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A photograph showing the profile of a woman wearing a black hijab and a young child with dark hair, both looking towards the left. The image is set against a light-colored background and is partially obscured by a white curved shape that frames the title.

Health promotion for improved refugee and migrant health

Technical guidance



This project is funded by
the European Commission.



Knowledge Hub
on Health and Migration

The Migration and Health programme

The Migration and Health programme, the first fully fledged programme on migration and health at the WHO Regional Office for Europe, was established to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020, providing support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect public health in the host community.

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Abstract

This technical guidance outlines current best practices, evidence and knowledge to inform policy and programme development in the area of health promotion for refugees and migrants. It highlights key principles, summarizes priority actions and challenges, maps available resources and tools and provides policy considerations and practical recommendations to improve health promotion activities for refugees and migrants in the WHO European Region. The target audience is not just those within the health or immigration sectors but also all those with a central role in policy-making at local, national and regional levels, and across all sectors of governance. Clinicians, fieldworkers and other practitioners are invited to draw upon this technical guidance; however, it is not intended to be at a level that would inform their daily work.

Keywords

HEALTH PROMOTION, TRANSIENTS AND MIGRANTS, REFUGEES, SOCIAL DETERMINANTS OF HEALTH, EUROPE

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Abbreviations

HIA health impact assessment

HiAP health in all policies

SDG Sustainable Development Goal

Summary

As for all people, refugees and migrants have the fundamental right to enjoy the highest attainable standard of health. Health, however, is influenced not only by biological factors, individual behaviours or even access to health services but also by many other overlapping and intersecting social, political and economic factors; these are known as the social determinants of health. Importantly, the processes of migration and displacement are also social determinants of health and can pose significant risks and increased vulnerability for poor health outcomes. Not only do many refugees and migrants originate from countries affected by poverty and conflict, poor or disrupted health systems and high burdens of disease, the conditions surrounding their migration may exacerbate health inequalities and expose them to greater health risks. These include conditions experienced in transit and destination countries, such as lack of clean water and adequate nutrition; the legal status of the individual and the policies that grant or deny access to services; and their living and working conditions. Social and cultural barriers to integration, low socioeconomic status, acculturation stress, exclusion and discrimination are additional factors that impact the health of refugees and migrants.

Addressing the impacts of migration and displacement on each person's health and advocating for the diverse and unique needs of refugees and migrants are imperative. Health promotion is a key mechanism through which to act. Health promotion is the process of enabling people to gain more control over, and improve, their own health and well-being, and that of their families and communities. Through a health promotion lens, health is seen not merely as the absence of illness or disease but rather as a means for everyday life in which people realize aspirations, satisfy needs and adapt and cope with their personal environment in order to achieve physical, social and mental well-being. The Ottawa Charter for Health Promotion was established in 1986 and provides the grounding framework for research, policy and practice on health promotion. It emphasizes how broader socioecological factors, and indeed the social determinants of health, impact health outcomes and even influence health-related behaviours. The Ottawa Charter outlines five key priority areas: building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services. It is important however, that these domains for action are approached collectively in a structured and systematic manner, as health promotion will not have as great an impact if it is conducted by isolated sectors (so-called silo action).

The approach of the Ottawa Charter can form the basis to guide the development of effective interventions for refugees and migrants in the WHO European Region. Policy considerations for decision-makers include to:

- adopt a health in all policies (HiAP) approach to ensure policies within all sectors of government, not just the health care sector, promote the health of refugees and migrants;

- improve social services and the quality of the physical and social environments in which refugees and migrants live;
- prioritize community-centred approaches that mobilize the resources and assets within refugee and migrant communities and build local capacities;
- invest in language support and health literacy initiatives to develop personal skills in the host country; and
- promote cultural- and diversity-sensitive approaches to health care and build a culturally competent health workforce that is responsive to the unique needs of refugee and migrant populations.



Introduction

Health promotion is the process of enabling people to gain more control over, and improve, their own health and well-being, and that of their families and communities (1). Through a health promotion lens, health is seen not merely as the absence of illness or disease but rather as part of everyday life in which people realize aspirations, satisfy needs and adapt and cope with their personal environment in order to achieve physical, social and mental well-being (1). As such, health is also about social and personal resources, and health promotion must go beyond simplistic understanding of what it is to be healthy or live a healthy lifestyle and emphasize a more holistic understanding of well-being.

As for all people, refugees and migrants have the fundamental right to enjoy the highest attainable standard of health, without distinction of race, religion, political belief or economic and social condition (2). Migrant health is, therefore, a human rights issue. This is a guiding principle of the WHO framework Promoting the Health of Refugees and Migrants (2). However, achieving such a standard of health cannot be done without ensuring pathways for safe, orderly and regular migration, and addressing the impacts of migration and displacement on an individual's physical and mental well-being. Advocating for the diverse and unique needs of refugees and migrants, both during and after migration, is imperative, and health promotion is a key mechanism by which this can be done. Moreover, such an approach is good public health practice that is to the benefit of all of society, as healthy migrants become valuable and productive members of their communities. Addressing their health needs is instrumental in facilitating integration and participation and positive social and economic development, as well as bridging development and public health issues. As such, health promotion of refugees and migrants must be a priority for all policy-makers in the WHO European Region (3).

The Ottawa Charter for Health Promotion

Established in 1986 at the first International Conference on Health Promotion in Ottawa, Canada, the Ottawa Charter for Health Promotion has since provided the grounding framework for research, policy and practice on health promotion (1,4). It is grounded in the recognition that health is influenced by many other overlapping and intersecting social, political and economic factors, not just by biological factors, individual behaviours or even access to health services. These are known as the social determinants of health and include, for example, income and income distribution, employment opportunities, education, food security, housing, gender, ethnicity and environmental conditions (5). Importantly, they also include migration and displacement and the conditions that surround these processes, which can pose significant risks and increase vulnerability to poor health outcomes. Moreover, many of the factors that drive migration contribute to health inequalities both within and between countries, and the fact of being a migrant can place a person at further disadvantage compared

with non-migrant populations (3). Migration, therefore, is not just socially determined but is also a social determinant in and of itself (6).

The understanding that health is influenced by many complex and interrelated determinants, including migration, is also underscored in other key international commitments and obligations. The Rio Political Declaration on Social Determinants of Health adopted in 2011 aimed to achieve social and health equity through intersectoral action on the social determinants of health and well-being (7). Echoing the sentiments of the Ottawa Charter, the Rio Declaration recognized that health inequalities arise from the social conditions in which people are born, grow, live, work and age, and, consequently, action on these determinants across all sectors of government is essential to achieve health equity and the creation of inclusive, economically productive and healthy societies. Incorporating key action areas for health promotion, the Rio Declaration prioritized adopting better governance for health and development, promoting participation in policy-making and implementation, reorienting the health sector towards reducing inequities, and strengthening global governance and collaboration. Within the WHO European Region, the European policy framework Health 2020 also emphasized key aspects of health promotion strategies (8). It called for transformation of the provision of services towards more integrated people-centred health systems, necessitating multisectoral whole-of-government, whole-of-society and HiAP approaches for health policy development. Health 2020 also specifically emphasized the need to enhance the role of the health sector in responding to the specific needs of different refugee and migrant groups, while also promoting coherence among the policies of various other sectors that may affect access to health services (9).

Representing the first time that migration has ever explicitly been incorporated into global development policy, the 2030 Agenda for Sustainable Development is a new opportunity to promote social justice and equity, the core foundations of the Ottawa Charter and related commitments (10,11). As health is a precondition for the three dimensions of sustainable development (social, economic and environmental), integrating health promotion into change efforts has the potential to push forward and act as a multiplier for the Sustainable Development Goals (SDGs). The mutually reinforcing relationship and overlapping priorities of health promotion and the SDGs (including in education (SDG 4), gender equality (SDG 5), decent work (SDG 8), reduced inequalities (SDG 10), inclusive communities (SDG 11), peaceful societies (SDG 16) and partnerships (SDG 17)) makes realizing synergies between health and other sectors both desirable and necessary. This was further emphasized in the Ninth Global Conference on Health Promotion in 2016, which called for a reframing of health promotion to reflect its transformative potential (12). The resulting Shanghai Declaration on promoting health in the 2030 Agenda explicitly recognizes in its call to action that health is a political choice, and it pledges to accelerate implementation of the development goals through increased commitment and investment in health promotion (13).

