

Review

# The Challenge of Promoting the Health of Refugees and Migrants in Europe: A Review of the Literature and Urgent Policy Options

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**Abstract:** This paper provides a rapid review of the literature on the current knowledge on health promotion for improved refugee and migrant health in the European region. The aim of the paper is to identify implications for future policy and practice. The literature review used standard systematic methodologies to search databases followed by data extraction and synthesis. General sources of grey literature were also included in the review as well as consultations with people working in the field. The paper identifies the lack of knowledge on how to engage with refugees and migrants in a culturally competent way, to address fear and violence and the application of health literacy. The review of the literature also identifies evidence to support peer education, working with community-based organisations and the tailoring of interventions to the needs of refugees and migrants. The paper concludes with a discussion of the technical content and future implications for the implementation of health promotion programs.

**Keywords:** health promotion; migrants; refugees; Europe; awareness raising; community capacity; health policy; cultural competence

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## 1. Introduction

European countries are experiencing an unprecedented flow of refugees and migrants with an estimated 31.9 million non-European nationals residing in Europe. In particular, the events in North Africa and the Middle East continue to raise migration trends, with an estimated 362,753 in 2016 and 172,301 in 2017 arriving via the Mediterranean of mostly African and Middle Eastern nationalities [1]. Many refugees and migrants come from countries whose healthcare systems are weak and where conflicts and poverty have impacted on the quality of services such as screening and vaccination. Women are especially vulnerable as they face challenges in regard to maternal, newborn, and child health and sexual and reproductive health. Children are prone to respiratory and gastrointestinal illnesses and if unaccompanied are vulnerable to trauma and violence. Communicable diseases are primarily associated with poverty, and refugees and migrants are particularly vulnerable to vaccine-preventable diseases such as measles, tuberculosis, and hepatitis and to food and waterborne infections. Many will become a core part of European society and become susceptible to chronic cardiovascular and respiratory diseases, cancers, and diabetes. Many refugees and migrants also suffer post-traumatic stress disorder, mood and anxiety disorders, and panic attacks, with symptoms of sleeplessness and feelings of stress [2].

The aim of this paper is to provide a review of the literature on the current knowledge on health promotion for improved refugee and migrant health in the European region and to identify implications for future policy and practice. Health promotion covers a broad range of activities that

overlap with other sectors and professional fields and has evolved as a set of principles involving equity and empowerment and as a practice that encompasses a range of communication, capacity building and politically orientated activities [3]. Simply put, the goal of health promotion is to enable others to gain more control over the influences on their lives and to improve their health [4]. Over time, as our understanding of society has changed, the role of the social determinants of health has developed as a new area of professional concern [5]. Developing policy solutions to address the social determinants of health has led to an inter-sectoral approach, Health in All Policies (HiAP), for example, recognises that health and wellbeing are influenced by government sectors other than health [6]. The Shanghai Global Conference on Health promotion has further positioned health promotion within the policy agenda of the sustainable development goals to ensure that all people enjoy peace and prosperity [7]. At a program level, health promotion is largely controlled by government or (government-funded) Non-Governmental Organizations that employ practitioners to deliver information, resources, and services. Whilst some countries have a dedicated health promotion workforce, many others work in nursing, education, and social welfare to provide technical information and to motivate people to make changes in their behaviour.

Understanding the perceptions of refugees and migrants can have important implications for health promotion practice which should recognize the subtle cultural and organizational differences between ethnic groups. Refugees and migrants are faced with restricted legal and human rights, a poor understanding of the local language, different spiritual and cultural beliefs, and a low income. This can lead to feelings of social isolation that can place them in a vulnerable position of poor health compounded by limited access to health care and social services [8]. The role of the health promoter is to facilitate training, resource allocation, and education and to work in partnership with refugees and migrant organisations to enable people to gain more control over their lives and health.

In this paper the internationally agreed definition for a migrant is used as “any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is”. In this paper the internationally agreed definition for a refugee is used as “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 opinions, 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” [9]. These definitions do not include people travelling for the purposes of tourism.

