Mig-HealthCare Roadmap & Toolbox

Health Promotion

Co-funded by the European Union's Health Programme (2014-2020)

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Health Promotion

1. Magnitude of the problem

Health promotion is about health and how to promote it. For the purposes of this roadmap we will adopt a working definition of health as put forward by the International Union for Health Promotion and Education (IUPHE) in 2007. We believe this sharply highlights the challenges that promoters of health will face when working with migrants/refugees since many prerequisites for health would seem to be lacking.

> *"Health is a basic human need. It is fundamental to the successful functioning of individuals and of societies. Health promotion aims to empower people to control their own health by gaining control over the underlying factors that influence health. The main determinants of health are people's cultural, social, economic and environmental living conditions and the social and personal behaviours that are strongly influenced by those conditions*" (Mittelmark, 2008).

Health may be considered as an intrinsic value or as a resource for the life of individuals and populations (Sherlaw & Lacouture, 2017). According to Nordenfelt it may be also viewed as being a holistic state of well-being and not a mere absence of disease or on the contrary, according to Boorse as an absence of pathology with respect to normal species functioning (Giroux, 2010). As Holland (2015) stresses this will very much have an influence on how one promotes health and indeed what one considers to be health. This is particularly important when dealing with marginalised groups such as migrants/refugees.

2. Reference to the problem concerning migrants/refugees

Health promotion among migrants/refugees

Health is considered a basic human need and indeed a human right (WHO, 2017). This sadly is not always upheld in the case of migrants/refugees. There are a number of cases showing the inhumane conditions existing in reception centres and camps especially in first entry countries (Agier et al., 2018).

In general, migrants coming to Europe are in comparatively good health on their arrival and preliminary residential period within a host country. The so-called healthy migrant effect may be largely explained through the fact of social selection and state screening (Constant, Garcia- Muñoz, Neuman & Neuman, 2018). Often the healthier and younger members of a society will choose or have the necessary resources to undertake the hazardous migrant journey from Africa, Syria, Afghanistan and other strife ridden countries. However it is equally true that their health is likely to deteriorate following arrival due to poor housing and living conditions which are a major determinant of health. Furthermore recent work in global public health ethics has put forward additional arguments that migrant health may be considered as a public global good (Widdows & Marway, 2015) and this adds further weight to humanitarian arguments (Wild & Dawson, 2018) about why it is vital to protect and promote the health of migrants for the good of all in society.

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Immediate health and medical needs among refugee and migrant populations derive from those present in the country of origin and those resulting from the displacement and migratory process. Dealing with these needs as soon as possible makes sense both for individual health and for effective use of health care systems. Preventive care includes health services that are used to prevent illness and other health problems or to detect them at an early stage so that treatment can be introduced when it works best. Typical examples of preventive care are screening and health checks, immunization, patient counseling and health promotion and education. Cross-border assessment and provision of health care is an important aspect of preventive care targeting those migrating across the Region (WHO, 2018c).

Coupled to this are problems of residency and work status, together with possible lack of language, cultural skills and discrimination which may influence the possibility to access healthcare. Even in states with generous provision for migrants e.g. France (André & Azzedine, 2016) broadly equivalent to provision for nationals, numerous tangible and intangible obstacles to health and health care may exist (Larchanché, 2012). Migrants may often lack such capitals, the social networks, knowledge, information, and cultural and language skills necessary to seek rights and respect in their new national environment. Furthermore they may also suffer racial or cultural discrimination and also have suffered, ill treatment, psycho trauma, violence and torture during their journey to Europe, thus they may be considered as being vulnerable to disease.

3. Reference to issues of particular interest

Cervical and breast cancer screening

Refugees and migrants have a lower risk for all neoplasms except cervical cancer, for which they are also more likely to be diagnosed at a later stage in their disease than the host populations in the Region (WHO, 2018c).

Once settled in a host country, research shows that migrants and refugees have lower incidence and prevalence cancer rates - with the exception of cancers that are related to early life infections like cervical cancer (WHO, 2018c). Thus, it is necessary to address cancer screening at the community level through culturally sensitive and linguistically appropriate services and raise awareness about the prevention of cancers such as cervical and breast cancer.

Findings from the 2018 Mig-Healthcare survey, conducted across 10 European countries, suggest that the rate of cancer screening among refugees and migrants is low. Only 5.1% of participants reported having had a colonoscopy. Of the female participants from this study, 20.4% had ever had a Pap test and 12.8% had ever had a mammogram.

Breast cancer is the most common female cancer in the world, while cervical cancer is the commonest female cancer in women from developed countries (WHO, 2017). Breast cancer screening is performed with the use of mammography in women aged 50-64 years combined with monthly self-breast examination, unless there are other specific risk factors that place a woman at higher risk for breast cancer such as family history (Perry et al., 2008). Cervical cancer screening at the population level is carried out with the use of cytology in detecting lesions in a cervical smear sample targeting women aged 25 to 65 years of age. (European

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Guidelines for Quality Assurance in cervical cancer screening, 2008). It has been shown that cultural and religious differences in immigrant populations along with language difficulties and dissatisfaction from the healthcare systems account for lower participation to organised cervical cancer screening activities (Rosano et al., 2017).

According to the 2018 WHO report on the health of refugees and migrants (WHO, 2018c) targeted screening of at-risk populations may be considered as a component of the comprehensive assessment of health, particularly for arriving refugees and migrants.

Colorectal cancer screening

Colorectal cancer claimed the lives of 154.000 people in the EU-28 in 2015, which corresponds to 11.7 % of all deaths from cancer and 3.0 % of the total number of deaths from any cause. Of these deaths, 3.3 % were in men and 2.6 % in women (EUROSTAT, 2018). In the EU-28, 20 Member States operated pilot or rollout colorectal cancer screening programmes in 2015 and 3 countries (Estonia, Germany and Luxembourg) were planning to initiate population-based programmes in 2016. Three countries (Germany, Greece and Latvia) only operate opportunistic colorectal cancer screening programmes. In Bulgaria, Romania and Slovak Republic, no programmes operate and in Austria and Sweden there is no national coverage (EU Report on cancer screening, 2017).

The recommended age group for colorectal cancer screening is 50-74 years and a set of recommended quality assurance guidelines for colorectal cancer screening is available as a guide to follow within the organised screening programmes (von Karsa et al., 2013).

At the European level, it is recommended that colorectal cancer screening programmes use the faecal occult blood screening test and colonoscopy should be used for the follow-up of test positive cases in the target groups of 50 to 74 years (both men and women) at a screening interval of 1–2 years. Other screening methods such as immunological tests, flexible sigmoidoscopy and colonoscopy are not presently recommended for population screening (Advisory Group on cancer screening in the EU, 2000).

It is estimated that of the estimated 152 million women and men in the age group of 50-74 years in the EU member states, 110 million (72%) are targeted by screening in 23 Member States that are implementing pilot or population-based colorectal cancer screening programmes.

With regards to refugee and migrant populations, it has been suggested that they perceive colorectal cancer risk as lower compared to the local population, hence their participation in colorectal cancer screening (with any screening test) is very small which in many cases leads to a colon cancer diagnosis at a later stage (Punzo & Rosano, 2018). Refugees and migrants from low income countries record lower colorectal cancer screening participation rates. However, data show that the incidence of colorectal cancer among recent immigrants in a host country is lower than the incidence in the local population, probably as an expression of the healthy immigrant effect, a trend that diminishes over time. It is estimated that 10 years after settlement in the host country, immigrants adopt the cancer risk profile of the host country. As such there is need to address the

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issue of colorectal cancer screening participation of refugees and migrants through tools and interventions that are linked to better health (Shuldiner et al., 2018).

Alcohol

Alcohol consumption is a cause of significant morbidity and mortality globally, accounting for roughly 5% of the total burden of disease (Margolese et al., 2004; Rehm et al., 2009;) and poses an important risk also for social harm worldwide (Rehm et al., 2003; 2004). In particular, alcohol use is the leading cause of disease among adolescents and young adults, particularly men and those living in high-income settings (Gore et al., 2011) and usually co-morbidity with psychiatric disorders (Sher, 2006). High levels of alcohol intake, especially in binges (e.g. more than 60g of pure alcohol consumption per day) increase the risk of liver cirrhosis, injuries, some forms of malignant neoplasms, alcohol use disorders, and cardiovascular disease (Yanget al., 2018).