Objectives

This technical guidance has been developed to assist policy-makers and decision-makers across all sectors of government to realize global and regional commitments and obligations with respect to refugee and migrant health. It aims to be a practical resource and uses the Ottawa Charter as a framework to detail the best available information, evidence and best practices to promote the achievement of the highest attainable standard of health for refugees and migrants in the WHO European Region.¹ Considering the speed and volume of migration to the Region today, this is essential for creating inclusive, peaceful and equal societies for all people.

Methodology

A rapid desk review was conducted in August 2018 of publications in English since the year 2000 using PubMed, Science Direct and Scopus plus systematic reviews and meta-analyses in public health, health promotion and social sciences. Search terms included combinations of “health promotion” or “health”, with “migrant” or “refugee”. Further sources were identified by snowball-searching of reference lists in the identified publications. Grey literature such as reports, discussion papers, existing guidelines, conference presentations and government policy documents were consulted, as well as publications of international and intergovernmental organizations. These are considered reliable sources as they are generally based on detailed evidence reviews and/or expert panel methods, with clear referencing of evidence. Additional documents were identified through expert consultation during the feedback and review process of this document.

The main limitations of this evidence review were that it was not a full systematic review and that sources were limited to those published in English. A further potential source of bias is that, within studies of health promotion for refugees and migrants, literature may not necessarily explicitly match the search term “health promotion” despite being about strategies or interventions that indeed promote health. Studies may also focus more on ethnic or racial minorities or people with culturally and linguistically diverse backgrounds. Consequently, the publications consulted in this review may not be exhaustive in terms of what is potentially relevant to refugee and migrant populations.

Selection of case studies and policy considerations was based on the evidence and research found during the rapid review in terms of known best practices and/or evaluations and impacts of such initiatives. Emphasis was placed on illustrating a variety of interventions that could be applied within the Region. They were also based on the principles and priorities of the Ottawa Charter and related global commitments.

¹ This technical guidance considers refugees and migrants broadly. Others in the series provide detailed guidance on promoting the health of specific subgroups such as children (including unaccompanied minors), older people and pregnant women and newborns, as well as on specific health concerns such as mental health, noncommunicable diseases and immunization.

Overview

Fig. 1 links migration health needs with the Ottawa Charter and Fig. 2 outlines intersectoral action to address these needs.

Fig. 1. Applying the Ottawa Charter to migration

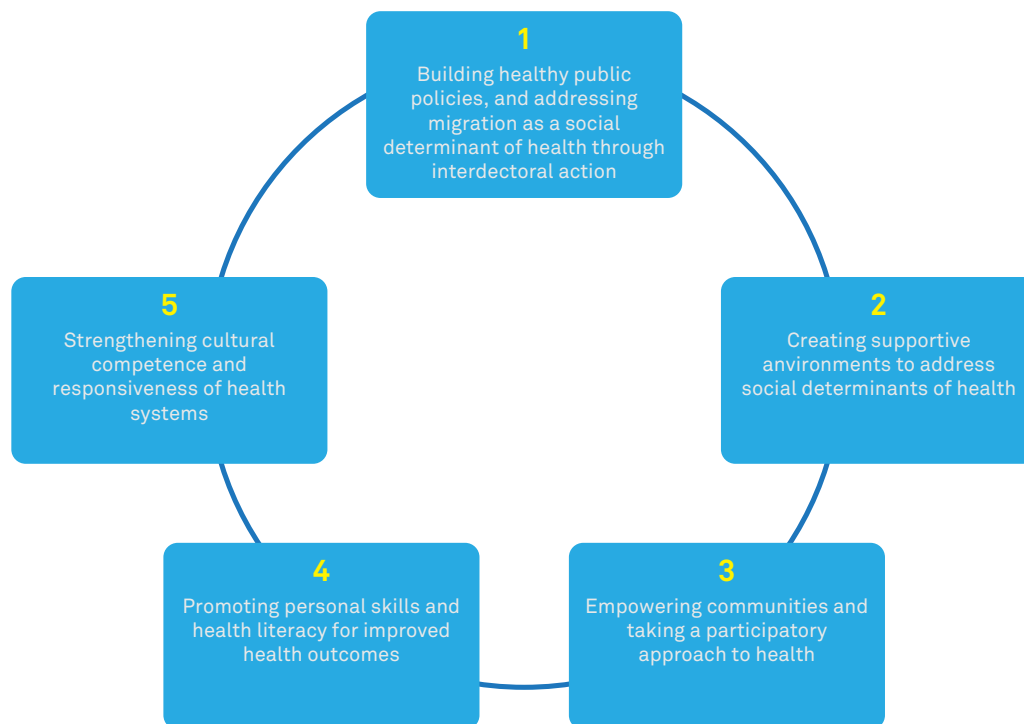
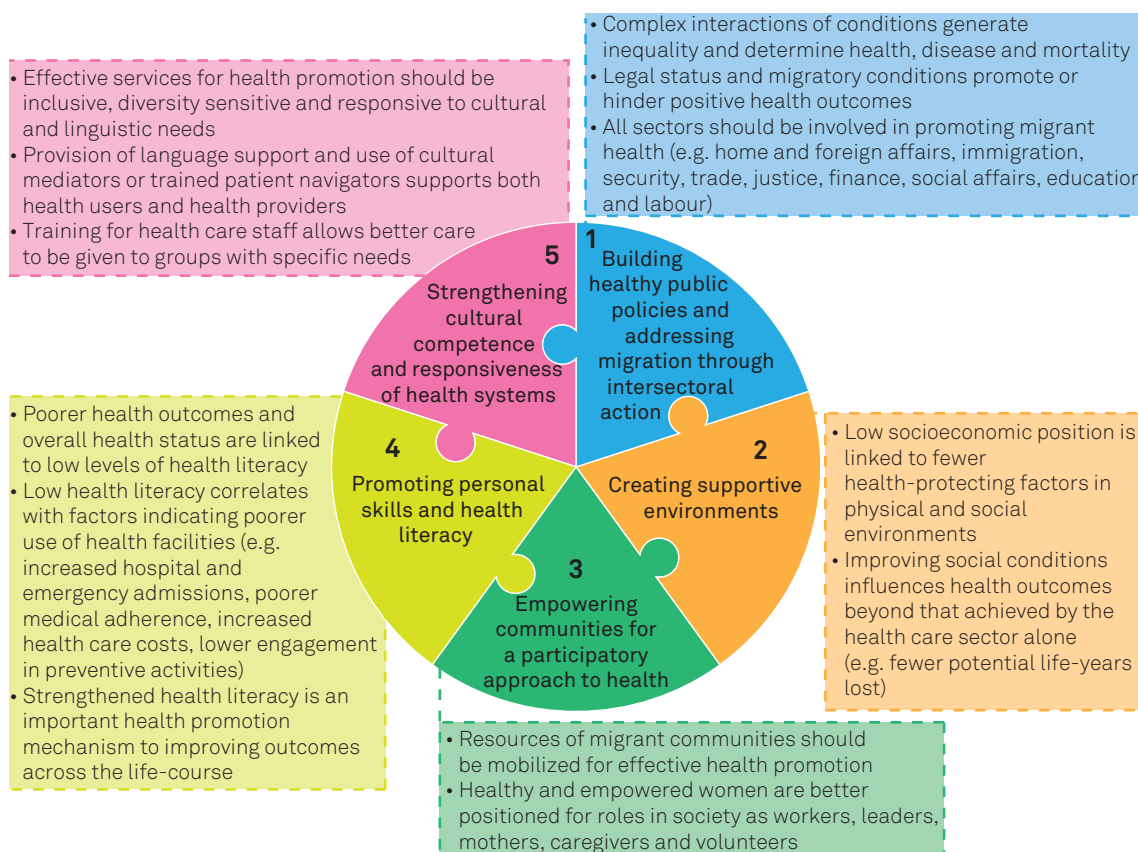


