Report – Final Evaluation of IOM Equi-Health Project

Report by

Prof Mark R D Johnson
Centre for Evidence in Ethnicity, Diversity and Health
UK

July 2017.

Contents:

Appendixes:

A. Introduction: Background Information

The objective of the EQUI-HEALTH Action has been to foster the improvement of access and appropriateness of health care services in EU/EEA Member States, including health promotion / prevention to meet the needs of migrants, the Roma and other vulnerable (primarily minority ethnic) groups, including irregular migrants residing in the EU/EEA. Equi-Health had a total budget of 2,555,000 EURO, supported by a 60% co-funding contribution from European Commission's Directorate General for Health and Food Safety (DG Sante).

The EQUI-HEALTH Action ("Fostering health provision for migrants, the Roma, and other vulnerable groups") was co- funded by a direct grant awarded to IOM from the DG Sante administered through the Consumers, Health, Agriculture and Food Executive Agency (Chafea) of the European Commission. The programme of work was launched in February 2013 by the Migration Health Division (MHD) of the Regional Office for Europe of the International Organization for Migration (IOM). Some key elements of the work were sub-contracted to specialists and supervised by IOM. IOM itself developed the concept, terms of reference, conceptual basis for the materials, platforms for dissemination, and provided extensive support and feedback to their consultants.

IOM is the UN Migration Agency, since 2016, an intergovernmental organization with 165 member states (www.iom.int), and works to help ensure the orderly and humane management of migration, to promote international cooperation on migration issues, to assist in the search for practical solutions to migration issues, and to provide humanitarian assistance to migrants in need, including refugees and internally displaced persons. Within IOM, the Migration Health Division (MHD cf www.iom.int/migration-health) has regional offices, following the IOM's own structures. The RO Brussels MHD European section works closely with European institutions and along with the RO Vienna, MHD co-ordinates with the regional office of WHO (the World Health Organisation).

The EQUI-HEALTH action was divided in the following 3 distinct but interrelated components:

I: MH at the Southern EU Borders (SEUB)

To increase understanding of the needs and priorities for improving migrant health in detention and border facilities in the southern EU Member States and enhance the capacity of public health authorities by promoting mechanisms for systematic data collection and referral in detention and border facilities in and between southern EU Member States. It would also, inter-alia, through training, strengthen the capacity of law enforcement authorities and healthcare providers to ensure access to and deliver, appropriate healthcare in detention and border facilities in southern Member States.

> This was primarily conducted in Bulgaria, Croatia, Greece, Italy, Malta, Spain, (and Portugal in training activities), thereby effectively covering the entire Southern, Mediterranean border of the EU.

II: Roma Health (ROMA)

To support national authorities in monitoring, sharing and strengthening national approaches to Roma (also known as Gypsy/Traveller in some MS) health in the EU

> This covered EU countries with high percentage of Roma nationals (Bulgaria, Croatia, Czech Republic, Romania, Spain and Slovakia), and with a high percentage of Roma migrants (Belgium, Italy, France, Spain in selected activities) and targeted explicitly Roma nationals, EU Roma migrants and TCN (Third Country National) Roma migrants

III: Migrant Health (MigHealth)

To support the development of a harmonized EU approach for access to and appropriate provision of healthcare for migrants (noting that the accepted EU definition of migrant includes descendants of migrant-originated populations).

> This component involved all 28 EU Member States plus Iceland, Norway and Turkey.

In earlier references to the Action, (see IOM presentation dated 21 Jan 2013; http://ec.europa.eu/health//sites/health/files/social_determinants/docs/ev_20130121_co06_en.pdf) only two components were listed (SEUB and Migrant/Minority Health). This reflected the EU's conceptualisation of vulnerable groups and the division of concerns within the EC. The latter component has been subdivided in distinct work packages, and in this review, for ease of reference and approach, since the ROMA activities were quite distinct and specific. It should be noted that the Roma diaspora forms a significant element of international migration, and while being explicitly targeted, is also relevant to action based on attention to 'irregular' and refuge-seeking migrants as well as Roma being targeted as an 'ethnic group' in-country.

All components, and the totality of the Action, were designed to address key issues identified by EU policies and Directives. They remain aligned with the current concerns of the Commission, and those identified in the 'Juncker priorities' and workplans of the European Parliament / Commission, as requiring concerted and shared action – namely the issues of inequalities in health, and of migrant health. During the timeframe of the action, the so-called 'refugee crisis' or migration crisis reached a state where levels of public and political concern were high and dominated many media discussions. The Action sought, and obtained, agreement to vary some of its objectives and activity, and attempted as far as possible to support national and international bodies to deal with the consequences of these population flows and public concern. Overall, it retained its connection with, and development of the identified priorities, actions and policies of the European Community and its bodies.

Component I of the Action builds on the "Increasing Public Health Safety Alongside the New Eastern European Border Line" (a project funded by the 1st Public Health programme in 2006), and supports implementation of Decisions 2119/98/EC and 2000/57/EC; Council Directive 2003/9/EC on minimum standards for the reception of asylum seekers, and the new International Health Regulations; and COM (2011) 292 "A dialogue for migration, mobility and security with the southern Mediterranean countries".

Component II of the action contributes to the aims of the Europe 2020 Strategy on the need to reduce health inequalities and implementation of COM(2010) 758 "The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion"; COM(2009) 567 "Solidarity in health: reducing health inequalities in the EU"; COM(2010) 133 "The social and economic integration of the Roma in Europe"; and COM(2011) 173 "An EU Framework for National Roma Integration Strategies up to 2020" (FNRIS).

Component III likewise contributes to the Europe 2020 Strategy on the need to reduce health inequalities and COM(2010) 758 "The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion" & COM(2009) 567 "Solidarity in health: reducing health inequalities in the EU".

This report represents the final external project evaluation, as provided for in the original project agreement with the EC/DG SANTE. It has the following objectives:

- Assess the relevance of the intended outcome and outputs of the Action against set baselines and targets in project proposal, per work packages and in general.
- Assess the efficiency of project implementation.
- Assess the effectiveness of the project in reaching its stated objectives.
- Assess the prospects for sustainability of the project.
- Assess the appropriateness of the project design and subsequent amendments
- Assess the management arrangements, including monitoring and evaluation, for achieving its stated objectives.
- Highlight key achievements and/or challenges.
- Examine the continued relevance of the Action concept and design, particularly the project logic in addressing identified problems and recommend further action(s) for funding as (potential) follow-up of this project.
- Identify the EU added value of the Action and the contribution to the 10 EU Junker priorities in terms of next steps/recommendations for the future

It takes into consideration the results and recommendations of the mid-term project evaluation.

Guiding principles and issues which the evaluation was required to consider included:

Relevance
Efficiency
Effectiveness
Sustainability
Outcomes
Unanticipated effects
European Added Value

B. Methods of the Evaluation

1. The prime source of materials for the evaluation was a careful reading of Equi-Health project documents, including reports, research and evaluation/monitoring data and published materials available on the Action website. These included:
   a. I and II Interim reports to CHAFEA/DG SANTE *(internal)*
   b. Project visibility materials (brochure/info sheets, policy briefs, website, videos, etc.)
   c. Assessment Reports on migrant health at the Southern EU Borders (5+1 in total)
   d. Country Progress Reports on the health components of National Roma Integration Strategies (8 in total, plus other related reports from the package)
   e. Mid-term project evaluation report *(internal)*
   f. Report on migrant health data collection, incl. template for harmonized data collection on/health assessment for migrants and approaches on referrals at the border and in detention
   g. Training packages for continuing education on migrant health for Health Professionals and law enforcement / border control officers (LEOs)
   h. 31 MIPEX health strand reviews on national law and policies on migrant health: 31 Country Reports, and the comparative overall MIPEX health strand report
   i. Thematic study and policy briefs on the costs of exclusion from care (Entitled '*Cost Analysis of health care provision for migrants and ethnic minorities*')
   j. Consensus guidelines on access to health services for irregular migrants ('*Recommendations on access to health services for migrants in an irregular situation: an expert consensus'*)
   k. Other documents incl. reports, minutes from meetings/expert working groups, agendas, and materials submitted by the IOM offices and those approached to submit evidence or be interviewed

2. Participation in the Final Equi-Health Conference on 11th May 2016, where the Evaluator took the opportunity to speak with project partners, key stakeholders from EU MS and other relevant people attending the event in Lisbon and the follow-on Conference organised by CHAFEA/DG Sante, IOM and the COST-ADAPT network, with the Portuguese Directorate General of Health (DGS).

3. Face to face and phone or Skype interviews were arranged and conducted with members of the IOM Brussels Project Management Team to discuss project implementation, as well as regular exchanges by e-mail, including approval of the 'Topic guide' used to focus discussion in interviews with other informants (see Appendix 3).

4. Interviews with key stakeholders were conducted by phone and/or Skype. Contacts were provided by IOM, including project partners from EU, government, academia, and NGOs/IOs. Others were asked to complete written responses to respond to the questions in the Topic Guide, as they felt relevant. Additional interviewees were sought using the Consultant's own networks of academics and practitioners or policy makers, and e-mail discussion lists. (see Appendix 2 for list)

C. Components of Equi-Health

I: SEUB (WP4-6)

A primary objective of the SEUB Component was to generate an awareness of the facts relating to the health of migrants along these borders, the factors affecting them, and the levels of relevant data collection. This was expected to raise awareness of necessary action to address identified gaps, support a degree of harmonisation and hence transferability and comparability of such data, and lead to recommendations applicable at both national and European levels. The process itself was hoped to create a potentially repeatable mechanism to collect relevant data, and by holding discussions about data collection mechanisms and referral systems to increase understanding of issues around migrant, occupational and public health, including in 'reception/detention' centres and border facilities, and thereby enhance the capacity 'front-line' as well as strategic staff of public health authorities, law enforcement services and healthcare providers to meet the needs of migrants in these situations.

Through increased knowledge of the health conditions of migrants, it was expected that a training programme could be developed, and capacity built among front-line staff and at national or regional levels to carry this forward as well as delivering enhanced services and preventing public health threats. The collation of data and development of local understanding was also expected to lead to greater international co-operation and a consensus of standards and needs, facilitating inter-country collaboration and exchange of data, and again, improved health conditions among migrant populations and those of the receiving communities. It was, however, consistently noted that 'Migrants are in general healthy when they start' and that they did not as such, pose any significant threat to public health or individuals through the importation of infectious or exotic diseases. Improved data collection and screening at borders was one way in which this can be assured and demonstrated, hence perhaps also reducing antipathy towards migrants and improving community feeling and cohesion (although this was never an explicit goal of the project).

Participating countries: Croatia, Greece, Italy, Malta, Spain (Portugal & Cyprus in certain activities, Bulgaria was also added)

The outputs from this element included the following:

6 (5+1)Situational Assessment Reports, including national and EU level recommendations on improving health services for migrants, based on desk research and field work with more than **400 interviews** with health professionals, law enforcement officers, CSOs and migrants, and **14 stakeholders**' **consultations tackling** migrant, occupational and public health challenges of the reception process. The reports were discussed and findings validated at **13 National Consultative Committees (NCCs)** meetings in participating countries and a Regional consultation.