Alcohol abuse among migrants and refugees

Migrants and refugees face difficulties associated with the major life changes they are experiencing and are struggling to some extent with adapting to the new country, confronting the additional burden of coming to terms with the circumstances that forced their relocation (Johnson, 1996). Therefore, concerns have been expressed about hazardous and harmful alcohol use amongst populations who have been forcibly displaced from their homes by armed conflict, human rights abuse and persecution (Johnson 1996; De Jong et al., 2002; UNHCR/WHO, 2008). Recent findings suggest that the highest-quality prevalence estimates of hazardous/harmful alcohol use ranged from 17%-36% in camp settings and 4%-7% in community settings among refugees, internally displaced persons (IDPs) and asylum seekers (Horyniaket al., 2016). Relocation commonly leads to worse living conditions, impoverishment and the loss of family, friends, assets, livelihoods and self-esteem, as well as cultural and social support (Miller 2004; Porter & Haslam, 2005). Excessive stress and anxiety may lead to post-traumatic stress disorder (PTSD) and depression, which further deteriorate their mental status, increasing thus the risk of alcohol consumption (Kozaric-Kovacic, Ljubin & Grappe, 2000). Furthermore, the living conditions refugee communities commonly experience are also accompanied with unemployment and poverty and, as a result, may reside in disadvantaged areas where cheap alcohol is often readily available (Dupont et al., 2005)

Additional factors that have been linked to alcohol consumption are the “killing time” phenomenon and boredom in camps. “Killing time” is defined as killing memories of trauma in their home country before the escape, killing time waiting for bureaucratic admission procedures in the host country and, as a consequence, killing the ennui during the process that sometimes take several years (Kooiman, 2004). Boredom on the other hand is related to lack of employment as it is impossible for asylum seekers to perform the occupation they were employed in, in their countries of origin. Especially, those who are highly skilled professionals, have to spend years and years doing nearly nothing.

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Risk factors for alcohol abuse

Despite the identified vulnerabilities among forced migrants/refugees, the existing evidence is limited as regards alcohol use and related harms among permanently resettled refugee populations. Available data state that most common risk factors for harmful alcohol use include male sex, younger age and experiences of trauma, but there is a relatively limited understanding of the ways in which these factors, and other experiences associated with forced migration, may influence harmful alcohol use. Despite these risk factors for hazardous alcohol use among forcibly displaced persons the evidence base is weak on the prevalence and patterns of alcohol use (Horyniak et al., 2016).

According to field reports, immigrants tend to have healthier lifestyles before they move to Europe (they walk more, eat homemade meals and use alcohol and substances with moderation) and the longer people stay in the countries of reception, the more they adjust to Western lifestyles as an acculturation to mainstream norms and a desire to gain acceptance in their new communities, exposing themselves to additional social stressors. (Durrant & Takker, 2003; Pfarrwaller & Suris, 2012). Interestingly, it has been hypothesised that migrants who are highly engaged in the host culture ('assimilation') may engage in substance use in order to adhere to mainstream norms and gain acceptance in their new communities. This may be a concern particularly in the context of resettlement in Western countries, where alcohol consumption, is normalised. Although some studies have recorded lower rates of alcohol consumption and alcohol use disorders among some migrant and refugee groups compared with their host population, contrasting research has found higher rates of alcohol use and related harms among some ethnic and cultural minorities (Horyniak, Higgs et al., 2016).

In refugee camp settings it is essential to acknowledge the existence of substance related problems. Furthermore, availability and access to treatment services for displaced populations is another challenging issue. Refugees may not be allowed to utilize local treatment services, services can be expensive, or refugees may not have access to services out of the camps. Cultural and language differences add more complexity to this situation.

Interventions to minimise harmful use of alcohol and other psychoactive substances can lead to positive changes but must be customised to the specific needs of each setting. Rapid assessments with appropriate tools, understanding the situation, partnership with workers and refugees, as well as inclusive approaches are all essential. It is important to recognize the value that migrants bring to their host countries. It's also important to recognize our moral and legal obligations towards people fleeing conflict and unrest.

Tobacco use

The global tobacco epidemic kills more than 7 million people per year according to World Health Organization (WHO) becoming one of the most significant public health issues (WHO, 2019). Direct tobacco use and second-hand smoking cause premature death especially to smokers from low or middle-income countries, where the burden of tobacco-related illness and death is heavier.

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The effects of tobacco use on health are lethal since it is one of the major risk factors and leading cause of many non-communicable diseases. Smoking increases the risk for multiple types of cancer such as lung, oral, pancreatic, colorectal and stomach cancer. It also, causes several cardiovascular diseases such as heart disease and stroke, atherosclerosis and myocardial infarction ending up to being responsible for 1 in 3 deaths by cardiovascular disease (CDC, 2018a). Smoking is also the main risk factor for Chronic Obstructive Pulmonary Disease (COPD) including emphysema, chronic bronchitis and asthma with almost 70% of the patients reporting as being smokers or ex-smokers.

Tobacco use among migrants and refugees

Little evidence is available regarding tobacco and substance use in particular among migrants/refugees in Europe. From the available evidence in contrast to the comparatively lower rates of substance abuse among migrants and refugees, levels of smoking among migrant men were higher, as shown by studies conducted in France and Finland (Khlat & Guillot, 2017; Salama et al., 2018; WHO, 2018). More specifically, migrant men in the two countries had significantly higher rates of smoking compared to migrant women from the same countries of origin and non-migrants, and this higher rate could be attributed to the socioeconomic disadvantage of migrant men. The gender difference for migrants from the same country of origin could be due to the influence of their countries of origin on their lifestyles in the host country (Khlat & Guillot, 2017; WHO, 2018) According to Solé-Auró, smoking behavior in immigrants did not differ significantly from the native-population (Solé-Auró, 2008). In Europe in particular, studies evaluating smoking behavior in immigrants are scarce as the majority focuses on the prevalence of communicable and non-communicable diseases (Khlat, Legleye & Bricard, 2019).

Health behaviors of migrant and refugee populations, including smoking are mainly determined by the place of origin, cultural background, gender and age (Salama et al., 2018). A significant factor influencing the prevalence and frequency of smoking among different individuals is acculturation. Acculturation, i.e., the adoption of the host country's cultural habits, customs and behaviors by the individual, exerts a significant role in the change of attitudes regarding health-related issues (Joshi et al., 2014). A study evaluating the migration-related changes of smoking, uncovered the low pre-migration prevalence and the diversity of post-migration trajectories suggesting that tobacco control programs targeting recently arrived migrants would contribute to prevent unhealthy assimilation (Khlat et al., 2018). Another study in Turkish immigrants' smoking behaviour showed that they adapted their behaviour towards the one of the Dutch/German majority population as the duration of stay was increasing (Reiss, Lehnhardt & Razum, 2015). The new environment thus exerts a key role on either improving or deteriorating the overall health and well-being of migrant populations.

Preventing tobacco use among migrants/refugees

Prevention strategies, policies and actions are taken from countries and international organizations with the World Health Organisation having the leading role in order to improve global public health. According to WHO report on monitoring tobacco use and prevention policies, tax raise is the most effective measure to reduce tobacco use, improve health and prevent youth and lower-income groups from starting tobacco use.

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Furthermore, health warnings through the pack warning labels also contribute to raise awareness on the health risks from the tobacco use and could steer to the cessation of smoking (WHO, 2017a). Anti-tobacco mass media campaigns and bans on tobacco advertising, promotion and sponsorship increase public awareness and provide gradually a more effective approach on changing the social norms and attitudes towards tobacco use.

In reality though, the vast majority of the multiple tobacco use preventive programs and cessation programs are targeted either at the adult general population or at youth and adolescents. Few programs focus on the prevention and cessation of tobacco use on migrant and refugee populations. According to a study on smoking behaviors of migrants in Austria, the existing intercultural differences of people with or without migrant background define attitudes towards smoking, addictive behaviors and preferences on cessation programs (Urban et al., 2015). Due to differences between cultural backgrounds, language and attitudes, a strong demand for tailor made preventive and cessation programs exists and needs to be met.

Nutrition

Prevalence of Malnutrition - Importance of healthy eating habits

According to the World Health Organization (WHO) malnutrition may be present in various forms, including under-nutrition (wasting, stunting, and underweight), inadequate vitamin or minerals intake, overweight and obesity, and resulting diet-related Non Communicable Diseases. It should be noted that people facing poverty are more prone to the different forms of malnutrition (WHO, 2018a).

According to the most recent data, at a global level 1.9 billion adults are overweight or obese and 462 million are underweight. Furthermore, 52 million children under 5 years of age are wasted, 17 million are severely wasted and 155 million are stunted, while 41 million are overweight or obese. Furthermore, around 45% of deaths among children under 5 years of age are linked to under-nutrition, being most prevalent in low- and middle-income countries. Equally important, as regards the aforementioned countries, rates of childhood overweight and obesity are rising (WHO, 2018a).

A healthy diet can not only prevent malnutrition in all its forms, but also chronic non-communicable diseases (NCDs), including diabetes, cardiovascular disease and cancer (WHO, 2018b). WHO Member States have agreed to take action to reduce the global population's salt intake by 30% by 2025, as well as to halt the rising prevalence of diabetes and obesity in adolescents and adults and childhood overweight by 2025 (WHO, 2013; WHO, 2014).