Fig. 2. Intersectoral action addressing migration as a social determinant of health



Evidence

Social determinants of health linked with migration

Refugees and migrants are not a homogeneous group and discerning the health status of these populations is difficult. Different groups face different challenges related to their health and well-being and have different specific health care needs. Vulnerability to poor health and disadvantage is also not consistent and cannot be generalized across all refugee and migrant groups. Many migrants are often healthier than host populations, especially during the initial years after migration (the so-called healthy migrant effect). However, such an effect does not necessarily extend to all groups of migrants; refugees, asylum seekers, unskilled labour migrants and irregular migrants, for example, are generally at higher risk for poor health outcomes (14,15). Many refugees and migrants originate from countries affected by poverty and conflict, poor or disrupted health systems and high burdens of disease. In addition, the conditions surrounding their migration may exacerbate inequalities and expose them to greater health risks, including conditions experienced during transit and in the destination country; the legal status of the individual; the policies that grant or deny access to migrant-friendly health and social services; and the working and living conditions to which they are subjected (16). Such conditions can increase vulnerability not only to infectious diseases but also to chronic and noncommunicable diseases, seriously exacerbating these or causing life-threatening complications through critical or prolonged interruptions in care or loss of medication and equipment for those with existing or even previously well-managed disorders (17). Additional factors that are detrimental for the health of refugee and migrant groups include social and cultural barriers to integration, low socioeconomic status, acculturation stress, exclusion and discrimination, changes in lifestyle and diet, and loss of family and friendship networks (3,17). Therefore, migration itself should be considered as a social determinant of health, and health promotion is key for these groups to achieve the highest attainable standard of health.

Evidence on health promotion initiatives

A rapid review of health promotion initiatives for refugees and migrants found diverse strategies employed globally to improve the health and well-being of different groups. These included developing information materials on various health topics, screening programmes, social/legal support and counselling services, training programmes and use of online resources and applications (18). Evidence regarding the efficacy of the different strategies, especially in the context of the WHO European Region, is not well developed. There are few data on refugee and migrant health in general and also little evaluation of intervention strategies in terms of what is or is not effective (19). Nevertheless, policy-makers should consider the evidence and best practice examples presented in this technical guidance and consult the resources provided.

A 2017 scoping review of 83 empirically evaluated interventions on improving migrant health globally found that many health promotion interventions failed to consider the broader framework of how socioecological factors, or indeed the social determinants of health, impact health-related behaviour change (19). Changing people's habits/behaviour in order to prevent illness is a central concept in health promotion. Most interventions reviewed targeted individuals and the measured change in their knowledge as the primary outcome, based on the assumption that gaining of knowledge on its own would be sufficient to result in meaningful behaviour change. However, these models tended to focus on the individual's own behaviours or lifestyles as the cause of illness and were often top-down and didactic in the way they were communicated. This risks victim blaming in the sense of placing responsibility for poor health on the inability of the individual to comply or change behaviour (20,21). Behaviour change models that focus on the individual and use knowledge as the key measure of impact are, therefore, unlikely to be effective if implemented in isolation without structural intervention, since they have little impact on the broader determinants and conditions that sustain poor health. Health promotion interventions need to consider the various macro-level factors that influence vulnerability to poor health (20), particularly for refugees and migrants, who often face multiple levels of disadvantage. Other concerns regarding the efficacy of the health promotion activities described were that most interventions did not necessarily reflect mortality and morbidity patterns accurately, nor the priorities of the migrant populations, and that nearly one third recruited patients already attending health centres and hospitals, thereby excluding migrants who did not seek health care. The last was likely to overestimate the effects of the intervention as non-attendees may be more likely to have other factors limiting their uptake of (any) health services (19).

In terms of the design and implementation of health interventions for refugees and migrants, broadly two approaches were identified. The first was designing routine services and health interventions for the majority population to be sensitive to diversity so that they would be equally effective for all citizens regardless of their ethnic, cultural, religious or other background (an inclusive approach) (19,22). The second approach was to implement services and interventions specifically for refugees and migrants that could then target their individual backgrounds (an exclusive approach). Certainly, interventions might need to be tailored specifically for particular refugee and migrant groups with situational or culture-related health concerns, such as female genital mutilation or attitudes towards immunization. However, the 2017 review of health promotion interventions found a general lack of clear information about the components of adaptation for targeted approaches, and little or no detail about the specific features for cultural tailoring (19). Furthermore, few interventions studied in the review explained how or why the original general population intervention was inadequate, what the adaptation design was or any refinement of the adaptation. Consequently, greater theoretical clarity is needed regarding the adequacy of culturally tailored approaches to health promotion (19).

Another concern in terms of the design of health interventions for refugees and migrants is that these groups, even when from the same country of origin, are not homogeneous (22), making interventions targeting such specific subgroups complex. Difficulties

could arise from several areas: increased stigma where people are demarcated as having special needs simply because of their migrant status, risks of overemphasizing cultural differences as explanations for the health of refugees and migrants relative to social determinants, and developing parallel services that may not be of the same quality as those serving the mainstream population (22). Although migration is a social determinant of health, it is one of a multitude of intersected factors that influence health and that health care providers need to consider, just as for factors such as gender, age or socioeconomic status. While needing to be cognisant of those specific vulnerabilities caused by migration, health promotion interventions must advocate for an inclusive approach that takes into consideration the beliefs, values, capacities, needs and social context of all people (22). Policy-makers and practitioners need to be aware of these issues and be critical in selecting the design and target group of interventions, thus ensuring that they meet the needs of those they intend to serve.

Areas for intervention

Effective promotion of the health of migrants in the WHO European Region must be approached collectively in a structured and systematic manner. It will not have as great an impact if approached in silos or only with regard to some elements at the cost of others. This technical guidance provides information using the five domains for action of the Ottawa Charter. Policy-makers should work to devise a contextually appropriate structured and robust strategy to pursue all five action areas concurrently.

Create healthy public policies

A core tenet of health promotion is that health is influenced by multiple intersecting factors outside the domain of the health sector. Health, disease and mortality are determined by complex interactions of various political, social, economic and environmental conditions that generate equality/inequality, including the processes of migration itself. For refugees and migrants, their legal status and the conditions experienced during the different phases of migration are greatly influenced by multiple sectors (e.g. home and foreign affairs, immigration, security, trade, justice, finance, social affairs, education and labour), which can promote or hinder positive health outcomes (23–27). Policy-making regarding migration issues has also typically been conducted in isolation within these sectors, which often do not include the health sector or routinely consider the health impacts or outcomes of their policies (28). These sectors may also have differing goals, possibly incompatible with health goals. As risks to health in this way go beyond the reach of the health care sector, there is a need to place both integration policies and health promotion actions on the agenda of all sectors at all levels (1,29,30). It also requires shared responsibility, coordinated intersectoral and whole-of-government efforts and the utilization of diverse approaches to create public policies that foster greater equity and improved outcomes for health and well-being (1,13,30). As such, health promotion advocates for a more coordinated approach to decision-making to address health issues facing refugee and migrant populations, and for the health sector to support other sectors to develop such policies in their own remits (31).