The Situational Assessment Reports are available on the EQUI HEALTH website: **http://equi-health.eea.iom.int/ .**

Regional Peer Review & Training of Trainers (ToT). *Modules on Migration & Health, Well-being, Public/individual health, Intercultural Competence*

Workshop for health professionals (HPs) to improve their knowledge on the public health implications of migration and strengthen the responsiveness of health services to migrants' needs (Lisbon 2014). *Participants from Croatia, Greece, Italy, Malta, Portugal, Spain, Turkey*

Workshop for law enforcement officers (LEOs) to exchange experiences and to increase LEOs understanding of the health challenges faced by migrants and the importance of appropriate and timely referrals to health authorities, as well as occupational health and self-protection (Rome 2015). *Participants from Belgium, Bulgaria, Croatia, Cyprus, Greece, Italy, Luxembourg, Portugal, Romania, Spain*

13 National Roll-out Training Sessions which resulted in over 1000 HPs & LEOs trained 'face to face', in Croatia, Greece, Italy, Malta and Portugal (2014-2016) and a further number getting 'on-line' training (in excess of 1000 in Italy).

II: Roma (WP7)

The Roma Health component of the EQUI HEALTH project promotes dialogue among key stakeholders on Roma health issues and supports the implementation of National Roma Integration Strategies (NRIS).

This Component or sub-action focused on promoting dialogue among the various key stakeholders (governmental and non-governmental groups) about Roma health issues. Eight Progress Reports or overview situational ('multi-stakeholder consultation') reports (following the model of the other components, of basing all activity on thorough baseline data collection) on national strategies which had a health focus, would allow EU MS to better monitor, share and strengthen their respective national approaches. It was originally expected that a training package would be developed for healthcare providers to develop competencies in working with ethnic minorities, including the Roma, and professional interchange activities would raise capacity and mutual interchange of expertise and understanding. In the event, a handbook for HPs was created.

Participating countries: Bulgaria, Belgium, Croatia, Czech Republic, France, Italy, Romania, Slovakia, and Spain

The outputs or achievements from this element included the following:

8 Progress Reports on the implementation of the NRIS and other national commitments in the field of health to allow EU Member States to better monitor, share and strengthen their national approaches. The Reports (now known as multi-stakeholder consultation reports) were discussed and findings validated at **13 NCCs** in participating countries, and also are available on the EQUI HEALTH website: **http://equi-health.eea.iom.int/**

Regional Intervention on "Health Mediation and the Roma", to share national experiences, training curricula and discuss successes and challenges of the intercultural health mediation programmes. **Four Study Visits** were carried out: in Bulgaria (2014), Belgium & France (2014), Romania (2015), and Spain (2016). Alongside or arising from this, a **Documentary on Roma Health Mediation was** filmed during the Study Visits in Bulgaria and Belgium/France for wider sharing.

Participants from Belgium, Bulgaria, Czech Republic, Croatia, France, FYROM, Italy, Moldova, Romania, Slovakia, Spain, and Ukraine.

The EU Community Health Mediation Network was a result of this element, and has supported or created collaboration, as a means of communication between health mediators in countries of origin and countries of destination. It can continue to be used as a tool for good practice sharing. (See below)

Summary of Findings on NRIS implementation

Promising practices: Almost EU Member States implement or plan Roma Health Mediation programs/ express high interest in exchange of experiences and practices

Gaps: Limited funding allocated for the strategies' implementation per priority areas/ Programs sustainability under question/ Expectations for EU funding.
There are also Coordination challenges at national and between central & regional levels/tasks set with agencies that do not have powers and capacities/ fragmented regulatory framework. Further, Information flow is hampered by local authorities and key stakeholders insufficiently familiar with NRIS priorities

8 Multi-stakeholder Reports on the implementation of the National Roma Integration Strategies **with a focus on healthcare** in Belgium, Bulgaria, Croatia, Czech Republic, Italy, Romania, Slovakia, and Spain can be found at http://equi-health.eea.iom.int/ (see above, and also http://eurohealthmediators.eu/).

The Regional Intervention on "Health Mediation and the Roma" was nominated for the **European Roma Spirit Award.**

III: MigHealth (WP8)

This Component in fact included several streams or activities:

D-9: MIPEX – The Migrant Integration Policy Index

The original proposals was to generate 30 'Country Briefs', but through collaboration with the academic, also EU-funded 'COST ADAPT' network, and the Migration Policy Group. Rather more was achieved, with additional funding provided by IOM's initiative. The principal elements were: first development of health integration policy indicators, in line with indicators for the other MIPEX sectors to allow cross-sectorial comparison and coherence of methodology, secondly piloting them and then a compilation of up-to-date evidence relating to entitlements and provision of services for people of migrant origin across the national settings of Europe, in order to provide a readily available source of information on national legal and policy frameworks within the overall MIPEX format and also then provided in the form of brief country reviews for policy makers. This was achieved by addition of Health Strand to the Migrant Integration Policy Index, the international 'MIPEX' periodical review of 'integration policies' conducted by the Migration Policy Group, through working in collaboration with the COST ADAPT research network. MPG is a Brussels-based non-profit European organisation dedicated to strategic thinking and acting on equality and mobility which reports associations with the European Programme for

Integration and Migration (EPIM), and the European Economic and Social Committee. Its periodic international reviews of integration policy, (MIPEX), which are funded by the EC/DG Home, have hitherto concentrated on other aspects of social policy and not considered health and social welfare. (see the MPG Website: www.migpolgroup.org)

Summary results are available at the webpage: **http://www.mipex.eu/**

The overview analytical report and the 31 country reports have now been published and are available at: https://publications.iom.int/books/mrs-no-52-summary-report-mipex-health-strand-and-country-reports

D-10: The Consensus study:

A second Strand to this element of the action was the planned development of consensual guidelines or recommendations on access to healthcare services for those in undocumented situations in order to foster a harmonized EU approach to access to and provision of healthcare for migrants, Roma and other vulnerable ethnic minority groups - the **Consensus document** on "Recommendations on access to health services for migrants in an irregular situation".

The Costing Study

An essential component of the Consensus, a milestone, was the development of a costing model to provide a background for discussion and a tool which would be required by commissioners and policy makers to estimate the relative value of creating policies which gave access to health care to these groups. This was achieved by undertaking a 'thematic study' of cost analysis for the consequences of non-provision of healthcare to migrants and ethnic minorities. The target / subject group for this project was defined as irregular migrants and ethnic minorities including the Roma, and the work was conducted in a selection of Member States (*Austria, Belgium, Italy and Spain).*

In total **10 Deliverables** were envisaged from the funded programme. The majority were completed within the envisaged timeframe of the Action, although not all were available in time to be considered for the original deadline of the Final Evaluation, which was therefore been delayed somewhat to allow time for their consideration. Those completed in time for consideration in the Evaluation are commented on below.

A financial report *was also required by the sponsor and was made available for comment by the Evaluator.*

In summary, the following Milestones were duly met:
A: Thematic Study on cost analysis of non-provision of health care. This will be published within the IOM Research Series. An information sheet is already available at: http://equihealth.eea.iom.int/images/Inforgraphicdescriptionfinal.pdf
B: Production of MIPEX Summary analysis (which was not required by the contract but is included as an additional output) – The **MIPEX Health Strand Summary Report,** published by IOM in hard copy and distributed on request, and also accessible at **http://bit.ly/2g0GlRd**

C: Summative Analytical report on the Situational Assessment reports relating to the 6 countries visited. This will be supplemented with further data on the EU Member states and other updates – being prepared for publication in the IOM Research series

It is appropriate to include here also:
D: An 'end of project' Conference, held jointly with the COST Action IS1103 'ADAPT' network on 11th May 2016, as a precursor to a conference on Migrants and Health Actions, organized by DG SANTE, CHAFEA and the Portuguese Ministry of Health (DGS) on 12-13th May. This was an opportunity to present the findings of the 38-country MIPEX study's health component, advocate for policy change, and facilitate networking as well as to present the outcomes of other elements of the Equi-Health Action, against a wider backdrop of other activities in related fields, such as the SH-CAPAC, IOM/EC RE-Health, AMAC, MEM-TP, C2ME, PROMOVAX, EU-HEP-SCREEN, PHAME, EURODHYAN, and TB & HIV related projects, as well as providing a platform for NGOs such as MdM, as well as IOM, WHO, and FRA. There are strong links between and within these projects, many of which derive from the activity of IOM and the networks associated with the EquiHealth programme, such as the emergent Re-Health supported by IOM, which picks up the findings on monitoring MH arising from WP4 and WP5 and developed into a unified health assessment and electronic database platform for data sharing and continuity of care between and within countries: **http://re-health.eea.iom.int/**

D. Outputs & Impact: Evaluator Observations on the outputs

Visibility materials – brochures, posters, website, etc. These have been produced to a high standard of appearance and finish throughout the action, and the website (www.equi-health.eea.iom.int , see also www.ec.europa.eu and www.health-inequalities.eu) is active and still being added to. Many posters and publications were on display and distributed at the final Conference in Lisbon, and were evidently appreciated by delegates. Further printed reports are being produced and circulated, and have met with a positive response in terms of requests for copies.

It should be noted, although of no evident effect on users, that there do already exist several sites with the term 'Equi-Health' in their titles – notably www.equihealth.com and www.equihealth.co.uk which are primarily concerned with the health of horses, and veterinary products. It is clear that the strong linkages between the 'migrant health' activities listed in this report have to a large extent meant that this has not proven a barrier to locating and accessing the relevant reports and sharing the information relating to migrant health with the appropriate community of practice.

Situational Analysis Assessment reports (SARs)- Available on-line at http://equi-health.eea.iom.int/index.php/southern-eu/milestones-and-deliverables-eu / (and in the IOM bookstore : https://publications.iom.int/books/assessment-report-health-situation-eus-southern-borders-migrant-occupational-and-public-health)

Report on migrant health data collection – Available at http://equi-health.eea.iom.int/images/Data_collection_report.pdf

Training package on Migrant Health for Health Professions and Law Enforcement Officers – This has now been completed and is being made increasingly available, following considerable demand from front-line staff in Southern / Eastern European

MS, and endorsement of the packages on the website of the European Commission DG Sante (Health & Food Safety Directorate) on their Public Health policy pages: http://ec.europa.eu/health/migrants/policy_en

Multi-stakeholder Reports on National Roma Integration strategies –available at http://equi-health.eea.iom.int/index.php/roma-health/milestones-and-deliverables-rh). Further, in compliance with the revised outcomes agreed mid-term, and rather than a simple follow-up report, IOM has implemented 3 case studies/ actions and a regional Intervention on Health Mediation and the Roma (see http://equi-health.eea.iom.int/index.php/roma-health/milestones-and-deliverables-rh\0

European Network of Community Health Mediators- this is being developed as a result of the Regional Intervention on "Health Mediation and the Roma" including four workshops and Study Visits of Roma health mediators and program coordinators (June 2014 in Bulgaria, November 2014 in Belgium & France, July 2015 in Romania and June 2016 in Spain) organized by IOM in partnership with the Federal Public Service Health - Belgium, National Network of Health Mediators - Bulgaria, and the University of Seville - Spain. Mediators and coordinators of intercultural mediation programs, Health Ministries, Public Health Institutes and CSOs from Belgium, Bulgaria, Croatia, France, Italy, Romania, Slovakia, Spain, and FYROM participated in the visits.

The network is supporting the development of a European Network of Community Health Mediators, establishing regular channels for communication & cooperation using an online platform: http://eurohealthmediators.eu/

There has also been the benefit of increasing the visibility of the health mediators' work at EU/CoE/National level, and the potential for institutionalization at EU level, of health mediation programs, possibly associated with official recognition of the health mediator's profession in the EU with harmonisation of the HMs tasks to a commonly recognised set, and harmonizing training and implementation of joint training programmes. Taken together with the outputs described in the following section, the project team consider that they have achieved more in both depth and width than had originally been expected or designed for, and the overall achievements can be seen to bear this belief out in practice.