## 2. The Methodology

A rapid review of the literature was used to understand the current knowledge on health promotion for improved refugee and migrant health in the European region. The review included searches that covered a period from 1 January 2007 to 31 December 2017. This period was selected because health promotion approaches for refugee and migrant health are relatively undeveloped and this timeframe was considered adequate to cover new literature. The review of the literature provides an overview of the available evidence within a specific time frame and used standard systematic methodologies to search databases followed by data extraction and synthesis. The search strategy focused on terms used in the title, key words, and abstract specifically for health promotion with a combination of the following keywords: (health promotion) AND (migrants or refugees); (health promotion) AND (migrant health or refugee health); (migrants or refugees) AND (health). Literature retrieved through the keyword search were screened through a hand-search by the author to identify the most relevant documents for the European context.

Electronic databases that provide an advanced search facility and include articles in public health, health promotion, and social sciences were used, including Pubmed/Medline, ScienceDirect, and Popline. In addition, electronic databases that provide a basic word search facility were also used, including Google scholar and ResearchGate. General sources of grey literature were also included in

the review such as BASE and WorldCat. The websites of key organizations in the field such as the International Organization for Migration and NGO agencies such as the International Federation of the Red Cross were included.

Secondary sources of information were also taken from systematic reviews and meta-analyses from a broader international context and were included in the review with a focus on European countries. The data extracted was a total of 357 records, but after review of the abstract and duplicate removal, this led to a total of 30 that were eligible for secondary review. A further four articles were added through referral by consultation with people working in the field, resulting in a total of 34 records that were finally used in the review in addition to other general citations.

### 3. The Findings

The findings of the literature review show what has worked and what does not work in health promotion for refugee and migrant health in Europe. Health promotion for refugee and migrant health has not been developed as a field of expertise, and much of the present experience only reflects what is already known: the importance of engaging with community-based organizations and using culturally appropriate methods and messages. The findings of the literature review also show that health promotion programs use a variety of techniques to raise awareness and to develop specific skills including communication activities using the mass and social media to raise awareness, health literacy, participatory theatre, peer education, printed materials in various languages, and counselling and self-help groups. However, increased resources, better training of health-care staff including cultural competence, and tailored health promotion programs were lacking [10].

A meta-analysis of health interventions for immigrants, mostly in the USA, found that they addressed only non-communicable diseases such as attendance at cancer screening services and used individually targeted approaches at health centres. Interventions for vulnerable groups especially for unaccompanied children and the elderly were found to be limited [11]. A systematic review of forty-two articles on economic migrants in Russia focusing on the social determinants, health behaviours, and health systems covered people originating from Central Asia (Uzbeks, Kyrgyz, and Tajiks). Practical strategies for improving the health of migrants included the development of online portals and apps for migrant health issues, the collation of the evidence of best practices, inexpensive legal support, and information on health and nutrition in migrant languages through local organizations. Creating employment opportunities and providing culturally competent health practitioners to implement health promotion programs were also important [12].

The review of the literature next discusses that there is insufficient evidence regarding how to

- Effectively engage with refugees and migrants in a culturally competent way;
- Address fear and violence;
- Apply health literacy in the everyday working lives of health professionals.

#### 3.1. Strengthening Cultural Competence

The review of the literature identified one study that aimed to better understand the perspectives of health researchers and promoters located in the USA, UK, Australia, New Zealand and Norway working with ethnic minority populations, specifically of African, South Asian and Chinese origin in regard to smoking cessation, increasing physical activity and healthy eating. The findings complemented what is already known about working with ethnic minority populations including the importance of community engagement and building trusting relationships, using preferred methods to deliver messages and materials and building linkages with existing local organizations. However, the study concluded that adaptive interventions to specific cultural norms, religion, or shared ancestry can add to the complexity of a program as they often did not offer a practical solution to the issue [13].

A health promotion program in The Netherlands on risk detection and reduction, wellbeing, quality of life, and participation was guided by Western values of independence and personal control.

