Appropriateness and effectiveness of mental health promotion interventions for adult refugees with mental distress.

Evaluation of the intercultural mental health promotion adult program of the Non-Governmental Organization AFYA in Vienna, Austria.

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Author`s Note

In the last few years, I have been working with a medical humanitarian organization as a field nurse in conflict and war zones, where I experienced different situations of displacement and flight.

When ISIS took control of territory in Northern Iraq, an exodus of displaced individuals from the north to the south of Iraq began. Many of those people had just lost their family members in a brutal and terrible way. I remember very well the painful recollection of one woman: *"Before, we were donating to poor people, but now we are the ones who depend on other people's donations".* I started to wonder from where those people got the strength to continue living their lives.

In Libya's detention centres, refugees and migrants were locked up in inhumane and life threatening conditions. During the implementation period of a health promotion program for detained people, I was positively surprised by the appreciation and impact of body workout and activity games on their overall wellbeing.

In addition to Iraq and Libya, I have also contributed projects for displaced people/refugees in Syria, Turkey, South Sudan, the Balkans, and Austria. Throughout the projects, my question remained the same. What makes refugees and migrants so resilient and how can anyone contribute to their overall well-being?

The diverse projects for which I worked were intended to support the internally displaced population, refugees who were in the process of migrating to another country, or individuals locked up in detention centres. Additionally, I have worked with asylum seekers who had just arrived in Austria. Despite this, I missed the experience of working with refugees in their adaptation and post-migration period. When I was granted the opportunity to evaluate the intercultural mental health promotion program for refugees and migrants of AFYA NGO in Vienna, I felt that this evaluation could answer some of my questions and would contribute value to my future professional as well as private life.

Table of content

Author`s Note iii
Glossary vi
Acronyms and abbreviations viii
List of tables and figures ix
1. Executive summary x
2. Background 1
2.1. Mental Health Disorders among Refugees and Migrants 1
2.2. The Austrian context 3
2.3. Intercultural Mental Health Promotion for refugees and migrants 5
2.3.1. Focused, non-specialized support 5
2.3.2 Key elements of Health Promotion 6
2.3.3. Mental Health Promotion 7
2.3.4 Salutogenesis versus pathogenesis 7
2.3.5. A culturally sensitive approach 8
2.4. AFYA's intercultural MHP program 9
2.4.1. Program development 9
2.4.2 Concept 11
2.4.3 Pilot phase 13
3. Study aim 15
3.1. Main aim 15
3.2. Specific objectives 15
4. Methodology 16
4.1. Study design 16
4.2. Study participants 17
4.3 Exclusion criteria 17
4.4. Data collection 18
4.4.1. Qualitative data 18
4.4.2 Quantitative data 21
4.5. Data analyses 22
4.5.1 Qualitative analyses 22
4.5.2 Quantitative analyses 23
4.6. Quality criteria 24
5. Ethical considerations 25
5.1 Ethical clearances 25

5.2 Ethical guidelines 25
5.3 Data protections 26
6. Results 27
6.1 Findings of qualitative data analysis 27
6.1.1 Psychosocial wellbeing 29
6.1.2 Appropriateness 32
6.1.3 Acceptance 37
6.1.4 Effectiveness 43
6.2 Findings of quantitative data analysis 49
6.2.1. Descriptive analyses 49
6.2.2. Thematic content analyses 50
7. Discussion 53
7.1 Discussion of study findings 53
7.2 Recommendations 61
7.3 Limitations 66
8. Concluding remark 68
9. References 69
10. Acknowledgement 73
11. Annexes 74
Annex 1: AFYA MHP - objectives, methods and framework 74
Annex 2: Template feedback form 75
Annex 3: Interview guidelines in English and German 76
Annex 4: Fieldwork - working plan 78
Annex 5: Ethical Clearance I 80
Annex 7: Consent form English and German 82
Annex 8: Kruskal-Wallis and Mann-Whitney-U test 84

Glossary

Appropriateness: "The quality of being suitable or right for a particular situation or occasion" (1).

Asylum/refugee status/recognized refugee: Foreigners are permitted to stay in Austria for 3 years, if protection against persecution is necessary. Individuals with asylum-status are allowed to work in Austria and can apply for a convention passport, which allows them to travel to other countries, with the exception of their home country (2).

Asylum seeker: A person who requests refuge in a foreign country and whose asylum application is still under review. Asylum seekers are not allowed to work during this period (2).

Cross-cultural approach: Interventions tailored for a culturally diverse and multicultural target population (3).

Culturally sensitive/culturally adapted interventions: Interventions which take into account a person's cultural background, age, sex, mother tongue and geographical location. Interventions are adapted to the needs of the target population (3).

Culture: There are various definitions of culture; for the purpose of this study, culture is defined as a "social matrix of experiences, including different features that construct daily functioning, self-understanding, and experience with diseases and wellbeing. It is shaped by norms, values, ideologies and beliefs" (3)(p 23). The definition of culture thus goes beyond one's geographical location to also encompass, variables such as gender, age, and educational level. Culture is a dynamic, changing system, that is expressed through physical reactions and verbal and non-verbal communication (3).

Effectiveness: "The ability to be successful and produce the intended results" (1).

Holistic health and overall wellbeing: World Health Organization (WHO) defines health not only as physical wellbeing, but the combination of physical, mental, and social wellbeing which forms the holistic health of a person. This state of overall wellbeing can be achieved by making "health" a part of one's everyday life. Social and personal resources can impact a person's ability to adapt to and cope with different situations and the ability to attain holistic health and overall wellbeing (4).

Intercultural: "Relating to or involving more than one culture" (1).

Mental Health Promotion: The Centre for Health Promotion at the University of Toronto and the Mental Health Promotion Unit of Health Canada defines Mental Health Promotion as: “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity” (5)(p 17).

Migrant: “Any person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons”” (6)(p 133).

Refugee: According to the 1951 Refugee Convention, a refugee is “a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” (6)(p 169).

Subsidiary protection: When a foreigner’s request for asylum is denied by responsible authorities and the person in question could be in danger or in a life-threatening situation, the person’s protection must be granted. Different to the asylum status, the subsidiary protection in Austria is limited to one year at the first step and can be extended to two years. Before the protection period ends, a new application for extension must be submitted to the authorities (2).

Acronyms and abbreviations

HP	Health Promotion
IASC	Inter-Agency Standing Committee
MHP	Mental Health Promotion
MHPS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organization
STARK	Skills Training der Affektregulation, ein kultursensibler Ansatz (skills training of affect regulation, a cultural sensitive approach)
START	Skills Training in Affective and Interpersonal Regulation
TRT	Teaching Recovery Techniques
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

List of tables and figures

Table 1: Numbers of new asylum applications in Austria from 2015 – 2019 p.4

Table 2: Numbers of accepted asylum applications from 2015-2019 p.4

Table 3: Numbers of approved (pos), rejected (neg) and other asylum decisions in Austria p.5

Table 4: MHP participants' demographics and attendance rates per MHP circle during the pilot phase p.14

Table 5: Data source triangulation p.16

Table 6: Interview participants' demographics p.20

Table 7: Facilitators' demographics p.21

Table 8: Feedback forms per MHP circle p.22

Table 9: Themes, main categories and subcategories p.28

Table 10: Feedback forms per country of origin p.49

Table 11: Number of answers and no answers per questions p.49

Table 12: Favourite methods, tools and topics extracted from the feedback forms filled by female participants p.51

Figure 1: IASC intervention pyramid for MHPS p.6

Figure 2: The illness-wellness continuum p.8

Figure 3: The cycle of problems in reference to the study findings p.54

Figure 4: The interruption of the cycle of problems in reference to the study findings p.54

1. Executive summary

Aim: The overall aim of the present study is to evaluate the innovative, intercultural Mental Health Promotion (MHP) program of the Austrian Non-Governmental-Organization (NGO) AFYA for distressed adult refugees and migrants in Vienna, Austria. The specific objective was to explore the program's appropriateness, acceptance, and effectiveness during its pilot phase (September 2018 to December 2019).

Background: The overall wellbeing of refugees and migrants plays a crucial role in their social inclusion and adaptation in the host country. However, stressors experienced by refugees and migrants can increase the risk of developing mental health disorders.

Method: A mixed-method was applied. A thematic content approach was used for the qualitative analysis of semi-structured individual interviews with program participants (n=12) and program facilitators (n=4). Furthermore, findings of 43 self-reported four point Likert satisfaction feedback forms were evaluated through a descriptive analysis.

Main findings/conclusion: Through AFYA`s focused, non-specialized, cultural sensitive, salutogenic and group-based approach, refugees and migrants experienced a beneficial effect on the overall wellbeing in the post-migration period. It can be concluded that AFYA`s intercultural MHP program is appropriate, accepted, and effective.

Recommendations: Study findings suggest increasing the number of body workout sessions and joint outdoor activities with other groups and the local population. It would be an added value to offer the program to more nationalities. Furthermore, the program should serve as a role model for other regions.

Limitations: Given the small sample size, the findings might not be generalized to all target groups. For future evaluations, the collection of data on participants' psychosocial wellbeing before and after program participation for a pre/post comparison would serve as an added value.

Study impact: The study contributes to a broader understanding of the benefit of intercultural MHP for refugees and migrants in their adaptation period in the host country.

2. Background

In this chapter, an introduction to the mental health aspects among refugees and migrants and their situation in the Austrian context is given. Refugees and migrants can be assisted by a focused, non-specialized, and salutogenic psychosocial support such as the culturally sensitive Mental Health Promotion (MHP). This possibility of psychosocial encouragement will be explored with the example of the intercultural MHP program of the Austrian Non-Governmental Organization (NGO) AFYA.

2.1. Mental Health Disorders among Refugees and Migrants

Risk factors

Refugees and migrants may experience different types of stressors before, during, and after migration. In their home countries, such stressors can be related to experiences with violence, war, torture, or loss of family members. During migration, exhaustion, detention, lack of basic needs, and others can account for additional stressors (5). In host countries, refugees and migrants may suffer from stressors such as change in roles and responsibilities (7), stigma, discrimination, or rejection by the host population. Other stressors include unemployment, loss of social status, language barriers, financial problems, family separation, social exclusion and others (8). These stressors can be risk factors for increased psychological distress and the development of mental disorders. Associated mental disorders can vary from trauma- and stress-related disorders, mood disorders, and anxiety disorders to psychotic disorders (9)(8), chronic pain, and other somatic symptoms (10).

Mental symptoms

Mental symptoms such as loss of energy, depressive mood, sleeping and concentration problems, irritability, fatigue, restlessness, difficulties with relaxation, and others may also exist prior to migration. However, the migration process may intensify or worsen these pre-existing conditions. Symptoms such as fatigue, trouble with sleeping and concentration, headache, or back pain may continue to appear years after arriving in the host country (11). These symptoms may also affect daily life and make the adaptation in host countries more challenging (9)(12)(13). The risk of

developing mental disorders after experiencing adverse situations depends on individual risk and protective factors (5).

Protective factors

Protective factors are social networks and support groups such as friendships, family cohesion or family reunification. Additional protective factors are community factors such as belonging to a group, networks within a community, social inclusion, or culturally sensitive services. Important individual protective factors are, for example, self-esteem, self-efficacy, interpersonal skills, or adaptability, among others (5).

Prevalence of mental disorders

The accumulation and interaction of the aforementioned risk and protective factors can contribute to the development of mental disorders. The prevalence of mental disorders due to potentially traumatic experiences among refugees and migrants is indicated by various epidemiological studies to be 30-33% (9)(13). While the previously mentioned stressors can have a pathological impact, it is also important to consider that many stress-related symptoms are a normal reaction to adverse events (14).

Resilience

Many refugees and migrants are left with no choice but to be resilient (12)(13). Resilience is "*the ability to manage or cope with significant adversity or stress in ways that are not only effective but may result in an increased ability to respond to future adversity*"(5)(p 19). By strengthening the frame of existing resources, refugees and migrants can be empowered, thus can regain more control over their lives(5). Moreover, difficulties encountered by refugees and migrants in their daily functioning can be tackled through strengthening resilience and developing interpersonal skills (5)(13)(15)**.** A person's social and personal resources can impact the ability to adapt and cope with different situations as well as attain overall wellbeing (4). Moreover, there is a correlation between an individual's level of adaptation and the acculturation strategy being implemented (16).

Acculturation process

Acculturation describes the process that occurs when two people with different cultures meet. Berry describes in the acculturation model four different strategies which can be used by refugees and migrants (17). These strategies include assimilation, marginality, separation, and integration. Regarding refugees, assimilation refers to the adoption of the new host culture and renunciation of the original culture. Assimilation is correlated with a medium level of adaptation (16). Moreover, marginality refers to the rejection by refugees of both the new culture and original culture alike. These refugees typically show a low level of adaptation. If refugees follow the separation strategy, they reject the new culture and only live according to their original culture (17). In the integration strategy, the new as well as original culture are incorporated in their daily lives. Berry describes the integration strategy to be the most effective for the adaptation process (16).

However, this acculturation process can also lead to acculturation-related stress, such as dissatisfaction, anxiety, depression, negative effects on one`s self-esteem or identity (18) and others. By implementing the assimilation strategy, refugees and migrants can feel pressured to exclusively live according to the culture of origin. By contrast, refugees and migrants following the separation strategy can feel pressured to adopt the new culture. Refugees and migrants who utilize the integration strategy may feel a high degree of pressure from both societies to maintain the original culture as well as adopt parts of the new culture (17).

2.2. The Austrian context

In 2015, 88.340 new refugees and migrants applied for asylum in Austria (19). That number corresponds to 1% of the Austrian population and 7% of all asylum applications in the European Union in 2015. Austria represented the fourth largest reception country in the European Union (20).

Austrian Policy on refugees and migrants

After the increased influx of refugees and migrants in 2015, the Austrian policy for admission of new asylum seekers became more restrictive in early 2016 (21). Border controls were intensified (22) and the number of new asylum applications was limited

to 37.000 per year (21). Furthermore, the previous unlimited right for refugees' residence was limited to three years. In addition, the wait time for a possible family reunification for individuals under subsidiary protection was extended from 12 months to 3 years (22) and financial support was reduced to the standard support of basic care (23). Additionally, adult refugees were required to meet certain financial prerequisites in order to apply for family reunification (22). Starting January 2021, legal counsel for asylum seekers will be provided by the Ministry of Interior. Prior to this decision, legal counsel had been provided by non-governmental civil society institutions in order to ensure objectivity in the counselling for asylum processes (23).

Asylum in Austria

By 2019, the number of new asylum applications had decreased by 85.8% compared to the year 2015, as illustrated below in table 1. Yet, there are thousands of people with refugee status in Austria, as shown below in table 2. The majority of refugees and migrants come from the following five countries: Afghanistan, Iraq, Russia, Somalia and Syria (19).

Table 1: Numbers of new asylum applications in Austria from 2015–2019 (24)

2015	2016	2017	2018	2019
88.340	42.070	24.300	13.400	12.510

Austrian Ministry of Interior 2019

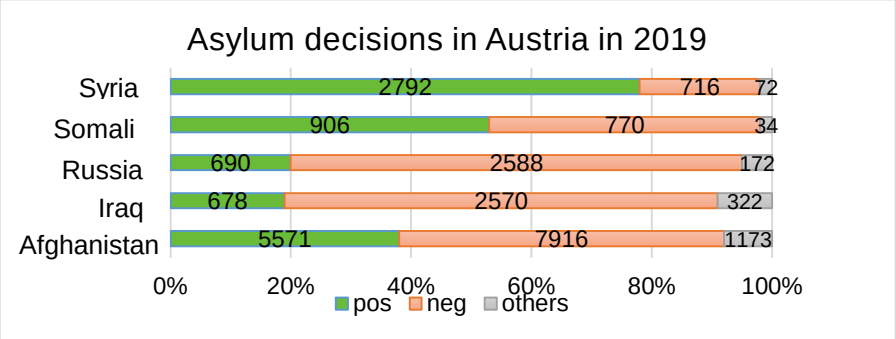
Table 2: Numbers of approved asylum applications from 2015-2019 (24)

2015	2016	2017	2018	2019
19.300 (79%)	27.552 (42%)	30.428 (46%)	20.809 (36%)	13.536 (28%)

Austrian Ministry of Interior 2019

In total, 28% of asylum applications were approved in 2019, while 63% were denied, and 9% was categorizes as other. The category "other" includes any asylum process that was stopped for any reason (24). Table 3 demonstrates the numbers of approved and rejected asylum applications among the five main nationalities in Austria in 2019. The asylum applications were approved for almost 80% of Syrians, for nearly a half of Somalis, for more than a third of Afghans and a fifth of Russians and Iraqi (19).

Table 3: Numbers of approved (pos), rejected (neg) and other asylum decisions in Austria in 2019 (19):



Fond soziales Wien 2019

Psychosocial wellbeing of refugees in Austria

Researchers at the Vienna University of Economics and Business conducted a study in a community setting in order to investigate the influence of economic, social, and cultural integration on the psychosocial wellbeing of refugees. The objective of the study was to provide a better understanding of the integration of refugees in Austria. The epidemiological study concluded that symptoms related to depression and anxiety in a sample of 515 refugees appeared to be severe in 4% of females and 2% of males; 17% of females and 8% of males showed moderate symptoms; 29% of females and 30% of males manifested few symptoms; 50% of females and 60% of males lacked any symptoms (7).

Individuals experiencing severe mental health symptoms require specialized care, such as psychiatric care and psychotherapy. However, the waiting time is between 6 and 12 months for psychotherapy with an interpreter in Austria (7). The majority of refugees and migrants experiencing few to moderate mental symptoms can improve their overall wellbeing with focused support such as mental health promotion (MHP) (13). Refugees and migrants without mental health symptoms can also benefit from the preventive and inclusive approach of MHP (5).

2.3. Intercultural Mental Health Promotion for refugees and migrants

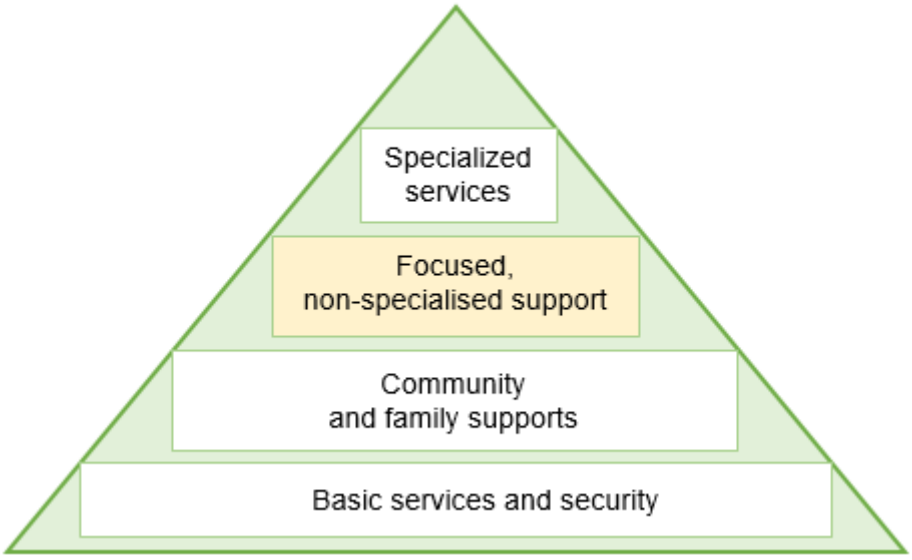
2.3.1. Focused, non-specialized support

The Inter Agency Standing Committee (IASC) guidelines on Mental Health and Psychosocial Support (MHPS) in emergency settings contains an intervention pyramid

for MHPS. The different layers of the pyramid represent services for psychosocial needs in different stages, as illustrated below in figure 1.

