013 & 2015)

Table 2: Core Social Enterprise Philosophies in Social Enterprises

- Environmental sustainability: Caring for the planet by acting in an environmentally friendly way.
- Social impact: Evidence-based practice on the social impact on people and communities.
- Social innovation: Developing new ideas that benefit society and having an "Open" innovation philosophy were sharing and collaborating is a core value.
- Multiple bottom-line caring for people, planet, and profits.
- Sustaining the venture increases social impact.
- Social entrepreneurs meet the needs of people and the planet.
- Entrepreneurial mindset to problem-solving.

Source: Social Enterprise UK 2013 &2015

What are the requirements for My Health if it wants to become a social enterprise?

They would need:

1. A constitution drafted by My Health members to associate and operate as a social enterprise (democratic), this should include an outline of the mission and vision of the social enterprise, articles and memorandum of association and constitution. Registration with the Charity Commission or Company House if in the UK or the country which the members wants to register the social enterprise.

2. A bank account and a business plan with financial projections. Key human resource officers to run the organisation needs to be in place. This is because leadership is vital to the sustainability of the social enterprise, someone must assume command of the project who is willing to learn about and apply social entrepreneurship principles. Shares could be given to each member of the consortium and based on the start-up capital contributed by interested members. Consortium members not interested in setting up a social enterprise could relinquish their rights to the intellectual property owned by My Health to allow the new venture to develop.
3. Once the social enterprise is set up it must professionally and proactively look for business opportunities in order to be sustainable, this may require employing a member of staff who is external to the consortium that is why a business plan is needed to factor in all the cost such as staff salaries and expenditures.

Which countries are the best places to register a social enterprise?

Europe has been a viable area for social enterprises, especially Western Europe, other parts of Europe are catching up. The UK offers many opportunities for social enterprises to thrive, and there are umbrella social enterprise support organisations such as Social Enterprise UK.

- In Spain, social enterprises usually come under cooperative associations such as Mondragon Cooperatives one of the largest in the world.

- In Greece, the Government has a 5-year strategy from 2017-2023 earmarking a €170 million social enterprise fund to establish 100 social enterprise support centres all over the country. Therefore, support is available for setting up a social enterprise in many European countries.
- In Romania, a social enterprise must reinvest 90% of its profit and apply employee equity in terms of equal and fair pay to its staff. Social enterprise can obtain certification and obtain EU funding through the Operational Programme for Human Capital (POCU).
- In Italy, in 1991, Parliament approved law no 118 completed with Decree 155 that recognises social enterprises other than cooperatives. The bill expands the range of activities social enterprises can do.
- In Germany, the German Cooperative Act (Gen G) acknowledges organisations such as social enterprises with explicit social and cultural missions; this extends to the economic goals of cooperatives broadening the spectrum.
- In Ireland, the legal structures are like the UK- Company Limited by Guarantee, Charity, Cooperatives and Company Limited by Shares that are subsidiaries of not for profits, etc.
- In the Czech Republic, the social cooperative legal structure is for social enterprises to operate, and the legal framework is evolving fast to accommodate social enterprises that are growing.

What are the legal requirements?

The most common legal structure in the United Kingdom is the Company Limited by Guarantee and the Community Interest Company (CIC). This can be achieved by drafting the constitution and downloading the registration forms. Once the forms are filled a solicitor should sign off the documents. Registration can be done in one week with about £100.

Practical steps for My Health to set up as a social enterprise:

- A democratic consultation and vote need to be taken by members on the way forward- whether to adopt a social enterprise legal structure or not.
- Develop a vision, mission statement, and objectives for the organisation
- Articulate a unique selling proposition, e.g. what are you offering to Governments, non-state actors, organisations, and communities.
- Formulate and implement a robust market research and marketing strategy
- Develop a business case
- Seek earned income apart from government grants to have a diversified income stream by trading, consulting, being commissioned, providing training and business services through contracts, grants and research income.

- My Health needs to continuously research the needs of the refugee and migrant sector and exploit opportunities that emerge by developing its offering –services it can render to refugees which can be commissioned by the health authority. Also, grants can be applied for to deliver some intervention. Market research should be conducted to find out whether there are opportunities for commissioning and contracts. There is likely to be a growing need for consultancy services and intervention for service users based on the burgeoning refugee population and migration in Europe. With My Health current products and services, there is scope to build on its intellectual property (the products and services it has developed) and human capital to develop a social enterprise. At the University of Greenwich, there is scope to develop the project as a start-up social enterprise.