However, it did not meet the expectations of female senior migrants with a Surinamese-Hindustani background. Despite the fact that the senior migrants were willing to invest in their health, and despite the fact that the professionals were willing to adapt the program to the seniors, it turned out that it was very difficult to achieve the goals of the program. The reason was a clash of expectations between the migrants and the professionals. The migrants expected to be given information, yet the aim of the program was for the migrants to formulate personal goals, to reflect on daily habits, and to work systematically toward lifestyle changes [14]. The design of the health promotion program was not culturally sensitive and did not adequately engage with the migrant population.

Whilst the literature did not clearly address a distinction between migrant and refugee interventions in regard to cultural and linguistic diversity, it did recognise that communication in a cross-cultural context is more than just the provision of interpretation services. However, this can play a valuable role, and the literature did discuss the utilization of bilingual health providers and the use of interpreters, cultural translators, and mediators. Research across five European countries has showed that where interpreters are used, general practitioners report a clearer understanding of migrants' symptoms and migrants are more likely to trust diagnoses [15]. The findings of a study of Turkish migrants in The Netherlands also reported greater trust in informal interpreters rather than formal interpreters. Patients felt empowered by their presence because they assumed that informal interpreters such as family and friends would act in their best interests [16]. The challenge faced by general practitioners on a daily basis because they do not have a shared language or cultural background can result in misunderstandings and communication breakdowns. To address this issue, guidelines for communication in cross-cultural general practice consultations in Ireland advocate the use of bilingual general practitioners as best practice although strategies such as the use of dictionaries or technological or visual aids were considered as having a lower acceptability among patients [17]. The lack of empathy and of cultural sensitivity of health personnel were also found to be important factors that have an influence on the health of migrants in the EQUI-HEALTH project. This aimed to improve access to quality health care services for migrants, Roma, and other vulnerable ethnic minority groups in the European Union, the European Economic Area, Croatia, and Turkey [18]. An intervention to increase knowledge levels in the Turkish community in The Netherlands was developed about the consequences of hepatitis B, such as liver cancer. However, appropriate communication about the available screening services for this disease in the community was lacking and was a cause of failure in the design of the intervention [19]. The review of the literature did not identify clear, pragmatic approaches to improve cultural competence in health promotion practice. Health promotion will not be culturally competent to work with migrants until this subject has become a core part of the theoretical and practical training of health promoters and the needs of migrants are always placed at the centre of health promotion programs [20].

### *3.2. Fear and Violence*

One systematic review examined the reasons for HIV status disclosure and nondisclosure among African immigrants residing in Europe and found that stigma and the social implications of disclosure contributed to avoidance behaviours such as not seeking support or helping others [21]. The fear of deportation because of HIV/AIDS was the most important determinant of reluctance to seek care for HIV, after adjusting for socio-demographic factors, knowledge level, stigmatizing attitudes, and fear of disclosure with migrants in Northern Sweden. Targeted health promotion interventions were needed to reduce fear and stigma, to empower migrant women, and to raise awareness about the benefits of seeking health care [22].

A cross-sectional population-based quantitative survey combined with an explanatory qualitative study in eight sites, representing a range of settlements in Greece aimed to document the types of violence experienced by migrants and refugees. The study found that the literature lacked epidemiological evidence on the experiences of violence and on the mental health problems that refugees and migrants faced during their displacement. The cross-sectional survey consisted of a

structured questionnaire on experience of violence and an interviewer-administered anxiety disorder screening tool. In total, 1293 refugees were included, of whom 728 were Syrians (41.3% females) of median age 18 years (interquartile range 7–30). Depending on the site, between 31% and 77.5% reported having experienced at least one violent event in Syria, 24.8–57.5% during the journey to Greece, and 5–8% in their Greek settlement. Over 75% (up to 92%) of respondents  $\geq 15$  years screened positive for anxiety disorder. Access to legal information and assistance about asylum procedures were considered poor to non-existent, and the uncertainty of their status exacerbated their anxiety. The study found evidence of high levels of violence experienced by Syrian refugees, high prevalence of anxiety disorders, and significant problems of the international protective response [23].