The first layer labelled “basic services and security” addresses basic needs such as food, sanitation, shelter, and protection. Following this, the second layer entitled “community and family supports” focuses on intact social networks. However, the emphasis of the present study is on the third layer. This layer represents “focused, non-specialized support”, where trained and supervised staff provide interventions for basic mental health care and psychosocial support in the community and at primary health care settings. The fourth layer designated as “specialized care” is important for people with severe mental health disorders who need specialized care such as psychological or psychiatric support (25).

Figure 1: IASC intervention pyramid for MHPS (25)



The Inter Agency Standing Committee 2007

The focused, non-specialized support will be explained in more detail through presenting the concept of Health Promotion (HP) and MHP.

2.3.2 Key elements of Health Promotion

In the first International Health Promotion Conference in Ottawa in 1986, the World Health Organization (WHO) defined health promotion as “the process of enabling people to gain more control over and improve their own health and well-being” (26)(p 1). The six key elements of HP are advocacy, creating supportive environments,

building healthy public policy, reorientation of health services, strengthening community, and developing interpersonal skills (5).

There are elements in common between health promotion and mental health promotion. Several of these elements include social, cultural, economic, family, community, and individual factors. These factors can have an impact on a person's overall wellbeing (5). WHO describes *health* or *overall wellbeing* of a person as the combination of physical, mental, and social wellbeing (4). The universal goal of HP is to promote holistic health and overall wellbeing(26).

2.3.3. Mental Health Promotion

MHP takes into account the protective and risk factors influencing mental health and overall wellbeing (5), as previously explained in chapter 2.1. Moreover, MHP interventions focus on resilience and power (5).

The Centre for Health Promotion at the University of Toronto and the Mental Health Promotion Unit of Health Canada defined *Mental Health Promotion* in 1996 as: "*the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience while showing respect for culture, equity, social justice, interconnections, and personal dignity*" (5)(p 17).

Furthermore, MHP addresses stigma associated with mental disorders (5). While MHP works towards the promotion of overall wellbeing, it also reduces risk factors including stress, distress, anxiety, and depression-related symptoms (5). Holistic health or overall wellbeing can be achieved by making "health" a part of one's everyday life (4).

2.3.4 Salutogenesis versus pathogenesis

MHP focuses on the principle of salutogenesis as opposed to pathogenesis (5). With a salutogenic approach, an emphasis is placed on health and health-related resources. Salutogenesis provides a link between health, stress, and coping strategies. In contrast to salutogenesis, pathogenesis focuses on risk reduction for diseases (27).

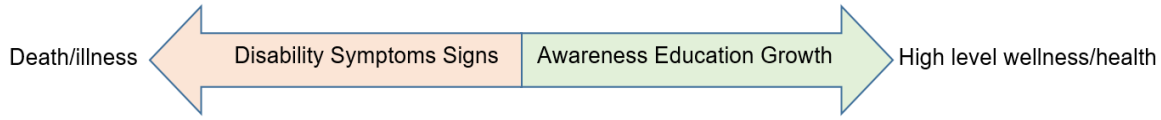
The Israeli-American sociologist Aaron Antonovsky used the image of a river in 1987 to explain salutogenesis:

"It is not enough to promote health by avoiding stress or by building bridges keeping people from falling into the river. Instead, people have to learn to swim" (27) (p. 194).

Figure 2 presents the illness-wellness continuum. The illness-wellness continuum portrays illness/death on one side and wellness/health on the other. The direction of live ideally should be characterized by wellness/health on the continuum, as presented on the right side of the graph. Some people are born into a higher level of wellness, while others are born closer into disease-prone conditions, in which life challenges are more difficult to handle (28).

It is important to recognize one's resources, regardless of being born closer to wellness or closer to disease. By recognizing available resources, a person can make better choices for life (27).

Figure 2: The illness-wellness continuum (28)



Rdodriguez, Daisy Magalit 2014

MHP and prevention programs include strategies of health awareness, good health, and optimum health to reach a high-level of wellness (28). Intercultural MHP is an important tool for tackling social exclusion and fostering social integration as well as reducing follow-up costs of non-treated adults and preventing chronic mental disorders (7)(9). Studies suggest that MHP programs should adopt a culturally sensitive approach (11).

2.3.5. A culturally sensitive approach

For the purpose of this study, culture is defined as a "*social matrix of experiences, including different features that construct daily functioning, self-understanding, and experience with diseases and wellbeing. It is shaped by norms, values, ideologies and beliefs*"(3)(p 23).

A culturally sensitive approach is considered if interventions take into account a person's cultural background, age, sex, mother tongue, and geographical location. Interventions are adapted to the cultural and psychosocial needs of the target population (3). Intercultural interventions "*relate to or involve more than one culture*" (1).

Refugees and migrants with psychosocial work experience and with cultural backgrounds similar to the background of users can be trained to provide MHP under the supervision of experts (9). It is essential to adopt culturally appropriate language in participants' mother tongue. Moreover, it is relevant and beneficial to be familiar with cultural traditions such as fasting periods and the use of symbols, metaphors or sayings which are intercultural shared. Workshop methods, elaborated concepts and activity goals should be culturally compatible (3). Furthermore, refugees and migrants should be involved in program planning to provide their point of view. By doing this, their needs will be easier to identify (8). Culturally sensitive programs have the potential to increase participants' acceptance, satisfaction, and program effectiveness (13)(12) fourfold, as supported by a meta-analysis (29).

2.4. AFYA's intercultural MHP program

The Austrian NGO AFYA provides intercultural MHP for adult asylum seekers, individuals who are eligible for subsidiary protection, migrants, and recognized refugees of any nationality or age in Vienna, Austria. AFYA is an Arabic and Swahili word meaning health and wellbeing. In German, the program name translates to health circles.

2.4.1. Program development

In 2015 and 2016, 130.410 refugees and migrants applied for asylum in Austria (table 1). In 2017, AFYA was founded by its current board members.

Funding

In 2017, the NGO was first funded by integration and small project funds of the Municipality of Vienna city. Since 2018, the NGO receives project funding from the National Action Plan for Integration. In 2019, additional grants became available from the Ministry of Social Affairs, Health and Consumer Protection and financial support

by CORE integration centre through European funds for regional development in the context of urban innovative actions initiative. Currently, in 2020, the program is financed by the department of Viennese Health Promotion of the Municipality of Vienna and the Austrian Health Insurance. Additional financial assistance is granted by private donors.

AFYA`s partners

An important partner of AFYA NGO for the implementation of traumacare is the Children and War Foundation. In the Austrian network Hemayat – a therapy centre for victims of torture and war survivors, die Boje – a therapy center for children and adolescents and the Nachbarinnen (neighbours) – a provider for social assistance and integration services and Refugees Vienna – a refugee information platform, are important partners.

The program`s evolution

AFYA's first program was Teaching Recovery Techniques (TRT) for refugee children. For the program implementation the NGO is working directly and very close with different schools in Vienna. In September 2018, the adult program for intercultural mental health promotion was implemented. The overarching goal of AFYA's adult program is to contribute to the general wellbeing of refugees and migrants in Austria. The intervention is not a therapy program, but focuses on teaching coping mechanisms, strengthening resilience mechanisms, and developing interpersonal skills.

International experiences and concepts were used to establish the frame for the concept of AFYA's MHP circles. AFYA draws on multiplicator-model experiences from Latin America and resource-poor countries in war and conflict zones. Individuals from a similar geographical background and speaking the same mother tongue as beneficiaries are trained for specific interventions and to facilitate programs under the supervision of professionals.

The basic concept of such "Health circles" using a multiplicator-model was earlier adopted by the Caritas Centre for Women Health, Asylum and Integration in Lower Austria. The focus of those health circles was on physical health only (30).

The Department of Psychotraumatology of University of Konstanz suggests following a multiplicator-model for new program implementations. When following a multiplicator-model, community members are trained and supervised by an expert team (9).

For the development of the program, other low-threshold approaches such as STARK, STAIRT or TRT were taken into consideration. STARK stands for “Skills Training der Affektregulation, ein kultursensibler Ansatz (skills training of affect regulation, a culturally sensitive approach). The program was developed by psychotherapists of Refugio Munich, a counselling and treatment centre for victims of torture, and researchers of Ludwig-Maximilians-University Munich in Germany. It is a culturally sensitive group therapy program with 15 modules about teaching strategies for perception of emotions and emotional regulation (13). The START concept stands for “Stress-Traumasymptoms-Arousal-Regulation-Treatment”. The 16 session concept focuses on regulation of emotions, strengthening resilience, and developing interpersonal skills. Furthermore, it was developed to decrease distress due to potentially traumatic experiences (15). AFYA’s Teaching Recovery Techniques (TRT) program developed by the Children and War Foundation for refugee children is an initially 5 (now 8) session program and group-based format, that was. It teaches coping mechanisms to handle mental distress due to adverse events with a culturally sensitive and preventive approach (31).

Thus far, there is no comparable Austrian program to AFYA’s intercultural MHP circles for adult refugees and migrants. Despite the fact that the previously described international and national examples contributed to the development process, the existing concept is still unique in Austria.

2.4.2 Concept

Structure

AFYAs MHP program is a low threshold intervention which is organized in MHP circles. One MHP circle includes +/-10 MHP modules conducted over a ten-week period. One module lasts approximately two hours and is conducted on a weekly basis. New participants can enter the group until the third module. The program takes place in housing, migrant integration services or education centres providing German

language classes. Participants aren't required to have a mental health diagnosis or undergo an initial mental health assessment prior to joining the program.AFYA team
There are two facilitators per group. 13 psychosocial facilitators were initially trained, while only seven of them have so far been working with AFYA NGO. First languages spoken by the facilitators are Somali, Farsi, Arabic, Chechen, and Kurdish. Facilitators examine and interpret materials and methods for cultural appropriateness and cross-cultural applicability. The facilitators are officially recognized refugees with psychosocial work experience from their countries of origin and trained by the AFYA expert team. The AFYA expert team is a multidisciplinary team of experts in the fields of project management, international health, medicine, evaluation process, adult education, psychotherapy, and trauma therapy. All facilitators received a one-month training from August to September 2018 consisting of three-hour sessions three days per week. The content of the training included roles and responsibilities of the facilitators, methods and tools for working in groups, and an introduction to key topics such as holistic and mental health of men, women and children. Furthermore, it included introductory concepts to psychology, psychiatry and psychotherapy, consequences of potentially traumatic experiences, death and mourning, methods and tools for strengthening resources and developing interpersonal skills, and visits to various migrant, social and health services in Vienna.

MHP circles objectives and content

Each of the 10 sessions has a specific theme and objective (annex 1). The primary focus is on mental stabilisation, strengthening resilience, and strengthening the ability to manage daily life challenges. Other objectives include coping mechanisms for dealing with stress, concerns, potential traumatic experiences, sleeping problems, nightmares and intrusive memories and mental images, familiarization of relaxation techniques, and addressing stigma towards mental distress. The goal is to empower participants and to strengthen their self-efficacy through developing new knowledge, resources, and tools on health awareness. The program’s content includes a broad spectrum of topics, methods, and tools and is a mixture of discussions, psychoeducation, awareness-raising, and a variety of physical exercises. The practical part is a combination of resource, emotion-regulation, and wellbeing-focused exercises, as well as creative activities and relaxation techniques. Relaxation encompasses breathing

exercises, (trauma-sensitive) yoga, and samurai shiatsu. Yoga exercises promote self-awareness and mindfulness. Additionally, it bolsters stress relief, focusing on the present moment, and the development of curiosity and tolerance towards emotions. Moreover, it strengthens self-confidence and the relationship with one's own body (38), among others. Shiatsu is an alternative medicine similar to acupuncture and focuses on working with energy flow. The meaning of Shiatsu translates to "finger pressure". Apart from being helpful for musculoskeletal and respiratory problems, shiatsu can furthermore support coping with insomnia, anxiety, depression, and weakness (39) among others. It can lead to improved mind and body awareness (40).

2.4.3 Pilot phase

The pilot phase ran from September 2018 until December 2019. During this period, the majority of participants were Somali and Afghan women, Syrian and Afghan men, and Russian (Chechen) women. The Chechen Republic represents a federal subject of the Russian Federation. For that reason, this group is presented as *Russian (Chechen)* in this study. The age range of participants was between 22 and 67 years with a sex distribution of 75% women and 25% men. In total, 108 women and 39 men of any legal status participated at least in one session in a MHP circles. 75% of the total participants were of official refugee status. Participants were derived from various asylum seekers' dwellings, through networks of migrant integration services, social media, and social networks. Participants who presented with severe mental health symptoms were provided with information and referred to specialized care (after participating in the program).

Table 4: MHP participants' demographics (country of origin/age/sex/legal status) and attendance rates per MHP circle during the pilot phase (Sep 2018 to Dec 2019)

MHP circles and location starting date (m/y)			Country of origin	Age range & average age	Sex		Asyl. seeker	Refugees	Others	% attendance
					F	M				
1	ABS Erd berg	Sep-18	Syria, Afghanistan	X	0	12	12	0	0	x
2	Con text AMS	Oct-18	Afghanistan	not available	12	0	0	12		60%
3	Core	Oct-18	Somalia	20 to 47y (Ø 32y)	12	0	0	12	0	82%
4	Inter face	Nov-18	Afghanistan	X	0	9	9	0	0	x
5	Core	Jul-19	Afghanistan	not available	14	0	0	14	0	39%
6	Erd berg	Jul-19	Syria	X	0	3	0	1	2	x
7	Core	Aug-19	Russian federation (Chechen republic)	24 to 67y (Ø 50y)	17	0	0	14	3	44%
8	Core	Aug-19	Somalia	22 to 51y (Ø 36y)	13	0	0	12	1	84%
9	Perchtolds dorf	Sep-19	Syria, AfghanistanTurkiey, Moldova, Armenia, Kosovo, Iran, Hungary	women: 13 to 52y (Ø 35y) men: 21 to 63y (Ø 43y)	16	15	11	20 (12 male/ 8 female)	0	19%
10	Core	Oct-19	Somalia	22 to 51y (Ø 37y)	8	0	0	8	0	66%
11	Core	Oct-19	Russian federation (Chechen republic)	35 to 60y (Ø 49y)	16	0	2	14	0	66%
Total					108	39	34	107	6	

Study justification

The overall wellbeing of refugees and migrants plays a crucial role in social inclusion and integration. Although the number of new asylum applications is decreasing in Austria, there are currently many refugees and migrants undergoing the adaptation process in the country. Mental health promotion and preventive interventions for refugees and migrants are an important global health topic in the host country.

Though AFYA's program draws on existing international MHP experiences, this particular approach is innovative in Austria. Such MHP activities for migrants and refugees are at the pilot stage in the country. The NGO considered it pivotal to understand the appropriateness and to examine the effectiveness of the implemented program for the culturally diverse group of migrants and refugees.

3. Study aim

3.1. Main aim

The main aim of the study was to evaluate AFYA`s intercultural MHP program for adult distressed refugees in Vienna/Austria during its pilot phase from September 2018 until December 2019.

3.2. Specific objectives

In order to achieve valuable answers to the research questions below in subchapter 3.3, following specific objectives were determined:

- To examine if and how AFYA's intercultural MHP program contributed to the overall wellbeing of refugees and migrants in Vienna/Austria.
- To explore the appropriateness, acceptance, and effectiveness of the program among the diverse target group.
- To provide recommendations to AFYA NGO.
- To explore differences between country of origin and satisfaction score.
- To describe observed differences or common patterns among the diverse target group.
- To explore differences between facilitators and participants in order to answer the aforementioned objectives.

3.3. Research questions

- How appropriate is AFYA's program in terms of meeting the perceived psychosocial needs of adult refugees?
- To which degree do the program's participants accept the MHP tools and messages?
- How effective is AFYA's program in terms of improving the psychosocial wellbeing of adult refugees?

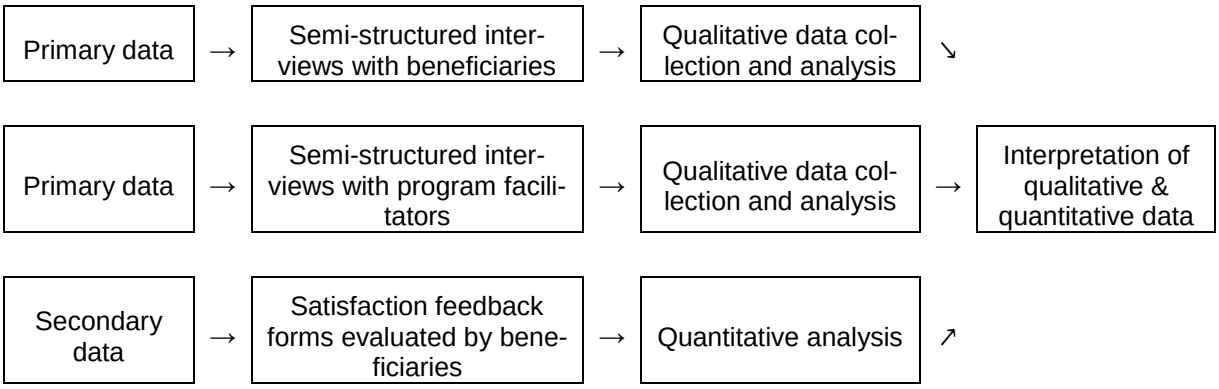
4. Methodology

Chapter 4 provides details surrounding the chosen study design, the sampling method for study participants and exclusion criteria for participation in the research. Further, the data collection and data analysis process are introduced. The chapter concludes with a description of the parameters used to assess the quality of the research.

4.1. Study design

The research project is a mixed-method study, with an emphasis on qualitative data analysis and data source triangulation of primary and secondary data, as shown in table 5.

Table 5: Data source triangulation



Qualitative method

The rationale for choosing qualitative methods was to gain insight into MHP participants' points of view and experiences as direct beneficiaries of the intervention. An additional factor included is the perspective of facilitators as providers of MHP sessions.

Quantitative method

The quantitative methods complemented the qualitative data findings with self-reported satisfaction feedback forms (annex 2) completed by participants at the end of each MHP circle. Feedback forms included a 4-point Likert satisfaction scale as well as a space for narrative comments.In this way, triangulation of results will be ensured (32).

4.2. Study participants

Sampling

A quota sampling was applied to recruit 12 program participants for taking part in semi-structured interviews. Those 12 refugees represented different groups. Men and women of varying ages and nationalities as well as participants of a variety of MHP circles having taken place during different periods of time. For MHP circle 2, there were no contact details available, with the exception of one woman who wasn't interested in study participation.

A strategy of maximum variation sampling allowed the recruitment of refugees with distinct lengths of stay in Austria, as well as those who participated in more than one MHP circle and other who engages in only a few sessions (33).

Exceptions

One Somali participant was recruited via snowball sampling, as all interview requests made by the Somali facilitator were rejected by program participants. Snowball sampling is used when no more participants can be recruited or study participation when participants recruit other participants (33).

One Afghan woman was recruited via opportunistic sampling, due to another woman not adhering to the interview appointment. Therefore, the opportunity was taken to recruit a participant with the same nationality and from the same MHP circle and neighbourhood. Opportunistic sampling is used when, for example, an opportunity appears during fieldwork to recruit a potential participant who is available and fits the criteria (34).