Malnutrition, Diet and Nutrition issues among migrants and refugees

Malnutrition in all its forms, and especially micronutrient malnutrition and under-nutrition are considered of major importance as regards refugee's health. The United Nations High Commissioner for Refugees (UNHCR) recognizes malnutrition not only as a physiological condition but also as a human rights issue (UNHCR/WFP, 2006). Causes of malnutrition include various interrelated factors such as disease, poor caring practices, poor environmental conditions, as well as lack of access to and availability of nutritious food (UNHCR, 2011).

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Refugee and migrant children tend to be more prone to diet-related health issues, both malnutrition and overweight/obesity (WHO, 2018c).

According to a Joint UNHCR and World Food Programme (WFP) review (UNHCR/WFP, 2006), among the most important findings concerning protracted refugee situations were:

- High rates of acute malnutrition
- High anaemia levels of children and women
- Insufficient nutritional technical support and/or expertise
- No nutritional surveillance system or growth monitoring in the camps
- Appropriate infant feeding practices not being implemented due to insufficient training, lack of guidelines and/or assessment of the problem
- Water quality issues and shortage in camps
- Micronutrient quality of the ration below standards
- Caloric intake of the ration below standards

Nevertheless, it should be noted that despite the extent of the problem, data describing the situation and the exact burden of malnutrition among migrants and refugees, and especially children are scarce, and if present they are not always reliable (UNHCR, 2011).

Malnutrition and micronutrient deficiencies may have a detrimental impact on refugee children's future. Thus they require proper screening, short and long-term follow-up to minimize potential health adverse effects (UNHCR, 2019a, 2019b).

Special focus should also be given on breastfeeding, as breastfeeding helps prevent malnutrition, certain diseases and mortality among infants and young children. Thus, it is of crucial importance to ensure that children start breastfeeding within 1 hour of birth, breastfeed exclusively until 6 months of age and continue breastfeeding with appropriate complementary foods up to 2 years or beyond guidance (WHO/UNICEF, 2013; WHO, 2019). The UNHCR has developed a policy related to the acceptance, distribution and use of milk products in refugee settings so as to protect and promote breastfeeding (UNHCR, 2006)

Undernutrition (wasting, stunting, underweight)

According to the 2013 International Organization for Migration Nutrition Surveillance Reports evaluating 9,063 refugee children aged 6-59 months (12% of all refugees examined in 2013) medium prevalence of wasting (5.3%), low prevalence of stunting (17.6%) and low prevalence of underweight (8.3%) were detected.

Furthermore, findings from a recent study evaluating the nutritional status of 982 refugee children, with the top countries of origin being Somalia, Iraq and Burma, 44.9% of children had at least one form of malnutrition. In more detail, children aged 0–10 years were affected by wasting (17.3%) and stunting (20.1%). Somali children age 0–10 years old had the highest prevalence of wasting (29.2%) and Burmese children age 0–10 years old had the highest prevalence of stunting (38.3%) (Dawson-Hahn et al., 2016).

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Additionally, according to a pilot study that examined 192 children aged 1-18 years in two refugee centres in northern Greece, 7.8% of the children were underweight, 4.6% were wasted, 7.3% stunted and 13% suffered from at least one form of malnutrition. Girls were more affected by malnutrition compared with boys. Furthermore, as regards adolescents, 21.7% of the girls and 10% of the boys experienced at least one form of malnutrition (Grammatikopoulou et al., 2019).

Vitamin A, D and B12 Deficiency

Vitamin A and D deficiencies are common in immigrants and refugees, reaching up to 80% (Benson et al., 2007; Lips & de Jongh, 2018; Chaudhry et al., 2018; Seal et al., 2005; Beukeboom & Arya, 2018). Furthermore, severe vitamin D deficiency (serum 25-hydroxyvitamin D < 25 nmol/l) may occur in up to half of children and adults of non-western origin. Various factors contribute to the development of vitamin D deficiency, including insufficient sunshine exposure, more pigmented skin, wearing skin-covering clothes due to religious or cultural reasons etc (Benson et al., 2007; Lips & de Jongh, 2018; Chaudhry et al., 2018).

Vitamin B_{12} deficiency is also common among refugees. This deficiency is mainly attributed to low intake of animal-source foods and intestinal parasites, such as Helicobacter pylori (Benson et al., 2015; Beukeboom & Arya, 2018).

Anaemia & Iron Deficiency

Iron deficiency anaemia occurs more often in women and children migrants (Redditt et al., 2015; Beukeboom & Arya, 2018). Depending on the migrants' country of origin, rates of anaemia have been reported to range from 12% to 55% (Tanaka et al., 2018; Pavlopoulou et al., 2017; McCarthy et al., 2013; Raman et al., 2009; Hayes et al., 1998). According to a recent study in a migrant outpatient clinic, 13.7% of all immigrant and refugee children (15.2% of immigrant and 12.3% of refugee children) presented with anaemia. Furthermore, low ferritin levels were observed in 17.3% of the overall sample (Pavlopoulou et al., 2017).

It should be also noted that anaemia is a major public health problem among refugee children in camps. Lutfy et al., assessed malnutrition among US-bound refugee children aged 6–59 months, from eight countries and showed that anaemia prevalence of ≥40% was detected in at least one survey of ten camps (12 surveys after 2008 of Burmese, Bhutanese, Sudanese and Eritrean children) (Lutfy et al., 2014).

Obesity

Migrants are highly likely to arrive in new countries with a healthy body weight. As duration in the host country increases, under the influence of socio-economic factors and stress, as well as exposure to different diet patterns, migrants and refugees appear to have a greater risk of obesity compared to host populations, approximately 10 to 15 years after migration (WHO, 2018; Murphy et al., 2017). Early prevention and education concerning healthy nutrition is important in order to halt the spread of the obesity epidemic to migrants and refugees. Activities to promote healthy weight in migrant/refugee populations should be a routine service at the community health care level.

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According to a stratified nutrition survey in four Western Sahara refugee camps in Algeria, evaluating 2.005 households, 1.608 children 6–59 months and 1.781 women (15–49 years), 2.4% of children were overweight, 53.7% of women were overweight or obese, and 71.4% had central obesity (Grijalva-Eternod et al., 2012).

Furthermore, findings from the aforementioned study by Dawson-Hahn et al., evaluating the nutritional status of 982 refugee children, show that 7.6% of children aged 0–10 years were overweight and 5.9% were obese. Children from Iraq had the highest prevalence of overweight (9.8%) and obesity (9.4%) (Dawson-Hahn et al., 2016).

Food insecurity

High levels of food insecurity are recorded among resettled refugees due to various reasons including low language proficiency and limited job skills (Gunell et al., 2015), as well as difficulties adapting to the new country (FAO and OPM, 2018).

The UNHCR has developed a Handy Guide to UNHCR Emergency Standards and Indicators, including key emergency standards for nutrition and nutritional screening guidelines (UNHCR, 2019a).

The UNHCR (2019b) has also developed an emergency handbook as regards Nutrition in camps so as to:

- Ensure coordination and collaboration between all those involved in a camp's nutrition activities.
- Ensure that all refugees in a camp have access to food.
- Establish programmes to treat acute malnutrition and effective referral mechanisms
- Establish infant and young child feeding programmes.
- Within the first 3 months conduct nutrition surveys and screenings to monitor the nutrition situation.

Physical Activity

According to the WHO, physical inactivity is considered the fourth leading risk factor for global mortality (6% of deaths globally), as well as the main cause for approximately 21–25% of breast and colon cancers, 27% of diabetes and approximately 30% of ischemic heart disease burden (WHO, 2019).

As mentioned above, migrants and refugees are likely to arrive in new countries healthier than the native population; however, as duration in the host country increases, their obesity and cardiovascular risks increase (WHO, 2018; Murphy et al., 2017; Singh & Siahpush, 2001). Regarding physical activity levels in specific, they are lower than those of the non-immigrant populations and they are associated with increased health inequalities (Ainsworth, 2000; Sternfeld, Sternfield, Ainsworth & Quesenberry, 1999; Gadd et al., 2005; Wieland et al., 2013; Fischbacher, Hunt & Alexander 2004; Williams, Stamatakis, Chandola & Hamer, 2011).

Similarities in the perceived barriers of migrants and refugees are revealed, with the most important ones being cultural differences, lack of familiarity and comfort to engaging in physical activities, as well as

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strength of beliefs in the health benefits of physical activity (Koshoedo, Simkhada & van Teijlingen, 2015; Koshoedo, Paul-Ebhohimhen, Jepson & Watson, 2015; Devlin et al., 2012; Wieland et al., 2013).

4. Important steps for the Health care sector

Health promotion in the Ottawa Charter was defined by the WHO (WHO, 1986) broadly as 'the process of enabling people to increase control over and improve their health'. Health is seen as a resource for everyday life, not the objective of living.

Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. Five priority areas for action were pinpointed which remain relevant today. These involve: Building healthy public policy. This has spawned health in all policies (HiAP) with its emphasis on intersectoral action between branches of government and public services. Creating supportive environments: this is well illustrated by the health cities movement. Strengthening community actions: this notably will involve NGOs and civil society. Developing personal skills: this links well with the health literacy approach. Reorienting health services: this is based on the recognition that many of the answers to health lie outside the bounds of the health sector and that the health sector itself should incorporate health promotion approaches to a greater extent. Lastly moving into the future affirms that socio-ecological approaches allied to gender equality at all phases of policy development are key to effective and just health promotion.

Recently the WHO has put forward 8 guiding principles for framing migrant health promotion (WHO, 2017). These include:

- The right to the enjoyment of the highest attainable standard of physical and mental health. [1]
- Equality and non-discrimination.
- Equitable access to health services.
- People centred, refugee and migrant and gender sensitive health systems.
- Non-restrictive health practices based on health conditions.
- Whole-of-government and whole-of-society approaches.
- Participation and social inclusion of refugees and migrants.
- Partnership and cooperation.

1 This right is enshrined in many international agreements and treaties e.g. The International Covenant on Economic, Social and Cultural Rights (1966); as declared in the preamble to the Constitution of the World Health Organization. Also, the International Covenant on Economic, Social and Cultural Rights, Article 2.2 and Article12, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status; status resolutions; resolutions WHA61.17 (2008) and WHA70.15 on promoting the health of refugees and migrants. Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) provide that migrant workers should enjoy equal Occupational Safety and Health rights as any other worker. See Framework of priorities and guiding principles to promote the health of refugees and migrants

http://www.who.int/migrants/about/framework_refugees-migrants.pdf

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These principles informed by research on health inequities offer an ideal to aim for, and may provide moral and legal grounds for improving the health of migrants. However many of them (like the IUPHE health definition) would seem to poorly match the on-the-ground realities in which newly arrived migrants find themselves. Recent debate in political philosophy, suggests that it may be more pragmatic to seek small definite measurable and achievable improvements without necessarily having and promoting a clear ideal vision of just provision for migrants (Valentini, 2011, 2012).

A recent rapid review of the health promotion literature (Laverack, 2018) has analyzed different strategies that have been used with migrants. These may be divided into a) general non-specific strategies and interventions based on universal health promotion principles and b) tailor–made interventions for specific migrant groups and for addressing specific health and prevention issues. Complementary strategies include health literacy, peer education and community health educator models in which members of the migrant community now having established their roots in the host country may play a key role acting as linguistic interpreters and cultural mediators. In general it was considered that tailor-made interventions, especially those engaging with the community-based organizations using culturally appropriate messages and methods were likely to be more effective than non-specific programs. Similarly (Netto et al., 2010) have advocated "*the use of community resources to increase awareness of the interventions and facilitate recruitment*" (…) *as fundamental*[2] *to adapting interventions for minority ethnic communities"*. This will imply the identifying and overcoming of barriers to participation, engaging with the community and adaptation with regard to religious values, culture, communication, information dissemination and language requirements. A range of interventions to raise awareness and develop skills have been explored. These include communication activities using the mass and social media, health literacy, participatory methods, peer education, printed materials in various languages, counseling and self-help groups. Emphasis has been placed on the importance of providing cultural competence training for health professionals which seemed too often lacking. In addition it was pointed out that there is a lack of evidence on key issues of how *"to effectively engage with refugees and migrants in a culturally competent way; address fear and violence; and apply health literacy in the everyday working lives of health professionals"*(Laverack, 2018). Mladovsky, Ingleby, McKee & Rechel (2012), in relation to health professionals also stress the importance of cultural competency in training to "overcome language, social and cultural barriers."

Strategies and their associated tools can be broadly-based or specific to disease conditions or public health problems. They may also be typically based on standard needs analysis driven by expert opinion and management OR alternatively highlight the strengths of individuals within a community group and the recovery of their ownership of their own life concerns and hopes.

[2] Our emphasis

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5. Examples of best practices

The Mig-HealthCare project reviewed and evaluated relevant interventions offered to migrants and refuges. We include in this roadmap some examples that can be used in different settings based on the evaluation process of the systematic review that was conducted by the Mig-HealthCare partners. More information about these and other promising practices can be found on the project's website http://www.mighealthcare.eu/ by accessing the report titled 'D5.1: Report on models of community health and social care and best practices'.

Tools based on the universal principle that health is a basic human right have been developed and have been used with migrant populations. They allow small groups to explore what health is and what are its determinants. Since the health of migrants is largely determined by the same factors that affect the host population, both populations being subject to similar risks, it may be argued that this offers a sound foundation for designing and building health promotion projects with migrants. Recently the 'Circle of health' (Beattie-Huggan, Harsch & Steinhausen, 2016) has been used with migrant populations. This allows health promoters and groups to explore health and its interactions with different Logic style framework plans which may be adopted and permit the creation of indicators for evaluation purposes (http://www.circleofhealth.net/). The 'Circle of health' and similar universal tools incorporating the social determinants of health may be used by and with migrants or non-migrants alike. Nevertheless it will be necessary to take into account the specific characteristics of the migrants involved particularly their origins, culture, language, educational background and the migrant journey and experience. Furthermore, health professionals using such universal tools will undoubtedly benefit from engaging with communities and community based organizations, involving peer mediators and cultural brokers with intimate knowledge of the migrant group. Since no particular adaptations in principle will be made to the tool itself it will be all the more necessary to consider issues of accessibility and how health promoters may use and adapt their practices with sensitivity inclusively to engage with migrants. This may entail accepting that one's expectations and values as a Western health promoter may be in tension with the expectations and means envisaged by the migrant community itself. In a Dutch study on promoting health with migrant seniors (Abma & Heijsman, 2015), cited by Laverack (2018) the professionals' expectations highlighted the values of independence and personal control which were very different from the expectation to receive information which the migrants had in mind.

The SALT (Stimulate, Appreciate, Link and Learn, and Transfer and Trust) approach originally developed in community programmes for tackling HIV/AIDS. This has recently been used with migrant communities in the Netherlands and Vilvoorde, Brussels to address civic participation in urban development. (See https://www.communitylifecompetence.org/ for further details)

In terms of using health promotion tools one must keep in mind that the use of most tools need adequate training and experience when used by groups. When in doubt choose the simpler tools. Always have in mind whether it will be suitable for your target audience. Have clear aims. Do not be afraid to adapt the tool according to circumstances, time and resources available and aims. Be sure you are happy with it and are

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capable of dealing with questions that may arise from both a knowledge and emotional perspective. Be ready for emotional difficulties. Arguably from a psychological perspective migrants potentially will suffer from several losses or grieves. Loss of their home country, loss of family and friends, loss of social status, possible loss of power, loss of control over their lives, possible loss of language and communication skills and, loss of identity (Belarouci, 2018). These are painful grieves which may be long and difficult to accept. It may be necessary to take these into account when pursuing health promotion goals. Living in a new country and new culture with different social and sexual mores can also offer new opportunities, personal freedoms and risks. Nevertheless in the case of migrant health, although cultures may differ and this may be taken into account, all problems that may arise and their solutions are not necessarily related to intercultural differences. Above all listen carefully and deeply to migrant participants as persons with unique histories.

Breast & cervical cancer screening

In several Member States, intercultural mediators act as a bridge between patients and health care professionals. Intercultural mediators help to facilitate effective, respectful and culturally aware dialogue between health care providers and users, support patients in navigating themselves through the health system and ensure that the patient receives appropriate follow-up services within the health system and with other key welfare, social and legal services. In Malmö, Sweden, for example, health advisors with a refugee or migrant background perform a similar role to intercultural mediators. They are refugees and migrants who had a medical background prior to their arrival in Sweden and so are well situated to engage with refugees and migrants in discussions about health topics.

Another interesting model is the Community Health Educator or Navigators (CHE or CHN) which have been recognized as an evidence-based approach to address health inequalities (Natale-Pereira, Enard, Nevarez & Jones, 2011), especially among the most vulnerable population groups, including migrant/refugee women. Involving bi-/multi-lingual lay members of the migrants and minority ethnic communities to participate in health promotion activities challenges traditional didactic health education practice as it transforms the form, content and mode of delivery of health promotion programmes in public health. CHEs, interpreters, cultural mediators and volunteers in the communities through the CHE or CHNs programme can act as advisors, providing information on the cultural beliefs of their respective communities, as collaborators in the planning, design and production of health literacy curriculum and materials, and as out-reach to vulnerable members of communities (Chiu, 2003). They form a critical link to community capacity building. There is a growing body of evidence to suggest that they are effective in reducing inequalities through empowerment and promoting the utilisation of preventive services (Travers, 1996). Increasing active outreach to those communities and assessing the needs of the women to make systems more culturally sensitive would help to ensure that migrant women take advantage of the existing surveillance programmes for breast cancer (WHO, 2018).