- My health needs to develop products and services that service users and commissioners need; in other words, is there a viable and sustainable demand for its offering, this needs to be critically considered, which means that detailed market research must be conducted to find out whether there is a market for its product or service. Market research may enable My Health to identify other needs that refugees may need, this could lead to new services and products being developed for social impact. My Health could be bold and agile enough to exploit new opportunities if they are not health care related but address other issues refugees may face such as social cohesion and mobility.

Other Options:

- My health can transition into a private company, however, there is a downside to this, as the aspect of profit-making does not go down well with Government grant providers due to the nature of public funding. This could preclude Government support if My Health becomes a private business. Setting up as a private company is an option; however, My Health would have to operate on a purely commercial basis and may not access certain types of public funding.

Conclusion

Based on the outcomes achieved, My Health has the potential and capability of articulating a unique selling proposition for developing a social enterprise that can consult, provide services and give advice to governments on health and social care interventions for refugees and migrants. Potential also exist to exploit other opportunities around social cohesion. There is scope to consider other legal forms of company formation. However, social entrepreneurship must be conducted in a professional manner if it is to meet its objectives and attain sustainability.

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Further Links

Social Enterprise in Spain

- http://www.lasociedadcivil.org/wp-content/uploads/2017/12/Pfeilstetter_GomezCarrasco.pdf

Mondragon

- https://www.mondragon-corporation.com/en/about-us/economic-and-financial-indicators/corporate-profile/

Greek Social Enterprise

- https://www.pioneerspost.com/news-views/20180522/greek-social-economy-young-and-optimistic-research-finds

Romania:

- Vitian International
- http://www.vitainternational.media/en/interview/2018/09/04/lucian-gramescu-this-is-how-i-make-social-enterprise-grow-in-romania/42/
- https://business-review.eu/news/analysis-improving-romanias-social-economy-sector-133953
- Italy :
- https://www.euricse.eu/wp-content/uploads/2017/11/WP-96_17-ICSEM.pdf
- Germany:
- file:///C:/Users/Owner/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/Country%20Report_Germany%20(1).pdf
- Ireland

- https://socialentrepreneurs.ie/?gclid=Cj0KCQjAm4TyBRDgARIsAOU75sqNLkcszK0hr0o9pVi9tg5CV0FXsqqIY_-fGPw6ismCb7ibLwuHns4aAvOBEALw_wcB
- https://www.socent.ie/resources/social-enterprise-policy-2019-2022/
- Czech Republic
- file:///C:/Users/Owner/OneDrive/BUSI1689/FINAL_SE%20Mapping_Country%20Report_Czech%20Republic%20(1).pdf

Appendix 1: Case Study: Public Health Social Enterprise (Wellbeing Enterprises)

- Established in 2006 as one of the first UK Community Interest Company (CIC), Wellbeing Enterprises is an award-winning health and wellbeing social enterprise that has been recognised for offering bespoke products such as health promotion and education to improve individual and community health and wellbeing. The organisation does this by educating the general public on health promotion and wellbeing actions, they unlock the assets within the community (human resource and local assets) and channel them towards improving community health and wellbeing. Wellbeing Enterprise works collaboratively with partners (such as the NHS) to tackle the underlying causes of poor health.

- The challenges associated with general wellbeing by people led to the conception of Wellbeing Enterprises. The public felt a lack of influence and control, a lack of a sense of meaning, belonging and connection with people and a lack of capability to manage problems and change. Therefore, Wellbeing Enterprise's core mission is to offer socially innovative services that seek to improve the wellbeing of people. Some of their services include wellbeing workshops, loneliness interventions through social prescribing, one to one group interventions, etc.

- Wellbeing's innovative idea was to devise ways to support the recovery of individuals and communities to achieve better health and wellbeing by working with partners in the NHS and other sectors to develop integrated services by approaching health and wellbeing in an asset-based way. Asset-Based Community Development (ABCD) views the community as one that has the solution to their challenges and works with them to address their challenges because people are connected to assets, educated and trained and their skills and talents mobilised. Such approaches empower people to gain a greater sense of control over their health and wellbeing.