4.3 Exclusion criteria

Asylum seekers were excluded from the study. The number of new asylum applications is decreasing in Austria (table 1). The circumstances are more complex for asylum seekers, due to the uncertainty of their legal status and length of stay (2) in Austria. Any data from circle 1 and circle 3 were excluded from the study, as those circles were exceptionally provided for asylum seekers.

The study focus was on recognized refugees and eligible individuals for subsidiary protection. This group accounts for 75% of the main target group of AFYA's MHP program and is expected to remain as such in the future.

4.4. Data collection

4.4.1. Qualitative data

Interviews

Qualitative data (primary data) consists of 16 semi-structured interviews (annex 4), including interviews with 12 MHP participants and four MHP facilitators. Two sets of interview guidelines (annex 3) were developed for the semi-structured interviews with MHP participants and facilitators. Interview guidelines supported the efficient use of available interview time and the conducting of interviews in a systematic way. Questions needed to be clear, objective, and sensitive (34). Therefore, the participants' interview questions were reviewed by facilitators for cultural appropriateness, whereas the wording was reviewed by German speaking experts in evaluation and qualitative research.

Interview locations

Interviews with program participants of MHP circles 4, 5, 7, 8, 10, and 11 were conducted in the CORE Integration Centre. The interviews with participants of circle 9 took place in the parish centre of Perchtoldsdorf, a catholic centre providing daily German classes for refugees and migrants in the outskirts of Vienna. These places were well known among program participants. All MHP circles were either provided in the CORE integration centre or Perchtoldsdorf parish centre. Both centres exhibited flexibility for the rental of additional rooms for interview appointments. These places were deemed culturally appropriate. One woman requested to conduct the interview at her home because her child was sick. Interviews with facilitators were conducted at AFYA office, the CORE centre, and in a café at one of the facilitator's hometown.

Translation

The interviews with MHP participants were conducted with Arabic, Chechen, Somali and Farsi interpreters. One interview with a Somali woman took place in German

without an interpreter, as requested by the participant. It appeared that the woman would not feel comfortable in an interview supported by an interpreter. The recruitment of Somali participants was a challenging process. Therefore, the researcher didn't want to lose the opportunity of interviewing the aforementioned woman.

Two participants switched between native language, basic German, and fluent English during the interpreters supported interviews. The Arabic and Farsi translators were hired from AFYA's daily worker pool. The Chechen and Somali interpreters were identified with the support of AFYA's facilitator team. They were also hired under an official employment contract (for day labourers). All interpreters received a detailed briefing from the researcher. Additionally, the copies of the consent forms and interview questions were shared with them before interview appointments. There was no translation needed for facilitator interviews since all facilitators were German speakers. The average interview time was 37.5 minutes for MHP participants and 51 minutes for facilitators with a time range of 26 to 65 minutes.

Interview participation

The first request for study participation was initiated by facilitators as they were known among program participants and spoke the same first language. Afterwards, time and location were agreed upon between participants, translators, and the researcher. Three of the planned interviews were cancelled by participants (annex 4). Table 6 shows the demographics of the final 12 MHP participants who took part in the study.

Table 6: Interview participants' demographics (country of origin, sex, age, length of stay in Austria), time of MHP participation and attendance

Country of origin	Sex	Age (years)	Length of stay in Austria (years)	Time of participation in MHP circle	MHP circle	% Participant attendance
Afghanistan	F	51	2.5	Sept/Nov 19	9	37%
Afghanistan	F	41	4	July/Aug 19	5	38%
Afghanistan	F	30	4	Sept/Dec 19	9	50%
Russian federation (Chechen Republic)	F	52	15	Aug/Sept 19	7	70%
				Nov/Dec 19	11	63%
Russian federation (Chechen Republic)	F	50	15	Aug/Sept 19	7	25%
Russian federation (Chechen Republic)	F	39	4	Nov/Dec 19	11	80%
Somalia	F	35	4	Sept/Nov18	4	84%
				July/Aug 19	8	88%
				Nov/Dec 19	10	88%
Somalia	F	45	3.5	July/Aug 19	8	88%
Syria	F	51	2.5	Sept/Nov 19	9	91%
Syria	M	49	3	Sept/Nov 20	9	55%
Syria	M	61	4	Sept/Nov 21	9	46%
Syria	M	64	3	Sept/Nov 22	9	73%

Additionally, the four facilitators who were the most involved in the program, were invited to participate in the study. Table 7 shows facilitators` demographics, including country of origin, sex, age, length of stay in Austria and the number of provided MHP circles.

Table 7: Facilitators' demographics

Country of origin	Sex	Age	In Austria since	# of MHP circles provided
Syria	M	34 y	5 y	3
Afghanistan	F	40 y	7 y	3
Russia (Chechen Republic)	F	50 y	16 y	2
Somalia	F	26 y	10 y	3

Transcription

All interviews were audio recorded through a voice recorder on a smartphone. The interviews were supported by an interpreter and transcribed by the interviewer only into German language, using a semantically content approach. All interviews were transcribed literally; structures of sentences were kept in original form and lines were numbered throughout all transcription documents (35).

4.4.2 Quantitative data

During the pilot phase, the feedback questionnaire was answered by 35% of the total registered participants. The facilitators distributed the feedback forms at the end of each MHP circle. Therefore, this number depended on the number of participants at the last session of each circle. Considering the number of participants who attended the last session, 61% of them completed the feedback forms. Table 8 depicts the number of available feedback forms per MHP circle.

Table 8: Feedback forms per MHP circle

# Circles		# Registered participants	# Feedback forms	% Completed feedback forms out of attendants of the last session	% Completed feedback forms out of the total registered participants
1	ABS Erdberg	x	x	x	x
2	Context (AMS)	12	9	100%	75%
3	Core Somali	12	0	0%	0%
4	Interface	x	x	x	x
5	Core Afghan	14	10	84%	72%
6	Erdberg	x	x	x	x
7	Core Chechen	17	5	71%	30%
8	Core Somali	13	6	47%	47%
9	Perchtoldsdorf	31	0	0%	0%
10	Core Somali	8	5	63%	63%
11	Core Chechen	16	8	100%	50%
	TOTAL	123	43	61%	35%

All narrative answers of the questionnaire written in any other language than German have been translated before the analysing process started.

4.5. Data analyses

4.5.1 Qualitative analyses

A thematic content approach was used for data analysis. Categories were developed directly from the data, using an inductive approach. An inductive approach was chosen for ideally relatively objective and analytic analyses (36)(37). The first step after reviewing the transcripts was to decide on a category and abstraction unit.

Definitions

The *category definitions* included individual daily life challenges, satisfaction, feedback, or recommendations of study participants in regards to the program concept. Additionally, it included set up and strategy, as well as any observed interpersonal changes related to the program. The category definitions were related to the interview questions (annex 3).

The *level of abstraction* was defined as expectations, feelings, experiences, observations, opinions, and psychosocial needs of study participants related to MHP (36). The *coding unit* was defined as a label for paragraphs or text passages in a transcript. It included considerable information in regards to the category system with clear and understandable information*. There was no room for interpretation remaining* (37). *The context unit* included one transcript of one interviewee, while *the analysing unit* consisted of all conducted interviews, as it is standard for inductive content analyses (37).

Themes, categories and subcategories

First, categories were identified based on information extrapolated from interview answers and data were coded using these categories (34). This process has been repeated for each transcript. Additional categories were developed using this data. Afterwards, paragraphs belonging to those categories were compiled. Later, categories were broken down into subcategories. In the end, categories and subcategories were assigned to themes related to the research questions (33).

At the end of the process, four themes, seven main categories, and 14 subcategories remained. They are represented in chapter 7.1. in table 9. During the analytic process, potential common patterns and major differences were observed. Any extracted common patterns among this diverse group of interviewees may contain noteworthy information (34). All data was managed manually via Microsoft Excel.

4.5.2 Quantitative analyses

In total, 43 satisfaction feedback forms (annex 2) were available for a quantitative analysis. Table 1o shows the number of feedback forms per country of origin. All questionnaires were answered exclusively by female participants. This occurred due to the fact that only circle 9 included male participants and in this specific circle as well in circle 3, there were no feedback forms administered. As previously mentioned, the number of evaluation feedback forms depended on the number of people who had attended the last session of each MHP circle.

The underlying data of the 4 point Likert scale were organized in Microsoft Excel and analysed with the statistic software SPSS version 25. Therefore, the level of

significance was set at p< .05. It was examined, if there was a difference between the countries of origin and the evaluation of AFYA`s program. A Kruskal-Wallis test was used to determine if there were statistically significant differences between two or more groups of an independent variable on an ordinal dependent variable (38).

A thematic content analysis was used for the narrative part. The main categories were *application of tools, favourite topics, participants` recommendations and satisfaction.*

4.6. Quality criteria

The following criteria were used to assess the quality of the research: objectivity, validity, reliability, and reproducibility.

The *objectivity* of the research was determined by including study participants of different MHP circles, age groups, countries of origin, and both sexes. The MHP circles were led by different facilitators at different periods of time. The four interview interpreters were not involved in any MHP circle. For the *validity check*, paragraphs with certain themes were reviewed and compared for homogeneity. *Stability* was tested via recoding parts of the data, such as the categories group and motivation. There were only a few differences. *Communication validation* was obtained by a consensus of research findings between the researcher and interviewed MHP facilitators. Moreover, after the field work was complete, qualitative findings were presented to the AFYA team and the findings were discussed. The principal findings were summarized, translated into Arabic, Somali, Farsi and Chechen, and shared with study participants by Whatsapp messaging application or email. *Reliability* was ensured through method triangulation of qualitative and quantitative data as well as data source triangulation of program participants and providers. The method of triangulation functioned to further reduce bias (36)(37). *Reproducibility* is ensured through transparent and close documentation of the entire research process. through a detailed work plan (annex 4) and interview guidelines (annex 3). Additionally, the interview context and transcription flow (chapter 4.4.1) were described. Study limitations and opportunities were identified at the end of the research process (chapter 8). Data collection and analysis were regulated by a predetermined regulatory system. The research is based on predefined and clear research questions. Furthermore, data were analysed systematically and stepwise (37).

5. Ethical considerations

Chapter 5 provides insight regarding the steps taken in order to obtain ethical clearance. Moreover, it gives an introduction to the adopted ethical guidelines and the procedures for data protection.

5.1 Ethical clearances

The ethical clearance was considered within AFYA (annex 5). AFYA board members considered ethical approval to be unnecessary for this study as it is an internal study with no plans for publication. Furthermore, the secondary data from the feedback forms the secondary data from the feedback forms was extracted from pre-existing program databases. The qualitative data collected will serve the exclusive and immediate purpose of reflecting on and improving all operational activity of AFYA NGO. Additionally, a second external part was consulted for ethical clearance (annex 6). A post-doctoral researcher from Vienna University of Economics and Business, Department of Socioeconomics, who specializes in migration and refugees' studies, approved the ethical part of the procedures related to ensuring respondents' anonymity, informed consent, confidentiality, and data security.

5.2 Ethical guidelines

The ethical guidelines of the Oxford Refugees Studies Centre provided the study`s framework for good research practice. The *do not harm principle* was followed (39). Furthermore, disturbances for participants have been kept at a minimum. All study participants were adults aged between 30 and 64 years. No minors were included in the study. Participation was voluntary and all participants had the right to withdraw from participation at any time without any consequences. All interviewees received adequate information about participation in the interview. Moreover, they received written information about the study purpose and detailed explanations. They were informed about the purpose of evaluating AFYA's program and serving the purpose of meeting the requirements for the researcher's master studies. All information was orally explained in the participants' mother tongue. Each participant gave their informed consent (annex 7) before data collection and received a copy of the signed written consent form. The consent forms included the name, phone number and email

address of the researcher, in case further questions or possible concerns would arise. Upon request, participants received the written consent form in their native language. That was only the case for one Farsi speaking participant. No conflict of interest was considered among the students and Austrian researchers as the study serves as an AFYA internal evaluation activity.

5.3 Data protections

Confidentiality and anonymity regarding participants' personal information was constantly protected. All interviews were audio-recorded. Participants' names were replaced with codes and all participant data were recorded using these codes. Names, contact information and other personal identifiers were not disclosed. The researcher had exclusive access to anonymized primary data (33).

6. Results

First, chapter 6 will represent the findings of primary qualitative data analysis in the subchapters psychosocial wellbeing, program`s appropriateness, acceptance and effectiveness. The subchapter psychosocial wellbeing is based on an interview question and provides background information to explore the research question regarding the program's appropriateness in terms of meeting the perceived psychosocial needs. The subchapters entitled appropriateness, acceptance and effectiveness are based on the research questions and contain notable information regarding how to achieve the study's specific objectives (chapter 3.2).
The chapter will conclude with secondary quantitative data analysis. Indications of differences on the evaluation of the MHP program by participants' country of origin might serve to achieve the respective study's specific objective.

6.1 Findings of qualitative data analysis

After the first data inspection, the following categories were derived: *motivation, favourite/least preferred topics, organisation, the most important thing learnt, psychosocial wellbeing, barriers and feedback/recommendations.*

After a few more revisions of the full data set, following changes were performed: *organisation* was separated into *content and structure*, *the most important things learnt* was put under *skills, recommendations* were put directly in the categories *communication strategy, content and structure*.

Culture combined with barriers and became *cultural needs and barriers*. The data suggested that cultural sensitivity can be essential in certain circumstances and alternatively pose as a barrier in others. The participants appeared to be motivated upon spending time with others of a similar cultural background. However, a particular participant felt stressed due to the potential of building a bad reputation in front of her community. *Cultural Needs and barriers* was placed under *structure.*

Psychosocial wellbeing was separated from *motivation*. The psychosocial wellbeing was not part of the research questions but reflects the psychosocial needs of participants. As previously mentioned, it was important to explore this to answer the research question regarding the program's appropriateness in meeting the perceived psychosocial needs of participants. Therefore, it became a separate theme.

The topics *participants` program awareness* and the *name of the MHP circles* developed after conducting six interviews. It was a special interest of AFYA NGO to understand more about participants' program awareness and their opinion about the program's name. Any relevant information obtained could help the program to make important modifications and raise awareness of the program. After a discussion with an AFYA chairwoman, a related question was included in the remaining six interviews with program participants. *Participants` program awareness* and *name of the MHP circles* were joined under the category *communication strategy*.

After the analysis process (see chapter 4.5.1), four themes, seven main categories and 14 subcategories were classified. Furthermore, the themes contained one or more categories and subcategories. All categories and subcategories were developed out of the total number of interviews in relation to the interview questions, as represented below in table 9. The findings will be explained in the subchapters.

Table 9: Themes, categories and subcategories

6.1.1 Psychosocial wellbeing prior to MHP participation a. Stress factors Home country Host country
6.1.2 Appropriateness for meeting the psychosocial needs a. Motivation Individual wellbeing Relevance to personal needs b. Comunication strategy Particpants`program awareness Name of the MHP circles
6.1.3 Acceptance of the MHP concept a. Content Favourite topics Least preferred topics b. Structure Accessibility Cultural needs and barriers
6.1.4 Effectiveness of the MHP program a. Group Learning experience Social network b. Skills New skills Application of tools

6.1.1 Psychosocial wellbeing

All study participants were invited to complete a retrospective self-assessment of stress level or psychosocial wellbeing prior to program participation.

a. Stress factors

92% of the interviewed MHP participants felt stressed in their lives prior to joining the MHP program. These stress factors were either related to difficulties in their home countries or to challenges in their current lives in Austria. These stress factors varied among both sexes, as well as among participants of different age groups and refugees with different lengths of stay in Austria.

Home country

It was observed that major stress factors of study participants with a shorter stay in Austria were related to problems or family situations in the home country.

Bad memories

The main stressors associated with home countries were bad memories due to violence and war, female genital mutilation and concerns about to the current situation of family members in the home countries.

“All refugees have similar problems. One part of my family is at home and the other part is here. I feel restless and worried. There are these ongoing thoughts and the stress” (E1).

Host country: Austria

During the adaptation period, the participants experienced daily life challenges due to language barriers, unemployment, economic and adaptation pressure, concentration problems, and having thoughts about situations that occurred before migrating from the home country.

Unemployment

Unemployment was one of the main concerns of two Syrian men and one Syrian woman. The stress factor unemployment could be more often observed among

older than younger and among more male than female study participants. These participants expressed concrete concerns about unemployment.

"No work makes sick. The whole time being at home and thinking. The thinking does not stop. Our families are still there or anywhere distributed in Europe and other countries. If I would have a job, I would forget that. But I don't have a job, so I am always thinking. That's the problem and makes me sick" (E2).

This participant described his busy work life as an architect in Syria, where he used to work until late at night. There, his daily life was filled with work, while in Austria he felt lower in status. In Austria, he enrolled in a volunteer program with the goal of meeting other people. He recognized the importance of social inclusion by enrolling in different group activities.

Language barriers

Language barriers were remarked by Chechen, Somali and Afghan participants as a stress component. Male participants didn't specify on language as stress factor. Female study participants described the household and childcare tasks as time-consuming and a potential barrier for learning German. Language problems were mentioned as an overriding concern mainly by participants who stayed already several years in Austria. Some study participants with a shorter stay in Austria were able to communicate in English.

"The very first problem was the German language. When I arrived to Austria, I couldn't speak any German, but a little bit of English. However, everybody was saying that I should speak German, but I could not" (D1).
"I feel ashamed that after so many years I am not speaking German in a better way. I participated in several German classes. Still, you have to find the time for it, if you have to bring the children all the time somewhere and have to pick them up" (C1).
A particular Afghan woman appeared desperate due to her inability to learn German as well as her mother tongue.

Family issues or problems in child care

Family issues were remarked by one-third of participants as a challenge, including daily child care, family situations, relationship problems, and new family constellations.

Health issues and personal wellbeing

Health issues in the host country were named by half of the participants as reasons for stress. A quarter of participants noticed depressive symptoms, mostly men.

"On the day that I received the information about the MHP circle, I have been sick. I was tired and I could not breathe. I had lots of stress and a depression" (E3).
"In the beginning, I was sad, withdrawn and isolated" (E1).

Male participants openly shared their personal stressors during the individual interviews. Their main stressors were family separation, depression and unemployment. Women struggled mainly with language barriers, family problems, problems with children, and body pain and expressed their feelings of being withdrawn and introverted. Furthermore, it was observed that social exclusion was mentioned by several study participants as major stressor.

"Since one year I am sick and the doctor told me, that I am not sick. But I have a problem and I don't know what is wrong with me. I have pain" (B2).

Five of the 12 study participants arrived less than 3.5 years ago in Austria. Four of the five referred to problems in their home countries and the situation of their families in the home countries as stress factors. Another five participants were in Austria for approximately 4 years. Two out of five reported having stress related to their home countries. However, three out of five interviewed participants stated language barriers as one of the main stress factors. Two participants were living in Austria for 5 years. Their primary stress factors were related to family problems in Austria and difficulties communicating in the German language. For the study participants who had resided for a longer period of time in Austria, it seemed that language problems were an overriding concern. By contrast, for the study participants who arrived more recently in Austria, the main stress factors and concerns were related to their home countries.

Facilitators` point of view

Facilitators' observations regarding stressors of program participants were in line with the retrospective self-assessment of study participants. However, facilitators also noted additional stressors among participants, such as nightmares and sleeping problems that further led to concentration problems.