This aspect of health promotion is reflected in the concept of HiAP outlined in the Helsinki Statement (32), which is “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity”. This approach was reinforced in the Rio Declaration (7) and founded on health-related rights and obligations. The Helsinki Statement emphasized the consequences of public policies and called for increased accountability of decision-makers for population health while recognizing that governments have various, and at times competing, priorities in which health and equity do not automatically gain precedence over other policy objectives (32). It offered a framework to combine health

and social equity goals with economic development and other interests. Application of the HiAP framework involves identifying implications for health and equity, assessing impacts and advocating and negotiating for changes. A HiAP approach also takes into consideration the fact that the information and services actually required to make informed and health-conducive choices may be outside the realm of the health sector, just as are many of the determinants of health (33). Ultimately HiAP and health promotion in this context is about the intersectoral development of “healthy public policies” that contribute to the creation of environments that promote health and well-being, as opposed to merely “public health policies”, which may focus too narrowly on health care and/or disease management (34).

While various tools and guidelines have been developed to assist health practitioners in their clinical management of refugees and migrants, there are no explicit decision-support tools for policy-makers to ensure health equity is considered in non-health sectors. The use of health impact assessment (HIA) or health equity impact assessment, for which a number of tools have been developed, can be one way to account for the needs of refugee and migrant populations by helping decision-makers in non-health economic sectors assess the health impacts of both existing and emerging policies and programmes (see Annex 1) (35,36). Using quantitative, qualitative and participatory techniques, HIA can support actionable recommendations in order to mitigate unintended harms and maximize benefits (35). While the considerations of health disparities is integral to most frameworks, and several tools emphasize the need to focus on disadvantaged and marginalized groups, a 2015 scoping review of the inclusion of migrants in HIAs found only 14% mentioned migrants in their evaluations, and only 2% included them in their recommendations (37). The extent of community participation also varies considerably between frameworks (36). A number of challenges to the incorporation of refugees and migrants in HIA have been identified: including these groups in the scope of the assessment, given timelines and resources; obtaining data on them and reaching and engaging these groups in the conduct of the assessment; and successfully appealing to decision-makers (38). Despite such challenges, refugees and migrants ought to be included in HIA to ensure economic and other policies and programmes across different sectors are sensitive to the needs of such groups, and to promote health at all levels. This is a potential strategy of achieving HiAP and building healthy public policies (Case study 1).

Case study 1. Health monitoring for policy development and evaluation (Finland)**Challenge**

Finland has been undergoing health care and social welfare reforms in recent years, taking on the HiAP approach to reduce inequities in health and well-being between population groups (39). The aim is to improve public health by influencing those determinants of health over which the health sector itself has limited influence. The reforms also specifically promote social inclusion and strengthened health and welfare for groups such as refugees, migrants and other minorities. The development and management of well-targeted and effective health-promotion activities and social services, however, is impossible without comprehensive and up-to-date data. National surveys in Finland have provided data for identifying and monitoring differences in health status, health behaviours and service utilization. These routine surveys are usually based on gender, socioeconomic situation and regional differences, and they do not have the ability to monitor migrant populations specifically (39). Consequently, while samples of these surveys generally always include some participants of migrant origin, the proportion is so small that no meaningful conclusions can be drawn and few facts are available on the health and well-being of migrant groups in Finland (39,40). There is also a challenge in that the private sector continues to be more involved in service provision, and it is essential to monitor inequalities to ensure gaps between populations are not widening (39).

Action

Since the mid 2000s, two specific studies have been developed to monitor the health of migrant populations in Finland. The Migrant Health and Well-being Study used interviews and clinical measurements conducted in 2010–2012 to collect information across six cities on the health, well-being, living conditions and service use of adults aged 15–64 years who were Russian-speaking or of Somali or Kurdish origin (40). The Survey on Work and Well-being among People of Foreign Origin was a national and regional health interview survey in 2014 regarding the employment, education, functional capacity, health, well-being, experiences of discrimination and service use of people of foreign origin aged 15–64 years (41). Both surveys were designed to allow comparisons with data gathered on the Finnish general population. Survey-based data in Finland, with indicators presented at the national, regional and local levels, are disseminated through various web-based portals that support the planning and management of health promotion activities (39).

Case study 1. (contd)

Results

Data on migrant health and social indicators have been essential at the national level for developing and evaluating policies and programmes and for assessing how national health policy targets have been met for different population groups (39). At the local level, this information is also used for monitoring the health of residents. Municipalities are obliged to submit annual statutory welfare reports, which are the catalyst for the planning, monitoring, evaluation and management of the welfare policy within the municipality (39). These reports are prepared in collaboration with other municipal sectors that are also directed at preventing health problems, decreasing the need for services and minimizing inequalities (39). In addition to welfare reports, Finnish legislation since 2011 has also obliged municipalities to utilize HIA (39). While there is continued reliance on traditional mortality statistics for health planning in many other countries, and information on other health outcomes may be underdeveloped or non-existent, Finland sets a good example for the availability and utilization of data on key health and social indicators (39). Using different survey methods to capture specific datasets, including for migrant populations, Finland offers a model that may be used for improving health information systems in other countries (39).

Create supportive environments

The second key action area on health promotion recognizes that health is inextricably linked to people's environment, and the conditions in which people are born, grow, live, work and age. Health promotion, therefore, must emphasize a socioecological approach, and the importance of safe, stimulating, satisfying and enjoyable living and working conditions. This includes the quality and sustainability of both physical and social environments with respect to urban design and density, mobility, housing and work spaces, as well as access to services, recreation, culture and heritage (8). It is particularly relevant in the context of rapidly changing environments in areas such as technology and urbanization, which offer great opportunities for prosperity but can also concentrate inequality and ill health (1,8). Health 2020 emphasized the importance of supportive environments for building resilience, a key factor in protecting and promoting health and well-being and achieving sustainable development (42). Resilience is the capacity for individuals and communities to adapt, absorb and anticipate disturbances and recover from adversity, including possible effects of migration (43). Importantly, resilience is not a given unmodifiable characteristic but can be built and strengthened by the development and availability of supportive environments (42). Where the physical and social environments in which people live are health promoting, they will be more empowered to sustain their own health in spite of difficult and stressful circumstances (8). This is essential to reducing the vulnerabilities and disadvantages that can be experienced during migration, settlement and acculturation.

Creating supportive physical and social environments is fundamental to addressing some of the key social determinants of health for refugees and migrants. Improving the conditions in which people live and work has enormous potential to promote health, and access to basic social services can act as a multiplier for better health outcomes. In fact, the comparatively greater contribution of social conditions on health than health care itself has been documented. A study of 30 countries in the Organisation for Economic Co-operation and Development on the association of specific health indicators with expenditure on both health and social care services (including housing and employment support) found that a greater ratio of spending on social services relative to health services was significantly associated with greater life expectancy, lower infant mortality and fewer potential life-years lost (44,45). These results indicate that expenditure on social programmes has the potential to influence health outcomes beyond that resulting from health spending alone, and seems to yield better returns than equivalent expenditure within the health sector (44,45). The working conditions of refugee and migrants particularly are a key opportunity for health promotion as it can be a major cause of poor health and inequality. Labour migrants can often be exposed to discrimination in the workplace, exploitation, dangerous working conditions and high occupational risk, as well as lack of sufficient compensation, contributing to a widening of inequalities between labour migrants and local populations (24). Moreover, work-related factors such as lack of correct documentation or informal arrangements may have a detrimental influence on the health of migrants. Creating supportive, safe and inclusive labour conditions is another important goal of health promotion activities to ensure that migrants experience the positive health benefits afforded by employment.

The availability of supportive environments is also critical for the integration of refugees and migrants into the communities in which they live, and for fostering positive social interactions and cultural exchange. As emphasized in the Common Basic Principles for Immigrant Integration Policy in the EU (46), integration is a dynamic two-way process of mutual accommodation by all migrants and residents, and frequent interaction through shared forums, intercultural dialogue and education is essential for social cohesion and improved well-being for all (30). Health promotion activities in this context should, therefore, focus not only on activities to increase participation among refugees and migrants but also within the wider community (30). Community-wide education on the health challenges facing refugees and migrants, as well as promoting a positive narrative about the contribution of these groups among the host population, is important to improve host country attitudes towards migration (18). This is also necessary to reduce stigmatization and discrimination based on a person's ethnic or migrant background, which is still widespread in the Europe and has significant consequences for health and well-being (3,47). Ultimately, the creation of supportive and inclusive environments must be a key priority for health promotion in order to develop resilience, facilitate integration and improve health outcomes among refugee and migrants in the Region (Case study 2).