Other promising practices identified include:

- Strategies to increase breast cancer screening uptake (Subramanian, Oranye, Masri, Taib & Ahmad, 2013)

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The study focused on South Asian migrant women. In this qualitative study three dominant themes were identified: (1) 'Target and Tailor' focused on awareness raising through multiple direct and indirect modes or approaches with underlying shared processes of involving men and the whole family, use of first language and learning from peers; (2) 'Enhancing Access to Services' included a focus on 'adding ancillary services' and 'reinforcement of existing services' including expansion to a one-stop model; and (3) 'Meta-Characteristics' centred on providing 'multi-pronged' approaches to reach the community, and 'sustainability' of initiatives by addressing structural barriers of adequate funding, healthcare provider mix, intersectoral collaboration and community voice. The outcome was relevant to increase uptake of breast cancer screening.

- Pictograph-enhanced instructions for breast cancer prevention (Choi, 2012). The study was conducted with immigrant women and participants perceived that the drawings were engaging and enhanced clarity of the intended healthcare messages. The black and white simple line drawings were well received by participants of varying race and ethnicity.

- Patient-target healthcare interventions to promote cancer screening programmes (Escribà-Agüir, Rodríguez-Gómez & Ruiz-Pérez, 2016). The results of this literature review showed that culturally adapted interventions appear to increase the rate of participation in cancer screening. The effectiveness of the interventions seems to be related to the use of small media, one-on-one interactions, small group education sessions, reminder strategies, and strategies for reducing structural barriers and out-of-pocket costs.

- Culturally tailored, narrative educational videos to increase cervical cancer screening uptake (Ornelas et al., 2018). In this pilot study refugee women were significantly more likely to report having heard of a test for cervical cancer and indicated significantly greater intentions to be screened after watching the video. Their knowledge on cervical cancer and screening also improved significantly, and they reported high levels of acceptability with the video. Our results suggest that the videos were acceptable to the target audiences and may be effective in increasing cervical cancer screening uptake among refugee women.

- Culturally-sensitive, faith-based education to promote breast cancer screening (Shirazi, Shirazi & Bloom, 2013). The qualitative study was conducted with Afghan immigrant women. Recommendations following from results of interviews: 1) Training of “grass roots” bilingual members of the community in all aspects of the program including planning, design, implementation, and evaluation; (2) incorporation of male-specific educational sessions led by male health advisors; (3) use of narrative communication consistent with the Afghan oral culture where storytelling is used to relate information and cultural/religious values; and (4) inclusion of Islamic faith components that are inspirational and relevant to the lives of the women and their male gatekeepers (e.g., husbands, brothers) and that will influence these men to understand the women’s needs and support them.

Colorectal cancer

- The burden of colorectal cancer can be reduced through organised colorectal cancer screening activities. According to the New Model of Primary Care Delivery which proposes a shift from hospital-based care delivery to primary care (Klabunde et al., 2007), this shift is promising to lead to an

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increased uptake of participation in colorectal cancer screening activities. As such, this best practice includes a) team approach, b) use of information systems, c) patient involvement in decision-making in their own care, d) monitoring practice performance in order to identify at increased risk or social disadvantage, e) reimbursement for cancer screening delivery and f) training opportunities in communication and cultural competence that will enhance screening effectiveness in vulnerable populations such as migrants and refugees.

- Colorectal cancer screening programmes should address the target population in a manner that takes into account any specific needs and vulnerabilities in order to maintain high participation rates. Such needs could be attitudes and beliefs; lack of knowledge, access barriers, gender differences, income disparities and others, many of which are prevalent is migrant and refugee groups (Aragones et al., 2009, Kiran et al., 2017).

Smoking

Only few tobacco use prevention or cessation programs directly focusing on migrant/refugee populations exist. Nevertheless important practices on the field of migrant health that act upon filling that gap are mentioned below, since they recognize tobacco use as major risk factor for their health.

More specifically:

- The project "CARE – Common Approach for REfugees and other migrants' health" aims to promote a better understanding of refugees and migrants' health condition and to support the adaptation of the appropriate clinical attitude towards refugees and migrants' health needs. Regarding healthy lifestyle promotion, the project suggests that tobacco cessation is an important target for community health education and primary care among recently-arrived refugees. Education about cancer and its risk factors with the provision of cancer screening are high priorities for this population. Different strategies for men and women should be developed to further decrease smoking prevalence and key persons from immigrant communities should be involved.

- The development of a smoking cessation program for Turkish-speaking migrants in Switzerland due to the high prevalence of smoking in this population had great results as the follow up showed. A specific group treatment for Turkish-speaking migrants was developed and tested in order to provide the migrant population with equal access to smoking cessation programs and to improve the migration-sensitive quality of such programs by sociocultural targeting (Schnoz et al., 2011). The program is now targeted and implemented on Turkish-speaking and Albanian-speaking migrant population as a regular service of the Swiss Public Health Program for Tobacco Prevention by the Swiss Association for Smoking Prevention.

- The study on the reach and effectiveness of a community program to reduce smoking among ethnic Turkish residents in Rotterdam, the Netherlands with a quasi-experimental design demonstrated that community interventions can provide great results in either quitting smoking or at least perceive the benefits of quitting, as it happened with the Turkish population in the intervention group (Nierkens et al., 2013).

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Nutrition

- U.S. Committee for Refugees and Immigrants (USCRI); Healthy Living Toolkit & Nutrition Resources (https://refugees.org/research-reports/). The U.S. Committee for Refugees and Immigrants has developed a toolkit for refugees/migrants, so as to educate and assist them on how to adopt healthier habits, as well as a handout regarding Nutrition Resources.
- Queensland Government; Multicultural Nutrition Resources (https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources). The Queensland Government has developed various multicultural nutrition resources targeting both health professionals and refugees/migrants, covering various thematic areas, as well as countries of origin.
- Supplemental Nutrition Assistance Program Education (SNAP-Ed). This study evaluated a) integrating Supplemental Nutrition Assistance Program Education (SNAP-Ed) into English as Second Language (ESL) classes taught at a worksite- training program for recently resettled refugees and b) the feasibility of using food purchase receipts. Resettled refugees (from 17 countries) participated in one hour SNAP-Ed for 12 weeks during ESL classes (50% completed 12 lessons). 59 participants turned in receipts and 93% used SNAP funds (Gunell et al., 2015). Furthermore SNAP-Ed has also improved food security among low-income Indiana households with children (Rivera et al., 2016).

- Healthy Immigrant Families. This randomized controlled trial evaluated a healthy eating and physical activity intervention for immigrant families recruited from Hispanic, Somali, and Sudanese communities. 6 healthy eating, 4 physical activity and 2 synthesizing information modules were delivered in 12 home visits (60–90 minutes) within first 6 months. Sustained diet quality improvement was achieved among adults but not adolescents (Wieland et al., 2018).

6. Toolbox

Please access our toolbox for examples of tools used with migrants/refugees concerning health promotion as well as the prevention of smoking and safe alcohol use, promotion of healthy nutrition and promotion of cervical and breast cancer screening.

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7. References

Abma, T. A., & Heijsman, A. (2015). Crossing cultures: health promotion for senior migrants in the Netherlands. *Health Promotion International, 30*(3), 460-472. https://doi.org/10.1093/heapro/dat061

Advisory Committee on Cancer Prevention (2000). Recommendationson cancer screening in the European Union Eur J Cancer. *36* (12), 1476-78

Agier, M., Bouagga, Y., Galisson, M., Hanappe, C., Pette, M., & Wannesson, P. (2018). *La jungle de Calais*. Paris: PUF.

Ainsworth (2000). BE. Race/ethnicity, social class and their relation to physical inactivity during leisure time: results from the Third National Health and Nutrition Examination Survey, 1988–1994. *American journal of preventive medicine,* (18), 46–53.

Alliance for Health Promotion (2016). Health Promotion Preliminary Research Report Looking Back ... Moving Forward 6th Global Forum on Health Promotion, Alliance for Health Promotion: Versoix, Switzerland

André, J.-M., & Azzedine, F. (2016). Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance. *Public Health Reviews, 37*(1), 5. https://doi.org/10.1186/s40985-016-0017-4

Aragones, A., Trinh-Shevin, C., Gany, F. (2009). Cancer Screening Practices among physicians serving Chinese immigrants. *J Health Care Poor Underserved*. *20*(1), 64-73

Belarouci (2018). IOM Train4 M&H sponsored training for trainers course. Paris

Benson, J., Phillips, C., Kay, M., Hanifi, H., Giri, G., Leahy, C., Lorimer, M. (2015). Low levels of vitamin B_{12} can persist in the early resettlement of refugees: symptoms, screening and monitoring. *Aust Fam Physician*, *44*(9), 668-73.