The Afghan facilitator brought attention to the problem of illiteracy among Afghan women and pointed it out as an additional stress factor. This corresponds to the signs of desperation of one Afghan woman, as she wasn't able to learn German nor her mother tongue. The male MHP facilitator noted:

"Male participants seem to obey to the cultural masculine role model during the sessions. Men are wearing a mask and are expected to remain strong."

This goes along with the example of another male participant, who mentioned during the interview that he felt socially pressured to manage different types of stressors in an effective manner, such as the economic stressor. As head of the family, it is perceived that he should remain strong and be able to take care of the family. Another man preferred to apply newly learnt tools at home only when his family was not nearby.

6.1.2 Appropriateness for meeting the psychosocial needs

The program's appropriateness for meeting the psychosocial needs of the target group was explored. The presented findings were based on participants' expectations and motivation for program enrolment as well as awareness and perception of the program's name "*Health Circle"*.

a. Motivation

MHP Participants were asked about their motivational factors for program participation. In general, participants were driven by intrinsic factors to enrol in the program. The only extrinsic factor identified was the fact that the program was free of charge. No major differences of motivational factors were observed among the diverse studied group. In general, the opinions of participants corresponded to the observations of facilitators.

Individual wellbeing

One-third of participants enrolled in the program with the expectation of distracting themselves from their problems. One participant was searching for answers for her inexplicable body pain, whereas another was actively and thoroughly seeking help.

"*I was hoping the course will support me to forget the stress, that's why I enrolled in the program" (D2).*

Relevance to personal needs

First try-out

Two-thirds of participants came to the first session to allow a first look at the program. One participant enrolled in three consecutive MHP circles, but came initially to the first session for a try-out. The *first try-out* motivational factor was discussed by participants of all of the possible countries of origin. Two male participants of circle 9 expected the program not to help.

"I didn't know what I can learn in that program. But I thought I would give it a try out and if I will learn something there, then I will come again" (D1).
"I didn't have an idea of what the program is. But I thought I will first have a look at it and if I will find it good, I will stay. Otherwise, I will not come again" (E4).

New knowledge

Two-thirds were expecting to acquire new knowledge in the program.

"*I want to learn everything. I want to learn German, I want to be able to go to the doctor by myself, I want to go alone to the unemployment support department and don't want to disturb others. I cannot remember anything. I forget everything. I would like to learn something, but I cannot" (B2).*

Interest

A minor portion of participants attended with a special interest in certain topics. For example, a woman in circle 9 was the only study participant who didn't feel stressed prior to program enrolment. The MHP circle 9 took place in parallel to German classes.

"And I think German classes are better and more fundamental than the MHP circle. I checked which topic was interesting. If there was an interesting topic in the session, I was attending the session, others I did not attend" (B3).

A Chechen woman who suffered from stress in terms of child care initially attended the program as pertinent information about it was provided.

Facilitators` point of view

Facilitators concluded that gaining new knowledge, having interest in specific topics or addressing the individual psychosocial needs constituted the main motivational factors. One facilitator explained that in the beginning she wanted to get a first glimpse of the program before continuing with facilitation. She ultimately decided to continue. One facilitator stated:

"If women are coming, it means that they want to get something out of it. They absorb information of what they are listening to. Maybe they knew it already before. If women are coming, it means that they are ready to take something. If they are not interested in it, they don't come again. But if they are attending the program, it means that they need it" (A2).

This statement corresponded to a participant's statement:

"Normal people, or a person who is not sick, cannot extract this information or doesn't understand, why that information is important. A non-ill person will not understand that information. But if a sick person attends the program and tries to understand the information, the person will think that it is beneficial (E3)".

Participants and facilitators supported the idea that study participants felt intuitive in the beginning of the program that it could address their psychosocial needs.

Also, facilitators observed that former participants mobilized their social network for program participation. Also facilitators themselves identified potential participants through their professional and social networks.

b. Communication strategy

The main differences regarding the participants' awareness of the program were observed among participants of circle 9 and other circles. However, individual interviewees developed similar ideas about program's name.

Participants' program awareness

Not all study participants were aware that the program was about mental health promotion and that it aimed to reduce stress in participants' life through teaching

coping mechanisms. The study's findings depicted varying levels of participants' awareness of the program prior to participation. One-third were only slightly aware of the program or had learnt about it later throughout the course of the MHP program. The main challenges were identified in circle 9. Circle 9 took place at the same scheduled time as the German course. The German teacher spread information about the program on a weekly basis through the Whatsapp group of the German class to motivate pupils to explore the MHP program. Therefore, many people from the German class joined the MHP circle.

"*I have learnt late from my neighbours about the health circles, that's why I have only been there three times" (E1).*

Except for circle 9, Chechen, Somali and Afghan women groups were separated into each circle. Participants of those groups received comprehensive program information from the facilitators beforehand. They were informed of the program's content, the aim of promoting mental health and improving wellbeing.

"I knew that it wasn't solely about diseases. I imagined it exactly like this… with exercises and mental health exercises" (C3).

Facilitators 'point of view

Facilitators reported that they consistently shared program information prior to the start of each MHP circle and felt that participants understood what the program was offering. In addition to this, facilitators found circle 9 to be exceptional, as it consisted of a mixed group of people from a German class. The German teacher organized the group of participants for the MHP circle and facilitators were not highly involved in the process. For other MHP circles, participants were derived from the community, integration services, or AFYA partners, but mainly from word of mouth propaganda, where facilitators usually played an important role in identifying potential program participants. Facilitators also explained that former participants played a key role in recruiting new participants as they brought friends or family members to sessions.

Name of the MHP circles

One-third of participants pictured the program to be physical or health-oriented only. Participants were asked to reflect on the word health circle. Some participants concluded that the name “health circle” transmitted an inaccurate image of the program. This was observed especially among participants of circle 9. A Syrian man was surprised that exercises such as the safe place and wellbeing button were part of the program. In these exercises participants were shown how to control their thoughts, feelings and behaviours.

“I thought it was for physical health and not for safety and so on” (E1).
“*If you hear that it is about health, you will think immediately ok, I am healthy, I don’t need to learn about health topics., Why should I go there? I can also sit at home and search in the internet about health topics. If I have a problem, I can check on youtube” (E2).*

Participants of other circles had fewer doubts at the program’s starting point, as they had a clear understanding about the program’s content. Therefore, they didn't provide much feedback regarding their understanding of the name "health circles"

Participants proposed to use phrases such as “you are not alone”, “we are together”, “men cay (men tea)”, “exchange group”, “try it out – you don’t have anything to lose” or “social meet up”. The suggestions were all reflecting “group” or “social network”, “solidarity” or “community”. Likewise, their psychosocial needs for social inclusion and belonging to a collective group were reflected by the proposed names.

Facilitators` point of view

Facilitators were not specifically asked in the interviews about their opinions regarding the program’s name asthe question was included in the interview guidelines, after the interviews with facilitators were finished. However, the topic appeared in the interview with the male facilitator. He also proposed to change the name of the program for male participants to *“men cay (men tea*)”. According to Arab customs and culture, tea cafes are regularly visited by men and are well accepted.

6.1.3 Acceptance of MHP concept

The following presented findings will shed light on the participants' acceptance of the programs methods, tools, topics, and structure.

a. Content

Indications for potential differences in terms of preferred topics were found among men and women as well as among refugees with varied lengths of stay in Austria. Additional contrary results were identified in terms of less preferred topics among program participants and facilitators.

Favourite topics

Body workout

The majority of participants preferred body workout like shiatsu and yoga as well as general sport activities. The majority of study participants' favourite topic was shiatsu/massage. Additionally, half of participants considered yoga to be among the most favourite topics. Male study participants were not offered yoga. However, male participants underscored the importance of body workout and sport as they learned about the benefits of sport and outdoor activities in improving depressive mood. The participants felt an immediate effect while performing shiatsu or yoga. Stress dissipated and participants felt a direct effect on their overall wellbeing.

Female participants and facilitators recommended an increase of the number of yoga and shiatsu classes in the MHP circles. Furthermore, participants wished to do more general body workout and include swimming in the program.

"Shiatsu exercises are not difficult. I can do it at home. I can introduce it to my family and we can practice it together. It is harmonious. I feel merciful afterwards. I have a good feeling afterwards" (C3).

"I really liked shiatsu, because it makes such a harmony in the body. In our culture, those kind of massages are not really liked and it is not often recommended" (C1).

"Massage was only for women. It is inspiring. I felt relaxed and cheerful afterwards. I have tried it and my wellbeing improved enormously" (B3).

"I didn't feel very well, but with yoga I felt very well. It was good for me because I suffer from lots of problems and with yoga I maintain a good feeling" (B1).

Other key topics

In addition, the sessions regarding intrusive images and concerns counted towards the most favourite topics. The sessions included exercises such as sorting out concerns and categorization of problems as well as controlling one's thoughts.

"In the beginning, I was very tired and sick. That's why I like exercises, where you learn to leave problems behind, to start a new life and to build up a new future" (E3).
"I like that exercise, where you fix a point and you put all your concentration on this point. Then you forget your problems" (E3).

Two out of three men suggested the invitation of specialists such as clinicians or trauma therapists to hold lectures. In contrast, one participant suggested having less theory. Women preferred yoga and shiatsu, while men expressed the importance of exercises to regain control over their thoughts.

Other favourable topics included learning about individual resources, sleeping hygiene, stress management, and creative sessions as well as information about chronic diseases and depression. Resource-oriented and positive-thinking exercises were mostly mentioned by participants with a shorter stay in Austria. One man drew attention to the art and creativity sessions.

"Sometimes we cannot speak, but by hand we can express" (E2).
"I have absorbed many new information, for example, how the family can enrichen us or how I can see what the family gives us. Here, I don't refer to money, but to strength and resources" (E4).
"First, I was sad, introverted and isolated. Once I started with the health circle, we received information and learnt what we can do if we are depressed, like going into nature for example. It helped me a lot" (E1).

Facilitators' point of view

The participants' feedback about their preferred topics, tools and methods corresponded with facilitators' observations. Some facilitators also mentioned their personal favourite topics, such as healthy lifestyle, relaxation exercises or resource-oriented exercises. Two facilitators explained the importance of ongoing self-training. Due to the wide array of topics, it is important that facilitators possess a solid knowledge about each of them.

Least preferred topics

The program participants didn’t list any least preferred topics with the explanation that there weren’t any.

Facilitators’ point of view

Facilitators didn’t observe any least preferred topics among participants. Moreover, facilitators had the impression that participants enjoyed the large variety of topics.

By contrast, there were several topics that facilitators found to be challenging for themselves. The challenging topics included female genital mutilation, psychosocial needs of men and women, and religion. Here, the opinions differed widely among participants and discussions demanded special attention from facilitators in order to maintain the group dynamic. Some women understood female genital mutilation as an important cultural part of their lives. By contrast, others viewed this topic as discriminatory toward women, traumatizing, and life threatening.

“If we talk about female genital mutilation, it becomes challenging. It’s a health topic. But they don’t like it.” (A3).

The facilitators found the discussions about religion challenging due to the diverse religious background and knowledge among participants and facilitators. The topic of mental health was devalued by participants during some group discussions, as as mental health wasn't considered to be important in their religion. Facilitators with less religious knowledge didn’t feel comfortable during these discussions.

„*Some of them were sceptical and say that things are not true or that doesn’t exist in our religion or that the religion delivers different information. Those discussions were tough ones. Because religion is such a broad topic” (A4).*

Other challenging topics for facilitators included discussions about women’s and men’s psychosocial needs and gender roles. Some women placed men on a higher level than themselves and thought that men and their psychosocial needs were more important than that of women. Alternatively, some women thought that women and men held an equally important status.

In general, women enjoyed discussing their psychosocial wellbeing during sessions, while men seemed to be more reserved. The male facilitator explained that mental health is a taboo for men.

The Afghan facilitator found it important to include sexual and reproductive health in the program's content. The majority of Afghan women seem to have little women's-health-related knowledge. This included health awareness about preventive gynaecological screenings or family planning. The Chechen and Somali facilitators didn't identify the need for including this topic into the program, as they perceived that Chechen and Somali women possess a solid knowledge about the topic.

However, all four facilitators recommended including chronic diseases in the program. Furthermore, facilitators found the framework for sessions' content (annex 1) to be very helpful. This framework was developed in a team workshop in September 2019 and served as a guide for all ongoing MHP circles. Despite this, the flexibility to adapt to the needs of the participants remained.

b. Structure

Program participants and facilitators shared opinions, feedback, and suggestions in terms of the program's time, length and location.

Accessibility

Time

*A*ll sessions were required to end by 5 pm as the CORE integration centre reduced its opening hours. Half of the participants thought that the time of their MHP circle was convenient, although some participants preferred to have it later in the afternoon. One participant of circle 9 didn't appreciate that she had to decide between MHP circle and German classes, as both activities coincided. Another participant and facilitator recommended that MHP circles should not be organized during school holidays or Ramadan.

Duration of sessions and MHP circles

67% of interviewed participants would have preferred to have longer sessions. Several participants also recommended ongoing MHP circles or the provision of more frequent or ongoing sessions in general.

Location

Most participants found the locations to be suitable for the program. Both locations were known by the majority of participants beforehand. Perchtoldsdorf was in the outskirts of Vienna therefore one participant suggested offering the program for men in Vienna's city centre, as well.

Facilitators' point of view

Three out of the four facilitators provided the MHP circles in the CORE integration centre. As the location closed earlier than in the past, the circles had to begin earlier in the afternoon. The facilitators struggled to be on time and some participants were unable to be punctual, because they had to pick up their children from school.

Facilitators agreed with participants that longer sessions would be more beneficial, especially due to the fact that occasionally deep discussion about certain topics would take longer than expected. However, with the new opening hours, facilitators felt pressured to provide the two-hour session, clean up the room and leave the location on time, which caused further stress.

The Chechen facilitator recommended a location closer to the Chechen district in Vienna. However, the Chechen participants didn't necessarily agree, as they found the CORE integration centre to be accessible.

Cultural needs and barriers

Women and men expressed different cultural needs, while potential barriers for attendance were similar among women and men.

Gender-sensitivity

Half of the interviewees explicitly favoured offering MHP circles for women and men separately. Separation of women and men was recommended by two women and two men who participated in circle 9. These men believed that women would feel uncomfortable in the mixed group. Additionally, another two Chechen women who participated in an exclusively female group pointed out the importance of holding all-female groups. Men didn't report having a preference of men-only groups. One participant of a women's group explained:

"*Men would have been also welcomed to join, however, there weren't any. But we appreciate that there are no men, especially if a person is not used to talk about problems easily. The women in our society have been particularly suppressed, that's why I am even happier that there is something now, where women get supported" (C1).*

Particularly, yoga sessions weren't offered in the mixed group. It was only provided to the women of the group.

Facilitators` point of view

Facilitators preferred to provide MHP circles in separate women's and men's groups. Circle 9 was an exception due to being a mixed sex group. In some cultures, it is not appropriate for women to do exercises in the presence of men, based on what facilitators recommended. Despite the facilitators not offering body workout in the mixed groups, other topics could be better discussed in the single-sex groups, as some topics were women- or men-specific.

Language

Participants appreciated that the program was provided in their first language. However, two participants would have preferred the MHP sessions to be in German language or to include German lessons in the program. Participants were eager practice German language at any given opportunity. Moreover, participants preferred not to have more than one first language in each circle to avoid spending too much time translating the content into numerous languages.

"And it is additional stress if I hear German language everywhere. In that case I prefer sometimes to only speak my first language" (C3).

The majority of reasons for missing a session included doctors' appointments, appointments at the employment office, poor health, child care, German classes, timing, or school holidays.

Facilitators point of view

Facilitators agreed that the provision of the program in the participants' first language was of added value. They found it especially important that participants could express their feelings, worries or problems in their first language. By contrast, facilitators thought that there should not be more than one native language spoken within an MHP circle. This was due to the fact that the translation into several languages was time consuming during the sessions.

6.1.4 Effectiveness of MHP

The theme "*program's effectiveness*" includes the categories *group* and *skills*, which are presented in the following subchapters.

a. Group

The majority of study participants reflected on the positive effect of being in the group setting. Two identified key categories were the learning effect and the effect of the social network on wellbeing.

Learning experience

Representatives of all MHP circles discussed the learning effect of the group based intervention.

" It is better to be together. That is great. I have an idea, then another person has another idea and another person has another idea. Together we have a super idea. We can learn from each other and from the experiences of others" (E2).

"I am happy that I can interact with women who are already here for a long time. Those women took initiatives for changes and didn't just stay at home. And I am learning from them how I can live a good life in Austria" (C3).

Facilitators` point of view

Every facilitator observed the positive effect of the group on participants. Participants learnt different skills from each other, such as, how to approach dealing with certain problems. While they would discuss certain problems in the group, participants would ask each other how they would deal with a specific problem. It appeared that they followed recommendations and advice from other participants.

Social network

Three-quarters of participants highlighted the positive effect of the social network on their overall wellbeing. Through the MHP program, they belonged to a group of people who spoke the same first language, came from a similar geographical area and shared similar experiences. Chechen and Somali participants expressed the need for being with women who speak the same first language. The Farsi-speaking study participants didn't express the need to live among others of their own culture and society. However, they didn't experience the cultural effect during the intervention, as their group was a mixture of women and men of different nationalities. Still, the women found it important to have women groups.

"For me, it's not just a health circle, but also psychological care. Simply, because here I can open up. Everybody suffers from different problems, but in the end the problems are somehow the same. And we are from a similar cultural background with similar problems" (C1).

One participant mentioned that she felt sceptical and doubtful about joining a group of women from the same country of origin. Coming from similar geographical areas and speaking the same mother tongue could be a motivational factor, but it could also serve as a barrier. The woman had a fear of being misunderstood by others. However, she understood that she could trust the group and benefited from being among people from the same cultural background.

"A reason why I didn't want to participate in the beginning was that our society is very introverted. We don't share many things about ourselves. There is this anxiety, that things could be misunderstood and people could talk bad about oneself. That

could damage one`s reputation. That's why we are cautious. That could be a reason why some people don't want to participate" (C1).

"It is the first program, where our people meet. It is the first time within 15 years, that I discover such a group, where our people meet and speak about such things. I liked it so much, that all of us are coming together here. Also, stress and worries were taken away by listening in sessions. While listening to others, you realize that others also do have worries" (C2).

"In addition I do have psychotherapy. But the effect of the group based program is different. In the group it`s nicer, because it is among our people. You feel more connected with the others" (C3).

The same groups of people allowed participants to normalize their problems and situations, learn from each other and be socially included. Participants of the group with the mixed countries of origin in circle 9 didn't focus on the cultural aspect as in other groups.

Facilitators` point of view

Facilitators observed that participants appreciated the new social contacts formed from the MHP groups. Some of them continued meeting each other even after the MHP circles ended. Facilitators noticed that participants expressed themselves openly during the program and seemed to have trust in the other participants of the groups.

"I have lots of experiences. If you are in psychiatric care, then the therapist is asking you many questions. But that's sometimes difficult if you are already burdened. Mental health disorders are not easy to heal. But if you feel understood, get the feeling of peace of mind and confidence and you develop relationships with people who care about you, then it is easier to recover and to feel better" (A3).