Other additional outputs reported include:

A **PDF book** presenting different **health mediation** models and case studies

A **Handbook for Health Professionals on culturally sensitive Roma Health Care** in Czech Republic

IOM produced a **film** documenting the Study Visits in Bulgaria, Belgium & France. The **documentary** presenting the work of mediators in Bulgaria can be found at http://equi-health.eea.iom.int/

Action to **strengthen Roma Health Governance in the neighbourhood of Polígono Sur** in Seville, Spain

MIPEX Health reviews – (31 have been completed, and a MIPEX Health Summary analysis provided). The individual national reports are now available on the IOM website, and have been debated and circulated within MS, to a varying degree. In some countries, such as Germany, a high-level meeting was held with senior officers of government. IOM and the network of researchers have continued to work for similar meetings to ensure effective impact and anticipate using publication of the reports to generate further such meetings. However, in some other states, it would appear that the bureaucracy, politicians and civil services have seen fit to take no notice, perhaps because of national / local political feelings about the issue. It is for example notable that (as suggested in the UK national report), while this evaluation report was being revised, a headline in a UK national newspaper observed that "Patient records (are) used to find illegal immigrants" (Guardian newspaper, 25 January 2017 p4). This forms part of an observed trend and policy decision in the UK to restrict access to health care services by non-UK citizens. This has recently been raised as a human rights issue in a report by 'Doctors of the World (Medecins du Monde) and a UK charity 'JustFair – "Right to Health for All" June 2017 - https://www.doctorsoftheworld.org.uk/Handlers/Download.ashx?IDMF=5346f811-fb9c-4ea4-8b56-594aad42bf89

We were advised, on the other hand, that concern had been expressed at a high-level that the MIPEX scores for Germany were 'even lower than Romania' – and officials wished to ensure a higher rating. Clearly, issues of political will and national policy objectives will interact with the 'objective' findings of any system of scoring, rather than any agreed international standard or minimum acceptable level of provision. The most positive aspect however, is that since the ratings and overall objectives of the Equi-Health initiative relate to decisions reached at the 2011 Council of Ministers, which was a collective agreement at an EU level, there remains some level of consensus and joint accountability against which these data can be compared, at least in those states which retain identification with EU values and rights frameworks.

Consensus recommendations on Health for Irregular Migrants. This report has been circulated for comments and endorsement to members of relevant e-mail discussion groups such as Minority-Ethnic-Health and other interested parties, and the IOM website also carries a web-link and call for others to endorse the statement. Comments have been, very largely, positive and continue to accrete to the overall total.
The paper, which relies on the findings and data of the MIPEX health reports, highlights that the category 'IM' includes not only 'third country nationals' (TCNs) from outside the EU, but also that the issue affects significant numbers of EU citizens including Roma, and uninsured citizens, and others who may find themselves in 'irregular situations' and excluded from universal health coverage. The Statement relates directly to, and can be seen as a response to, the United Nations call for Universal Health Coverage as one of its 17 'Sustainable Development Goals, and the New York declaration of the United National Summit for Refugees and Migrants of 19th September 2016.

At the time of evaluation, the IOM website listed endorsements from 22 individual experts, mostly academic or practicing health professionals in mental and public health, but including economists and people working in national or regional health administrations, and 5 institutional endorsements (http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus). The full document (a 60-page paper with detailed explanations, recommendations and

references: Ingleby & Petrova-Benedict 2016) is stated on the website to carry the fuller list of supporters. Correspondence on the www.jiscmail.ac.uk/minority-ethnic-health list-serv discussion group indicated that many had found it very useful, such as a remark by Julia Puebla-Fortier that it would be cited at the forthcoming 2nd Global Consultation on Migrant Health in Sri Lanka later in February 2017 (Posted note 1/2/2017). It has also been cited in guidance from the UK Care Quality Commission on Human Rights in Health Care (draft made available to evaluator).

Thematic study on costs of non-provision of Health Care

A crucial element of this package also supporting the consensus was the production of an 'infographic' poster-type summary of the issues and contributing factors relevant to any discussion about equity and costs/cost-savings involved in meeting the health care needs of 'Irregular Migrants' (and, it is stated, EU Citizens without insurance, who might also be expected or required to pay for their treatment). In bold, colourful figures it does present a clear basis for discussion, although needing considerable interpretation and explanation. For four 'index' conditions (Epilepsy, Depression, Coronary Heart Disease and Asthma) case studies are demonstrated illustrating the costs associated with a patient, in a selected Member state for each of these (Belgium, Austria, Spain, Italy), and the conclusion drawn that early intervention (timely treatment) can produce very significant savings in treatment costs both to the individual and to the health care system. While on its own not a complete and unarguable demonstration of the issues, the poster (infographic) does provide a useful and authoritative, well referenced and constructed, basis for progress in the area, and has been used as part of the debates leading to the 'Consensus Statement'. It is accompanied by an 'Explanatory Note', and both are available on the Equi-Health website (equi-health.eea.iom.int) although they may need to be more widely considered and used in future, beyond the original distribution by the Austrian Center for Health & Migration (July 2016). It was not possible in the time available for this end-of-project evaluation to obtain and consider detailed 'Google analytic' or other data on the use made of these two documents. None of those interviewed made any direct reference to use or impressions of this output but they may well have used it.

A '**Final Conference'** was held in Lisbon 11 May 2016 and a complementary meeting followed on from it (May 12-13 2016). The event was attended by around 100 participants, including the Evaluator, and following its conclusion, they were invited by IOM to complete a short 'evaluation' feedback survey, rating a number of aspects of the event on a scale from 1-4 (Dissatisfied to Very satisfied). Around half of those attending completed the survey, which is a good response rate. High levels of appreciation were expressed in relation to the organisation of the event, including arrangements made for international travel (and handled by IOM's offices). Content was also rated highly (averaging 3.5 out of a possible 4) and highest ratings appeared to attach to the MIPEX and Consensus guideline elements as well as a very interactive and dramatic 'Forum Theatre' presentation on TB. "The added value of the events was the presence of professionals from various backgrounds (academia, civil society, national health authorities etc) who contributed to the depth of the discussions …".

More than one of the informants for the ETR noted that they had been personally uplifted or 'inspired by the project and the Lisbon Conference', and the contacts made at that event with other activists in the field, which would prove the basis or springboard for future development of actions, applications and project proposals.

Much of the impact and value of the overall EH programme's outputs can be seen to be 'intangible' but the data show that the quantity of the outputs at least matches or in most cases, exceeds, the expected levels, and the quality standards of production are high – as evidenced by the comments from users of them and other participants in the Action. Overall, this tends to suggest to the evaluator that 'value for money' has been achieved. This conclusion is now examined in relation to the feedback given by members of the Action and others approached to express opinions as part of the evaluation, analysed against the key principles required of the evaluation in the Brief.

E. Analysis of Responses to the Survey/ Interviews

Almost without exception, those approached to comment on the Action and its components were favourable in their opinions, and felt that the exercise, and/or their participation in it, had been of value. At the same time, many suggestions were made as to ways in which improvements could be made, or further developments could carry forward the benefits of the Action. The main responses are summarised below, using indicative quotations from submitted evidence, under the headings designated as 'key priorities' for the evaluation.

Relevance and the EU's priorities

The Evaluation was specifically tasked to consider the timeliness, relevance and appropriateness of the Equi-Health Action in relation to the emergent context, and weighed against the so-called "Juncker Priorities", which were in fact promulgated after the commencement of the Action itself : http://ec.europa.eu/archives/juncker-commission/priorities/index_en.htm

In these, the EC President Jean-Claude Juncker proposed a better coordinated working program of EU institutions and identified 10 key issues for 2015, developing these from a paper presented on the day of his confirmation in Parliament, 15 July 2014.
Particularly related to the Action, appear to be the following Priorities:

7. An area of justice and fundamental rights based on mutual trust
The President described this as ensuring that "Our European Union is more than a big common market". It should also be a Union of shared values, justice, protection and fairness with full respect for fundamental rights and the rule of law. This requires joint European action, and it would seem unarguable that the Equi-Health Action has contributed to such activity and agreement on fundamental principles, essential to implementation of activity to assure the fundamental rights of migrants and minorities.

8. Towards a new policy on migration
The President noted that "recent terrible events in the Mediterranean have shown us that Europe needs to manage migration better". Self-evidently, the focus of the SEUB and Migrant Health components of Equi-Health address very specifically this concern.

9. A stronger global actor
It can be fairly argued that collaborative action within the EU on issues of such global concern (since refugee flows are not confined to those moving towards Europe) will enhance the ability of the EU and its member states, to act on a global level.

It was further noted by Juncker and Timmermans that the Commission 'would like to concentrate its efforts in areas where there is a strong chance of adopting new legislation', and **not waste time where lack of consensus is preventing from such advance (***emphasis in original on EU website***)**. The contribution of the Equi-Health Action in formulating and progressing consensus on matters such as the rights and requirements of 'irregular' migrants to health care, and priorities in refugee health, is fundamental, especially in such a sensitive area as this (see also comments below under 'Findings and Conclusions' relating to international interest in the issue)

It should be noted that during the time of the Action, the whole of Europe was affected by a global increase in the levels of migration and more specifically, asylum seeking, largely provoked by an upswing in levels of violence and disruption in the Middle East/North and East Africa, some associated with 'Islamic' fundamentalism, others with the situation in Syria and resistance to its President, and others with natural disasters and drought. These lead to dramatic headlines in national media, and a strong populist movement across many countries with consequent political impact, possibly including the rise of right-wing political parties, 'Brexit', and other matters which necessarily all created issues of concern for the European Community and its institutions. Many of those interviewed for the evaluation drew attention to this as a justification for its existence – or that some elements of the Equi-Health had assisted them in managing their consequences.

> **Spanish Academic**: An important strength of the project has been the timing, meaning the importance to put in value in at this moment subjects such as Roma health, undocumented migrants at borders and highlighting the importance of health policies in times of social and economic crisis.

> **Austrian Academic**: Then there was the Refugee Crisis in 2015 when we were in the middle of the study and the number of (asylum) applications exploded – the effects on politics were very sudden, attention of media was very high and public opinion changed – very toxic … (which is why the EH economic evidence to prove you can save money by early access may be even more helpful in future debates)

Relevance

It can, following on from the above, hardly be denied that the Action and its activities and outputs have had a very high level of relevance to policy matters arising during its currency. The 'Migrant Crisis', as some media reports describe it – notably the significant rises in flows of refugees and asylum seekers from the 'Middle East' and northern/ eastern Africa, along the southern/eastern borders of the EU, almost risked overwhelming the SEUB projects, with demands for the support they gave to front-line workers. As one senior official observed:

> **National Health Ministry:** The Equi-Health project has been developed during a considerable change of migratory dynamics. It has a positive impact, helping to design and to map the reception processes also reengineering and optimizing them, in particular relating to the irregular migrants component, facilitating networking amongst several institutions and establishing a multilevel approach.

> **Local Organiser (Balkan region):** With the massive influx of migrants along the so-called Balkans route, the topic continued to gain momentum, as did the emergency response effort. The training sessions delivered before the migration crisis in Croatia yielded some lasting results as many of the participants in EHP training applied their knowledge as emergency first responders.

A particular strength of the EH approach was its multi-level, multi-agency approach which avoided the compartmentalisation of expertise into professional 'silos', and encouraged both 'public sector' (state) and non-governmental bodies (mainly voluntary or charity-led NGOs) working across a variety of areas of migrant need and impact, to work together- sometimes for the first time, and extended their competence into new areas of work:

> **Spanish Academic:** Also, the SEUB has focused on no-healthcare-providers (i.e. those which did not historically provide healthcare among their activities) such LEOs and NGO activists involved in humanitarian care to recent massive migrant arrivals. This was a gap not enough addressed in previous initiatives and therefore it has been a reference to the subsequent crisis of mixed migrant flows.