Benson, J., & Skull, S. (2007). Hiding from the sun - vitamin D deficiency in refugees. *Aust Fam Physician*, *36*(5), 355-7

Beukeboom, C., & Arya, N. (2018). Prevalence of Nutritional Deficiencies Among Populations of Newly Arriving Government Assisted Refugee Children to Kitchener/Waterloo, Ontario, Canada. *J Immigr Minor Health*, *20*(6), 1317-1323

Beattie-Huggan, P., Harsch, S., & Steinhausen, K. (2016). A framework for global health promotion: The Circle of Health. *Health and Medicine.* *https://www.researchgate.net/publication/333504614_A_framework_for_global_health_promotion_The_Circle_of_Health*

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

CDC (2018a). Heart Disease and Stroke. Retrieved from https://www.cdc.gov/tobacco/basic_information/health_effects/heart_disease/index.htm

CDC (2018b). Secondhand Smoke Infographics. Retrieved from https://www.cdc.gov/tobacco/infographics/secondhand-smoke/index.htm#multiunit

Chaudhry, A. B., Hajat, S., Rizkallah, N., & Abu-Rub, A. (2018). Risk factors for vitamin A and D deficiencies among children under-five in the state of Palestine. *Conflict and Health*, *12*(1). https://doi.org/10.1186/s13031-018-0148-y

Chiu, W. H. (2003). Income Inequality, Human Capital Accumulation and Economic Performance. *The Economic Journal*, *108*(446), 44–59. https://doi.org/10.1111/1468-0297.00272

Choi, J. (2012). Development and pilot test of pictograph-enhanced breast health-care instructions for community-residing immigrant women. *International Journal of Nursing Practice*, *18*(4), 373–378. https://doi.org/10.1111/j.1440-172X.2012.02051.x

Chronic Obstructive Pulmonary Disease, Emphysema (n.d.). Retrieved from https://www.nhlbi.nih.gov/health-topics/copd

Constant, A. F., García-Muñoz, T., Neuman, S., & Neuman, T. (2018). A "healthy immigrant effect" or a "sick immigrant effect?" Selection and policies matter. *The European Journal of Health Economics: HEPAC: Health Economics in Prevention and Care, 19* (1), 103-121. https://doi.org/10.1007/s10198-017-0870-1

Dawson-Hahn, E. E., Pak-Gorstein, S., Hoopes, A. J., & Matheson, J. (2016). Comparison of the nutritional status of overseas refugee children with low income children in Washington State.*PLoS ONE*, *11*(1). https://doi.org/10.1371/journal.pone.0147854

De Jong, G. F., Chamratrithirong, A., & Tran, Q.-G. (2010). For Better, for Worse: Life Satisfaction Consequences of Migration . *International Migration Review*, *36*(3), 838–863. https://doi.org/10.1111/j.1747-7379.2002.tb00106.x

Devlin, J. T., Dhalac, D., Suldan, A. A., Jacobs, A., Guled, K., & Bankole, K. A. (2012). Determinants of physical activity among Somali women living in Maine. *Journal of Immigrant and Minority Health*, *14*(2), 300–306. https://doi.org/10.1007/s10903-011-9469-2

Dupont, H. J. B. H. M., Kaplan, C. D., Verbraeck, H. T., Braam, R. V., & Van De Wijngaart, G. F. (2005). Killing time: Drug and alcohol problems among asylum seekers in the Netherlands. *International Journal of Drug Policy*, *16*(1), 27–36. https://doi.org/10.1016/j.drugpo.2004.06.002

Durrant, R., & Takker, J. (2003). *Substance Use and Abuse: Cultural and Historical Perspectives.* SAGE Publications. http://dx.doi.org/10.4135/9781452229676

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Escribà-Agüir, V., Rodríguez-Gómez, M., & Ruiz-Pérez, I. (2016, October 1). Effectiveness of patient-targeted interventions to promote cancer screening among ethnic minorities: A systematic review. *Cancer Epidemiology*. Elsevier Ltd. https://doi.org/10.1016/j.canep.2016.07.009

European Commission (2017). Cancer Screening in the European Union- Report on the implementation of the Council Recommendation on cancer screening. Retrieved from https://ec.europa.eu/health/sites/health/files/major_chronic_diseases/docs/2017_cancerscreening_2ndreportimplementation_en.pdf

European guidelines for quality assurance in cervical cancer screening (2008). Retrieved from http://screening.iarc.fr/doc/ND7007117ENC_002.pdf

EUROSTAT (2018). Cancer Statistics-specific cancers. Retrieved from https://ec.europa.eu/eurostat/statistics-explained/pdfscache/39738.pdf

FAO and OPM (2018). Food security, resilience and well-being analysis of refugees and host communities in Northern Uganda. Rome.

Fischbacher, C. M., Hunt, S., & Alexander, L. (2004). How physically active are South Asians in the United Kingdom? A literature review. *Journal of Public Health*, *26*(3), 250-8. https://doi.org/10.1093/pubmed/fdh158

Gadd, M., Sundquist, J., Johansson, S. E., & Wändell, P. (2005). Do immigrants have an increased prevalence of unhealthy behaviours and risk factors for coronary heart disease? *European Journal of Cardiovascular Prevention and Rehabilitation*, *12*(6), 535–541. https://doi.org/10.1097/00149831-200512000-00004

Giroux, E. (2010). *Après Canguilhem définir la santé et la maladie.* Presses Universitaires de France.

Grammatikopoulou, M. G., Theodoridis, X., Poulimeneas, D., Maraki, M. I., Gkiouras, K., Tirodimos, I., … Chourdakis, M. (2019). Malnutrition surveillance among refugee children living in reception centres in Greece: A pilot study. *International Health*, *11*(1), 30–35. https://doi.org/10.1093/inthealth/ihy053.

Grijalva-Eternod, C. S., Wells, J. C. K., Cortina-Borja, M., Salse-Ubach, N., Tondeur, M. C., Dolan, C., … Seal, A. J. (2012). The Double Burden of Obesity and Malnutrition in a Protracted Emergency Setting: A Cross-Sectional Study of Western Sahara Refugees. *PLoS Medicine*, *9*(10). https://doi.org/10.1371/journal.pmed.1001320

Hayes, E. B., Talbot, S. B., Matheson, E. S., Pressler, H. M., Hanna, A. B., & McCarthy, C. A. (1998). Health status of pediatric refugees in Portland, Me. *Archives of Pediatrics and Adolescent Medicine*, *152*(6), 564–568. https://doi.org/10.1001/archpedi.152.6.564

Holland, S. (2015). *Public Health Ethics*. John Wiley & Sons.

Horyniak, D., Higgs, P., Cogger, S., Dietze, P., & Bofu, T. (2016, May 3). Heavy alcohol consumption among marginalised African refugee young people in Melbourne, Australia: Motivations for drinking, experiences of

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

alcohol-related problems and strategies for managing drinking. *Ethnicity and Health*, *21*(3), 284-299. https://doi.org/10.1080/13557858.2015.1061105

Horyniak, D., Melo, J. S., Farrell, R. M., Ojeda, V. D., & Strathdee, S. A. (2016). Epidemiology of substance use among forced migrants: A global systematic review. *PLoS ONE*, *11*(7). https://doi.org/10.1371/journal.pone.0159134

IOM, (2016). Empowerment of migrants by ensuring their health and wellbeing (IOM Input to the Round Table 3.1 Background paper).

Johnson, T.P. (1996). Alcohol and drug use among displaced persons: An overview. *Subs Use Misuse*, 31, 1853–1889

Joshi, C., Torvaldsen, S., Hodgson, R., & Hayen, A. (2014). Factors associated with the use and quality of antenatal care in Nepal: A population-based study using the demographic and health survey data. *BMC Pregnancy and Childbirth*, *14*(1). https://doi.org/10.1186/1471-2393-14-94

Khlat, M., & Guillot, M. (2017). Health and mortality patterns among migrants in France. *Migration, Health and Survival: International Perspectives*, *193*.