Case study 2. Grorud Valley Urban Regeneration project (Norway)

Challenge

The Grorud Valley in Oslo, Norway, has a population of nearly 140 000 people, with significant cultural diversity (48). It is expected that migrants and their children will soon make up 50% of the population, representing over 140 nationalities. There are, therefore, particular challenges associated with this area, including lack of integration and social exclusion (49). In some of the more deprived areas of the Grorud Valley, many people are also living in relative poverty, with a high proportion of unemployment and dependency on social welfare compared with the rest of Oslo and Norway (49).

Action

In alignment with the Norwegian strategy to reduce social inequalities in health (2007–2017), the Grorud Valley Urban Regeneration project 2006–2016 (now prolonged until 2026) is an intervention aimed at improving the environment and living and working conditions in the Grorud Valley area. More than €160 million was invested and more than 35 stakeholders (including seven ministries and seven directorates at the state level) engaged in multisectoral cooperation on the urban regeneration project to deliver physical and social development projects (49,50). Migrants were a particular target group of the project, with a strong emphasis placed on public participation and cultural inclusion for improved health and well-being (49). The project had four focus areas:

- improvement of people's living conditions with activities concerning school, language skills, employment, health, cultural activities and inclusion;
- urban redevelopment to improve people's safety and sense of security, including creating new indoor and outdoor meeting areas;
- improvement of the natural environment such as waterways and wildlife, as well as of green areas, sports areas, cultural heritage and local history; and
- creation of environmentally friendly transportation.

Specific initiatives included a project across eight schools, where in some almost all students have a different cultural background, to facilitate Norwegian language learning and prevent dropping out; all 4- and 5-year-old children being offered free core kindergarten hours to help in preparing for primary school and arrangements for mothers to meet and participate in social and learning activities during kindergarten hours; a meeting venue where more than 20 organizations offer activities including in employment services, nutrition and exercise; and creation of parks and cultural heritage sites to promote recreational activities (49).

Case study 2. (contd)**Results**

Evaluation of the project in 2011 demonstrated that it was making positive progress in meeting its objectives (51). The project has shown that there are major benefits to health and well-being from emphasizing the interaction between physical and social measures, and the different focus areas of the project have drawn on each other to their mutual advantage (interaction effects/added value) (51). The project has contributed to sustainable urban development, reduced poverty and social inclusion of both migrants and the mainstream Norwegian population, which are important for building individual and community resilience. Increased public interest and participation in the community have been observed, and there is improved engagement with previously hard-to-reach migrant populations (51). It is also a positive demonstration of effective intersectoral collaboration, with the collective engagement of residents, organizations, neighbourhood associations, housing cooperatives, city districts and public institutions (51).

Strengthen community actions

Health promotion is about the empowerment of communities, drawing on existing human and material resources in the community to strengthen participation in, and direction of, health matters throughout the life-course (1,45). Empowerment is a necessary prerequisite for people to engage in and co-produce services, activities and policies in a meaningful way (45). It is a participatory approach and works through effective community action in priority setting, decision-making, strategic planning and implementation for improved health outcomes. In the context of health promotion, empowerment is, therefore, about supporting refugees and migrants to exert their health-related rights and responsibilities and to choose pathways that best fit their needs while contributing to the development of healthy environments (45). Migrants are understood to be not only health consumers but also health creators (52). Gender is a particularly important aspect in this area of health promotion as it is both a critical dimension of health and a key factor shaping the migrant experience (53,54). Gender impacts not only freedom of movement but access to and control over such things as resources and information (54). Men and women also differ, both in terms of the risks and opportunities faced during migration and in the roles and responsibilities assigned to them by society; these influence the causes, consequences and management of poor health (29). When women are empowered with respect to their health, they are better positioned for the roles they have as workers, leaders, mothers, caregivers and volunteers. Healthy women are important catalysts for positive health outcomes and social change that extend across various domains in the wider community (52). The integration of gender into health promotion activities and the empowerment of women

are essential for the success of such activities and for stronger, healthier and more resilient communities (29).

The concept of empowerment as an aspect of strengthening community actions is also related to building community capacity. Capacity-building is the process of enablement to increase the assets, skills and attributes that a community is able to draw upon to be able to take control over its own health matters and well-being, and cope with challenges (55,56). Community capacity is a necessary precondition for developing, implementing and maintaining effective community-based health promotion interventions (55). There are a number of established descriptions and techniques for strengthening and measuring community capacity in a cross-cultural context using aspects of community capacity that allow individuals and groups to better organize themselves. The domains approach (56) uses nine empowerment domains to evaluate, measure and operationalize community capacity-building: improve participation, develop local leadership, increase problem-assessment capacities, enhance the ability to question, build empowering organizational structures, improve resource mobilization, strengthen links to other organizations and people, create an equitable relationship with outside agents, and increase control over programme management. Each domain is an indication of a robust and capable community, with strong organizational and social abilities to mobilize action (55). Such domains, or indicators, are distinct from both population health indicators and programme-specific indicators.

Working with community-based and voluntary organizations that support refugee and migrant groups can be an effective tool for promoting empowerment and strengthening community capacity and action (57). This may include forging working relationships with diaspora organizations, which have been recognized as potentially effective development partners (18). Cooperation with community-based organizations can be an effective way to bolster these efforts; the work of these organizations may span advocacy, humanitarian assistance, integration-related activities and provision of specific health promotion services (e.g. in nutrition, reproductive health or disease prevention). Collaborative partnerships can bring diverse expertise to address the complex health needs of refugees and migrants (18). Moreover, such organizations are often well placed to leverage their network and resources to enhance participation and ensure local cultural needs are being addressed, and they often have stronger links with emerging migrant and ethnic minority communities than do public sector organizations (57). This may be particularly the case for refugees and asylum seekers, where lack of trust in public authorities can be a barrier to engagement (57). In this way, community-based organizations can play a key role as interagency intermediaries between government services and the specific needs of refugee and migrant communities, and provide an efficient link for the delivery of information, resources and services (Case study 3). They also have potential to improve impact and cost-effectiveness of interventions.

Case study 3. Neighbourhood Mothers project (Germany)

Challenge

The area of Neukölln in Berlin has a long history of welcoming migrants, with currently more than 40% of the population being foreign born (58): up to 85% of the students in some schools in the area do not have German as their first language and many migrants are from Turkey and, more recently, Roma families from Romania and Bulgaria. Rapid growth of the area, combined with changes in the demographics of the population, has led to a number of challenges. These include isolation of newly arrived migrants and difficulties in reaching out and engaging families who do not yet speak German (58).

Action

Neighbourhood Mothers began as a grassroots outreach project aimed at promoting access to information and services that would help families with young children up to the age of 12 (58). It is based on the principle that the best people to help migrant mothers are those who have shared similar experiences, that is other migrant mothers. Mothers in the area who are migrants, are unemployed and can speak German undergo training, including on primary schooling, to be able to connect parents with early education professionals and teachers. They are then sent out to meet with newly arrived and often isolated families (58,59). The mothers first meet informally, over a cup of tea, and talk about the challenges of everyday life in their new homes, especially as it relates to their children and families, education, health and well-being (58). They continue to meet on a regular basis to discuss specific needs and what supports or services are available to the family in the community. The programme also cooperates closely with local childcare centres, cafes for parents, school-based youth centres, school officials and teachers, with all contributing to the success of the programme (58). The programme now has a network of over 100 neighbourhood mothers from different nationalities and is sustained by strong partnerships with various local and regional bodies, including the Senate Department for Urban Development and the Environment, and the Senate Department for Integration, Labour and Social Affairs (58). The project has been replicated in other parts of Berlin and has also been adapted in Denmark (58).