### 3.3. Applying Health Literacy

Health literacy is the ability to access, understand, appraise, communicate, and apply health information to maintain good health and make sound health-related decisions. Health literacy aims to influence individual health-seeking behaviour including the utilization of screening, compliance to taking drugs and treatments, and the management of chronic disease [24]. It is important that health literacy interventions work collaboratively with migrant groups in order design appropriate health promotion programs. A systematic review of the literature on health literacy found that there is a lack of interventions for vulnerable groups such as migrants. Some health professionals such as nurses have also shown little familiarity with the use of health literacy. Health literacy interventions targeted to immigrant populations have produced mixed results regarding their effectiveness and there is often a limited role that some professions such as nursing have in using these types of interventions [25].

A study in Sweden found that the majority of refugees had poor health literacy and were not able to access, understand, appraise or apply health information. The cross-sectional study of refugees participating in language schools specifically found that 60% had inadequate and 80% had limited functional health literacy, which is measured as the ability to read and understand information, while 27% had inadequate and 62% had limited comprehensive health literacy, which included the ability to obtain, synthesise, process, and utilise information [26]. One study assessing patterns of functional health literacy among four migrant populations in Switzerland found that proficiency in health literacy was associated with various factors such as demographics age, gender, level of education, and ethnic background [27]. The evidence from a study in the UK on the experiences of African migrant communities in accessing health information and services found that participants were concerned about their inability to communicate. Their lack of health literacy skills and proficiency in English was an underlying problem in seeking information and support. The study concluded that there was a need to work collaboratively with migrant groups in order to identify and develop appropriate health literacy and culturally sensitive communication strategies [28].

The findings next discuss that the review of the literature found that there is evidence to support:

- Peer education interventions;
- Working with community-based organisations; and
- Tailoring interventions to the needs of refugees and migrants.

### 3.4. Peer Education Interventions

Peer education is an approach in which people are supported to promote health among their peers rather than by health professionals because lay persons are felt to be in the best position to encourage healthy behaviour to each other [29]. The Community Health Educator model is a health promotion approach that was applied in the United Kingdom in which lay members of ethnic communities were trained and recruited to participate in the delivery of cancer screening. The model enabled peers to not only facilitate awareness-raising but also to involve community members in defining their own health agendas and in the planning and delivery of health promotion activities in their communities.



The model used three stages: Stage 1. Identification of local needs; Stage 2. Development of a health intervention; and Stage 3. Implementation and evaluation [30].

An intervention to address concerns about HIV by migrants used a phone counselling service which was successfully operated by a Training Operating Unit of the National Institute of Health in Italy. The presence of peer mediators answering in the languages of the migrants led to an increase in the number of calls. The creation of this network also helped health operators and peer educators to develop their professional and cultural competences and to become more aware of the health needs of people of different cultural backgrounds [31]. One project in the United Kingdom developed participatory videos in four ethnic language groups by involving migrants in the production of a breast-screening health promotion material. Migrant communities were engaged in the different stages of the video production to provide a more culturally sensitive approach that went beyond language and passive participate. It concluded that participatory video has the potential to promote health messages in communities to strengthen capacity and cultural identities [32].

### *3.5. Working with Community-Based Organisations*

The STI/HIV prevention program aimed to improve the sexual health of Amsterdam residents of African, Antillean, Aruban, and Surinamese origins. The program enhanced the participation of migrant community-based organisations (CBOs) in sexual health promotion through a grant scheme and by providing support to CBOs in developing, implementing, and monitoring STI/HIV projects within their own communities. CBOs have an important role as intermediaries between government services and the specific needs of migrant communities whilst at the same time supporting ongoing STI/HIV prevention programs. The strategy found that using the knowledge and resources of CBOs to promote migrant sexual health through the combination of enhanced participation, a grant scheme, and support and training of health professionals had the potential for the future effectiveness of similar programs [33].