The impact has extended beyond the specific work of the Action itself, and linked into other relevant initiatives of the IOM, EC, and other stakeholders, and given added currency to these at a time when they were clearly salient to the demands arising from the 'crisis':

> **EU Official:** The great strength of the project was an opportunity to move on migrant work during the crisis and open up MS national authorities and present new actions, like RE-Health & Patient Held Records (PHR and E-PHR), SH-CAPAC, EU-IMMUN, EUR-HUMAN, CARE-NEW, and involve NGOs from eleven countries, placing this before a wider audience.

A member of the IOM's central team observed that "Overall the project WPs were well aligned with the two (policy) components identified in the proposal. In terms of the expected outcomes, whereas those related to increased capacity of EU MS are likely well achieved through trainings and engagement, it is not clear whether the 'citizens' health security' was improved – this is also a higher level objective".

Efficiency

Efficiency is a difficult concept to assess in the context of a unique enterprise which has few comparators. It can, for example, be seen as a measure of the leverage of further resources towards the ends of the project, or as a measure of the internal use of funds and personnel. For the purpose of this evaluation, it has been seen as a question of whether any evident wastage of effort or resources was noted, and whether the resources allocated were suitably disposed to the overall benefit of the collective package of work – given that from the point of view of the funding bodies, money allocated to this project was unavailable to other potential sites of investment. Concern was expressed that any moneys not actually disbursed would be lost to the

sector, and this would, in a sense, also be a sort of inefficiency, rather than the more familiar suggestion that overspending on a project was wasteful.

> **IOM Officer**: Efficiency – we were able to stretch funds and worked with partners to get provision in kind, venues, etc
>
> Several audits through the course of the project have found no complaints
>
> **EU Official**: Some scepticism about whether they will use all the budget – first and second reports showed lower than expected consumption – it seems to be good value but will need to be seen to use all the resources or they are lost to the sector (both migrants and health) – ... (there is) concern that all budgeted expenditure is claimed and used.

Those engaged in actually developing the projects, and delivering the associated services, however, had few doubts about the efficient use of resources. Indeed, they were more likely to note that they had been obliged to supplement the resources – which from the donor's perspective might be seen as adding value, although some informants believed that a higher quality of some data might have been achieved with greater input – but as the overall quality and effectiveness of the outputs were not called into question, it may be considered that higher levels of resourcing might not have led to significantly more impact for the given levels of input, which is a more conventional measure of efficiency.

> **Roma Mediator**: Yes, they were appropriate and adequate and covered the needs of the implementation without excess. I think they were also appropriate for achieving the project results.
>
> **Spanish Academic:** Nevertheless, we have some difficulties to cope with some components. The financial resources were insufficient and this made difficult the execution of a complete work and the quality of it. For instance, we were not satisfied with the qualitative analysis of the field work held in Spain. In the field work we did not have resources for transcription of the interviews, therefore the content analysis was poorer than we are used to.
>
> Equi-Health has been very ambitious in relation to the available funding.
>
> **Mediterranean Health Ministry Officer**: It looked like an enormous project in the beginning, however as we started to break it down into small tasks it was becoming more interesting and more manageable.
>
> **IOM Officer:** The programme was thinly resourced, staff was stretched and overall been rather effective in producing needed results.

There may, however, be some legitimate concern about whether greater impact and effectiveness might have been achieved with greater attention to other aspects of the programme's design and resourcing or political support, which raises a somewhat different question than whether the resources allocated were in fact used efficiently:

> **Voluntary Sector Partner:** The resources required to assemble the content and undertake the analysis required to develop the guidelines (*for IMs*) were, I

think, adequate. Additional resources could have been brought to bear on the political side, to ensure (greater) uptake at the national level of the guidelines (emphasis added) (perhaps these efforts were underway, and I wasn't aware).

Efficiency is also contextual – it was noted that not only was the Action innovative and therefore hard to compare with others, but the sensitivity and instability of those for whose ultimate benefit the project was working (i.e. in many cases, irregular migrants or refugees, and other by-definition vulnerable groups), means that conventional approaches and expectations may not be appropriate – time has to be taken to develop relationships of trust, collect relevant information, and build sensitively on these to produce effective outcomes: any 'short-cuts' which might appear attractive to financial scrutiny, might undermine the whole process and lead to a waste of the initial groundwork:

> **Austrian Academic**: Partnerships do have to be developed, especially with IM and vulnerable groups – you need to have good relationships with people working on the ground and trustful … because IM/VP are very aware anyone may be an enemy or cheat you so trust is vital and a whole spirit of access is about protection – including information, so it takes time for researchers to establish trustful relationships … where we did not have those (in one MS) we did not get access to data, except via (an NGO partner) as we have a longer relationship and networking with them … there wasn't time in the project timeline to develop from scratch. – reliable data are hard to collect.

It was also noted that all forms of cross-border, cross-agency working have their own added hidden costs and implications, and at the same time, advantages:

> **EU Official:** IOM is always working very slowly - Any international organisation will do – and they have to find the matching funding, as we don't pay it all, we cannot direct totally … they too have difficulties as EU and national legislation interact and there is very little formal international legislation to rely on in health rights – and the beauty of International Organisations like IOM is that they are always there – and never say no, are always happy to do more work, extend – though this leads to delays …. But they are linked to other organisations and can be invited to, or do work with other Directorates and with an overall perspective, they can cope better with the (local) political tensions.

It is evident that there is no single measure of 'efficiency', but that there were no major criticisms of the EH Action as being inefficient, while it was generally deemed to have made very effective use of the relatively limited resources available, and to have leveraged additional activity and resources through partnership working.

Effectiveness

While efficiency measures the degree to which resources are not wasted but used to achieve the ends of an intervention, effectiveness is a more difficult thing to measure, being concerned with the degree to which, without consideration of costs, objectives are achieved and the desired results shown to be brought about. With interventions affecting complex organisations and situations, which depend on human social action, it can be difficult to demonstrate the linkage between the project undertaken and any

changes in society or measures of (e.g.) health – but the production of outputs alone, without some measure of their impact and of change in practice or the situation of migrants, does not constitute 'effectiveness'. However, creation of partnerships and better working relationships, or the uptake of new training which is expected to lead to changes in practice, in the future, can certainly be demonstrated from the EH Action's elements, and there was some consensus that it had led to the beginnings of change, whose continuance could not be solely the responsibility of the IOM itself.

It was generally agreed that the Action had laid the foundations for improved equality of care and reduction in problems for health-care systems, but also that the responsibility for this reaching fruition was a local one for national and regional governance bodies. The events associated with the EH Action had provided the stimulus and opportunity to begin such a process:

> **Roma Mediator:** Although Bulgaria as a state has adopted NRIS, most of the municipalities lack understanding why such policies are needed on local level and how the strategic documents could be "translated" locally in order to improve the lives of the people living on their territory. These meetings were also a good opportunity to present the National Health Mediation Program and to invite new municipalities to join it in 2017.

Some informants believed that additional 'political' (non-partisan) pressure might be needed to ensure adoption of policies and practices, but accepted that in the current climate of opinion, this might present difficulties, especially for bodies seen as 'external' and not locally elected or otherwise empowered to dictate policy. In such situations, it might be that a mediating influence to resist pressures to reduce provision was in itself an achievement and evidence of effectiveness.

> **Spanish Academic**: We believe that one of the weaknesses is the little impact at policymaking level; it is not clear how Equi-Health is going to influence in a decisive way in this regard. More determination should have been employed to make the project more assumed by policymakers and governing bodies. IOM is an institution well positioned and considered in these spheres and thus it should have been played a more determining role in this sense. However, we understand the difficulties of talking about health policies in times of austerity, talking about Roma health when the Decade of Roma inclusion is over, and talking about refugees in the middle of a crisis and when xenophobia is arising. In this sense, we should not forget the buffer effect that Equi-Health may have had in all these areas.

Other respondents were perhaps more critical, although perhaps from a position of impotence themselves, or out of frustration, seeking a more powerful partner to support their own efforts:

> **Voluntary Sector Partner: (**We felt there was **)** No clearly articulated plan, or discussion of a plan, about that subsequent advocacy and opportunities to coordinate efforts.

It is fair to include here the response of IOM, who noted that while they felt these were interesting points, they had concentrated efforts in producing good quality evidence. They had not invested so much time in clearly articulating a plan for action

for their partners in terms of next steps when the project will be over, since in their view this was work in progress and the advocacy is continuous. This would not, they hoped, stop at the end of the project for IOM (which is essentially a project-based, funding-dependent organisation) but would be taken up and supported with other projects and activities. They accepted that this may not have been so evident for their many project partners engaged in the process of working locally.

As another partner noted, the implementation and embedding of change was a matter for local actors to take up:

> **Austrian Academic**: Not yet, necessarily, a main question mark for future endeavour to close the gap between the evidence we produce and the policy and practice change that should follow …

Overall, the greatest effectiveness was to be seen in the generation, sustaining and continuance of partnerships and relationships between relevant agencies in the field, locally and internationally:

> **IOM Officer:** Great partnerships with some (who maybe heavily depended on the funding of the programme) - esp with academia throughout Europe - (A) Very small team established a very wide network and reached many partners, MS, stakeholders, with very timely tools. …. (the programme's strengths had been that it was) Timely; innovative and in a complex political environment, able to send important and consistent 'public health' messages. We can only hope that the work will be used for years to come and politics will not water down the public health relevance .

Given that the Evaluator has also seen evidence of the funding of subsequent projects and use, or renewal of many of the outputs listed as arising from the Action, this seems a reasonable claim. We should also note that while the majority of the Action was concerned with direct action and service provision 'on the ground', the linkages to selected influential academics have great potential to influence future training, research/evidence generation, and eventually, policy and professional standards, although these may take some time to be adopted and implemented. Additional evidence from a selection of correspondence monitored by the Evaluator is also included in an appendix to this report (see Appendix 1**).**

Sustainability

There was clear acceptance that the effectiveness and effects of the EH Action would be nullified if there was no sustained effort to ensure that they were continued beyond the life of the project-funding. While those involved in the various activities of the Action may themselves have been personally committed to its ends, without guarantees of future funding or else 'mainstreaming' into normal local expenditure plans, many of the innovative elements of the Action would potentially be lost. However, there was considerable optimism that this could be achieved and the investment of the EU budget in these activities would be of lasting value. Especially, it was expected and hoped that some of the techniques and systems developed for various elements would be of continuing use:

IOM Officers: Yes, absolutely, they can. Money and other resources are wasted if not used beyond the life of the project.

On data collection, clearly WP outputs like MIPEX have been successful, and more could be done to ensure all other tools and reports are efficiently used in future beyond life of the project

Regional Government Officer: The comparisons provided will continue to provide a baseline for future studies.

Regional Organiser (Balkans): With additional funding and constant attention, this is quite likely. ... With greater attention being paid to health issues across Europe, hope remains that this most needed activity can be implemented.

National Health Ministry: Training and the re-engineering of processes are sustainable; of course, they need adaptation and revision in case of new needs, but in principle we have created local resources and procedures, with the availability of new competences.

Other informants pointed to sources and promises of potential future support, and placed the onus for sustained activity on those active in the field to build on the Action by bidding for these funds, and the goodwill existing for its ends. Others accepted that they themselves also had responsibility to work for this end, using the linkages created through the EH Action and its associated networks.