Results

Using a peer-education strategy, the Neighbourhood Mothers programme works to promote social inclusion and well-being by drawing and building on the existing resources and capacities of the local community. It recognizes that mothers have a unique role within their families and communities in terms of taking care of their health and are, therefore, important agents for change and health promotion activities. The intervention also empowers women on both sides of the relationship. Newcomers are connected to essential social services and are at reduced risk for isolation, while neighbourhood migrant mothers gain employment, income and status in the community (59). Furthermore, the project benefits the local government on a larger scale by facilitating interaction with otherwise hard-to-reach and isolated families across relevant sectors and encouraging social cohesion as a whole (59).

Develop personal skills

Personal and social development is important to increase the options and pathways available to people to exercise more control over their own health and their environments, and to make choices more conducive to health (1). Enabling people to learn and to cope with the conditions in which they live and manage illness is essential and must be facilitated in school, work, home and community settings (1). Language skills are a core component of this approach, as language proficiency is a key facilitator of integration and for accessing and utilizing services such as health and social services (30). More specifically, health literacy is an important concept for promoting the personal and social development of refugees and migrants for improved health. Health literacy is the ability to access, understand, appraise, communicate and apply health information to maintain good health and well-being and to make sound health-related decisions (21,60,61). Levels of literacy in this context include functional literacy, which relates to skills needed to function in everyday situations; interactive literacy, which relates to skills needed to actively participate in everyday life and cope with changing circumstances; and critical literacy, which relates to skills needed to analyse information and use it to exert greater control over life events and critical situations (45).

It is increasingly recognized that health literacy is a critical determinant of health and a potentially modifiable contributor to health inequalities (13,33). That is, people's health literacy levels have significant influence on their ability to coherently advocate for their own health-related needs, and also on their health-seeking behaviours, including utilization of screening and immunization programmes, compliance with curative and preventive treatments and management of chronic diseases (34,62). Strengthened health literacy enables engagement with health promotion activities, increases use of health services and improves health outcomes across the life-course; conversely, lower health literacy is more associated with unhealthy choices and riskier behaviours (13,45). Lower health literacy has also been found to be correlated with increased hospital and emergency admissions and longer inpatient stays, poorer medical adherence and increased adverse medication events, increased health care costs, lower engagement in prevention activities, higher prevalence of health risk factors and comorbidities, poorer disease outcomes and overall health status, and less effective communication with health care practitioners (33,45). Some research has suggested that poorer health outcomes among certain populations, including refugees and migrants, are at least in part attributable to lower levels of health literacy in the host environment (33,61). Linguistic barriers and variances in cultural understanding and belief around health and health care limit access to resources (including information and communication technologies) and culturally appropriate services. These barriers together with differences in the operation of health care systems are potential constraints to health literacy among refugee and migrant populations. Improving health literacy as a strategy for health promotion may be an effective way to reduce health inequalities in the host country.

It is important to emphasize that refugee and migrant groups are not homogeneous in respect to health literacy levels, and that health literacy is associated with other demographic and social factors such as age, gender, socioeconomic status, educational attainment, ethnic background and access to social supports (63). As such, measures of health literacy should not rely solely on proficiency of language literacy and numeracy. Moreover, the concept of being health literate is contextually and culturally specific (64). Migrants are never health illiterate but have their own knowledge, values and attitudes about health and illness. Importantly, these influence their health-seeking behaviours, approaches to disease management, recognition of symptoms and perspectives on concepts such as chronic disease, mental illness, self-rating and communication of health concerns, and decision-making in regard to acting on the instructions of health care providers (62–64). In a European health care context, cultural beliefs and understandings may differ or even be at odd with those that underlie the mainstream health system; consequently, developing health literacy is rather a process of acculturation and resocialization (64). It is also important to ensure that all of a population can use the access methods of a health system (Case study 4).

Case study 4. The NHS Widening Digital Participation programme (United Kingdom)

Challenge

With the continuing shift towards digital by default and digital-first services throughout the health care system in the United Kingdom, there is a risk for growing health inequalities in the country (65). Overlap between groups who are digitally excluded and those at risk of poor health is significant, with clear correlation, for example, between the socioeconomic status of a ward area and the levels of basic digital skills of its inhabitants and their average life expectancy (66). Marginalized and vulnerable groups tend to be more digitally excluded and in worse health (66). With 12.6 million people in the United Kingdom lacking basic digital skills, and 5.3 million having never been online, the health inequalities already experienced by these groups may become more pronounced as health services increasingly require higher levels of digital health literacy for navigation (66).

Action

The NHS Widening Digital Participation programme (September 2013 to March 2016) was intended to improve the digital skills and digital health literacy of groups most affected by health inequalities to allow them to take charge of their own health (65). These include those who were unemployed, disabled, in receipt of benefits or living in social housing; minority groups (Black, Asian, other ethnicities), refugees and asylum seekers, gypsies and travellers; and those learning to speak English as a second language (65). Over the three years of the project, more than 387 000 people were reached to help them to manage their health with digital tools and resources, and more than 221 000 people trained to use digital health resources (65). Furthermore, 8000 volunteers were trained to promote awareness and use of digital resources (65).

Case study 4. (contd)

Results

The improved digital health literacy skills and confidence gained by those supported through the programme led to direct impacts on their behaviour, resulting in changes in lifestyle and/or the way they engaged with health services (65). Learner achievements included accessing health information online for the first time, going online to find health services, booking general practitioner appointments, ordering repeat prescriptions, using the Internet and sites such as NHS Choices to search for non-urgent medical advice, and using the Internet to look up information on health conditions and tips for staying healthy (65). Such behaviour changes have resulted in significant cost savings for the National Health Service in the United Kingdom. Evaluation of the programme found total annual potential savings of £6 million (€6.6 million) from reduced visits to general practitioners (£3.7 million) and accident and emergency departments (£2.3 million) (65). Other positive outcomes included learners reporting feeling less isolated or lonely and feeling more self-confident as a result of learning digital skills, as well as feeling that they were more informed about their health and were more confident using online tools to manage their health, including exploring ways to improve mental health and well-being (65).

Reorient health services

Reorienting health services for the promotion of refugee and migrant health is about ensuring that available services are inclusive, diversity sensitive and responsive to the particular cultural needs of target groups. Central to this is cultivating the cultural competence of health practitioners in order to effectively engage with refugees and migrants in a sensitive way in a cross-cultural context: placing people at the centre of health care interactions and meaningfully considering the diverse needs, beliefs and experiences of patients, including with respect to vulnerable subgroups. As language mediates most experiences of practitioner–patient interactions, effective cross-cultural health communication is an important aspect of cultural competence. The utilization of bilingual and bicultural health providers, as well as the use of interpreters and cultural mediators, has been the focus of much research. Studies have demonstrated that where bilingual health workers are unavailable, formal interpreters are considered best practice interventions for intercultural consultations by migrant service users, general practitioners and health service planners (67,68). Efforts to surmounting linguistic barriers through such interventions are important for ensuring appropriateness of care, patient satisfaction and improved health outcomes (69). It also has the potential to improve cost–effectiveness of health care, including through increasing the accuracy of patient medical histories and reducing unnecessary diagnostic testing (69).

Cultural competence in this context also relates to health literacy, as discussed above, but emphasizes the health literacy responsiveness of health systems and caregivers (33). Health literacy responsiveness is about the way in which services, environments and products make health information and support available and accessible to people with different health literacy strengths and limitations (33). Essentially, variations in the accessibility of information place greater or lesser burdens on the health literacy of individuals (33). The more readily accessible such information is, and the more permeable services are designed to be, the lower people's health literacy is required to be for uptake and utilization (33,34). The 2015 Migration Integration Policy Index found that many countries in the WHO European Region have yet to make progress in regard to the responsiveness of services, including in the provision of language support (70).

Cultural competence and the development of sustainable diversity-sensitive, adaptive and person-centred care systems is not, however, only a question of language and interpretation (69). Culture can be thought of as an ever-evolving array of collective values, ethics, assumptions, beliefs and traditions that influence people's understandings and experiences of health and illness (71). Recognition and description of disease as well as decisions to accept, resist or reject health care interventions depend, to a great extent, on people's systems of belief and culture (34). Paying attention to cultural contexts within health policy and care services is, therefore, critical, as even the best medical care is limited if its provision does not align with the priorities and perceived needs of those it seeks to serve (71). Failure to attend to differences in culture increases likelihood for negative outcomes such as diagnostic errors, adverse drug interactions (e.g. from combined use of traditional and conventional medications), inadequate adherence to prescription regimens or follow-up or missed opportunities for screening (69). Stereotypes and assumptions about cultural differences, and perceptions of social deservingness, can be embedded within health care systems may lead not only to further marginalization over time but also lower quality and efficacy of care (34,71). Culturally competent health care is important not only as an end in its own right but also for its potential to reduce disparities in the accessibility and quality of health care between refugee and migrant groups and mainstream populations (69).

Reorienting health services to include a cultural understanding of refugee and migrant populations is, therefore, critical to developing health resilience and ensuring equity in health systems. Applying an approach based on cultural contexts of health calls for the critical examination of the values practitioners may attribute to others and to themselves, their perceptions and their decision-making processes regarding health (Case study 5) (71). It requires recognition that all forms of knowledge and practice (including clinical medical models of health) are influenced by culture, thereby opening up new models of care and the utilization of mixed-method research with evidence that goes beyond the scientific and biological. Viewing care in purely clinical terms leaves health systems ill-equipped to address the fluidity of culture and the intersecting social factors, such as migration, that are drivers of health and illness among refugee and migrant groups (71).

Case study 5. Adaptation training for Syrian health professionals (Turkey)

Challenge

The flow of refugees from the Syrian Arab Republic since the beginning of conflict in 2011 has been described by the Office of the United Nations High Commissioner for Refugees as the greatest wave of migration in recent history, with millions displaced (72). Turkey hosts the largest number of refugees, with more than 2.9 million Syrians under temporary protection in the country (72). Turkey also hosts an additional nearly 350 000 asylum seekers and refugees from other countries, predominately Afghanistan and Iraq (72). Access to health care for refugees in Turkey is a major concern. While the country offers universal health care, many are reluctant or unable to access health facilities and utilize services because of barriers, particularly language and cultural barriers (73).

Action

With support of the European Union, the Ministry of Health in Turkey has engaged in an initiative to employ Syrian health professionals to work in the Turkish health system among the refugee community. Seven training centres have been established across Turkey where Syrian refugees who are doctors, nurses, midwives or other specialists have undertaken a WHO-supported adaptation course with the aim of certification for employment by the Ministry of Health to work within health facilities in Turkey (74). The training course has both theoretical and practical components to familiarize them with, and support their adaptation to, the Turkish health care system and any differences in regulations (74,75). It is not intended to re-teach their profession (73). In 2017, over 850 Syrian health professionals had been trained to practise in Turkey (76). The training centres have also provided training for Turkish–Arabic translators to provide translation services in both primary and secondary care facilities (72).

Result

The integration of Syrian medical professionals into the health system in Turkey helps to address many of the specific needs of the refugee communities. It serves to overcome the main constraints faced by these refugees in accessing care, namely the linguistic barriers and the cultural aspects of administering services (73,75). Enabling the Syrian health staff to work also empowers them in helping and serving their communities, providing social and psychological benefits. This initiative is not only a good example of partnerships in practice but also of novel ways of reorienting health services to deliver diversity-sensitive and culturally competent care (75).

Policy considerations

Relevant policy considerations are provided across the five priority areas of the Ottawa Charter and have been selected with a view of advancing its goals. The considerations, therefore, reflect many of the basic principles of health promotion that are relevant to all population groups and are inclusive in nature. Nevertheless, they have been put forward with diversity sensitivity in mind in order to maximize potential benefits for refugee and migrant groups specifically, which is the ultimate aim of this technical guidance. Annex 1 contains available resources for each of these five priority areas to support policy-making.

Priority areas to support policy-making

Adopting a HiAP approach to ensure policies within all sectors of government promote the health of refugees and migrants

- Available tools and resources should be used to promote greater consideration of potential health consequences of public policies and programmes within non-health sectors.
 - There is no single agreed method for undertaking such assessments (e.g. HIA or health equity impact assessment) but multiple guidance documents and frameworks are available (see Annex 1). Decision-makers should select tools that have been designed for a comparable context, purpose and level of available resources (36).
 - Assessments should deliberately include different subgroups of refugees and migrants in their scope and empower them to have a proactive role in defining and addressing concerns. Equity considerations must be well defined, and migration status should be regarded as distinct from ethnicity, culture, language or religion.
 - Assessments should engage refugees and migrants through community consultation although the diversity of migrant populations may make authentic engagement challenging. Multistakeholder dialogue including relevant advocates, agencies and community organizations and partnerships may be useful to ensure migrants are not only considered but reciprocally understood in order to maximize the nuance and value of the assessment recommendations.
 - Issues of interpretation, limited resources for facilitation and competing interests can constrain participation of migrants.
 - Assessments should consider all those affected by migration, such as local disadvantaged populations, in order to promote sustainable policy recommendations and reduce the risk of polarizing certain communities.

- Assessments should be evidence informed, and capacity to source migrant-specific data should be promoted, particularly for less accessible populations such as temporary workers, asylum seekers and irregular migrants.
- Gaps in data could be addressed by sourcing international and regional sources of data, using equity extrapolation methods where appropriate. Local organizations and advocates for migrant communities may also have data on indicators such as service utilization.
- Investment in health information systems and health-monitoring activities increases the availability of comprehensive and up-to-date comparable and disaggregated data, which is critical for monitoring health inequalities and the development, implementation and management of effective and targeted health promotion activities.

Improving social services, and the quality of physical and social environments

- Promotion of integration and cultural exchange between refugees and migrants and the wider communities in which they live improves health and well-being for all. Intercultural dialogue and education can help to develop a positive narrative around migration and raise awareness of migrant cultures and the positive contributions of migrants to society. The European Union has published the Common Basic Principles for Immigrant Integration Policy in the EU (46) to foster meaningful integration and improved social cohesion (46).
 - The Council of Europe Intercultural Cities Programme supports cities in renewing their policies through an intercultural lens, and in developing intercultural strategies to help manage diversity in a positive way (77). Thematic initiatives include countering diversity-related prejudice, the economic benefits of diverse communities and refugee inclusion. The programme also provides good practice examples and numerous resources for developing intercultural cities such as policy briefs and evidence papers, as well as guidelines and to-do lists.
 - The Observatory of Public Attitudes to Migration (78) helps to enhance understanding of the attitudes towards migration in different host countries in Europe based on indicators such as welfare, security, culture and economics. This knowledge can help in developing interventions that also engage host communities for reducing stigma and discrimination against migrant populations.
- Expenditure on social services has potential to bring greater return on investment for health outcomes than equivalent expenditure within the health care system. Such investments can strengthen individual and community resilience, improve the quality of physical and social environments and improve health outcomes for refugees and migrants. Place (public spaces, and natural and physical environments) and housing are particularly important considerations as these are significant determinants of health and well-being, and of health inequity, both within and between migrant populations and host communities.

- Areas of lower socioeconomic status, where refugees and migrants often live, are more likely to suffer negative consequences associated with poor physical and social environments: poor air and noise quality, proximity to pollution, lack of public transport links, restricted access to services, social isolation and feeling of insecurity. Commitments to regenerate these more deprived areas will have positive effects for all living there. Regeneration projects should pay attention to urban design, effective transport, safe and inclusive meeting spaces, different housing types and housing affordability. Support for local business and job opportunities should also be prioritized, including through community-based and volunteer organizations working with refugees and migrants.
- Tools are available to support the development of healthy environments.
 - The Place Standard tool of NHS Scotland (79) assesses quality of place, including places that are well established, undergoing change or still being planned. It provides a simple framework to think about the physical elements of space (e.g. buildings, spaces and transport links) as well as the social aspects (e.g. community inclusion and social contact) to help in deciding priorities and actions.
 - The Scottish National Standards for Community Engagement (80) are good practice principles to support user engagement in the creation of supportive environments, including in community planning and health and social care. The National Standards were developed for, among others, public sector bodies to identify target communities and plan how they can be fairly involved in shaping local plans and services. This resource may be helpful for other European countries and for tailoring specifically to engage migrant communities.

Prioritizing community-centred approaches that build local capacities

- Investment in community-centred approaches can help to mobilize resources and assets within refugee and migrant communities: the skills and knowledge, social networks and local groups and organizations that are the foundations for effective health promotion. Community development, social-network methods, peer support and education, health champions, volunteer schemes, co-production projects and community-based commissioning are all part of such an approach (81). While cost-effectiveness of such community capacity-building and volunteer programmes is difficult to measure, research indicates they nevertheless bring a positive return on investment (81).
 - Effective community-centred approaches must place migrant communities in an active role and avoid entirely top-down programming as this not only creates passive involvement for communities but also risks missing the interests and concerns of individuals (55). Importance should also be placed on applying existing evidence to the local context and adapting approaches for maximum efficacy.
 - Where appropriate, frameworks such as the domains approach can guide assessing and increasing community capacity (see above (56)). Practical

application of the domains approach to health promotion initiatives in cross-cultural settings has been outlined and described as a promising practice in Turkey (73).

- Gender should be an important aspect of all health promotion activities for refugees and migrants so that both men and women are empowered to realize their full health potential. Women have the potential to be positive agents for change and multipliers for improved health outcomes. Approaches should be applied that are not only sensitive to gender but also transformative in that they take into account gender-specific factors that can hinder the promotion of health and address the causes of gender-based health inequalities among refugee and migrant communities (29,82).
- The resources, trusted status and existing communication channels of local community-based organizations and civil society partners, including diaspora organizations, means that these networks can help in reaching and engaging with refugees and migrants, acting as interagency intermediaries to improve impact and cost-effectiveness of interventions.

Investing in language support and health literacy initiatives to develop personal skills

- General and job-related language support and training courses should be widely available and provided free of charge because language learning is an essential component of effective integration and specifically facilitates access to health care and social services (30).
- Relevant health literacy interventions for refugees and migrants include improving access to health education in primary and secondary schooling, and engaging in outreach initiatives to target adults. Interventions should embrace information and communications technology, including mobile technology and social media, as means to disseminate information and for migrants to actively seek information (18).
- The development and implementation of health promotion activities should be supported by an evidence base and key indicators to identify, measure, monitor, evaluate and report on factors such as health literacy levels, patterns of health-seeking behaviour and service engagement. These data can then be used to develop local-, regional- and country-specific recommendations on relevant areas and needs for capacity-building given different social, economic and political contexts (33).
 - There are resources, such as Ophelia, for effective development of health literacy policies and interventions (83,84). Ophelia supports the identification of community health literacy needs and the development and testing of potential solutions using three phases: identifying the health literacy strengths and limitations of the community (e.g. using the Health Literacy Questionnaire and the Information and Support for Health Actions Questionnaire); co-creation of health literacy interventions; and implementation, evaluation and ongoing improvement.

- Tools that measure individuals' health literacy should be used with caution.
 - Individual data need to be supplemented with data about the roles, influence and experiences in decision-making processes of family or community members.
 - Measurement approaches must be able to detect the different capacities that people have for engaging with health information and allow for the fact that individuals and communities may develop their own effective strategies for engagement.
 - Qualitative investigation should be encouraged to supplement and inform quantitative health literacy measurements.

Promoting cultural- and diversity-sensitive approaches to health care, and building a culturally competent health workforce

- Cultural-sensitivity training across the health care sector should be provided for all professionals from initial training through to continuous professional development. Leadership and management staff should also be targeted to promote both the ethical and economic imperatives of culturally sensitive health care.
- Training should include modules on developing awareness of unconscious stereotyping and of how cultural practices and related assumptions about others can lead to marginalization and increased inequities.
- The health literacy responsiveness of health services depends on a culturally competent workforce and provision of readily accessible information, for example in multiple languages and via outreach initiatives. This is essential to reduce barriers to utilization of health services and reduce the gap between community needs and support provision.
- Migrants, and their children born in the host country, should be recruited into the public sector workforce, not just into health care but also into other sectors such as education and law enforcement that influence health and well-being. This will better reflect and allow effective responses to the ethnic and cultural diversity of their communities and societies (30).

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Annex 1. Resources and tools to support policy considerations for health promotion

A HiAP approach to ensure policies within all sectors of government promote the health of refugees and migrants

European Policy Health Impact Assessment: a guide

http://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_a6_frep_11_en.pdf

European Portal for Action on Health Inequalities: health impact assessment

<http://www.health-inequalities.eu/tools/health-impact-assessment/>

International Association for Impact Assessment: tips, best practice and guidance documents

<https://www.iaia.org/publications.php>

National Collaborating Centre for Healthy Public Policy, Canada: health impact assessment guides and tools (inventory)

<http://www.ncchpp.ca/docs/HIAGuidesTools2008en.pdf>

WHO short guides to health impact assessments

<http://www.who.int/hia/about/guides/en/>

<http://www.who.int/hia/tools/process/en/>

United Kingdom Department of Health and Social Care: health impact assessment of government policy (a) guide to carrying out an assessment, (b) guide to sources of evidence and (c) guide to quantifying health impacts

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216009/dh_120110.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216006/dh_120109.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216003/dh_120108.pdf

Improving social services and the quality of physical and social environments

Intercultural cities programme

<https://www.coe.int/en/web/interculturalcities>

NHS Scotland Inequality briefing 4: place and communities inequality

<http://www.healthscotland.scot/publications/place-and-communities>

NHS Scotland Inequality briefing 5: housing and health inequalities

http://www.healthscotland.scot/media/1250/housing-and-health_nov2016_english.pdf

Observatory of Public Attitudes to Migration

<http://www.migrationpolicycentre.eu/opam/>

Place Standard Tool

<https://www.placestandard.scot/#/home>

Scottish Community Development Centre: National Standards for Community Engagement

http://www.voicescotland.org.uk/media/resources/NSfCE%20online_October.pdf

WHO Regional Office for Europe: Health 2020 (pp. 122–34)

http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf?ua=1

Prioritizing community-centred approaches that build local capacities

Health Evidence Network synthesis report 59: domains approach

[http://www.euro.who.int/__data/assets/pdf_file/0010/382429/hen-59-eng.pdf?ua=1,](http://www.euro.who.int/__data/assets/pdf_file/0010/382429/hen-59-eng.pdf?ua=1)

NHS England: guide to community-centred approaches to health and wellbeing

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/402889/A_guide_to_community-centred_approaches_for_health_and_wellbeing__briefi____.pdf

Usability of the domains approach: Sport, Peace and Development (pp. 319–38)

<https://www.sportanddev.org/sites/default/files/downloads/sportpeaceanddevelopmentreduced.pdf>

Investing in language support and health literacy initiatives to develop personal skills

Ophelia: optimising health literacy to improve health and equity

<https://www.ophelia.net.au/>

<https://www.ophelia.net.au/bundles/opheliapublic/pdf/Info-Sheet-7-The-Ophelia-Approach.pdf>

WHO Regional Office for South-East Asia: health literacy toolkit for low- and middle-income countries

http://apps.searo.who.int/PDS_DOCS/B5148.pdf?ua=1

Cultural- and diversity-sensitive approaches to health care, culturally competent health workforces

Migrant Integration Policy Index: health system responsive to migrants' needs

<http://www.mipex.eu/health>

WHO Regional Office for South-East Asia: health literacy toolkit for low- and middle-income countries

http://apps.searo.who.int/PDS_DOCS/B5148.pdf?ua=1

The WHO Regional
Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
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