The Stadtteilmütter (Neighbourhood Mothers) project started in 2004 in Neukölln, Berlin on the principle that the best people who are able to help immigrant mothers are those who have shared similar experiences such as other immigrant mothers. The advice that is provided by women with a similar culture helps build trust and the confidence needed to ask questions, get answers, and become receptive to change. The approach uses a peer education strategy in which the mothers first meet informally to talk about their needs of everyday life especially as it relates to their children and families, their education, health, and wellbeing. The mothers meet on a regular basis in a small group setting to discuss specific challenges such as the health and social care services that are available in their community. Neighbourhood Mothers receive training on primary schooling and can connect parents with teachers. The project also cooperates closely with local childcare centres, parent cafes, and youth centres. The sustainability of the approach depends on the inclusion of Neighbourhood Mothers from different nationalities and on partnerships with local and regional government authorities. The project has been replicated in other parts of Berlin and has also been adapted in Denmark. The real success of this approach lies in the way it empowers women and by increasing the interaction of immigrant families with local service providers [34].

Community-based organisations can help promote social media applications and improve social support between refugee and migrant groups. Engaging with community-based organisations is good health promotion practice because it can improve the impact and cost-effectiveness of programs and help to establish an inter-agency approach that provides an important link between migrant communities and government services [15].

### *3.6. Tailoring Interventions to the Needs of Refugees and Migrants*

Refugees and migrants often have specific cultural health concerns, for example, female genital mutilation (FGM) was estimated at between 60,000–80,000 foreign-born women aged 15 and over in Italy alone in 2016 [35]. An evidence review of what works to eliminate FGM identified the

training of health professionals as change agents and in particular community-led approaches to address alternative rituals and public statements combined with legal measures [36]. A review of immunization services found that tailored communication interventions have been successful in improving the uptake of programs among refugees and migrants. The tailored measures included door-to-door vaccination initiatives, media campaigns, and peer education interventions [37]. A study in Norway of more than 50,000 adults showed that participation in community cultural activities such as dancing, singing, and traditional events was associated with good health, satisfaction with life, and low anxiety and depression, even when the data were adjusted for confounding factors [38]. Another study compared the patterns of hospital use by migrants living in the Lazio Region, Italy, with those of the resident Italians. The study was based on the hospital discharge data collected by the Lazio Region Hospital Information System. Of 56,610 migrants admitted to hospitals in Lazio during 2005, the main reason for hospitalisation of males in acute care was injuries (approximately 25% of discharges), reflecting the high level of violence and injury in the migrant population and the need for tailored interventions [39].

#### 4. Discussion

The review of the literature on the current knowledge on the provision of health promotion to improve migrant and refugee health in the European region identifies gaps in how to engage in a culturally competent way, to address fear and violence and the application of health literacy. The findings have identified evidence to support the use of peer education interventions, of working with community-based organisations, and the use of tailored interventions to meet the needs of refugees and migrants. Understanding the perceptions of refugees and migrants should include an appreciation of their human rights, broader determinants of health, and structural factors that go beyond behaviour change. The current health promotion literature does not reasonably consider the larger structural factors that are at work but rather focusses on communication and skills development, often at an individual level.

The purpose of the awareness raising is to provide current information and to refer refugees and migrants to essential services. The information is provided through appropriate communication channels to the specific target group such as health workers, refugees, and migrants. In particular, face to face communication by a peer educator or health professional can be an effective approach. Other channels of communication to facilitate the exchange of information and the development of relevant skills include the mass media, social media and the use of materials such as leaflets and videos in local languages. Health promotion has an important role to raise the awareness of refugees and migrants about their rights, the available healthcare support, and resources. Health promotion also has a role to raise awareness to promote health and to prevent disease and injury.

The evidence for the use of health literacy is inconclusive, although the effectiveness of this approach can be improved if developed in collaboration with refugees and migrants. Print materials, video, and social media can also be effective if used with appropriate languages and the messages are reinforced through small group or inter-personal communication, for example, in smoking cessation and for adherence to the treatment of tuberculosis [40].