The facilitator also explained:

Psych hygiene and self-care is also important. It`s is also important to put some borders. That's also important for the women, because if they see me as best friend, I can`t help them in the best way. But if they see me as facilitator, it works much better" (A3).

b. Skills

The following findings will present newly acquired learnt skills and the application of the tools for living daily life.

New skills

Participants stated that the ability to categorize problems, sort out concerns, normalise problems, and cope with stress were among the most important lessons learnt.

"My new skill is, that I don't keep problems anymore for myself. I open up. It helped me. I can't say that now all the problems are solved. However, if I compare for example how I handled stressful situations in the past and how I cope with stress now, I can say that the MHP circle helped me" (C1).

"The trainer and the exercises helped me. First, I was depressive and tired and now it is much better. Because I experience a different feeling than before" (E1).

"We have learnt to categorize problems. If you have problems in my home country, you keep problems away. You can't talk about them. You have to accept; you can't talk about it. It's just like this. In the past, I overreacted immediately and became easily angry, but now I can better categorize my problems and can control myself in a more effective way" (B1).

"Categorizing problems. To leave the problems behind and to understand, which problems you can solve and which one you can't solve, further which problem is complex and which ones is not complex. That's very helpful. I learnt how to handle stressful situations how to find solutions for problems" (E4).

"I suffered from lots of stress and anxiety. When I talked to the facilitator about my problems, she gave me some exercises for homework. I completed all of them and started to understand my problem. That's very good" (D1).

They gained self-efficacy, became more self-confident, strengthened self-awareness and self-perception, learnt how to relax and gained emotional stability and self-confidence. Furthermore, they learned to open up and empowered themselves.

“I have always been diffident, shy and unsecure. I had doubts about everything. Here, I could open up a lot and became extroverted. The course helped me to become social and unreserved” (C1).

“I have learnt how to have to trust. To have trust in myself” (D1).

“I have learnt how to make a plan for life. How can I continue with life? We start from zero. How can I continue without help from others? How can I arrange my future?” (E4).

All study participants felt, that the learnt coping mechanisms were helpful for dealing with stress. Half of them noted body workout as an important tool specifically for stress management.

“The MHP circle helped me to cope with stress” (D2).

One woman stated that she had too many problems for the program to be able to fully assist her with addressing. However, this participant also described how the program sessions helped to distract her and disconnect herself from thoughts and handle stressful situations.

Application of tools

Participants were invited to reflect on the newly learnt tools they were applying at home, as they were attributed to program participation. Among all study participants, there were differences observed among both genders, refugees with various lengths of stay in Austria, and participants with psychosocial needs. *“When I am worried, I am practicing newly learnt things at home. I recall what the facilitators advised us and then I become calmer” (C2).*

Almost half of all participants were committed to body workout such as shiatsu/massage or yoga at home. Primarily women engaged in shiatsu and yoga.It was not offered to men.

“*The program helped me a lot to cope with stress. If I have stress now, I remember at home what we have learnt in the course. And then I am doing, for example, shiatsu” (C3).*

Relaxation techniques such as tipping and breathing exercises were practiced by both sexes. A quarter of participants, mainly men, incorporated exercises for controlling and directing their thoughts and emotions into their daily life. Such

exercises included, for example, safe place or favourite place and sleeping exercises.

“My wife is in a similar situation. We are performing the exercises together, breathing exercises and safe place” (E1).

The categorisation of problems and use of special communication techniques were applied in daily routine.

“Certain communicating strategies are helpful to reduce stress. But it is not just helpful in stress situations, but also in daily life, like in child care or in the relationship. I have learnt to open up” (C3).

The majority of participants residing in Austria for less than 3.5 years spent time at home for positive thinking and resource-oriented exercises. Examples of such exercises included how to live a happy life in a foreign country, make a life plan, or leave problems behind.

“I practice at home how I can live healthily and how I can live a happy life in a foreign country. It encourages me to focus on how to be happy. The time of the program was a very important and precious time. The MHP session appointments were always my priority” (E1).

Some participants explained that occasionally they were assigned homework by the facilitators and found it motivating to practice these exercises at home. A third of participants practised exercises at home together with their children or partner.

Facilitators’ point of view

Two facilitators mentioned that giving homework to participants helped them with remembering exercises more easily. The homework included exercises that were easy to apply at home.

6.2 Findings of quantitative data analysis

The following chapter will present the quantitative data analysis. Any indications for possible correlations or differences between the countries of origin and their associated satisfaction scores will serve to answer the specific objective.

6.2.1. Descriptive analyses

As shown in table 10, the total 43 feedback forms were answered by 19 (44.2%) Afghan participants, 13 (30.2%) Somali participants and 11 (25.6%) Russian (Chechen) participants.

Table 10: Feedback forms per country of origin

Country of origin	N	Percentage
Afghanistan	19	44.2
Somalia	13	30.2
Russian federation (Chechen Republic)	11	25.6
Total	43	100

The feedback questionnaires were conducted at the end of the MHP circles which took place in October 2018, July 2019, August 2019, and October 2019. Most of the participants (30.2%) were surveyed in October 2019 and 20.9% of the participants received the questionnaire in October 2018. 23.3% were surveyed in July 2019 and 25.6% in August 2019. Table 11 illustrates the number of answers and no answers per question.

Table 11: Number of answers and no answers per questions

	Answers		No answers	
	N	%	N	%
Q1: new, useful knowledge	43	100,0	0	0,0
Q2: tried out at home	42	97,7	1	2,3
Q3: comfortable group	42	97,7	1	2,3
Q4: felt understood by facilitators	40	93,0	3	7,0
Q5: some uncomfortable topics	37	86,0	6	14,0
Q6: will further recommend it	41	95,3	2	4,7

Differences on the evaluation of the MHP program by participants' country of origin

To examine a difference in satisfaction levels among countries of origin, a Kruskal-Wallis test was applied. The Kruskal-Wallis test was used instead of ANOVA, as the requirement of distribution of normality and homogeneity of variance (annex 8) was violated (38).

No significant difference was found between the 3 groups regarding questions 1,2,3,4,6 and the total satisfaction. However, the results of the Kruskal-Wallis H test showed that there was a statistically significant difference in the satisfaction score between the different groups in reference to question 5: $\chi2(2) = 8.833$, $p = .012$, $df=2$, with a mean rank satisfaction score of 23.34 for Afghan, 16.06 for Somali and 13.10 for Russian (Chechen) participants (annex 8). In question 5, participants were asked if there were any uncomfortable topics included in the program.

In the next step pair-wise comparisons (Afghan/Chechen, Chechen/Somali, Somali/Afghan) were made using Mann-Whitney-U test in order to assess which countries of origin differ significantly in their evaluation of question 5. The calculation of the Mann-Whitney U-test revealed a statistically significant difference between the participants from Afghanistan and the Russian federation (Chechen Republic) regarding question 5 ($U= 47$, $p = .027$) (annex 8). Afghan participants tended to express a higher degree of satisfaction in reference to question 5 about uncomfortable topics than Russian (Chechen) participants.

6.2.2. Thematic content analyses

The feedback form included a narrative component in questions 2, 5, 7, 8, 9 and 10, which are explored below. Feedback forms were only available in German; therefore, several participants needed assistance for oral interpretation or written translation.

Application of tools

35% described the types of exercises that they practiced at home in the narrative section. More specifically, 14% continued doing yoga, swimming, general sport, or shiatsu/massage. 10% practiced relaxation exercises at home by doing breathing exercises and exercises targeting stress. Participants also incorporated positive thinking, a healthy lifestyle and playing games into their daily life.

Favourite topics

In contrast to uncomfortable topics, the majority of the studied group mentioned having a number of favourite topics. 35% participants had a preference for group dynamic and group-setting. This included meeting new people, making friends, belonging to a group, sharing with others and being able to open up among the group. Shiatsu (30%) and stress management (28%) were ranked second and third place. The category health and disease (21%) included information about depression and disease prevention, as well as how to live a healthy life. Relaxation exercises, yoga, outdoor activities and sport were additionally preferred by 19% of participants.

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Table 12: Favourite methods, tools and topics
extracted from the feedback forms completed by female participants

	Content	N	%
1	Group	15	35%
2	Shiatsu	13	30%
3	Stress	12	28%
4	Health	9	21%
5	Relaxation exercises	8	19%
	Yoga	8	19%
	Outdoor activities	8	19%
	Sport	8	19%
7	Positive energy	5	12%
8	Learning new things	4	9%
9	Controlling thoughts	3	7%
10	Female genital mutilation	2	5%
10	Games	2	5%
10	Facilitators	2	5%
11	Resources	1	2%
11	Parents table	1	2%
11	Content of the program	1	2%

Participants' recommendations

Participants' recommendations on existing topics

26% of participants recommended doing more yoga and shiatsu. Yoga was offered exclusively to female participants. 7% recommended doing more outdoor activities. Other recommendations included doing more general exercises and body workouts.

Participants' recommendations on new topics

14% of participants recommended including swimming in the program. The majority of recommendations for swimming were made by Afghan participants, while the other recommendations were provided by people of any other countries of origin. Other recommendations were to have longer sessions and include topics about women's health into the programs content.

Participants' recommendations to others

The majority of participants shared information obtained from the program with their partners, mothers, families, children, and friends. The participants shared information with these individuals regarding yoga, outdoor activities and shiatsu and that they felt comfortable doing it. Furthermore, participants shared that they learned many things, and that the MHP circle was helpful for regaining control and living a healthy lifestyle. Some participants answered question 9 only with a yes.

Satisfaction

On question 10, 47% gave additional feedback about program satisfaction. They appreciated the nice and positive atmosphere which participants attributed to the friendly and motivating facilitators. Participants felt understood by facilitators. In general, participants stated that they felt comfortable in the group. Some of them mentioned that they will miss the group and that they were pleased to have met new people. Moreover, participants appreciated the presentation of the program being in their first language. Every participant found the new tools and knowledge helpful for their lives. The majority tried out newly learnt methods and tools at home. They stated that they would recommend the MHP program to family and friends.

7. Discussion

In this chapter, the study findings of the qualitative and quantitative analysis are discussed to answer the research questions about the appropriateness, acceptance and effectiveness of AFYA's MHP program. Afterwards, specific recommendations on the MHP program`s concept are discussed. The chapter will conclude with study limitations.

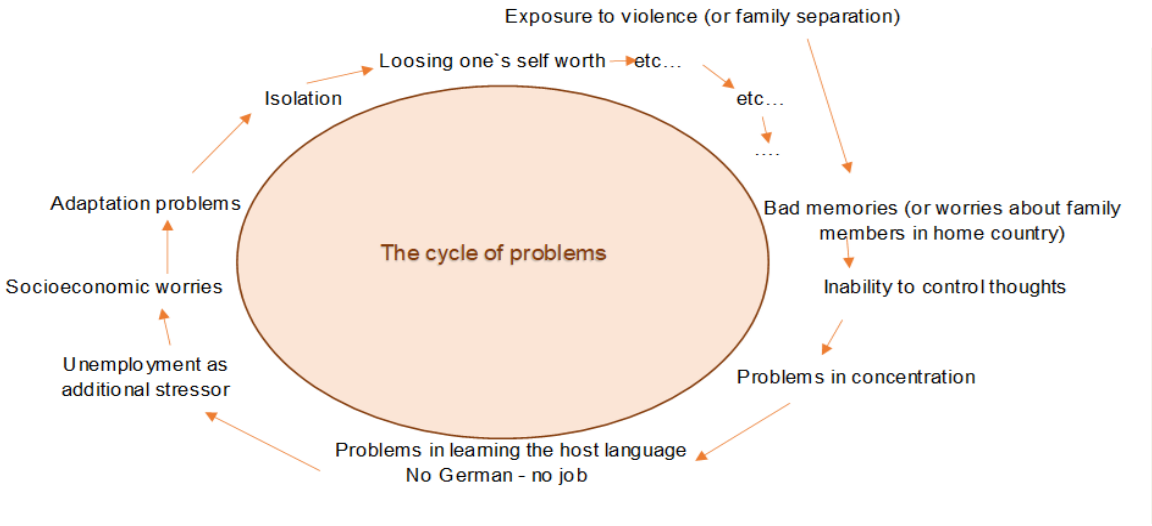
7.1 Discussion of study findings

Summary of findings

Study participants carry their individual stories and experiences throughout their migration trajectory. However, their refugee status in Austria is what they each had in common. During the interviews, participants were asked to complete a retrospective self-assessment regarding their psychosocial wellbeing prior to participating in the program. These results corroborate the findings of numerous other research and projects geared to gain understanding of mental health among refugees and migrants.

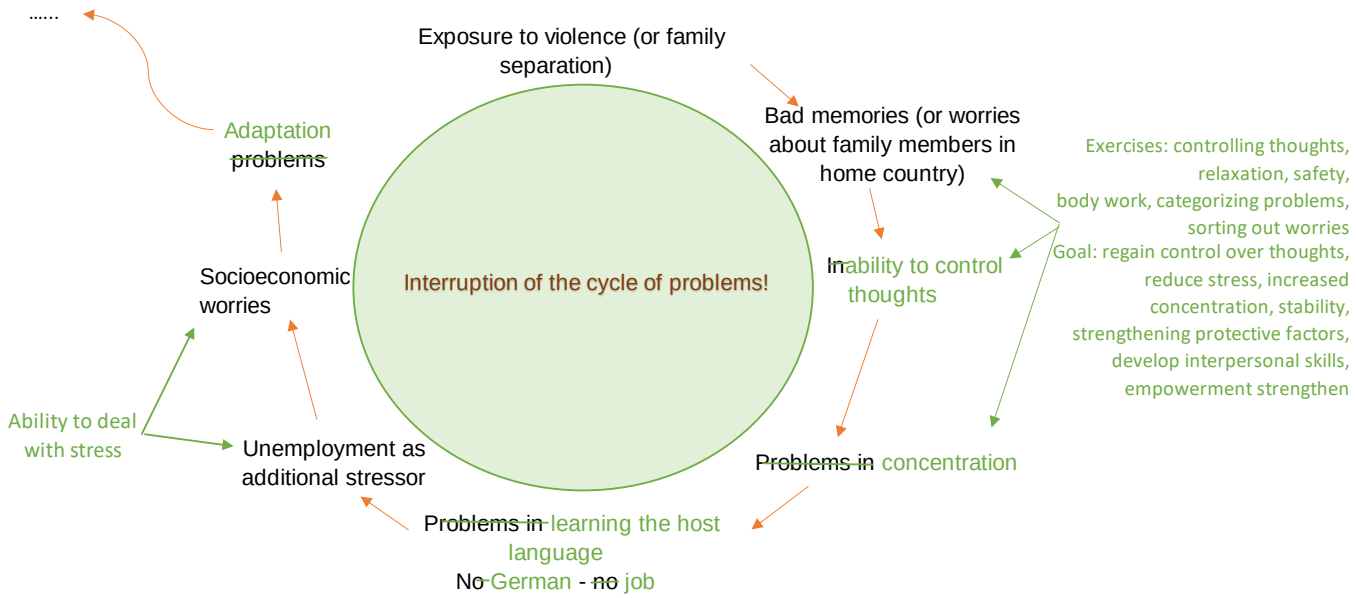
As illustrated below in figure 3 in reference to study findings, a psychosocial stressor can cause a variety of difficulties and refugees and migrants might find themselves in a cycle of these problems. The cause of their difficulties may have already occurred in the home country. One problem leads to several other problems. For example, when a refugee is exposed to violence and flees to a safer country, intrusive memories and concerns about the family remaining in the home country may occupy the person's thoughts. This person may lose control over his or her own thoughts, which may further lead to concentration problems. These concentration issues may represent a barrier to learn the host language. Without speaking the host language, such as advanced German, it may be more challenging to find a job. Unemployment can exacerbate socioeconomic concerns. Socioeconomic concerns may include incapability of adapting to daily life in Austria. Acculturation problems may lead to social isolation. Being unemployed and socially excluded may affect one's self-worth. And the spiral continues.

Figure 3: The cycle of problems in reference to the study findings



The study findings demonstrate that different kinds of stressors and mental symptoms can still be present years after arriving in the host country (8) (10). With the provision of MHP, the cycle of problems (figure 3) could be interrupted, as visualized below in figure 4. The study findings are used to illustrate that AFYA's MHP intervention could assist in tackling participants' stressors and daily life challenges at various levels with various methods and tools.

Figure 4: The interruption of the cycle of problems in reference to the study findings



Intrusive memories during the post-migration period may be addressed through various specific exercises. For example, the safe place exercise fosters the feeling of

personal safety, which some refugees may have lost during their migration trajectory. Participants' self-efficacy was improved and they regained control over their own thinking. Interestingly, male participants emphasized different exercises for regaining control over conscious thoughts. Exercises for learning how to categorize problems may assist in sorting out concerns. Furthermore, it could help with understanding which problems may be actively tackled by the participant and which ones are beyond control. A normalisation of certain problems naturally occurred as participants realized that others faced similar daily life challenges. Women participants underscored the beneficial effects of yoga and shiatsu, including the release of tension through general working out. Also, relaxation techniques such as breathing exercises helped to reduce participants' stress levels and emotional stability was reported. Various specific exercises helped foster the ability to concentrate. Literature findings depict that diversification of methods and utilization of a group-setting contributes to improved attentiveness and capability to learn for refugees with concentration difficulties or intrusive memories (40). AFYA's diverse offer in the program seemed to represent an added value. For example, one participant highlighted the benefit of creative sessions, as it offered the possibility to express emotions by hand as opposed to verbally. This is in line with the literature that argues that creativity can be used to express unpleasant memories (40). Increased concentration may further support learning the host language German. On one hand, speaking the host language empowers refugees and migrants; on the other hand, it is necessary for applying to jobs. Finding a job may reduce socioeconomic concerns. To a greater extent, it may foster social inclusion. The feeling of being socially included may increase one's self-worth and be supportive of the adaptation process. Based on figure 4, it can be inferred that with MHP interventions the cycle of problems could be interrupted at various levels.

Furthermore, study findings support the importance of overall wellbeing during the post-migration period. This is consistent with the findings of a previous survey conducted with 3.950 refugees from Somalia, Iran, Iraq and Afghanistan living in the Netherlands. In the study, the overall wellbeing played an important role in adaptation and socioeconomic integration (41). Studies illustrate that post-migration life conditions may play an important role in how pre-migration experiences influence a person's wellbeing. This is reinforced by a long-term study about refugees from former Yugoslavia, who lived in general good conditions following migration. Mood-related

disorders gradually decreased in those refugees (42). A registry-based study with 518 Syrian refugees in Germany also concluded that positive conditions in the post-migration period can serve as protective factors for refugees (43).

Appropriateness

One of the research questions in this study sought to determine the program's appropriateness in terms of meeting the perceived psychosocial needs of study participants. The interviews offered insight into participants' program expectations. The expectations of several participants were satisfied, while for others the program went beyond their expectations. It is also noteworthy that no participant expressed any sign of disappointment regarding the program's content.

Additionally, qualitative data contributed to a better understanding of AFYA's communication strategy. Interview findings support literature findings which propose to include the word men in communication material for the male population. Men appear to give more attention to interventions that are men-focused and provided by male facilitators (41). During the study phase, AFYA modified the name of the program for men groups to men's cay (men's tea). Literature findings do not explicitly suggest the same method for engaging female participants. However, qualitative study findings propose that the inclusion of the word *women* in AFYA's advertising material could be appealing for women. This is supported by the finding that women found the female groups important.