Khlat, M., Legleye, S., & Bricard, D. (2019). Migration-related changes in smoking among non-Western immigrants in France. *European Journal of Public Health*, *29*(3), 453–457. https://doi.org/10.1093/eurpub/cky230

Kiran, T., Glazier, R. H., Moineddin, R., Gu, S., Wilton, A. S., & Paszat, L. (2017). The impact of a population-based screening program on income-And immigration-related disparities in colorectal cancer screening. *Cancer Epidemiology Biomarkers and Prevention*, *26*(9), 1401–1410. https://doi.org/10.1158/1055-9965.EPI-17-0301

Klabunde, C. N., Lanier, D., Breslau, E. S., Zapka, J. G., Fletcher, R. H., Ransohoff, D. F., & Winawer, S. J. (2007). Improving colorectal cancer screening in primary care practice: Innovative strategies and future directions. *Journal of General Internal Medicine, 22*(8), 1195-205. https://doi.org/10.1007/s11606-007-0231-3

Kooiman, J. (2008). Exploring the Concept of Governability. *Journal of Comparative Policy Analysis: Research and Practice*, *10*(2), 171–190. https://doi.org/10.1080/13876980802028107

Koshoedo, S., Simkhada, P., & Van. Teijlingen, E. (2015). Review of Barriers to Engaging Black and Minority Ethnic Groups in Physical Activity in the United Kingdom. *Global Journal of Health Science*, *1*(2), 85-96. https://doi.org/10.5539/gjhs.v1n2p85

Koshoedo, S. A., Paul-Ebhohimhen, V. A., Jepson, R. G., & Watson, M. C. (2015). Understanding the complex interplay of barriers to physical activity amongst black and minority ethnic groups in the United Kingdom: A

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

qualitative synthesis using meta-ethnography Health behavior, health promotion and society.*BMC Public Health*, *15*(1), 643. https://doi.org/10.1186/s12889-015-1893-0

Kozarić-Kovacić, D., Ljubin, T., & Grappe, M. (2000). Comorbidity of posttraumatic stress disorder and alcohol dependence in displaced persons. *Croatian Medical Journal*, *41*(2), 173-178. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emed5&NEWS=N&AN=2000221670

Larchanché, S. (2012). Intangible obstacles: Health implications of stigmatization, structural violence, and fear among undocumented immigrants in France: Migration, illegality and health: Mapping embodied vulnerability and debating health-related deservingness. *Social Science and Medicine, 74*(6), 858-863.

Laverack, G. (2018). The Challenge of Promoting the Health of Refugees and Migrants in Europe: A Review of the Literature and Urgent Policy Options. *Challenges, 9*(2), 32. https://doi.org/10.3390/challe9020032

Lips, P., & de Jongh, R. T. (2018). Vitamin D deficiency in immigrants. *Bone Reports*, *9*, 37–41. https://doi.org/10.1016/j.bonr.2018.06.001

Lutfy, C., Cookson, S. T., Talley, L., & Rochat, R. (2014). Malnourished children in refugee camps and lack of connection with services after US resettlement. *Journal of Immigrant and Minority Health*, *16*(5), 1016–1022. https://doi.org/10.1007/s10903-013-9796-6

Margolese, H. C., Malchy, L., Negrete, J. C., Tempier, R., & Gill, K. (2004). Drug and alcohol use among patients with schizophrenia and related psychoses: Levels and consequences. *Schizophrenia Research*, *67*(2–3), 157–166. https://doi.org/10.1016/S0920-9964(02)00523-6

McCarthy, A. E., Weld, L. H., Barnett, E. D., So, H., Coyle, C., Greenaway, C., … Cetron, M. (2013). Spectrum of illness in international migrants seen at geosentinel clinics in 1997-2009, part 2: Migrants resettled internationally and evaluated for specific health concerns. *Clinical Infectious Diseases, 56*(7), 925-33. https://doi.org/10.1093/cid/cis1016

Miller, Kenneth & M. Rasco, Lisa. (2004). The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation.

Mittelmark, M.B. (2008) (corresponding author on behalf of the IUHPE). Shaping the future of health promotion: priorities for action, *Health Promotion International*, *23* (1), 98–102. https://doi.org/10.1093/heapro/dam033

Mladovsky, P., Ingleby, D., McKee, M., & Rechel, B. (2012). Good practices in migrant health: the European experience. *Clinical medicine (London, England)*,*12*(3), 248–252. https://doi.org/10.7861/clinmedicine.12-3-248

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Murphy, M., Robertson, W., & Oyebode, O. (2017). Obesity in International Migrant Populations. *Current Obesity Reports, 6*(3), 314-323. Current Medicine Group LLC 1. https://doi.org/10.1007/s13679-017-0274-7.

Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer*, *117*(15), 3543–3552. https://doi.org/10.1002/cncr.26264

Netto, G., Bhopal, R., Lederle, N., Khatoon, J., & Jackson, A. (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*, *25*(2), 248-257. https://doi.org/10.1093/heapro/daq012

Nierkens, V., Hartman, M. A., Nicolaou, M., Vissenberg, C., Beune, E. J. A. J., Hosper, K., … Stronks, K. (2013, October 7). Effectiveness of Cultural Adaptations of Interventions Aimed at Smoking Cessation, Diet, and/or Physical Activity in Ethnic Minorities. A Systematic Review. *PLoS ONE, 8*(10). https://doi.org/10.1371/journal.pone.0073373

Ornelas, I. J., Ho, K., Jackson, J. C., Moo-Young, J., Le, A., Do, H. H., … Taylor, V. M. (2018). Results From a Pilot Video Intervention to Increase Cervical Cancer Screening in Refugee Women. *Health Education and Behavior*, *45*(4), 559–568. https://doi.org/10.1177/1090198117742153

Pavlopoulou, I. D., Tanaka, M., Dikalioti, S., Samoli, E., Nisianakis, P., Boleti, O. D., & Tsoumakas, K. (2017). Clinical and laboratory evaluation of new immigrant and refugee children arriving in Greece. *BMC Pediatrics*,*17*(1), 132. https://doi.org/10.1186/s12887-017-0888-7

Perry, N., Broeders, M., de Wolf, C., Törnberg, S., Holland, R., & von Karsa, L. (2008). *European guidelines for quality assurance in breast cancer screening and diagnosis. Annals of oncology : official journal of the European Society for Medical Oncology / ESMO*, 19, 614–622. https://doi.org/10.1093/annonc/mdm481

Pfarrwaller, E., & Suris, J.-C. (2012). Determinants of health in recently arrived young migrants and refugees: A review of the literature. *Italian Journal of Public Health*, *9*(3). https://doi.org/10.2427/7529

Porter, M. & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis. Journal of the American Medical Association, 294, 602-612. http://doi.org/10.1001/jama.294.5.602

Punzo, O., & Rosano, A. (2018). Access to Colon Cancer Screening of Migrants in Four European Countries. In *SpringerBriefs in Public Health* (pp. 33–42). Springer International Publishing. https://doi.org/10.1007/978-3-319-73630-3_4

Raman, S., Wood, N., Webber, M., Taylor, K. A., & Isaacs, D. (2009). Matching health needs of refugee children with services: How big is the gap? *Australian and New Zealand Journal of Public Health*, *33*(5), 466–470. https://doi.org/10.1111/j.1753-6405.2009.00431.x

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Redditt, V. J., Graziano, D., Janakiram, P., & Rashid, M. (2015). Health status of newly arrived refugees in Toronto, Ont: Part 2: chronic diseases. *Canadian Family Physician Medecin de Famille Canadien*, *61*(7), 310-5. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC4501621

Rehm, J., Samokhvalov, A. V., Neuman, M. G., Room, R., Parry, C., Lönnroth, K., … Popova, S. (2009). The association between alcohol use, alcohol use disorders and tuberculosis (TB). A systematic review. *BMC Public Health*, *9*. https://doi.org/10.1186/1471-2458-9-450

Reiss, K., Lehnhardt, J., & Razum, O. (2015). Factors associated with smoking in immigrants from non-western to western countries - what role does acculturation play? A systematic review. *Tobacco induced diseases*, *13*(1), 11. https://doi.org/10.1186/s12971-015-0036-9

Rivera, R. L., Maulding, M. K., Abbott, A. R., Craig, B. A., & Eicher-Miller, H. A. (2016). SNAP-Ed (Supplemental Nutrition Assistance Program–Education) Increases Long-Term Food Security among Indiana Households with Children in a Randomized Controlled Study. *The Journal of Nutrition*, *146*(11), 2375–2382. https://doi.org/10.3945/jn.116.231373

Rosano, G. M. C., Spoletini, I., & Vitale, C. (2017). Cardiovascular disease in women, is it different to men? The role of sex hormones. *Climacteric*, 2, 125-128. https://doi.org/10.1080/13697137.2017.1291780

Salama, E., Niemelä, S., Suvisaari, J., Laatikainen, T., Koponen, P., & Castaneda, A. E. (2018). The prevalence of substance use among Russian, Somali and Kurdish migrants in Finland: a population-based study. *BMC public health*, *18*(1), 651. https://doi.org/10.1186/s12889-018-5564-9

Seal, A. J., Creeke, P. I., Mirghani, Z., Abdalla, F., McBurney, R. P., Pratt, L. S., … Marchand, E. (2005). Iron and Vitamin A Deficiency in Long-Term African Refugees. *The Journal of Nutrition*, *135*(4), 808–813. https://doi.org/10.1093/jn/135.4.808

Sherlaw,W., Lacouture, A. (2017). Santé ou santés ? in Breton, E., Jabot, F., Pommier, J., & Sherlaw, W. (Eds.). *La promotion de la santé. Comprendre pour agir dans le monde francophone*. Rennes: Presses de l'EHESP

Shirazi, M., Shirazi, A., & Bloom, J. (2013). Developing a Culturally Competent Faith-Based Framework to Promote Breast Cancer Screening Among Afghan Immigrant Women. *Journal of Religion and Health*, *54*(1), 153–159. https://doi.org/10.1007/s10943-013-9793-z

Shuldiner, J., Liu, Y., & Lofters, A. (2018). Incidence of breast and colorectal cancer among immigrants in Ontario, Canada: A retrospective cohort study from 2004-2014. *BMC Cancer*,*18*(1). https://doi.org/10.1186/s12885-018-4444-0

Singh, G. K., & Siahpush, M. (2001). All-cause and cause-specific mortality of immigrants and native born in the United States. *American Journal of Public Health*, *91*(3), 392–399. https://doi.org/10.2105/AJPH.91.3.392

Solé-Auró, A., & Crimmins, E. M. (2008). Health of immigrants in European countries.*International Migration Review*, *42*(4), 861–876. https://doi.org/10.1111/j.1747-7379.2008.00150.x

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Sternfeld, B., Ainsworth, B. E., & Quesenberry, C. P. (1999). Physical activity patterns in a diverse population of women. *Preventive Medicine*, *28*(3), 313–323. https://doi.org/10.1006/pmed.1998.0470

Subramanian, P., Oranye, N. O., Masri, A. M., Taib, N. A., & Ahmad, N. (2013). Breast cancer knowledge and screening behaviour among women with a positive family history: A cross sectional study. *Asian Pacific Journal of Cancer Prevention*, *14*(11), 6783–6790. https://doi.org/10.7314/APJCP.2013.14.11.6783

Sustainable Development Goals (2019). Migration data for sustainable development goals. Retrieved from https://migrationdataportal.org/sdgs

Swiss Association for Smoking Prevention. Retrieved from https://portal.at-schweiz.ch/index.php/fr/projets/programme-national-d-arret-du-tabagisme/conseils-en-matiere-de-sevrage-pour-les-personnes-de-langue-turque-et-albanais

Tanaka, M., Petsios, K., Dikalioti, S. K., Poulopoulou, S., Matziou, V., Theocharis, S., & Pavlopoulou, I. D. (2018). Lead exposure and associated risk factors among new migrant children arriving in Greece. *International Journal of Environmental Research and Public Health*,*15*(6). https://doi.org/10.3390/ijerph15061057

Travers, K. D. (1996). The social organization of nutritional inequities. *Social Science and Medicine*, *43*(4), 543–553. https://doi.org/10.1016/0277-9536(95)00436-X

UNHCR (2019a). A Handy Guide to UNHCR Emergency Standards and Indicators. Retrieved from https://www.refworld.org/pdfid/3dee456c4.pdf;

UNHCR (2019b). Emergency Hanbook, Nutrition in camps. Retrieved from https://emergency.unhcr.org/entry/254165/nutrition-in-camps

UNHCR (2011). Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations. Retrieved from https://www.unhcr.org/publications/operations/4f1fc3de9/unhcr-operational-guidance-use-special-nutritional-products-reduce-micronutrient.html

UNHCR (2006). UNHCR policy related to the acceptance, distribution and use of milk products in refugee settings. Retrieved from https://www.unhcr.org/publications/operations/4507f7842/unhcr-policy-related-acceptance-distribution-use-milk-products-refugee.html

UNHCR & WFP (2006). United Nations High Commissioner for Refugees, and World Food Program. Acute Malnutrition in Protracted Refugee Situations: A Global Strategy. Retrieved from https://www.unhcr.org/45fe62642.pdf

Urban, M., Burghuber, O. C., Dereci, C., Aydogan, M., Selimovic, E., Catic, S., & Funk, G. C. (2015). Tobacco addiction and smoking cessation in Austrian migrants: A cross-sectional study. *BMJ Open*, *5*(6). https://doi.org/10.1136/bmjopen-2014-006510

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

Valentini, L. (2011). *Justice in a Globalized World: A Normative Framework*. Oxford, New York: Oxford University Press.

Valentini, L. (2012). Ideal vs. Non-ideal Theory: A Conceptual Map: Ideal vs Non-ideal Theory. *Philosophy Compass, 7*(9), 654-664. https://doi.org/10.1111/j.1747-9991.2012.00500.x

Von Karsa, L., Patnick, J., Segnan, N., Atkin, W., Halloran, S., Lansdorp-Vogelaar, I., … Valori, R. (2013). European guidelines for quality assurance in colorectal cancer screening and diagnosis: Overview and introduction to the full Supplement publication. *Endoscopy, 45,* 51-59. https://doi.org/10.1055/s-0032-1325997

WHO (1986). The Ottawa Charter for Health Promotion. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

WHO (2005). The Bangkok Charter for Health Promotion in a Globalized World. Retrieved from https://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/

WHO (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Commission on Social Determinants of Health Final Report. Geneva: World Health Organization, Retrieved from https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=D1E9027202E1BB1FB9C3DF4766244923?sequence=1

WHO (2010). A conceptual framework for action on the social determinants of health. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/44489/9789241500852_eng.pdf;jsessionid=C55A378AA8947029EC1C7FFCCD7F0CF6?sequence=1

WHO (2013). Global action plan for the prevention and control of NCDs 2013–2020. Geneva: World Health Organization. Retrieved from https://www.who.int/nmh/events/ncd_action_plan/en/

WHO (2014). Comprehensive implementation plan on maternal, infant and young child nutrition. Geneva: World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/113048/WHO_NMH_NHD_14.1_eng.pdf?ua=1

WHO (2017). Framework of priorities and guiding principles to promote the health of refugees and migrants. Retrieved from http://www.who.int/migrants/about/framework_refugees-migrants.pdf

WHO (2017a). Monitoring tobacco use and prevention policies. Retrieved from https://www.who.int/tobacco/global_report/en/

WHO (2018a). Malnutrition. Retrieved from https://www.who.int/news-room/fact-sheets/detail/malnutrition

WHO (2018b). Healthy Diet. Retrieved from https://www.who.int/en/news-room/fact-sheets/detail/healthy-diet

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).

WHO (2018c). Report on the health of refugees and migrants in the WHO European Region: no public health without refugee and migrant health. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0005/392774/ermh-summary-eng.pdf

WHO (2019). Adelaide Recommendations on Healthy Public Policy. Retrieved from https://www.who.int/healthpromotion/conferences/previous/adelaide/en/

WHO (2019). Global Strategy on Diet, Physical Activity and Health. Retrieved from https://www.who.int/dietphysicalactivity/pa/en/

WHO (2019). Migration and health: key issues. Retrieved from http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues

WHO (2019). Tobacco. Retrieved from https://www.who.int/news-room/fact-sheets/detail/tobacco

WHO & UNHCR (2008). Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide. Retrieved from https://www.who.int/hac/network/unhcr_al_eng2.pdf

WHO & UNICEF (2013). Global strategy for infant and young child feeding. Retrieved from https://www.who.int/nutrition/publications/infantfeeding/9241562218/en/

Widdows, H., & Marway, H. (2015). A Global Public Goods Approach to the Health of Migrants. *Public health ethics*, *8*(2), 121-129.

Wieland, M.L., Hanza, M.M.M., Weis, J.A., Meiers, S.J., Patten, C.A., Clark, M.M., Sloan, J.A., Novotny, P.J., Njeru, J.W., Abbenyi, A., Levine, J.A., Goodson, M., Capetillo, G.D.P., Osman, A., Hared A., Nigon, J.A., & Sia, I.G. (2018). Healthy Immigrant Families: Randomized Controlled Trial of a Family-Based Nutrition and Physical Activity Intervention. *Am J Health Promot*, *32*(2), 473-484. https://doi.org/10.1177/0890117117733342

Wieland, M. L., Tiedje, K., Meiers, S. J., Mohamed, A. A., Formea, C. M., Ridgeway, J. L., Asiedu, G.B., Boyum, G., Weis, J.A., Nigon, J.A., Patten, C.A., & Sia, I. G. (2013). Perspectives on Physical Activity among Immigrants and Refugees to a Small Urban Community in Minnesota. *Journal of Immigrant and Minority Health*, *17*(1), 263–275. https://doi.org/10.1007/s10903-013-9917-2

Wild, V., & Dawson, A. (2018). Migration: a core public health ethics issue. *Public Health*, 158, 66-70. https://doi.org/10.1016/j.puhe.2018.02.023

Williams, E. D., Stamatakis, E., Chandola, T., & Hamer, M. (2011). Assessment of physical activity levels in South Asians in the UK: Findings from the Health Survey for England.*Journal of Epidemiology and Community Health*, *65*(6), 517–521. https://doi.org/10.1136/jech.2009.10250

Yang, P., Tao, R., He, C., Liu, S., Wang, Y., & Zhang, X. (2018). The Risk Factors of the Alcohol Use Disorders-Through Review of Its Comorbidities. *Frontiers in neuroscience*, *12*, 303. https://doi.org/10.3389/fnins.2018.00303

Co-funded by the European Union's Health Programme (2014-2020)

This document is part of the project '738186 / Mig-HealthCare' which has received funding from the European Union's Health Programme (2014-2020).