EU Official: In 2017-18 there will be a new Action on Migrant Health – a cross-sectional priority from 2017, being led by the Portuguese and Norwegians and this could be a good way to take things forward if it can be linked to IOM's EH, and Re-Health.

German Academic: From this perspective the EH was a really good project as it goes beyond 'doing a project here and a project there' but is linked to a lasting concept of equity and human rights, especially when linked to the longer term roles of COST HOME/ADAPT networks … now we have to keep it living.

If these expectations and intentions are carried through – and the evidence suggests that they have been, as for example in the (relatively short-term) Re:Health (re-health.eea.iom.int) and CARE (careformigrants.eu) projects, then the legacy of the EH Action will endure and its sustainability will be ensured through successive actions and projects. Certainly, Dr Gianfranco Constanza, Director of the Italian INMP, expressed his confidence at the CARE end-of-project event in March 2017, that the high levels of participation by national Public Health institutions would ensure the sustainability of the lessons learned (www.careformigrants.eu). Other projects, such as the '8 NGOs in 11 countries' initiative of MdM (www.medecinsdumonde.org) , EUR-HUMAN (led by the University of Crete: www.eur-human.uoc.gr), and a planned '1st World Congress' on migrant health in 2018 (www.merhcongress.com), suggest these issues and evidence will continue to influence policy and practice.

Outcomes

While the outputs of the projects within the Action have been enumerated above, and the effectiveness of its work-streams also discussed, a number of comments were made by respondents to the survey and interviews, which related to specific outcomes from work undertaken within the EH Action. These also tend to reinforce the judgement above that the funding has made a difference to the lives of migrants, and to national or regional practice. That said, the point was also made here, that successful outcomes depend on local political will and professional support:

> **German Academic**: "Who knows what Governments will do? I hope that the symbolic power of the combination of IOM and DG Sante will impress physicians associations and politicians to take action.
>
> **Spanish Academic:** As for the Roma communities in general, the increased knowledge of the local health mediators on the situation in different EU countries could also be beneficial because the mediators will be able to better prepare the members of their community on what they could expect travelling abroad, what kind of documents they need, etc.

It is clear that some structural changes have occurred, which can be traced in origin to the initiative, and which will have lasting effects:

> **National Health Ministry:** As said before, at national level a concrete collaboration has been established among national authorities (MoH, MoI, Ministry of Labour, Ministry of Defence) for the migration issues management, considering different mandates. At local level, the project has facilitated the coordination mechanism among the local health authorities, Prefectures, Juridical entities and Municipalities
>
> **Spanish Academic:** Regarding Roma, we understand that the success might have been bigger than the initially expected. At first, the goal was to assess the implementation of Roma health policies and, as a bonus other outcomes have been produced, such as the consolidation of a European network of Roma health mediators.

During the compilation and revision of this report, new evidence of impact and continuing activities based on the Action continued to accrete, but cannot be exhaustively recorded here. It is to be hoped that 'traceability' will be maintained by those involved in the ongoing projects, and that the use of the new forums and databases / repositories discussed throughout the report, will support this.

Unanticipated Effects/ Other Challenges and Learning Points

In evaluation of any intervention, it is customary to report unanticipated effects arising from the planned changes. In medical and physical interventions, this can sometimes demonstrate that adverse effects counter the potential gains achieved. In social and organisational developments, it is perhaps less likely that harmful effects will be noted, but nevertheless, it is important to reflect on some learning points that were possibly unexpected, and which have consequences for future similar interventions and initiatives.

As noted above, there is considerable antipathy in certain sections of the population to support given to migrants and refugees, and suggestions made in political statements and media coverage that 'provision' can lead to increased attractiveness of Europe as a destination, thus increasing flows and pressures on European institutions from the flows associated with the so-called 'migrant crisis'. This theory has been extensively debated and is generally disregarded as a justifiable conclusion, and there was no evidence given during the evaluation which led in any way to suggest that improved health care services for migrants would, or had, led to greater demand from that source. Indeed, professionals and practitioners were generally glad that sources of information, advice and support and new mechanisms to reduce the strains of provision and record keeping had been created.

However, there were some areas of tension between partners that had not been expected. In many cases, these arose from national or local customs and norms of ethical behaviour and scientific research:

> **Spanish Academic:** At the same time, we had some difficulties to agree the ethical framework we usually work with the contractor (Ethical commission approval, design of informed consent, and so on). In our point of view it was not sufficiently considered. However, this difficulty was resolved successfully.
>
> **Belgian Health Official:** (there were some) Problems – of different cultures or expectations over confidentiality and consent between Western and Eastern Europe – an incident when our people were invited to enter Roma people's houses without being sure if they had given explicit consent – and when a (Bulgarian) film crew wanted to film a family in France and had been advised by local officials not to – created some tension – it was not IOM's mistake, but the attitude of the film crew was very embarrassing ….
>
> *(It was also noted by others involved that this had possibly arisen from a misunderstanding, and possible lack of awareness of conversations in the Roma language between the film crew and the families concerned)*

There were, at times, inevitably, occasional tensions or misunderstandings between national and international organisations, statutory agencies and NGOs or other 'third sector' bodies, who have different constitutional abilities and duties, and may be frustrated with each other's style of working:

> **IOM Officers:** Strong partnerships and networks are evident among university partners in Europe, with the EC themselves and selected MS externally. Relationships with WHO and other UN partners could have received more effort and political engagement.
>
> **National Health Ministry**: A collaboration letter between IOM and WHO has been signed under the auspices of the MoH, but no concrete actions have been taken for the purpose (*this appears to be the result of a lack of awareness in one party of what the other was in fact doing*).
>
> **Roma Mediator:** Partnerships depend on the specific scope of each of the organizations participating in the Initiative. The organizations being NGOs,

governmental structures, universities – these are actors with different agenda and way of work. Still, in my view, such partnerships are enriching for each of the parties since they provide different and valuable point of view.

IOM Officer: Weaknesses – was often politics – whenever moved away from working with academics, it requires continuous engagement with local authorities who are responsible for implementation and action … at both local and national levels, and also NGOs, with a lot of consultation …. (but) there have been regular changes of political control, focal points of agreement – (it was only workable) thanks to the role of the IOM local offices, which had not previously worked on health so much …so this did build some capacity and extended their relationships

Overall, it appears that lessons were learned and better working relationships across sectors established during the Action, and no lasting harm done. It is worth noting that any inter-sectoral or international activity cannot assume that all values, processes and objectives are universal! Such shared values depend on practice and experience – and their development is part of the longer-term value of such actions, as discussed below.

European Added Value

The Action, across all three streams and the many projects associated with it, especially taken in conjunction with the support it offered to, and gained from, the COST Action IS1103 'ADAPT' network, had a high level of 'European Added Value'. This was clearly expressed and made visible at the 'end of project' Conference held jointly with the COST network on 11th May 2016, as a precursor to a conference on Migrants and Health Actions, organized by DG SANTE, CHAFEA and the Portuguese Ministry of Health (DGS) on 12-13th May. In addition to discussion of the 38-country MIPEX study's Health component, there was passionate advocacy for policy change, interaction between professionals, statutory agency staff, grass-roots community groups and activists, and extensive networking. This was clearly and demonstrably 'European Added Value' in action. This can be seen across all of the streams or components of the Action:

Belgian Health Official: The Equi-Health Roma project and meetings helped to brief our mediators and get in touch with Roma mediators in other countries where there are more substantial populations – this for us was the main added value – as also is the newly established Euro-Health Mediators Network.

Cultural Mediator (Roma) In my opinion the project contributed for the establishment of a useful and needed dialogue between coordinators of mediation programs on European level with possibilities for exchange of practical information and improving the national programs by borrowing models and good practices from the other countries.

Value added arose from links to other networks as well as creation of new ones:

Spanish Academic: Equi-Health has also been involved in the Project to develop Equity Standards in Healthcare for Migrants and Vulnerable Groups, promoted by the (WHO) HPH network and led by Antonio Chiarenza (Italy)

> We understand that the alliances that promoted Equi-Health have .... allowed increasing the strengths of partners. .... our participation in the project has prompted multiple alliances at national and European level. For example, regarding Roma, we have built partnerships with the ASPCAT, the Equi-Sastipen Roma Network, and the Interuniversity Institute of Social Development and Peace at University of Alicante.....

The guidelines and recommendations for the MIPEX Health reports were also said to consolidate existing research and analysis on the issue of undocumented migrants' access to health services and their right to access those services. The process itself was of considerable value.

> Given the strength of the analysis and its comprehensiveness, as well as the fact that the document reflects substantial input from key actors and experts (WHO, IOM, MdM, MSF, PICUM, etc.), it has a degree of authority that strengthens its value as a tool for advocacy.

> **Austrian Academic:** The Equi-Health 'thematic study' was a real step forward as it managed to merge qualitative and quantitative approaches in social sciences with economists to develop a beautiful methodology to look into specific cases, with primary data … and combine with methods of economics using 'Big data' …

> **EU Official**: The Process is actually of greater value – how people meet and cooperate and create consensus, this is of greater value than the outputs themselves …

All in all, the evidence submitted to the evaluation provided a positive assessment against all of the key priorities and dimensions which were required to be considered.

> **Spanish Academic:** The difficulty of a project with such characteristics and ambitious goals, with so many open fronts, required a great management effort, not only by the IOM and its leaders but also by the coordination of multiple partners, networks and other stakeholders. In this regard, the result has been very positive.

In concluding this section of the Evaluation, it is appropriate to repeat the comment of one informant, who noted that "We are not leading a horse to water, but to something they have never drunk before – so who can tell if they feel they have benefited?".

F. Reflection on the Mid-Term Evaluation

The Midterm Evaluation (MTE) was in general very favourable to the ongoing progress of the Equi-Health action and its component projects. It noted in particular (Section 3.1.1.) the high level of energy and commitment given to the overall project(s) and the crucial role played by the IOM country co-ordinators and central office. It also noted that there was ongoing internal evaluation and continual development and reaction to changing circumstances and needs. The complementary nature of the components, in particular for example the role of MIPEX Health in collating data which were of value to the SEUB and other elements, was highlighted.

The MT Evaluator also made a number of suggestions or recommendations, and expressed certain concerns – notably in relation to sustainability and dissemination, and the embedding of the projects and activities in day-to-day planning and direction of other programmes and the activities of stakeholders such as the Directorates of the European Commission. It recommended a period of reflection and consultation on dissemination, sustainability and embedding, and suggested that a series of summary reports and recommendations be oriented towards the specific national governments of participating Member States. 'A lot of work had been done but there was an issue of enough done to pull it all together', especially given perceived problems of coordination between the three main EU Directorates of Justice, Home Affairs and Health (SANTE). The Mid-Term evaluator was concerned that there was no apparent sign of any specific action having been taken in respect of these concerns and recommendations, and nothing in the information received by the Final Evaluator suggested that any of their informants was aware of this having happened, beyond production and consideration of the MIPEX work. It would seem, above all, that there will need to be, after the conclusion of the fieldwork and preparation of final reports from the projects and overall Action, a period of time and adequate resource to be dedicated to the preparation and dissemination of more targeted, concrete and 'short-form digestible' reports for stakeholders and national or regional bodies. It would also be useful to clarify more clearly, the relationship with, and complementarity between, the actions and projects of IOM and those undertaken under the auspices of the World Health Organisation (Europe Office WHO) in relation to public health and migration. Further clarification as to responsibility and lines of communication and ownership of action in the complex EU environment might also be helpful. Stronger links might also be developed with ASPHER and EUPHA – the main groups concerned with public health at a European level. Action relevant to this suggestion has begun, with a joint project between IOM and ASPHER on Migrant Health training during two ASPHER workshops in 2016 and also submitted within two tenders to EC/DGS, (in 2017) whilst many within EUPHA participated within the COST ACTION as contributors to the MIPEX Health reports and IOM has been involved with all EUPHA MH Conferences including membership of the Scientific Board.