The functioning of a network of community-based organisations is crucial to supporting refugee and migrant health promotion. However, non-government organizations and voluntary and social associations that work with refugees and migrants are not strong in some European countries. Where a network does not exist or is weak because of a lack of capacity, it is the role of government policy to strengthen this by providing the appropriate training and resources to the community-based organisations. Government funding for the development and capacity building of non-government organisations working with refugees and migrants is an important policy option. Government and third-sector agencies have a vital role in connecting with refugee and migrant communities, especially those at highest health risk. Social networks and partnerships can give refugees and migrants a voice in shaping health services and enables them to play an active part in how society interacts with them [21].

The review of the literature identifies that, for refugee and migrant communities to be able to take action to resolve their needs, sometimes in partnership with health promotion agencies, they must build their capacity through gaining the relevant knowledge, skills, and competences. This has yet to emerge as an important area of training in health promotion, and there is the need to support innovative mixed-methods research to build a new evidence base on refugee and migrant health including a full systematic review of the global evidence on health promotion.

The interpretation of the findings for the application of health promotion programs at a national level has provided guidance for future policy options to improve refugee and migrant health as follows: (1) invest in tailored health promotion interventions, (2) invest in training for professional cultural competence, (3) invest in approaches that place refugee and migrant needs at the centre of health promotion, and (4) invest in strengthening a network of community-based organisations that support refugees and migrants (see Table 1).

**Table 1.** Investing in refugee and migrant health promotion.

Policy Option	Priority Interventions to Be Implemented by Healthcare Providers
Invest in tailored interventions	Sexual health and reproductive health programmes including abolishment of Female Genital Cutting and the promotion of condom use. Immunization programmes. Smoking cessation programmes. Adherence to the treatment of tuberculosis.
Invest in training for professional cultural competence	In-service and online training. Public health curricula of tertiary education. Workplace mentoring. Availability of translators and cultural mediators. Workplace policy. Reflexive professional practice.
Invest in approaches that place refugee and migrant needs at the centre of health promotion	Needs assessment skills. Professional training in quantitative and qualitative methods. Community-centred approaches: peer and volunteer activities, develop partnerships and provide better access to community resources.
Invest in strengthening a network of community-based organisations that support migrants	Build community capacity. Strengthen social networks and partnerships. Area-based initiatives. Health action zones.

#### 4.1. Invest in Tailored Health Promotion Interventions

Migration can lead to greater psychosocial disorders, drug and alcohol use, and an increased exposure to infectious diseases and violence. Consequently, this can have a direct effect on the sexual, reproductive, and mental health of refugees and migrants. It is essential to get the basics right first by ensuring that a culturally sensitive health promotion service can deliver interventions that address the priority concerns and can have the greatest impact to improve health. Health promotion has an important role to raise the awareness of refugees and migrants about the promotion of health and wellbeing. The review of what works in health promotion for refugees and migrants identified that culturally sensitive and tailored interventions were more effective than mainstream approaches alone, for example, as shown in sexual health and immunization programs [37] and in the abolishment of Female Genital Cutting [36].

The selection of tailored health promotion interventions can include peer education for the promotion of condom use and engaging with community-based organisations for screening services and immunization. The evidence for the use of health literacy is inconclusive, however, the effectiveness of this approach can be improved if developed in collaboration with refugees and migrants [26]. Print materials, video [6], and social media can also be effective if used with appropriate languages and the messages are reinforced through small group or inter-personal communication.



#### *4.2. Invest in Training for Professional Cultural Competence*

Cultural competence means appreciating the specific needs of different communities and working in a meaningful way that pays attention to shared needs. Health promoters do not routinely receive training on cultural competence and on how to create a meaningful relationship with refugees and migrants. The purpose is to ensure that health promoters are properly trained to provide the foundation for empathy and a critical awareness of the different cultural perceptions of health and wellbeing of refugees and migrants.