On one side, the wording for both sexes should transmit an idea about what the program is – a mental health promotion program. On the other side, the fact that the word *mental health* can be stigmatizing and represent a barrier for participation must be considered. Literature findings describe the use of language to be critical for engaging participants in psychosocial programs (3). Furthermore, previous literature reported that psychosocial programs should be presented to the target group as anything other than psychosocial or mental health programs. This strategy functions to help avoid stigma toward mental health support (41). In addition, study findings from facilitator interviews demonstrated a lack of emphasis on the importance of mental health in some of the participants' religions. Therefore, future research questions that could be asked include the role of religion in enrolling in MHP programs.

Despite, study findings neither support the direct use of terms such as mental health nor present the program as something different than it is. This could bear the risk of fostering the wrong expectations. It was observed that the program`s name could create some confusions in reference to the program`s name “health circle”, as it doesn’t immediately indicate MHP. Study findings suggest creating program names that reflect the participants' psychosocial needs, such as social inclusion and community or social network for motivating potential participants to enrol into the program.

After enrolment, the first session appears to play a key role as a deciding point for further attendance. Despite this, participants felt that the program could address their needs after attending the first session.

During the pilot phase, only 25% of the total program participants were men. This is in accordance with the study findings outlining the challenges in motivating more men for program participation. The male facilitator's suggestion to establish smaller groups for men (2-3 participants) raises the question of its benefit. Considering the positive effect of the group-setting on study participants, the effect of small groups remains unanswered at this stage of understanding.

AFYA’s chosen cultural sensitivity and low-threshold approach may play an important role in participants’ decision to attend the MHP program. The low-threshold approach provides effortless, easy, and secure access for participation. This could point to the likelihood that there may be fewer barriers for enrolling in such programs than in specialized mental health interventions in individual settings.

Acceptance

Another research question in this study sought to determine to which degree the program's participants accepted the MHP tools and messages. Study findings indicate that facilitators and former participants played an important role in establishing new groups for MHP circles. Facilitators spoke the same first language and had experience in delivering key information about the program's content. Many potential program participants were derived from their social and professional networks. In addition to this, former participants recommended the program to family members, friends,

colleagues, or neighbours, many of whom enrolled in the program. Qualitative findings indicate that numerous participants learned about the program through facilitators or former participants. This underscored the importance of word of mouth propaganda in mobilizing the target group for program participation.

Moreover, it seems likely that the fact that all facilitators were immigrants themselves inspires trust. Previous research depicts that facilitators with a similar geographical background are familiar with the cultural history and context of participants. Therefore, they are more equipped to recognize the ways in which participants' express feelings and concerns (3). Applying a multiplicator model to AFYA's MHP program proved to be effective and well-accepted among study participants. Furthermore, sharing a mother tongue supported the formation of relationships between facilitators and participants. These findings are consistent with literature reviews demonstrating that culturally sensitive mental health programs could be more effective than interventions that are not culturally adapted (3). Based on the assumption that AFYA's facilitators may have experienced similar challenges and stressors as program participants during the post-migration period, they could be considered a model by program participants. Despite their individual migration experiences, facilitators have managed to build a new life in Austria. Facilitators' professionalism and fostering of a cheerful and motivating atmosphere were appreciated by participants.

Moreover, there were similarities between the expressed opinions, observations, experiences, and recommendations for improvement by program participants and those described by facilitators. However, their opinions regarding the least preferred or challenging topics differed widely. While participants didn't report having any least preferred topics, facilitators experienced discussions around religion, female genital mutilation, and the role of women and men and their psychosocial needs to be very challenging. Extensive discussions on such topics challenged facilitators and could jeopardize the group dynamic.

A data triangulation demonstrated that each study participant expressed satisfaction with the diverse offer of methods, tools and topics. They found it interesting and helpful for their lives. This study did not detect any significant differences between Afghan, Somali and Russian (Chechen) participants in their total satisfaction scores.

The results of quantitative data analysis demonstrated that predominantly Chechen participants identified uncomfortable topics in the program. The name “memories” was given as a specific narrative example for this topic. This could be because group discussions and listening to other participants’ stories could trigger negative memories and images. This quantitative finding is difficult to explain. However, it is important to bear in mind the potential mistakes or misunderstandings with regards to the completion of these responses. In fact, the 4 point Likert Scale order of this specific question was inversely compared to all other questions. Furthermore, the question remains as how participants were guided in completing the feedback forms.

In contrast to quantitative findings, qualitative data suggested no indication of uncomfortable topics experienced by Chechen participants. This could be due to the fact that participants may feel hesitant sharing such information during face to face interviews. Interviewees may feel more inclined to provide a socially acceptable answer than to give anonymous feedback on a satisfaction scale. Only one woman identified having a mixed-sex group in the program as being an uncomfortable situation.

Surprisingly it was reported by one Russian (Chechen) participant, that shiatsu is usually not much trusted in the Chechen culture. However, all Chechen participants noted shiatsu as their favourite tool. This finding may suggest that even if certain tools and methods are new and initially viewed with scepticism they can be accepted and appropriate.

Another suggestion could be to consider offering yoga, stretching or other similar exercises to male participants. While reviewing the literature, information was obtained regarding the benefit of yoga in promoting self-awareness and mindfulness. It bolsters stress relief, focusing on the present moment, and the development of curiosity and tolerance towards emotions. In addition, it strengthens self-confidence and the relationship with one’s own body (38). Qualitative findings showed that men particularly felt stress due to excessive thinking. Practices such as yoga, meditation or mindfulness exercises could encourage a distraction from ongoing thinking about the past and future. There is room for further progress in determining the acceptance and effectiveness of mindfulness exercises among the diverse target group.

Effectiveness

The present study was designed to assess the effectiveness of AFYA's intercultural MHP program. With the provision of MHP, participants developed interpersonal skills, stress coping mechanisms, and improved resilience. Participants reported a beneficial effect on their overall wellbeing. Data triangulation shows that after attending the program, participants felt more prepared to cope with stress. Furthermore, qualitative findings indicate that protective factors described in previous literature reviews as well as social networks, social inclusion, and self-efficacy (5), got strengthened.

An important study finding explores the reported beneficial effect of the group-setting. This supports literature findings, in which non-Western cultures are described to be more group-oriented (18). Additionally, the group-effect is reported to play a crucial role in addressing the psychosocial needs for social inclusion and normalisation of problems (18)(44). This is in line with an interesting qualitative finding, in which a participant joined a group-based volunteer program with the sole purpose of being a member of a group and meeting new people.

Furthermore, other literature mentions that the cultural aspect of group composition plays a fundamental role in coping with stress (18). It is worth mentioned that a Russian (Chechen) participant experienced the group-setting with people from the same country to be an initial barrier for participation. However, this barrier was overcome and the woman ultimately felt comfortable in the group. This feeling of fear was also discovered by an Austrian study about posttraumatic stress in asylum seekers from Chechnya, Afghanistan, and West Africa in 2004. It was found that Chechens tend to be more suspicious and fear being misunderstood among compatriots. Another finding of the aforementioned study depicted that Chechen asylum seekers emphasized the importance of being among people of the same cultural background and mother tongue in order to reduce the feeling loneliness (18). Furthermore, a Norwegian survey study involving 101 Somali refugees noted that social support and sharing problems with social contacts represented helpful mechanisms to cope with depressive symptoms (44). This is why it is important to overcome any initial feelings of fear in order to experience the notable benefit of the group. In reference to the findings regarding the group effect, we found that

occasionally bringing participants together from the diverse MHP groups would be beneficial.

The New African Football Association (NAFA) is an Austrian integrative sports association that brings together a diverse group of refugees, migrants and Austrian nationals to engage in intercultural sports activities. The problem with many diverse languages being spoken was overcome by making German the official association language. For encouragement, German language courses were provided prior to the sports activities (11).

The various types of body workout represent the most favourite tool among women in quantitative findings. Data triangulation in qualitative findings indicate a beneficial effect of body workout on participants' overall wellbeing and capability to cope with stress. An extensive amount of literature has been published on promoting mental health through physical exercises. A recent study conducted by Utrecht University in the Netherlands with refugees living in a reception centre concluded that bodywork fosters distraction from intrusive memories and thoughts and supports the sense of belonging to a group (45). Furthermore, bodywork can encourage acculturation, adaptation, integration, and social inclusion (46). Participants and facilitators expressed a wish to increase the number of body workouts in the MHP circles. However, the effectiveness of increased body workout remains unanswered at present.

7.2 Recommendations

Shift to salutogenesis

Post-migration daily life stressors have an impact on overall wellbeing. Furthermore, study findings showed that overall wellbeing played an important role in the ability to tackle daily life challenges.

Despite Austria experiencing one of Europe's highest influx of refugees in 2015, a similar MHP intervention has not yet been offered in Austria. Moreover, the conditions of asylum or prolonged asylum processes can increase the risk factors for developing mental disorders. These conditions are also counterproductive for proper adaptation of refugees and migrants.

AFYA's focused, non-specialized MHP program with its salutogenic approach can be preventive or complementary to specialised care such as psychotherapy. Despite individual stress levels, 100% of study participants felt more prepared by the intercultural MHP program to cope with stress and to tackle daily life challenges. Additionally, it can strengthen one's overall wellbeing, as the focus is on developing interpersonal skills. This empowerment gave them the ability to regain control over their lives.

The program demonstrated a salutogenetic approach, rather than pathogenic, where one would concentrate on treating symptoms only. Here resilience, resources, and empowerment are in the centre of attention in regards to supporting refugees and migrants in host countries. This is supported by qualitative literature findings, which demonstrate that study participants sympathized with resource-oriented exercises. As described in the literature, a person's social and personal resources can impact the ability to adapt and cope with different situations and attain wellbeing (4).

Study findings suggest that prevention or sufficient reduction of risk factors for the development of mental disorders is not enough. Promotion and strengthening protective factors are essential in order to move across the illness-wellness continuum. It is encouraging to compare study findings with Antonovsky's (1987) image of the river, which illustrates that an individual's protective factor must be strengthened by learning how to swim instead of simply avoiding the risk of falling into the river (27) (p. 194).

Most studies focus on specialized mental health interventions and treatment for mental health disorders with a specific focus on potentially traumatic experiences prior to migration. Research in focused, non-specialized support through intercultural MHP in the post-migration period in host countries remains limited.

Standards versus flexibility

Interview observations refer to personal favourite methods, tools and topics among facilitators. One question is, in what way facilitators' appreciations of certain methods, tools and topics contribute to their effectiveness on program participants. Further, it raises the question to what extent it is crucial that facilitators identify with all the provided methods, tools and topics.

In September 2019, a standard content for each module was defined (annex 1). Despite the framework standards, certain flexibility remained with facilitators to respond to the specific needs of each group. An observation of little knowledge about basic women health care was only made in the Afghan women's group. The other facilitators wouldn't find it appropriate to include such basic health topics in the program. That leads to the question of how feasible it is to standardise the modules. The balance between facilitators' personal preferences on methods, tools and topics, the wish for standards and the culture-, or group-specific needs will need further observation.

Application of new tools

The study findings indicate a possible correlation between participants' personal needs and the application of newly learnt tools in daily life. Participants continue to practice these newly learnt tools at home, which increase the necessary skills to be able to cope with personal stressors and meet their psychosocial needs. For example, a particular female participant felt stressed due to child care burdens. Her favourite topic was discussions and information about child care. She reported having gained communication skills that she applied at home in her family life and childcare. Another example includes the experience of a participant's distress caused by intrusive memories. The participant felt the need to regain control over his thoughts and practised the safe place exercise with a family member to distract himself from intrusive memories. It is also worth noting that by practicing exercises with family members and friends, AFYA`s MHP program reached out to more than the intended audience.

Under certain assumptions, practising these exercises could be construed as a response to perceived psychosocial needs. Participants recognized a positive change in their wellbeing which they attributed to participation in the program. Moreover, participants shared certain exercises with their family and friends. Future research on participants' application of tools could expand the understanding of factors influencing the application of newly learnt tools in daily life.

Cultural sensitivity

At the end of each MHP circle, facilitators distributed German feedback forms to participants. Occasionally, participants required assistance with oral or written translation from facilitators. In addition to this, it could be difficult to provide confidentiality to potentially illiterate participants. Moreover, the fact that some questions with narrative components were only answered with a yes could lead to the assumption that participants didn't understand the correct meaning of the question at hand. The program's culturally sensitive approach could be strengthened by offering feedback questionnaires in the respective first languages of participants.

Recommendations for future research

- To explore the effects of yoga and other mindfulness exercises on men.
- To conduct additional qualitative research on culturally sensitive and gender-specific program names for the MHP circles. This could explain which terms motivate women and men to participate.
- To identify ways to motivate more men to participate in the MHP program.
- To continue to explore the effectiveness of MHP on refugees and migrants in the post-migration period. A larger sample size would allow more exploration of cross-cultural differences.

Recommendations to AFYA NGO

Content, tools and methods

- To give special attention to the first session. Also, to discuss the content of the program at the first session in order to ensure ongoing attendance.
- To begin and end sessions with yoga and shiatsu or other mindfulness exercises, regardless of gender.
- To include a minimum of one outdoor activity at each MHP circle.
- To offer joint outdoor activities or body exercises in German language with other MHP circles of different nationalities and local Austrian population to foster social inclusion and combat stigma.

- To invite specialists, such as trauma therapists or doctors for presentations on specific topics.
- To organize excursions to women's counselling centres and include women's health related topics for women's groups.

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Program structure

- To consider the continuation of ongoing MHP circles and increase the duration of each module to three hours in a location with more flexible and longer opening hours.
- To translate feedback forms to each participant's first language and revise feedback after each MHP circle.
- To collect pre- and post-data regarding psychosocial wellbeing and needs for comparative results.
- To open the MHP circles to women and men of more nationalities.
- To sensitize partners, the community, and health services about the effectiveness of a culturally sensitive MHP and the multiplicator model.

Recommendations on national level

- To utilize AFYA's program as a pilot model for MHP for refugees and migrants and expand the concept to other districts in Austria.
- To contribute to acceptable post-migration conditions for refugees and migrants by ensuring quality integration services and psychosocial interventions.

7.3 Limitations

The findings of this study must be considered in light of several limitations. Due to the small sample size and the non-homogenous constellation of the studied group, the findings can only provide indications and not be generalized.

Another limitation concerns the exclusion of asylum seekers, notwithstanding the fact that AFYA's MHP program is open to refugees and migrants of any legal status. Due to a lack of resources and the study purpose, it was decided not to include all of the target groups in the study. Only refugees with approved asylums were included in the study.

Furthermore, the number of interviews per nationality and MHP circle depended on willingness and availability of program participants. For example, Somali women were more hesitant to participate in the study. Therefore, only two Somali participants were successfully recruited for interviews.

It is also important to mention that due to the lack of available quantitative (secondary) data of male participants, the quantitative findings only represent women`s feedback.

The lack of baseline data on participants' psychosocial wellbeing or mental health status for pre- and post-intervention comparison posed as another limitation for the evaluation. Participants were asked to complete a retrospective self-assessment about their psychosocial wellbeing prior to program participation. This could have caused a recall bias.

In addition, various factors could have influenced the study findings. For example, the participants' educational background or information about their asylum processes were not explicitly asked during the interviews.

A major source of limitation was due to the involvement of six languages in the research process: Somali, Chechen, Arabic, and Farsi as mother tongues of participants, German as the official language of the country of study, and English as the official language of the student's master program in global health. Agreement on dates and times presented a challenge as several people were involved in the planning of the interview appointments. Additionally, this language limitation could present a translation bias. All interpreters had different levels of experience in translation. For example, one translator was a professional interpreter, while another had no previous experience before interpreting face to face interviews. Moreover, one interview was

conducted in German without a translator, as requested by the participant. The participant's level of German comprehension was advanced. However, for expressing certain emotions, the participant resorted to using google translator. This could have led to another translation bias. Cross-cultural differences in expressing psychosocial needs, feelings, and distress as well as the different ways of responding must be acknowledged.

Interviewer bias could have also influenced the study as interview participants perceived that the researcher was representing AFYA NGO. Program participants may have considered providing answers in favour of the NGO. Additionally, facilitators may have felt uncomfortable sharing sensitive information reflecting challenges in their work as program facilitators. Nevertheless, it should be noted that the researcher observed openness and a positive atmosphere during interviews.

8. Concluding remark

This research aimed to evaluate AFYA NGO's intercultural MHP program for distressed refugees and migrants in Vienna/Austria. Based on quantitative and qualitative data analysis, it can be concluded that AFYA's MHP program is appropriate, accepted and effective. The cultural sensitive, salutogenic and group-based program contributes to the overall wellbeing of the target group in the host country.

These key findings contribute to a broader understanding of the beneficial effect of intercultural MHP for refugees and migrants in their adaptation period in the host country. AFYA's professional network may benefit from the evaluation findings, too, as the study gives insight into the effectiveness of applying such a MHP multiplicator model in a Western country like Austria.

9. References

1. Cambridge University Press. Cambridge Business English Dictionary [Internet]. [cited 2019 Oct 10]. Available from: https://dictionary.cambridge.org/dictionary/english
2. UNHCR. Help Austria. Asylum in Austria [Internet]. 2019 [cited 2019 Oct 3]. Available from: https://help.unhcr.org/austria/asylum-in-austria/the-asylum-procedure/
3. Maercker A, Heim E, Kirmayer LJ, editors. Cultural Clinical Psychology and PTSD. Boston, Göttingen: Hogrefe Puplishing; 2019. 420 p.
4. World Health Organization. Health promotion for improved refugee and migrant health. Technical guidance [Internet]. Copenhagen; 2018 [cited 2019 Aug 20]. Available from: http://www.euro.who.int/en/publications/abstracts/health-promotion-for-improved-refugee-and-migrant-health-2018
5. Ballon D, Gamble N, Waller-Vintar J, CAMH. Best practice guidelines for mental health promotion programs: Refugees [Internet]. Centre for Addiction and Mental Health (CAMH). Toronto; 2012. Available from: http://www.multiculturalmentalhealth.ca/wp-content/uploads/2013/10/CAMH-Best-Practices-Refugees.pdf
6. IOM. International migration law. Glossary on migration. [Internet]. Geneva; 2019. Available from: https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf
7. Kohlenberger J, Buber-Ennser I, Rengs B. Refugee Health and Integration Survey. Psychosoziale Gesundheit und Gesundheitszugang von Gefluechteten in Oesterreich (Psychosocial health and health care access of refugees and migrants in Austria). [Internet]. Vienna; 2019. Available from: https://www.wu.ac.at/fileadmin/wu/h/press/Presse_2019/190109_WU_Projektbroschuere_ReHIS.pdf
8. Bäärnhielm S, Laban K, Schouler-Ocak M, Rousseau C, Kirmayer LJ. Mental health for refugees, asylum seekers and displaced persons: A call for a humanitarian agenda. Transcult Psychiatry. 2017;54(5–6):565–74.
9. Elbert T, Wilker S, Schauer M, Neuner F. Dissemination psychotherapeutischer Module für traumatisierte Geflüchtete: Erkenntnisse aus der Traumaarbeit in Krisen- und Kriegsregionen (Dissemination of psychotherapeutic modules for traumatized refugees: Findings from trauma work in crisis and war z. Nervenarzt. 2017;88(1):26–33.
10. Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J, et al. Common mental health problems in immigrants and refugees: General approach in primary care. Cmaj. 2011;183(12):959–67.
11. UNHCR-ERFEC. Facilitators and barriers: Refugee integration in Austria [Internet]. Austria; 2013. Available from: https://www.refworld.org/pdfid/5278dc644.pdf
12. Hassan G, Ventevogel P, Jefee-Bahloul H, Barkil-Oteo A, Kirmayer LJ. Mental health and psychosocial wellbeing of Syrians affected by armed conflict. Epidemiol Psychiatr Sci. 2016;25(2):129–41.
13. Koch T, Liedl A. STARK: Skills - Training zur Affektregulation - ein

kultursensibler Ansatz. Therapiemanual fuer Menschen mit Flucht- und Migrationshintergrund (STARK: skills - training for affect regulation - a culturally sensitive approach. Therapy manual). Muenchen: Schattauer; 2019. 201 p.

14. Ventevogel P, Schinina G, Strang A, Gagliato M, Juul Hansen L. Mental health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the move in Europe: A Multi-Agency Guidance note [Internet]. 2015. Available from: http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2016/mental-health-and-psychosocial-support-for-refugees,-asylum-seekers-and-migrants-on-the-move-in-europe.-a-multi-agency-guidance-note-2015
15. Hassija C, Cloitre M. STAIR Narrative Therapy: A Skills Focused Approach to Trauma-Related Distress. Curr Psychiatry Rev. 2015;11(3):172–9.
16. Gurieva S, Kinunen T. Adaptation or acculturation: that is the question. Atl Press. 2019;331:272–7.
17. Schwartz SJ, Zamboanga BL. Testing Berry's Model of Acculturation: A Confirmatory Latent Class Approach. Cult Divers Ethn Minor Psychol. 2008;14(4):275–85.
18. Wilson JP, So-kum Tang C. Cross-Cultural Assessment of Psychological Trauma and PTSD. International and cultural psychology. Wilson JP, So-kum Tang C, editors. New York: Springer; 2007. 405 p.
19. Fonds soziales Wien. Flüchtlinge, Asyl und Grundversorgung. Grafiken und Daten zu Wien, Österreich und der EU (refugees, asylum and basic care. Graphs and data about Vienna, Austria and EU) [Internet]. Vienna; 2019. Available from: https://fluechtlinge.wien/export/sites/fluechtlinge/downloads/FSW-FaktenFluechtlinge.pdf
20. Aiginger K, Kohlenberger J. Österreich: Aufnahmeland wider Willen und ohne Strategie? (Austria: a reception country against its will and without strategy?). Vienna; 2020.
21. Rosenberger S, Müller S. Geographies of Asylum in Europe and the Role of European Localities. Before and After the Reception Crisis of 2015: Asylum and Reception Policies in Austria. Glorius B, Doomernik J, editors. Cham: Springer; 2020. 93–110 p.
22. Maas J. The impact of migration policy changes on the public opnion on immigration. A Case Study of Austria and Sweden [Internet]. University of Gothenburg; 2019. Available from: https://gupea.ub.gu.se/bitstream/2077/62832/1/gupea_2077_62832_1.pdf
23. Amnesty International. Human Rights in Europe. Review of 2019 [Internet]. London; 2020. Available from: https://www.amnesty.org/en/documents/eur01/2098/2020/en/
24. Bundersministerium für Inneres. Asyl. Statistiken. Statistiken 2019. Jahresstatistiken (asylum. statistics. statistics 2019. yearly statistics) [Internet]. 2019 [cited 2020 Jan 21]. Available from: https://www.bmi.gv.at/301/Statistiken/start.aspx#jahr
25. Inter- Agency Standing Committee (IASC). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings [Internet]. IASC. Genvea;

2007. Available from: https://www.who.int/mental_health/emergencies/9781424334445/en/

26. World Health Organization. Ottawa Charter for Health Promotion, 1986. In Ottawa; 1986. p. 2. Available from: https://www.who.int/healthpromotion/conferences/previous/ottawa/en/

27. Eriksson M, Lindstrom B. A salutogenic interpretation of the Ottawa Charter. Health Promot Int [Internet]. 2008 Jan;23(2):190–9. Available from: file:///C:/Users/usuario/Downloads/AsalutogenicinterpretationoftheOttawacharter.pdf

28. Rdodriguez DM. The balance concept in health and nursing. A universal approach to care and survival. Bloomington: iUniverse; 2014. 257 p.

29. Griner D, Smith TB. Culturally adaped mental health intervention: A meta-analytic review. Psychotherapy: Theory, research, practice, training. 2006.

30. Caritas. Zentrum für Frauengesundheit. Caritas Asyl & Integration NÖ. Frauen Gesundheit im Zentrum. Handbuch für Interkulturelle Gesundheitstrainerinnen (Women health. Manual for intercultural health multiplicators). Niederösterreich; 2014.

31. Children and War Foundation. Mission and goals [Internet]. [cited 2020 Feb 6]. Available from: https://www.childrenandwar.org/about-us/our-mission-and-goals/

32. Hug T, Poscheschnik G. Empirisch forschen. Studieren, aber richtig (Empirically research. Studying, but in right way). 2. Auflage. Wien: Verlag Huter & Roth KG; 2015. 191 p.

33. Nigel K, Horrocks C, Brooks J. Interviews in Qualitative Research. 2nd ed. Seaman J, editor. Los Angeles, London, New Dheli, Singapore, Washington DC, Melbourne: SAGE; 2019. 363 p.

34. Patton MQ. How to Use Qualitative Methods in Evaluation. 2nd ed. New Pury Park: SAGE Publications; 1987. 176 p.

35. Dresing T, Pehl T. Praxisbuch Interview , Transkription & Analyse. Anleitungen und Regelsysteme für qualitativ Forschende (Manual interview, transcription and analysis. Guideline and rules for qualitative researchers) [Internet]. 8. Auflage. Dresing T, Pehl T, editors. Marburg: Eigenverlag; 2018. 72 p. Available from: www.auditranskription.de/praxisbuch

36. Mayring P. Qualitative Content Analysis Theoretical Foundation, Basic Procedures and Software Solution [Internet]. Klagenfurt; 2014. Available from: file:///C:/Users/usuario/Downloads/ssoar-2014-mayring-Qualitative_content_analysis_theoretical_foundation.pdf

37. Flick U, Von Kardorff E, Steinke I. Qualitative Forschung. Ein Handbuch (Qualitative research. A manual). 13. Auflag. Steinke I, editor. Hamburg: Rowohlt Taschenbuch Verlag; 2019. 767 p.

38. Field A. Discovering statistics using IBM SPSS Statistics. London: SAGE; 2013. 952 p.

39. Refugee Study Centre. Queen Elizabeth House. University of Oxford. Ethical Guidelines for Good Research Practice [Internet]. Vol. 26, Refugee Survey Quarterly. 2007. Available from: http://rsq.oxfordjournals.org/

40. Preitler B. An ihrer Seite sein. Psychosoziale Betreuung von traumatisierten Flüchtlingen (At their side. Psychosocial care for traumatized refugees). Innsbruck: Studienverlag Ges.m.b.H; 2016. 172 p.

41. Bakker L, Dagevos J, Engbersen G. The Importance of Resources and Security in the Socio-Economic Integration of Refugees. A Study on the Impact of Length of Stay in Asylum Accommodation and Residence Status on Socio-Economic Integration for the Four Largest Refugee Groups in the Netherlan. J Int Migr Integr [Internet]. 2014 Aug 23;15(3):431–48. Available from: http://link.springer.com/10.1007/s12134-013-0296-2

42. Hynie M. The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. Can J Psychiatry. 2018;63(5):297–303.

43. Georgiadou E, Zbidat A, Schmitt GM, Erim Y. Prevalence of mental distress among Syrian refugees with residence permission in Germany: A registry-based study. Front Psychiatry. 2018;9(AUG):1–12.

44. Markova V, Sandal GM. Lay explanatory models of depression and preferred coping strategies among Somali refugees in Norway. A mixed-method study. Front Psychol. 2016;7(SEP):16.

45. Waardenburg M, Visschers M, Deelen I, van Liempt I. Sport in liminal spaces: The meaning of sport activities for refugees living in a reception centre. Int Rev Sociol Sport [Internet]. 2019 Dec 9;54(8):938–56. Available from: http://journals.sagepub.com/doi/10.1177/1012690218768200

46. Spaaij R, Broerse J, Oxford S, Luguetti C, McLachlan F, McDonald B, et al. Sport, Refugees, and Forced Migration: A Critical Review of the Literature. Front Sport Act Living [Internet]. 2019 Oct 11;1(October):1–18. Available from: https://www.frontiersin.org/article/10.3389/fspor.2019.00047/full

10. Acknowledgement

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Furthermore, I would like to thank my supervisor Stella Evangelidou and co-supervisor Nuria Casamitjana for their valued support and advice regarding the development of this project.

Finally, I would also like to thank my family and friends for encouraging and motivating me during this master program.

11. Annexes

Annex 1: AFYA MHP - objectives, methods and framework

The framework was worked out among AFYA team in a workshop on 23rd September. The below table shows, which contents/methodologies should be included in each session.							
OBJECTIVE	METHODS/CONTENTS						
Empowerment							
Strenghten ressources	Favourite place (place of safty)	Relaxation(silence/ meditation)	Good nutrition (topic need to be worked out more)	Shiatsu samurai	Games		
	What are my resources, what gives me energy	Sleeping disorders, good sleep, slowing down	Bodywork/ outdoor activities	Mother tongue as ressource	Breathing exercises		
	Positive thinking	Quick relaxation exercise	Tapping exercise	Parenting/child care	Shiatsu/yoga/bodywork/ tapping exercises		
Normalization of mental stress/trauma	What is good for me	To change nightmares	Psychoeducation	Death and mourning (topic need to be more worked out)	Shiatsu/yoga/bodywork/ tapping exercises		
	Stres splan (Bodymap)	Breathing exercises	Games	Parenting/child care			
Strenghten health awareness	Violence/FGM	Breathing exercises	Games	Parenting/child care	Shiatsu/yoga/bodywork/ tapping exercises		
Practicing self-perception	Emotion thermometer, talking about emotions	A letter adressed to myself	gender roles, theater, roles games	Body language exercise (emotions)	Parenting/child care	Breathing exercises	Shiatsu/yoga/body work/ tapping exercises
To give stability	Piano exercise	Sort out worries (sponge exercise)	Games	Shiatsu/Yoga/Body exercises/Tapping exercises			
	wellbeing button	Parenting/child care	Breathing exercises				
Information/knowledge	Parenting/child care	Violence and law/rights: FGM	Austrian Health System	Breathing exercises	Shiatsu/yoga/bodywork/ tapping exercises		
other objectives			Painting in couples				

Session	MAIN TOPICS	Should be included in EACH SESSION	
0	Introduction of AFYA	Relaxing exercises, games, breathing exercises, repetition	After each session, the following must be reflected: the interactivity of the group, openness of participants, the ability to interpret their non-verbal communication, etc.
	Explanation of mental health circles		
	Group introduction		
	Info: it is possible to bring new people until the 3rd session, afterwards the group should remain with the same participants		
1	What is good for me		
	What gives me energy		
	My favourite place		
	Emotion thermometer		
2	Stress plan (bodymap)		
	Quick relaxation exercise		
	Wellbeing button		
3	Talking about emotions (games, body exercises)		
	Gender roles (stigma) - role play/theatre		
4	Sort out worries "sponge"		
	Piano exercise		
	Self empowerment/positive thinking		
5	Sleeping disorders/slowing down (tips and experiences)		
	Changing nightmares		
6	Yoga/body exercises/Shiatsu/tapping-exercise		
7	Trauma/violence/FGM		
	A letter addressed to myself		
	Parents/child care (topic needs to be more worked out by supervisors/experts)		
8	Life circle		
	Psychoeducation (=> and important contacts)		
ENDE	Feedback form		
	Feedback discussion		
	Certificates		

Annex 2: Template feedback form

		 Strongly agree	 Agree	 Disagree	 Strongly disagree
1	I have learnt things in the program which are useful for my life.				
2	At home, I have tried out some of the things that I have learnt in the program. For example:				
3	I felt comfortable among the group.				
4	I feel that the trainers understood me.				
5	Some of the topics in the MHP circles were uncomfortable for me. For example:				
6	I would recommend the program to a friend.				
7	The following 3 things I liked the most: 1. 2. 3.				
8	If I could change something in the program, it would be following:				
9	I have told my family/friends the following about the program:				
10.	Additional comments:				

Annex 3: Interview guidelines in English and German

English version of interview questions for MHP participants

Introduction:

- Information and explanation about the interview, consent form

Demographic questions for study participants

- Age, sex, nationality, length of stay/residence in Austria, legal status, when did you participate in the program/how many MHP circles did you facilitate

Interview questions for program participants

1) What motivated you to participate in the MHP program? What else?
2) Which part did you like the most? For which reasons?
3) Which part did you like the least? For which reasons?
4) Which topics or situations made you feel comfortable and which ones made you feel uncomfortable?
5) What do you think about the program`s set up and the way how sessions are provided?
6) What was the most important thing that you personally learned in the MHP program?
7) Is there something that you do different now because of participating in the MHP program?
8) Is there something that you would change in the MHP program?
9) Do you feel that at the beginning of the MHP you have been stressed?
10) How these sessions have helped you in dealing with your mental distress?
11) What do you think are the reasons, why some people do not attend in the program?
12) Before we finish with the interview, is there any other topic related to the program that we didn't talk about and you would like to mention?
13) How do you perceive the program name "health circle"?

(question 13 was added after the 6th interview)

Interview questions for program facilitators

1) What do you think motivates people to participate in the MHP program?
2) What could be obstacles for participation?
3) What are the main motives for which participants have lost to follow-up the sessions?
4) Have you observed which of the topics and methods participants like the most? What could be the reasons?
5) What are the topics that are less tolerated? What could be the reasons?
6) What do you think about the program`s set up and the way contents are delivered?
7) Do they tell you about what they do different now in their daily life because of attending the MHP?
8) Do you have any recommendations what AFYA could change in the MHP program?
9) Before we finish with the interview, is there any other topic related to the program that we didn't talk about and you would like to mention?

German version of interview questions for program participants and facilitators

Einleitung:

- Information über das Interview, Einverständniserklärung

Persönliche Daten:

- Alter, Geschlecht, Nationalität, in Österreich seit/Aufenthaltsstatus, wann haben Sie am Gesundheitskries teilgenommen/wie viele Kurse haben Sie geleitet?

Interviewfragen für TeilnehmerInnen

1) Was hat Sie zur Teilnahme am Gesundheitskreis motiviert? Was noch?
2) Welchen Teil der Gesundheitskreise haben Sie am meisten gemocht? Aus welchen Gründen?
3) Welchen Teil haben sie am wenigsten gemocht? Aus welchen Gründen?
4) Bei welchen Themen oder Situationen haben Sie sich wohl oder unwohl gefühlt?
5) Wie finden Sie die Art und Weise wie Themen vermittelt werden und die Gesundheitskreise aufgebaut sind?
6) Was ist das wichtigste, dass Sie persönlich im Gesundheitskreis gelernt haben?
7) Gibt es etwas, dass Sie jetzt anders machen, weil Sie an den Gesundheitskreisen teilgenommen haben?
8) Gibt es etwas das Sie an den Gesundheitskreisen verändern würden?
9) Haben Sie sich ich zu dem Zeitpunkt als Sie sich zur Teilnahme am Gesundheitskreis entschieden haben, gestresst gefühlt?
10) Wie haben Ihnen die Gesundheitskreise geholfen mit Stress umzugehen?
11) Was glauben Sie sind die Gründe, warum einige Leute nicht an den Gesundheitskreisen teilnehmen?
12) Gibt es noch irgendein Thema bezüglich Gesundheitskreis worüber Sie gerne sprechen wollen?

Interviewfragen für MentorInnen

1) Was glauben Sie motiviert Menschen an den Gesundheitskreisen teilzunehmen?
2) Was könnten Hindernisse zur Teilnahme sein?
3) Was sind die Hauptgründe warum manche Teilnehmer nicht mehr zu den Gesundheitskreisen kommen?
4) Haben Sie beobachtet, welche Themen und Methoden die TeilnehmerInnen am meisten mögen? Was könnten die Gründe dafür sein?
5) Welche Themen werden weniger gut von den Teilnehmern akzeptiert werden?
6) Wie finden Sie die Art und Weise wie Themen vermittelt werden und die Gesundheitskreise aufgebaut sind?
7) Erzählen Ihnen die Teilnehmer was Sie in Ihrem Alltag jetzt anders machen auf Grund der Gesundheitskreise?
8) Haben Sie irgendwelche Empfehlungen, was AFYA an den Gesundheitskreisen ändern könnte?
9) Bevor wir das Interview beenden, gibt es noch irgendein Thema bezüglich Gesundheitskreis worüber Sie gerne sprechen wollen?

Annex 4: Fieldwork - working plan

WORKING PLAN - FIELD WORK			
DATE	**LOCATION**	**PURPOSE**	**DETAIL**
23/07/2019	Phone	Meeting	Topic discussion with AFYA chairwoman
3/9/2019	Afya office	Meeting	MHP circles reflection meeting with full AFYA team
18/9/2019	Afya office	Meeting	Discussion about research question and methodology with AFYYA chair-woman
23/9/2019	Afya office	Meeting	Intervision of MHP circles - workshop with full AFYA team
31/10/2019	London	Training	Participation in the TRT (Teaching Recovery Technics) training by Children and War Foundation in London - TRT methods and tools are partially provided in MHP circles for adults
01/11/2019	London	Training	Participation in the TRT (Teaching Recovery Technics) training by Children and War Foundation in London - TRT methods and tools are partially provided in MHP circles for adults
06/11/2020	Afya office	Meeting	Data collection of demographics of program`s participants
13/11/2020	Afya office	Meeting	MHP circles reflection meeting with full AFYA team
20/11/2019	Liesing (café); 1:45 pm	Interview Afghan facilitator	Initial interview request by student
21/11/2019	Core inegration centre; 1:30 pm	Interview Chechen facilitiator	Initial interview request by student
26/11/2019	Phone	Briefing Afghan translator	Briefing about study, interview and content form
27/11/2019	Afya office; 2:30 pm	Interview Somali facilitator	Initial interview request by student
27/11/2019	Afya office; 5pm	Interview Syrian facilitator	Initial interview request by student
03/12/2019	Phone	Briefing Chechen translator	Briefing about study, interview and content form
04/12/2019	Parish centre Perchtoldsdorf; 8:30 am	Interview Iranian participant	Initial interview request by facilitator
05/12/2019	Core integration centre; 10 am	Interview Afghan participant	Initial interview request by facilitator
05/12/2019	Core integration centre; 2 pm	Interview Chechen participant	Initial interview request by facilitator
05/12/2019	Core integration centre; 3 pm	Interview Chechen participant	Initial interview request by facilitator
05/12/2019	Core integration centre; 4 pm	Cancelled - interview chechen participant	Reason: heatlh issues
05/12/2019	Core integration centre	MHP circle mod-ule body work	Participation in Shiatsu session to learn about the program`s content
10/12/2019	Core integration centre; 10 am	Interview Somali participant	Initial interview request by student during Shiatsu session
11/12/2019	Phone	Briefing Syrian translator	Briefing about study, interview and content form

11/12/2020	Afya office	Meeting	Feedback of field work process to AFYA chairwoman
11/12/2019	Parish centre Perchtoldsdorf; 9 am	Cancelled - interview Afghan participant	Reason: cancelled by participant with short notice
12/12/2019	Parish centre Perchtoldsdorf; 9 am	Cancelled - interview chechen participant	Reason: participant didn`t appear to appointment
12/12/2019	Perchtoldsdorf; participant`s home; 10 am	Interview Afghan participant	Initial interview request by student & translator; opportunistic sampling
13/12/2019	Parish centre Perchtoldsdorf; 9 am	Interview Syrian participant	Initial interview request by facilitator
13/12/2019	Parish centre Perchtoldsdorf; 10 am	Interview Syrian participant	Initial interview request by facilitator
13/12/2019	Parish centre Perchtoldsdorf; 11 am	Interview Syrian participant	Initial interview request by facilitator
17/12/2019	Corte integration centre; 9 am	Interview Chechen participant	Initial interview request by facilitator
09/01/2020	Afya office	Data collection	Data collection - attendance of study participants
14/01/2020	Afya office	Meeting	Discussion about MHP circles development & concept
15/01/2020	Phone	Briefing Somali translator	Briefing about study, interview and content form
16/01/2020	Core integration centre; 2pm	Interview Somali participant	Initial interview request by 1st Somali participant; snowball sampling
17/01/2020	Parish centre Perchtoldsdorf; 9am	Interview Syrian participant	Initial interview request by facilitator
27/1/2020	Afya office	Meeting	Feedback of field work process to AFYA chairwoman & discussion
03/02/2020	Afya office	Evlauation research feedback	Feedback of interview findings to full AFYA team & discussion
11/2/2020	Afya office	Meeting/data collection	Data collection & translation of feedback forms
12/03/2020	Impact Hub Vienna; 17-21h	General Assembly AFYA	Evaluation feedback of student cancelled due to health issues;
June 20	Phone	Evaluation research feedback	Feedback of interview findings to all study participants (program participants) via what`s app or email

Annex 5: Ethical Clearance I

Preysinggasse 7-9/4
1150
Wien

office@afya.a
t www.afya.at
0670 605 99 71

Wien, 2. Dezember 2019

To whom it may concern

Masterthesis Sandra Miller – Ethical clearance

This is to inform you that the board of AFYA welcomes the initiative of Mrs Sandra Miller to conduct an evaluation of our Mental health promotion programme "Gesundheitskreise" as part of her thesis for the Master programme in International Health.

The AFYA board members consider no need for ethical approval for this study for the following reasons:

- This is an internal study with no plan for publication
- Part of the data used are existing data from the programme implementation
- Additional (qualitative) data collected will serve the only and immediate purpose of reflecting on and improving an operational activity of AFYA

Do not hesitate to conduct us for any other questions.

Sabine Kampmüller, MIH

Chairwoman

Annex 6: Ethical Clearance II

WU WIRTSCHAFTS UNIVERSITÄT WIEN VIENNA UNIVERSITY OF ECONOMICS AND BUSINESS

EFMD EQUIS AACSB AMBA

Vienna, 06.04.2020

Master Thesis Proposal, Ms. Sandra Miller

To whom it my concern:

The research ethics clearance application for the master thesis proposal "Appropriateness and effectiveness of mental health promotion interventions for adult refugees with mental distress", submitted by Ms. Sandra Miller on March 31st, 2020, has been reviewed according to the Ethical Guidelines issued by the Refugee Studies Center at the University of Oxford.

As a researcher working in migration and refugees studies with groups of vulnerable respondents, I was satisfied with the procedures to ensure respondent anonymity, informed consent, confidentiality and data security. I have hence no objections to the research as intended in the submitted proposal and welcome Ms. Miller's initiative to evaluate the AFYA pilot MHP program in Austria, one of the European countries most heavily affected by the 2015 refugee inflows.

Yours sincerely,

Dr. Judith Kohlenberger

DEPARTMENT SOZIOÖKONOMIE
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Annex 7: Consent form English and German

Consent Form for participation in the evaluation study of AFYA NGO

Study Title: Appropriateness and effectiveness of mental health promotion interventions for recognized adult refugees with mental distress. Evaluation of the intercultural mental health promotion adult program of the Non-Governmental Organization AFYA.

Study conducted by: Sandra Miller, a student of International Health, is conducting the evaluation study as part of the master`s thesis in collaboration with AFYA NGO.
Contact details: millersandy@gmx.at 0650/9974669;

Purpose of this Study:
The aim of the study is to examine if and how AFYA`s intercultural mental health promotion program contributes to the overall wellbeing of the participants. The study findings will inform program modifications and/or revision of the program's strategy, therefor data will be used by AFYA NGO for internal use and not be published. Further, the study results will be presented as part of the master thesis.

Benefits:
There may be no personal benefit from your participation in the study but the knowledge received maybe of educational value to AFYA NGO with regard to appropriateness and effectiveness of intercultural mental health promotion programs.
Voluntary:
Participation in this study is completely voluntary.
Confidentiality and anonymity:
Your confidentiality will be maintained in the following manner:

- Your name, contact information and other direct personal identifiers will not be disclosed at any time.
- The interview will be audio recorded. Each participant will be assigned an electronic code;
- The student will record any data collected during the study by this code, not by name;
- Original data files will only be stored on the student's personal device.

Rights

- Your participation is voluntary.
- You are free to stop your participation at any point.
- Refusal to participate or withdrawal of your consent will not have any consequences for you.
- If you have any questions about this study, you should feel free to ask them now.
- If you have questions later, desire additional information, or wish to withdraw your participation please contact the student by phone or e-mail.
- You may have a copy of this consent form for your own records.

Voluntary Consent

- By signing below, you agree that the above information has been explained to you and all your current questions have been answered.
- You understand that you may ask questions about any aspect of this research study during the study and in the future.
- By signing this form, you agree to participate in this research study.

_____
Participants signature and date

I certify that I have explained the nature and purpose of this research study to the above individual. Any questions the individual has about this study have been answered and any future questions will be answered as they arise.

_____
Signature of person obtaining consent and date

Consent form German: Einverständniserklärung für die Teilnahme an der Evaluation der AFYA Gesundheitskreise

Titel der Studie: Akzeptanz und Wirksamkeit psychischer Gesundheitsförderung für anerkannte erwachsene, gestresste Flüchtlinge. Evaluierung der interkulturellen Gesundheitskreise zur Förderung der psychischen Gesundheit für Erwachsene – ein Projekt der Organisation AFYA.

Studien Durchführung:
Sandra Miller, Studentin des Masterlehrganges "Internationale Gesundheit", führt die Studie im Rahmen ihrer Masterarbeit in Kollaboration mit der Organisation AFYA durch.
millersandy@gmx.at 0650/9974669;

Studienzweck:
Der Studienzweck ist Hinweise zu erlangen, ob und wie AFYAs interkulturelle Gesundheitskreise zum allgemeinen Wohlbefinden beitragen. Die Studienergebnisse dienen als Grundlage zur Konzeptanpassung oder Konzeptveränderungen, daher werden die Daten nur innerhalb der Organisation AFYA verwendet und nicht veröffentlicht. Des Weiteren wird die Studie als Teil der Masterarbeit der Studentin präsentiert.
Die Studie bringt Ihnen möglicherweise keinen persönlichen Vorteil. Die Studienergebnisse können aber sehr informativ und hilfreich sein für AFYA in Bezug auf Akzeptanz und Wirksamkeit der Gesundheitskreise.

Freiwillig:
Die Teilnahme an der Studie ist komplett freiwillig.
Vertraulichkeit und Anonymität:

- Ihr Einverständnisformular wird in den Unterlagen der Studentin verwahrt und nicht an Dritte weitergegeben.
- Ihr Name, Ihre Kontaktinformationen und andere persönliche Daten werden zu keinem Zeitpunkt weitergegeben.
- Das Interview wird mittels Diktiergerät aufgenommen. Jedem/Jeder TeilnehmerIn wird ein Code zugewiesen. Es werden für alle gesammelte Informationen Codes anstatt von Namen verwendet.
- Originaldateien werden nur auf dem persönlichen Computer der Studentin gespeichert.

Rechte:

- Ihre Teilnahme ist freiwillig und Sie können Ihre Teilnahme jederzeit beenden.
- Eine Verweigerung an der Studie teilzunehmen oder der Widerruf Ihrer Einwilligung hat keine Konsequenzen für Sie.
- Wenn Sie Fragen zu dieser Studie haben, können Sie diese jetzt stellen.
- Wenn Sie später Fragen haben, zusätzliche Informationen wünschen oder Ihre Teilnahme widerrufen möchten, wenden Sie sich bitte telefonisch oder per E-Mail an die Studentin.
- Sie erhalten eine Kopie des Einwilligungsformulars für Ihre eigenen Unterlagen.

Freiwillige Einwilligung

- Mit Ihrer Unterschrift erklären Sie sich damit einverstanden, dass Ihnen die oben genannten Informationen erklärt und alle aktuellen Fragen beantwortet wurden.
- Sie können jederzeit während der Studie und auch in Zukunft Fragen zu dieser Forschungsstudie stellen.
- Mit der Unterzeichnung dieses Formulars stimmen Sie der Teilnahme an dieser Forschungsstudie zu.

_____
Unterschrift Studienteilnehmer und Datum

Ich bestätige, dass ich dem/der oben genannten StudienteilnehmerIn die Art und den Zweck dieser Studie erklärt habe. Alle Fragen, die die Person zu dieser Studie hat, wurden beantwortet, und alle zukünftigen Fragen werden beantwortet, sobald sie auftreten.

Unterschrift Student und Datum

Annex 8: Kruskal-Wallis and Mann-Whitney-U test

Kruskall-Wallis test results

Item	Category	*N*	*MW*	*SD*	Mean Rank	*p*
Question 1	Afghanistan	19	3.74	0.452	19.84	.144
	Russian federation	13	4.00	0.000	25.50	
	Somalia	11	3.82	0.405	21.59	
Question 2	Afghanistan	18	3.78	0.732	23.47	.336
	Russian federation	13	3.77	0.439	21.27	
	Somalia	11	3.64	0.505	18.55	
Question 3	Afghanistan	19	3.95	0.229	22.39	.638
	Russian federation	13	3.85	0.376	20.27	
	Somalia	10	3.90	0.316	21.40	
Question 4	Afghanistan	19	3.95	0.229	20.95	.100
	Russian federation	13	4.00	0.000	22.00	
	Somalia	8	3.75	0.463	17.00	
Question 5	Afghanistan	19	3.68	0.820	23.34	.012
	Russian federation	10	2.20	1.549	13.10	
	Somalia	8	2.88	1.126	16.06	
Question 6	Afghanistan	19	3.63	0.496	18.95	.343
	Russian federation	13	3.77	0.439	21.77	
	Somalia	9	3.89	0.333	24.22	
Total satisfaction	Afghanistan	18	3.7963	0.26541	21.53	.194
	Russian federation	10	3.6833	0.27722	16.20	
	Somalia	8	3.6667	0.17817	14.56	

STATISTICAL TESTS

Tests for Distribution of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistik	df	Signifikanz	Statistik	df	Signifikanz
Q1	,504	36	,000	,451	36	,000
Q2	,506	36	,000	,337	36	,000
Q3	,539	36	,000	,246	36	,000
Q4	,534	36	,000	,312	36	,000
Q5	,375	36	,000	,677	36	,000
Q6	,492	36	,000	,485	36	,000
Total_Satisfaction	,185	36	,003	,871	36	,001

a. Signifikanzkorrektur nach Lilliefors

⇨ No normal distribution

Test for Homogeneity of Variance

		Levene-Statistik	df1	df2	Signifikanz
Q1	Basiert auf dem Mittelwert	16,087	2	40	,000
	Basiert auf dem Median	2,029	2	40	,145
	Basierend auf dem Median und mit angepaßten df	2,029	2	27,703	,150
	Basiert auf dem getrimmten Mittel	12,071	2	40	,000
Q2	Basiert auf dem Mittelwert	,191	2	39	,827
	Basiert auf dem Median	,216	2	39	,807
	Basierend auf dem Median und mit angepaßten df	,216	2	32,637	,807
	Basiert auf dem getrimmten Mittel	,447	2	39	,643
Q3	Basiert auf dem Mittelwert	1,826	2	39	,175
	Basiert auf dem Median	,437	2	39	,649
	Basierend auf dem Median und mit angepaßten df	,437	2	33,101	,649
	Basiert auf dem getrimmten Mittel	1,826	2	39	,175
Q4	Basiert auf dem Mittelwert	11,670	2	37	,000
	Basiert auf dem Median	2,477	2	37	,098
	Basierend auf dem Median und mit angepaßten df	2,477	2	16,132	,115
	Basiert auf dem getrimmten Mittel	9,432	2	37	,000
Q5	Basiert auf dem Mittelwert	9,319	2	34	,001
	Basiert auf dem Median	2,569	2	34	,091
	Basierend auf dem Median und mit angepaßten df	2,569	2	21,878	,100
	Basiert auf dem getrimmten Mittel	9,040	2	34	,001
Q6	Basiert auf dem Mittelwert	5,568	2	38	,008
	Basiert auf dem Median	1,075	2	38	,351
	Basierend auf dem Median und mit angepaßten df	1,075	2	35,635	,352
	Basiert auf dem getrimmten Mittel	5,568	2	38	,008
Total_Satisfaction	Basiert auf dem Mittelwert	1,881	2	33	,168
	Basiert auf dem Median	,499	2	33	,612
	Basierend auf dem Median und mit angepaßten df	,499	2	27,625	,613
	Basiert auf dem getrimmten Mittel	1,625	2	33	,212

⇨ No homogeneity of variance; requirements for ANOVA are not met;Kruskall-Wallis test will be used.

Kruskall-Wallis Test
ONEWAY deskriptive Statistiken

		N	Mittelwert	Std.-Abweichung	Std.-Fehler	95%-Konfidenzintervall für den Mittelwert		Minimum	Maximum
						Untergrenze	Obergrenze		
Q1	Afghan	19	3,74	,452	,104	3,52	3,95	3	4
	Chechen	13	4,00	,000	,000	4,00	4,00	4	4
	Somali	11	3,82	,405	,122	3,55	4,09	3	4
	Total	43	3,84	,374	,057	3,72	3,95	3	4
Q2	Afghan	18	3,78	,732	,173	3,41	4,14	1	4
	Chechen	13	3,77	,439	,122	3,50	4,03	3	4
	Somali	11	3,64	,505	,152	3,30	3,98	3	4
	Total	42	3,74	,587	,091	3,56	3,92	1	4
Q3	Afghan	19	3,95	,229	,053	3,84	4,06	3	4
	Chechen	13	3,85	,376	,104	3,62	4,07	3	4
	Somali	10	3,90	,316	,100	3,67	4,13	3	4
	Total	42	3,90	,297	,046	3,81	4,00	3	4
Q4	Afghan	19	3,95	,229	,053	3,84	4,06	3	4
	Chechen	13	4,00	,000	,000	4,00	4,00	4	4
	Somali	8	3,75	,463	,164	3,36	4,14	3	4
	Total	40	3,93	,267	,042	3,84	4,01	3	4
Q5	Afghan	19	3,68	,820	,188	3,29	4,08	1	4
	Chechen	10	2,20	1,549	,490	1,09	3,31	1	4
	Somali	8	2,88	1,126	,398	1,93	3,82	1	4
	Total	37	3,11	1,265	,208	2,69	3,53	1	4
Q6	Afghan	19	3,63	,496	,114	3,39	3,87	3	4
	Chechen	13	3,77	,439	,122	3,50	4,03	3	4
	Somali	9	3,89	,333	,111	3,63	4,15	3	4
	Total	41	3,73	,449	,070	3,59	3,87	3	4
Total_Satisfaction	Afghan	18	3,7963	,26541	,06256	3,6643	3,9283	3,00	4,00
	Chechen	10	3,6833	,27722	,08767	3,4850	3,8816	3,33	4,00
	Somali	8	3,6667	,17817	,06299	3,5177	3,8156	3,33	3,83
	Total	36	3,7361	,25315	,04219	3,6505	3,8218	3,00	4,00

Ranks

	Nationalität	N	Mittlerer Rang
Q1	Afghan	19	19,84
	Chechen	13	25,50
	Somali	11	21,59
	Total	43	
Q2	Afghan	18	23,47
	Chechen	13	21,27
	Somali	11	18,55
	Total	42	
Q3	Afghan	19	22,39
	Chechen	13	20,27
	Somali	10	21,40
	Total	42	
Q4	Afghan	19	20,95
	Chechen	13	22,00
	Somali	8	17,00
	Total	40	
Q5	Afghan	19	23,34
	Chechen	10	13,10
	Somali	8	16,06
	Total	37	
Q6	Afghan	19	18,95
	Chechen	13	21,77
	Somali	9	24,22
	Total	41	
Gesamt_Zufriedenheit	Afghan	18	21,53
	Chechen	10	16,20
	Somali	8	14,56
	Total	36	

Statistik für Test[a,b]

	Q1	Q2	Q3	Q4	Q5	Q6	Total_satisfaction
Kruskal-Wallis H	3,869	2,179	,899	4,605	8,833	2,143	3,275
df	2	2	2	2	2	2	2
Asymptotische Signifikanz	,144	,336	,638	,100	,012	,343	,194

a. Kruskal-Wallis-Test

b. Gruppenvariable: Nationalität => Mann-Whitney test to investigate significant difference is in Q5

Mann Whitney-U test

Ranks

	Country of origin	N	Mean Rank	Sum of Ranks
Q5	Afghanistan	19	17,53	333,00
	Russia	10	10,20	102,00
	Total	29		
Total_satisfaction	Afghanistan	18	15,78	284,00
	Russia	10	12,20	122,00
	Total	28		

Test Statistics[a]

	Q5	Total_Satis-faction
Mann-Whitney-U	47,000	67,000
Wilcoxon-W	102,000	122,000
Z	-2,714	-1,161
Asymptotische Signifikanz (2-seitig)	,007	,246
Exakte Signifikanz [2*(1-seitige Sig.)]	,027[b]	,286[b]

a. Gruppenvariable: Nationalität
b. Nicht für Bindungen korrigiert.

Ranks

	Nationalität	N	Mittlerer Rang	Rangsumme
Q5	Afghanistan	19	15,82	300,50
	Somalia	8	9,69	77,50
	Total	27		
Total_Satisfaction	Afghanisch	18	15,25	274,50
	Somalisch	8	9,56	76,50
	Gesamt	26		

Test Statistics[a]

	Q5	Total_Satisfac-tion
Mann-Whitney-U	41,500	40,500
Wilcoxon-W	77,500	76,500
Z	-2,274	-1,806
Asymptotische Signifikanz (2-seitig)	,023	,071
Exakte Signifikanz [2*(1-seitige Sig.)]	,066[b]	,080[b]

a. Gruppenvariable: Nationalität
b. Nicht für Bindungen korrigiert.

Ranks

	Country of origin	N	Mean Rank	Sum of Ranks
Q5	Russia	10	8,40	84,00
	Somalia	8	10,88	87,00
	Total	18		
Total_Satisfaction	Russia	10	9,50	95,00
	Somalia	8	9,50	76,00
	Total	18		

Test Statistics[a]

	Q5	Total_satisfaction
Mann-Whitney-U	29,000	40,000
Wilcoxon-W	84,000	76,000
Z	-1,040	,000
Asymptotische Signifikanz (2-seitig)	,298	1,000
Exakte Signifikanz [2*(1-seitige Sig.)]	,360[b]	1,000[b]

a. Gruppenvariable: Nationalität
b. Nicht für Bindungen korrigiert.