It is recognised, within this evaluation and these recommendations, that "projectized" (i.e. project-funded, externally supported) actions have to conform to timelines and expected deliverables. While those involved may be in agreement with the need to take time to reflect and consider, such a contingency is rarely included within the funding awarded. The project team did produce, beyond the original brief, extra summaries or digests as recommended, and anticipate that those responsible for implementation would themselves take time to consider these. However, as commented above (under 'relevance') the mid term evaluation was completed during

the height of the "reception crisis" or so-called migration crisis, which was, indeed, "not exactly time to stop and reflect".

It should also be noted that IOM is a service agency, with the requirement to attract and conduct practical projects 'on the ground' and also to find allied funding, and it may be considered that some of these recommendations would be better addressed to, or taken on by, another institution such as an academic body or supranational policy agency. However, IOM has begun to publish an increasing amount of material and reports on its website and make these also available in 'hard copy' to facilitate this process. It also takes an active role in events such as those involved in developing the *WHO Toolkit for assessing health system capacity to manage large influxes of refugees, asylum seekers and migrants,* and the proposed MERH2018 Congress on Migrant Health

As the MTE states clearly, (Sect 4) "Equi-Health is a flagship action within the migration and health department in IOM and with the co-funder EC/DG Sante and Chafea. It encompasses a policy area that is a nexus between two central policy areas – migration on the one hand and health on the others … A project such as this must develop a capacity through its activities and results to influence policy change and policy development". While the 'Final Conference' in Lisbon in May 2016 was highly successful in terms of numbers attending, the evaluation of participants, and the quality of presentations and materials shared at the event, it has as far as can be seen to date, had little impact on policy or practice, or in terms of media coverage and influence on public debate – where if anything the terms of discussion have deteriorated significantly. This is to be regretted, and it is important to stress that the value of Equi-Health will, as the MTE suggested, be mitigated or vitiated if a higher profile and greater awareness of the successes of the project in terms of development of good practice and training materials, are not more widely appreciated. While this may seem a harsh judgement, it is an inevitable consequence of the current climate of opinion in Europe, and may change, depending on the outcome of various electoral processes during 2017. The same criticism / problem also applies to other conferences and actors, including the regular EUPHA conference on migration-health, and when policies are revised to take account of new research, it is also true that credit is seldom given to those who provided that new insight. The responsibility for addressing this, may not lie with IOM or DGS, but with another level of the 'complex EU system'.

<u>Recommendations from the MTR:</u>

a) Recommendations for the project team

1. Set aside a designated, significant amount of time over the next few months to step back from all the project actions in the core work packages and all the dissemination activities that have been undertaken over the past two years, so as to enable a period of reflection, consolidation and discussion on what has been achieved on the ground and what structural impact the activities have had. Within existing project parameters, the current situation that Europe is facing with mass movement of migrants, provides a major opportunity to reflect on strategies for continued interaction with MS.

End-Term reviewer Comment – This would still be a desirable action – insofar as the 'End of Project Conference' did not provide an opportunity to do this. A continuing

space for such reflection would be of considerable value, and the involvement of key actors, notably the IOM RO Brussels office staff, in other initiatives would be helpful to the development of future actions and activities, along with the insights of the DG Sante/Chafea sponsors.

2. Produce short, policy-related briefs and/or other outputs based on findings from each country participating in the project. These outputs should highlight concrete achievements of the strand(s) of the project implemented in each country and suggest ways to take migrant health policy and practice agenda. The individual, easily digestible outputs would then provide a comparative framework in terms of what has been done in each country, what has/has not worked, and lessons learnt, which could be presented to and discussed with the EC and MS. This should be done as a separate activity and not as part of the final conference.

This recommendation stands, and was reflected in some of the feedback from those interviewed in the EndTerm review. The Country reports from the MIPEX exercise have to some extent met this objective, however, as they have become available and get discussed. Several informants looked forward to these – and the Roma NRIS country reports had certainly had that effect locally. All the contracted and funded 'deliverables' were produced as planned, and more in addition. Responsibility for their use, however, must rest with agencies and individuals beyond the IOM team.

3. Re-connect with partners who have made significant positive changes to migrants' access to healthcare within their countries and/or local area over the past two years. This could be done with the active involvement of IOM country co-ordinators. Discuss with the stakeholders which changes can be sustained, strengthened, and broadened in scope and geography, and set up a plan that can be submitted to a funder at national or international level.

This recommendation stands, and was reflected in some of the feedback from those interviewed in the EndTerm review – it is understood that there may be moves to bid for funding from future EC proposed or announced funding streams to support this. Some of the activities associated with Re:Health, the 'CARE' (careformigrants.eu) package, and EURHUMAN demonstrate this, and the project team also noted that they had been approached by 'the majority of applicants' to other EU funding calls on migrant health, to act as partners!

4. The positive connections and collaborations that have been created with other migrant health related projects in the EU should be extended - with support from IOM Headquarters - in a systematic way to more global connections and sharing of lessons learnt in other continents and countries – e.g. in Africa, Asia, South and North America. IOM country co-ordinators in other parts of the world who are working with national governments on migrant health are a useful focal point.

This seems intrinsically sensible but will require support from IOM HQ and also, some funding. It may be that WHO can be persuaded of the value of such an approach.

4. Strengthen the community health aspects of the project actions – training activities, health assessments, data collection - in relation to all parts of the project, not only the Roma health component. In this synergy with other EC funded projects could

be continued. For instance, training of health professionals could be more inclusive of primary care providers dealing with disadvantaged ethnic minorities (migrants and their children) established within local communities, as well as visa over-stayers. Learning from other parts of the world could also include broader community health approaches relating to chronic diseases and uptake of screening. Where such a broader consideration of migrant and minority health is recorded in current project outputs, they should be clearly highlighted.

This recommendation stands, and was reflected in some of the feedback from those interviewed in the EndTerm review and the responses of IOM in subsequent bids for other new projects. It might be regarded as a generic learning point for all future similar work.

b) Recommendations for the EC (DG SANTE and other policy makers and funders)

1. During the next phase of the project the EC should continue with the already positive ongoing discussion with the project team and IOM more generally on what has been achieved by Equi-Health, what it means for the development of policy, and how future plans on collaboration and funding could be shared between different departments – e.g. DG SANTE, DG HOME, DG JUSTICE – given that the field of migrant health overlaps several EC directorates. The good start in this inter-sectoral capacity encouraged by the Equi-Health project should be continued and expanded in relation to migrant health, given also the current situation in Europe.

This recommendation stands, and was reflected in some of the feedback from those interviewed in the EndTerm review – it is clear that DG staff and officers are supportive of this approach, in general, but may be hampered by formal role and policy descriptions, although it is understood that Re:Health did involve DG Home and DG Justice.

2. The EC (DG SANTE, CHAFEA) should continue an active role in bringing together key implementing organisations in Europe such as IOM, WHO and ECDC during consultative processes in moving forward the migrant health agenda, to ensure that research and action programmes that are related to each other (e.g. public health and community health) support each other from the outset thus avoiding the organisations setting up as competitors and duplicating efforts.

This recommendation stands, and was reflected in some of the feedback from those interviewed in the EndTerm review – it remains as a long-term finding from the ETR.

Finally, those interviewed for the Final Evaluation were asked (if appropriate) if any of their feedback had been addressed following the MTR: One national health officer noted that:

> "I had suggested that the content need to look clear and attractive; not like a newspaper article if we are to attract professionals to stay till the end of the training sessions. This was acted upon in some areas. I also suggested that now that we now have the know-how and we have experience as trainers coming from different countries receiving migrants we could be available to train health and social care professionals in countries which are new to a sudden

> influx of migrants. I am not sure if this was taken up however we did train 2 groups of cultural mediators in (a southern MS)... and a group of health professionals in ... (another state)".

Others were not so sure that their feedback had been acted on, but there were few adverse comments and in view of the timings of the overall action, it is perhaps more appropriate to ensure that the learning from both reviews is used to improve future projects. Not all activities in relation to migrant health – especially those undertaken in haste under pressure to meet crises, are evaluated at this level of scrutiny, and this in itself does provide some opportunity to reflect and learn lessons.

G. Findings and Conclusions

A key value which tends to demonstrate and underscore the value of the Equi-Health Action was the importance of the processes, and indeed, of the structure or conception of the Action as a whole. It was, first and foremost, not a scientific or academically structured project, but an organic one based on the creation, development and use of networks of individuals and agencies across Europe. In the process of achieving its goals, within each work-stream and as a whole, it brought together, or built on a selection of key stakeholders and actors working across the gamut of migrant and minority health in Europe. It seems that nearly all the main national experts and relevant agencies were at some time or other involved in the Action, whether through answering questions and creating the responses to the Situational Reports, MIPEX studies or Consensus statements, or in development and delivery of training packages. This was an achievement, insofar as it created perhaps for the first time, an integrated network of practice and policy (and expertise) combining both academic, professional and 'non-governmental' (or advocacy) sectors, across minority ethnic, migrant, and 'Roma' (as distinct from other 'minority ethnic' groups of migrant heritage), most of whom attended or were represented at the concluding 'Lisbon' workshops. It remains to be seen whether the relationships built in the process, and developed at that event, survive and continue to inform and support policy and practice in the field in future. It is clear that this is an unparalleled resource, which deserves to be nurtured and extended, and used to create new knowledge and capacity, and reduce the 'start-up' time for future initiatives in the field.

At the same time, it might be suggested that this was equally a weakness, insofar as it proved quite difficult to obtain external validation or comment on the processes and products of the Action from external (i.e. non-member) actors – although it is very clear that at least in certain member states, there does exist a large body of expertise and concern for minority/migrant health – both in the academic sphere and the broad field of health and social care professional practice. Similarly, it must be recognised that this is a concern, and field of evidence, that is not confined to the European Union, but shared widely, especially in countries of migration-reception (such as Canada, Australia, and the USA) and indeed, countries more recently affected by migration flows and refugee numbers across the 'Middle East' ('West Asia'), or 'Arab' states and Mediterranean eastern/southern Littoral, sub-Saharan Africa, and elsewhere. There are many journals dedicated to this issue and other refugee questions, such as: *Diversity & Equality in Health & Care; Ethnicity & Health; BMC Public Health; The International Journal of Diversity in Organisations, Communities and Nations; International Journal of Migration Health and Social Care Information; Journal of Immigrant and Minority Health; Migration and Health (PLOS*).

The professions of Nursing, Social Work and Public Health, both in Europe and elsewhere, are also very heavily committed to understanding and responding to, the challenges of migrant/minority health, and should be actively engaged with as their members are frequently at the front-line, alongside law enforcement officials and 'border' staff. It did not appear, from the responses to the evaluator's enquiries and background knowledge, that many in those sectors were very aware of the Equi-Health Action – any more than members of the extensive 'COHEHRE' network of educators engaged in training the next generations of health professions across Europe. It cannot, however, be solely the responsibility of a front-line project-based, and heavily engaged organisation such as IOM to ensure that this awareness is

implemented! It is, rather, a matter of regret that the professions so closely involved in 'EH' issues, should be so unaware of the potential resources available through this and the other projects and actions mentioned in this evaluation. It may be that the Commission's publicity offices could find a role in advancing this, within the constraints of their own constitutional boundaries.