Building a workforce that is culturally competent will require a policy framework that provides for the implementation of diversity training across all levels and professions of health care systems (with a particular focus on leadership and management staff) to endorse both the ethical and the economic imperatives for promoting culturally sensitive health care. This will include in-service and online training and become part of the qualifications of health promotion courses in the curricula of tertiary education to support international professional competencies and standards. Training should be completed in conjunction with workplace mentoring and the availability of translators and cultural mediators. Cultural competence will also require a reorientation of workplace policy to create settings that are situationally aware and have organisational structures that encourage a reflexive professional practice to avoid unconscious stereotyping and the marginalization of perceived outsiders [16].

#### *4.3. Invest in Approaches That Place Refugee and Migrant Needs at the Centre of Health Promotion*

Placing refugee and migrant needs at the centre of health promotion programs provides a foundation to build their capacity in a culturally sensitive way that goes beyond language and inter-personal communication and is situated in how communities function at a local level to use health promotion services. Identifying the needs of and considering the beliefs and customs of refugees and migrants is an essential first step in delivering a health promotion approach that puts them at the centre of the program. The purpose is to work with refugee and migrant communities in a meaningful way that enables them to increase control over the influences on their lives and health.

A needs assessment approach involves quantitative as well as qualitative methods to determine priorities of what should be done, what can be done and what can be afforded [8] and is an important stage in developing a health promotion program that engages with refugees and migrants. Placing refugee and migrant needs at the centre of health promotion programs requires the use of “community-centred approaches” that represent the most practical, evidence-based policy options to improve health and wellbeing. Community-centred approaches are not just community-based, they are about mobilising assets within communities, promoting equity and increasing people’s control over their health and lives. The “family of community-centred approaches” could be used as a policy template for other countries [41] and in particular, community capacity building and community engagement can bring a positive return on investment in approaches that strengthen communities, provide a role for peer and volunteer activities, develop partnerships, and provide better access to community resources.

#### *4.4. Invest in Strengthening a Network of Community-Based Organisations That Support Refugees and Migrants*

Community-based organisations that support refugees and migrants are able to use their resources to enhance participation, promote cultural competence, and develop the skills and knowledge of community members. Community-based organisations can help promote social media applications and improve social support between refugee and migrant groups [15]. Engaging with community-based organisations is good health promotion practice because it can improve the impact and cost-effectiveness of programs and help to establish an inter-agency approach that provides an important link between migrant communities and government services. The existence of a network of community-based organisations can provide an efficient link for the delivery of information, resources and services by the providers of health-services. Area-based initiatives, for example, tackle social or economic disadvantage at a neighbourhood level through partnerships and multi-faceted

programs where health is often alongside economic development, urban regeneration, access to services, and education [42]. For refugee and migrant communities to be able to take the necessary action to meet their needs, they must also be able to build their capacity through gaining the relevant knowledge, skills, and competences. This can be achieved at both an individual level and at a collective level by using established techniques to strengthen and measure capacity building in a cross-cultural context, in particular the “domains approach” that uses those aspects of community capacity that allow individuals and groups to better organize and mobilize themselves [43].

## 5. The Limitations of the Review

This was not a full systematic review of all the evidence, and the focus was on literature in the English language. The review was purposefully focused on European countries because this is currently a critical geographical area of concern for the health promotion of migrants and refugees. It is possible that some evidence was not included in the review because of the geographical focus. However, because it was specifically on health promotion for refugee and migrant health, it is unlikely that this was a substantive amount of literature.

## 6. Conclusions

This paper is based on the best available information provided through a rapid review of the literature, and the findings are considered to be suitable for countries in Europe that want to develop a more systematic approach to strengthen the impact of future policy for refugee and migrant health promotion. This paper purposefully does not address broader policy considerations for different European countries such as health financing, project budgeting, health systems, national insurance schemes, the rise of nationalism, and social welfare. It is hoped, however, that this paper will contribute toward a clearer policy perspective and to a better understanding of what can work in promoting the health of refugees and migrants and what areas also need to be further supported in the development of effective health promotion programs.

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