Additional Considerations and Suggestions

A number of other comments and suggestions were made during the evaluation, which deserve to be reported here, as they bear on the overall conclusions, and may include suggestions of value which could be taken up in future related initiatives, or can be seen as ways in which the learning and development associated with EH and other related projects/ activities can be further enhanced and used. In some cases, it may be that they have indeed already been overtaken by events or new initiatives, but they are reported here for completeness.

Issues of Subsidiarity:

The matter of health service provision is, in fact, one that is reserved to Member States discretion, insofar as this is compatible with EU-wide or other international obligations relating to the welfare of migrant workers, vulnerable people, human rights, etc. It is also a matter of considerable political sensitivity and national pride - as one informant commented:

> … when you put migration and health together you get even less – it is always tight to get people on board … A lot is changing with other priorities, moving away from Roma and migrant peoples towards refugees – politicians wrangling with the central (national) government over this too.

This, as indicated above in discussion of 'impact' or effectiveness, means that rather than a purely scientific issue with professional discussion and agreement over standards, norms and outputs or interventions, all aspects of the Action were subject to local political or organisational priorities and at time, obstacles. Despite an overall 'fit' with EU agreed priorities and other European Directives, without local support or sponsorship at a political level its ability to impact on policy and practice is restricted.

Validation of Training in national standards of professional practice

Given that a significant element of this project (as with the previous 'PBHLM' work and the EU-funded MEM-TP) particularly in the SEUB, involved the development of training modules for a variety of professionals, and given the centrality of the need for 'appropriate competences' to meet new challenges in those professions, it was considered important that the educational elements were backed up with appropriate theoretical and pedagogical support, theory and validation. With these, it could be easier for the new modules and competences to be adopted and recognised as 'transferable skills' or legitimate grounds for progression within a profession. Various comments were made which had a bearing on this matter:

> Greater involvement of suitable experts such as Educational or Training assessors to ensure validation and appropriate attention to theories of learning … may facilitate action/acceptance of subsequent recommendations.

> Involvement of public health and other similar professional bodies to validate and 'badge' training for professional accreditation in a wider range of MS – and if possible, supra-nationally or at least in a transferable manner.

From the perspective of the IOM, it was recognised that both PHBLM and EH were pioneering in terms of professional training. Indeed they felt that all this work had in fact been done in cooperation with such public education bodies. They reported that in countries where training was done, it has been accredited as 'continuing education' by the respective bodies. They also state that in future tenders this will be more explicitly designed into the project planning.

Consolidation of learning and retention of outputs:

Much concern was expressed about the need to ensure the continued availability of the outputs, products and learning from the Action and its component projects, and anxiety that, as with other 'project-based' activities, these might cease to be accessible unless some way was found to ensure continuity not just in terms of on-the-ground provision, but in terms of records, tools, and evidence of effect that could be used to influence scientific discussion and 'evidence-based practice' in future development.

> A central observatory or repository like COST Home or MEHO would be useful – one of the main qualities of the programme is that it is a network of expertise that continues … (*It is noted that the MEHO site did in fact stop functioning some time after the closure of the project*)

> Maybe we do need some repository or network to keep the work and learning alive

> It would be a good idea to store all the outputs on one place – COST-ADAPT has been very useful but will need to apply for future funding

> Evaluation or Good Practice articles in reputable and peer-reviewed academic and professional journals where they will enter the approved 'knowledge base' for 'Gold Standard' Systematic Reviews etc (such as the Cochrane Library, Campbell Collection etc)

There was strong support for a network and repository of good practice and materials – and at the very least, a mechanism to ensure all 'Intellectual Property' is jointly held by the co-funding bodies and maintained in publicly accessible online sites. While these matters are incorporated in the funding agreement, there was evidently some confusion among some partners in relation to this. However, it is understood that subsequent developments, and the hosting of most materials on the websites and server managed and supported by IOM itself, ensure some degree of continuance and accessibility to the products of the Action and other related materials.

The MTE explicitly highlights the importance of the original proposal in 'establishing a mechanism for networking and exchanging good practice …" and also refers to the value of the ADAPT (COST) network, whose funding has now come to an end. There remains, as was observed by participants at the Lisbon workshops in May 2016, a lack of a 'one stop shop' or single point of access, similar to the national resource which

was briefly available to the UK NHS and hosted by the Health Protection Agency (http://www.hpa.org.uk/migranthealthguide but subsequently archived, and recently relaunched in June 2017 at www.gov.uk/topic/health-protection/migrant-health-guide). It is possible that such a site might be legitimately held by Chafea on behalf of DG Sante and DG Home, as pertaining to the protection of communities and European–level health risks, rather than falling under the heading of a national health policy reserved to MS competence. This possibility and programme was not mentioned in responses to the evaluation survey, but appears to resemble the newly created initiative between the EU and WHO in creating the MIHKMA (Migration and Health Knowledge Management) platform and the EU Health Policy Platform and 'Agora' (discussion group) launched in April 2016 (www.ec.europa.eu/dgs/health-food-safety/dyna/enews/enews.cfm?al_id=1677)

Issues of Evaluation:

While 'process' evaluation and 'face value' validity can be established by a report such as this, some people did consider that this might not attain the 'gold standard' levels of proof of effect that might be required for other clinical or organisational interventions. It was suggested that more 'SMART' (i.e. specific, measurable, applicable and reasonable, time-limited) objectives or 'targets' would make it easier to demonstrate conclusively the impact and value of such a broad-ranging and complex activity as the Equi-Health Action. While a list of specific 'deliverables' was provided and to a large extent achieved, and outputs additional in number and scope were produced which demonstrate the activity levels of those involved, there were very few concrete measures of impact or effect, such as circulation levels, attendance at events, or coverage in other circles such as citation by academic or policy bodies. The testimony of those approached for comment was eloquent, but to a large extent depended on their prior involvement in the Action, rather than representing external use of its activity. It is, however, recognised that it is difficult to identify and record such evidence of 'external' validation or use of outputs and their impact on processes or policies.

Against this must be set the observation by members of the Action's team that there has hardly been a Migrant Health event, of which there have been many in the past two years in Europe, where the work of the EH Action has not been presented. At the Colombo conference (the 2nd WHO/IOM Global consultation on Migrant Health in Sri Lanka: https://www.iom.int/migration-health/second-global-consultation) the three background papers cited EH and it was referred to also during the event. It was also presented to all the European Deans of Public Health at the ASPHER retreat in 2017 and also at meetings in Lisbon, at the IHPH, EUPHA Vienna meeting, World Health Summit in 2015 and elsewhere. Many of these are listed in the final report which is now being prepared for release (Deliverable 3 – see appendix 5).

Appendixes

Appendix 1: Evidence of External Approval and Sustainability

Attention was drawn during the evaluation, largely by project partners, to a number of achievements which represented a form of external validation for the project's activity. These came in terms of funding for further use made of the outcomes from the Action. Other comments were also identified which supported the usefulness of these outcomes. Further potential for the extension of the findings and processes of the Equi-Health Action was also evident in projected and published calls for tenders or submissions to planned EU funding streams, and other sources of funding. A selection is listed below. Attention is also drawn to the findings of academic studies of migrant health policy such as that by Kentikelenis AE and Shriwise A (2016) which reported favourably on the EH initiative amongst others, and the complexity of roles and responsibilities in the field.

Most significantly, the European Commission 'Public Health' division of the Directorate General for Health and Food Safety, on its page dedicated to Migrant health, draws very strongly on the work of IOM and specifically, the EH packages, to move the agenda of migrant health along, noting that it:

- Works with the European Centre for Diseases Prevention and Control, the World Health Organization Europe and the International Organisation for Migration to better identify and address the needs of EU countries and refugees.
- Develops training programmes for healthcare professionals. These will help healthcare professionals learn about diseases that they are not familiar with and provide information on cultural perspectives and specific needs among the people arriving.
- Produced a Personal Health Record and an accompanying Handbook for health professionals to help healthcare professionals build medical histories of incoming migrants and refugees and identify their immediate needs. (*The links refer to outputs of the EH Action).*

http://ec.europa.eu/health/migrants/policy_en

Funding for continued activity achieved:

Roma (the Roma health mediation exchange programme).
"We are pleased to inform you that the University of Sevilla - The Center for Community Research and Action (CESPYD**)** has been awarded a grant by the Open Society Foundations. The purpose of the grant is to provide support for the project "*A Multi-Level Advocacy Framework to Implement the NRIS' Health Component in At-Risk Local Contexts in Spain"*, for the following duration 1 November 2016-1 November 2018."
(Source: e-mail to partner at University of Seville;)

The CARE Action (www.careformigrants.eu)

The components of the CARE (Common Approach for REfugees and other migrants health) action incorporated a number of activities including 'monitoring of migrant and refugee health status', building on the IOM/EU Personal Health Record developed during the Equi-Health Action, and responding to, or answering, the revealed need to centralize and produce such data to promote continuity of care and ensure appropriate service delivery, thereby also reducing costs for healthcare systems. While now ceased, the project's objectives – along with those noted in the EH Action, are in fact continued through new initiatives such as the MYHEALTH and MigHealth-Care projects announced in May 2017 (ec.europe.eu/newsroom/sante on 2 May 2017)

Other components relevant to the work of the Equi-Health Action, and its findings or recommendations, include:

- A proposed healthcare model of interdisciplinarity to establish a 'common approach' – clearly a development from the EH 'Consensus' statement.
- Non Communicable Disease monitoring – linked to the call for better data
- Public Health Planning – which also comments on the need to make stronger links with 'civil society' and NGO agencies – which was an essential element in the design and activity of Equi-Health
- Training – for health and non-health professionals – much of the proposed curriculum for which is recognizably linked to the training developed for SEUB
- Awareness raising – for the general public, combating false perceptions and providing also better information for migrants and refugees on their rights – a project which will doubtless be assisted by the existence of the data and policy survey collected by the MIPEX project.

Impact on WHO Regional Office strategies

The EH project has had a significant impact on, and input to, the recent (2016) EURO WHO **Strategy and action plan for refugee and migrant health** and also the EC/DG Sante /WHO direct agreement **MIHKMA project ,** which can be seen to be directly building on the work of Equi-Health.

Strategy and action plan for refugee and migrant health in the WHO European region

The 66th Session of the WHO Regional Committee Meeting EURO, 12-15 September 2016 in Copenhagen included an agenda item on refugee and migrant health. In particular, the EURO '*Strategy and action plan for refugee and migrant health in the WHO European region*' and a related *draft Resolution*, were presented and discussed. The Resolution holds MS and WHO accountable by asking the Regional Director to monitor implementation of national policies and regulations and the Strategy and action plan for refugee and migrant health in the WHO European Region, and to report to the 68th, 70th and 72nd sessions of the Regional Committee for Europe in 2018, 2020 and 2022.

IOM along with other partners had been involved in the drafting of the Strategy and action plan. The interagency coordination was followed by extensive coordination among MS. The Regional Director mentioned that she hopes that the EURO strategy may turn into a global strategy for WHO. Supportive comments came from a wide range of MS. Both Strategy and draft Resolution were adopted. Dr Mosca, Director MHD, delivered a keynote speech on behalf of the Director General, followed by a

Key note speech by Steven Corliss, Director Programme Support and Management UNHCR.
This year migrant health has reached the agenda of Regional Committee meetings in various regions of WHO. EURO is possibly most advanced with its concrete strategy for its MS and the related Resolution, much driven by the so called 'migrant crisis' in Europe and spearheaded by the Government of Italy.

Relevant links:
http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/66th-session/documentation/conference-documents
http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/66th-session/documentation/conference-documents/eurrc66conf.doc.4-rev.1-strategy-and-action-plan-for-refugee-and-migrant-health-in-the-who-european-region
http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/66th-session/news/news/2016/09/day-2-highlights-rc66-adopts-european-strategy-and-action-plan-for-refugee-and-migrant-health

MIHKMA: a new EC/ WHO EURO initiative, Migration and Health Knowledge Management
Project briefing, 14 September 2016, (presented by Santino Severoni (WHO Copenhagen) and Isabel de la Mata (EC)
Objective of MIHKMA: to develop a knowledge management system to raise awareness, foster knowledge, and increase uptake of migrant health knowledge, good practices an evidence based approaches across the EU.
Duration: 2 years
Donors: EC, DG SANTE. Isabel de la Mata explained that this activity should complement ongoing EC funded activities, including those carried out by IOM, and ensure developed and endorsed tools and training materials are widely made available and taken up by MS and others. The expectation is that IOM's Equi-Health and earlier border health programme (PHBLM) tools may form an important part of this knowledge system.
http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2017/03/knowledge-management-project-launched-to-better-address-migrant-health-care-needs

Future Potential activity from announced funding streams
(Note – this is not an exhaustive list but represents some possibilities suggested to the Evaluator, and illustrates the potential future continuing value of the learning developed by projects associated with Equi-Health.)

SEUB - Training Package
The European Commission has released two tender calls, for development of an additional/advanced unit on mental health and on communicable disease, which build on the training packages developed for Equi-Health and its predecessors. Both explicitly draw attention to the preceding work of the EH package – as do other calls for projects in related fields.

Call for tenders N° Chafea/2016/Health/03 concerning development of specific training modules for health professionals, law enforcement officers and trainers, on migrants' and refugees' health, addressing communicable diseases and mental health

problems – on https://etendering.ted.europa.eu/cft/cft-display.html?cftId=2049

See Also

http://ec.europa.eu/chafea/health/grants.html

http://ec.europa.eu/chafea/news/news.html

The UK National Institute for Health Research has also issued a call for research proposals, which may attract bids using some of the insights of the EH action.

http://www.nihr.ac.uk/funding-opportunities/migrant-health-and-wellbeing-16123/5736

Other Evidence of Impact

External Comment from a 'Minority-Ethnic-Health Network' member (an international academic and professional discussion list-serv with over 500 members):

Re MIPEX Health - Thank you this is extremely timely and something I'd been looking for to support local work on health needs and mobilising evidence on ethnicity and health. I've had a tricky day and this really cheered me up - apologies for over enthusiastic email but in difficult times good to take the time to share and thank.
I am public health principal at Doncaster council and inequalities lead. We are undertaking a BME needs assessment and I'm particularly interested in illuminating issues around migrant health. We are taking a stepped approach - describe, explain, prescribe and this comprehensive work helps both with describe & explain and means we can make compelling arguments around taking action. I'm also an honorary research fellow at SCHARR, linked to the NHS CLAHRC public health and inequality theme in the Yorkshire/Humberside Region. ***Susan M Hampshaw*** smhampshaw1@sheffield.ac.uk

Another query was recently posted on the same MEH list-serve:

Hi,

I'm trying to help a sympathetic commissioner to write a business case for fairly minimal specialist health care provision for asylum seekers and 'vulnerable migrants'.

She completely understands the ethical and effectiveness arguments for such a service, and the simple fact that if you meet people's health needs early it is bound to be less expensive, but is floundering in her attempts to find hard economic facts to convince less sympathetic commissioners with their hands on the purse strings.

Does anyone know of any research into the cost-effectiveness of providing an appropriate service? To me it's blindingly obvious, but that doesn't wash these days..... Cath Maffia - Director TS4SE Cooperative
TS4SE is the trading name of Training and Support 4 Services and Exiles (TS4SE) Cooperative Limited. TS4SE is not for profit organisation and is a Company Limited by Guarantee. www.ts4se.org.uk

Several List members pointed her enquiry towards the EH-funded resource on costings for IMs as providing evidence that would be helpful to her.

Appendix 2: Equi-Health Final Evaluation – Informants Participating:

Individuals & Academics
Hiranthi Jayaweera (UK: Mid-Term Evaluator)
Cristina Santinho (Portugal)
Manuel García-Ramírez (Spain)
Ainhoa Ruiz (Spain)
Ursula Karl-Trummer (Austria)
David Ingleby (NL)
Michael Knipper (Germany)
Diliana Dilkova (Bulgaria)

National Policy Makers & Executives
Serena Battilomo (Italian Ministry of Health)
Tona Lizana (Catalonian Public Health Agency)
Drew Millard (Scotland NHS)
Marika Podda Connor (MoH, Malta)
Tihomira Ivanda (Croatia Ministry of Health)
Hans Verrept (Belgium Ministry of Health)

International / NGOs
WHO - Severoni Santino
WHO - Piroshka Ostlin
MSF Greece - Apostolos Veizis
PICUM – Alyna Smith

IOM Head Office Staff
Davide Mosca
Poonam Dhavan

IOM Equi-Health project team:
Roumyana Petrova-Benedict
Mariya Samuilova
Jordi Noguera

IOM Country Offices/ Consultants
IOM Croatia: Ivan Pitesa
Slovakia: Jarmila Lajčáková

European Institutions /CHAFEA
Isabel de la Mata (senior advisor) EC- DG Sante
Cinthia Menel-Lemos (project officer), EC- CHAFEA
ECDC Teymur Noori

Appendix 3: Topic Guide for Interviews (The questions)

1. What is/was your role in Equi-Health? At what time? Which activities (Roma, ADAPT/Mipex, SEUB, Consensus, Irregular Migrants/ Conference .....?

2. Do you think the objectives and structure of the work packages, fitted the priorities identified regarding migrant and minority health?

3. Have the work packages you were involved in / were aware of, been successfully implemented? Can you give some concrete examples?

4. Were the resources – e.g. personnel, review and data collection methods - that are used appropriate and adequate? How successful have they been in producing the expected results?

5. What about the balance between local/national/international resources and expertise?

6. How successful are the partnerships in this project? Give examples/ details

7. Could these partnerships (have) worked better? If so how?

8. Have the resources and methods used been cost-effective – i.e. value for money? In what ways?

9. What have been the strengths of the project/components/work packages?

10. What have been the weaknesses of the project/components/work packages?

11. How have any weaknesses, or barriers to achieving objectives, been dealt with?

12. To what extent have the time frame and work plan been successful?

13. How have any unavoidable delays been dealt with? Have these been successful? In what ways?

14. What do you think of the ways the project(s) have been managed, directed, and supervised?

15. How does Equi-Health interact with other regional migration and health projects you are involved in /; know of?

16. How far has Equi-Health coped with political and social tensions during implementation?

17. Do you feel the final project outcomes and outputs are of value to key stakeholders? How?

18. Do you feel that project outcomes and outputs are beneficial to its #target# ie migrants? How?

19. Are the activities and interventions likely to be sustainable beyond the life time of the project?

20. How far has the project contributed to the longer-term capacity development of project partners and other key stakeholders at regional, national and local levels?

21. Can you point to policy or practice changes in your own MS/Organisation arising from involvement in Equi-Health projects?

The responses to these questions/ prompts were analysed and summarised into the headings of the guidance provided to the Evaluator:

Relevance
Efficiency (Taken as indicating 'value for money' or use of resources)
Effectiveness
Sustainability (Looking to the future)
Outcomes
Unanticipated effects (Unlooked for effects or 'learning points')
European Added Value

Appendix 4: Bibliography and List of Key Sources (websites etc)

Acronyms and Organisations (not further explained in the text)

COHEHRE – the Consortium of Institutes of Higher Education in Health & Rehabilitation in Europe – www.cohehr.eu – see also annual conference website 2017 www.cohehere2017.ips.pt and its archival site of the 2106 Conference, whose theme was 'Learning and Practising Respect and Solidarity for All' – also subtitled 'Diversity and social exclusion'

EUPHA – European Public Health Association – professional validation and standard-setting, conferences, etc https://eupha.org/

ASPHER – Association of Schools of Public Health in the European Region – sets out Core Competencies for undergraduate and postgraduate training in public health and co-ordinates activity by national schools of public health www.aspher.org . ASPHER was a WHO initiative and has been active for 50 years.

PLOS – Public Library of Science – an international, open-access series of peer-reviewed academic journals of high standard https://www.plos.org/

BMC – BioMedCentral - an international, open-access series of peer-reviewed academic journals of high standard http://www.biomedcentral.com/journals

Cited Works

Ingleby D and Petrova-Benedict R. 2016 *Recommendations on access to health services for migrants in an irregular situation: an expert consensus*. Brussels: International Organization for Migration (IOM) Regional Office Brussels, Migration Health Division. Available at: http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus

Kentikelenis AE and Shriwise A 2016 'International Organisations and Migrant Health in Europe' *Public Health Reviews (BMC)* 37:19 DOI 10.1186/s40985-016-0033-4 (www.publichealthreviews.biomedcentral.com)

Appendix 5: **Equi-Health Action Programme 'Deliverables' (summary)**

1/ Final interim report – (Due for submission 6 months after end-of-contract).
2/ Visibility materials – brochures, posters, website, etc. These have been produced to a high standard of appearance and finish throughout the action, and the website is active and still being added to. Many posters and publications were on display and distributed at the final Conference in Lisbon, and were evidently appreciated by delegates. Further printed reports are being produced and circulated, and have met with a positive response in terms of requests for copies.
3/ Final public report – This will, like the end-of-project report, appear after the Evaluation is completed, but is actively being compiled to incorporate a summary of the work done in the last 4 years.
4/ Final evaluation report - This report
5/ Situational Analysis Assessment reports (SARs)- These were all produced and made available on-line at http://equi-health.eea.iom.int/index.php/southern-eu/milestones-and-deliverables-eu / They are also available in the IOM bookstore : https://publications.iom.int/books/assessment-report-health-situation-eus-southern-borders-migrant-occupational-and-public-health) . See also Milestone C below.
6/ Report on migrant health data collection – This has been completed and is available at http://equi-health.eea.iom.int/images/Data_collection_report.pdf
7/ Training package on Migrant Health for Health Professions and Law Enforcement Officers – This has now been completed and made available internally – and is increasingly being made more widely available, following considerable demand from front-line professionals, and the interest of the European Commission which has noted it on their DG Sante (Health & Food Safety) Public Health website - http://ec.europa.eu/health/migrants/policy_en
8/ Multi-stakeholder Reports on National Roma Integration strategies – Now available at http://equi-health.eea.iom.int/index.php/roma-health/milestones-and-deliverables-rh). Further, in compliance with the revised outcomes agreed mid-term, and rather than a simple follow-up report, IOM has implemented 3 case studies/ actions and a regional Intervention on Health Mediation and the Roma (see http://equi-health.eea.iom.int/index.php/roma-health/milestones-and-deliverables-rh\0
9/ 31 **MIPEX reviews** – These have been completed, and while the publication of these was not an agreed deliverable, these have been widely requested. Therefore an overview report, and local reports, are being produced.
MIPEX Health Strand Country Reports are being published one by one at **equi-health.eea.iom.int/index.php/migrant-health/milestones-and-deliverables-mh**
10/ Consensus recommendations on Health for Irregular Migrants – were circulated for comments and endorsement to members of relevant e-mail discussion groups such as Minority-Ethnic-Health and other interested parties. The final agreed version of **Recommendations on access to health services for migrants in an irregular situation**, has been published online at **http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus**