

Editorial

Health Education and Migration

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Despite the vastly differing ideological and political standpoints that it provokes, migration has become a firmly embedded global policy issue in the twenty-first century. In 2015, an estimated 244 million people were defined as international migrants, an increase of 71 million since the year 2000 (UNDESA 2015). A further 740 million people are estimated to migrate within their own country (IOM 2015). Many millions more, even if not moving themselves, are directly affected by migration. As well as increasing in its extent, migration has also increased in complexity, involving mixed flows of economic, forced, and irregular migration, generating an increasingly diverse demographic profile of migrant people.

Migration is increasingly recognised as a determinant of health (Davies et al. 2010; Casteñeda et al. 2015). On the one hand, migration can extend and improve people's wellbeing in a myriad of ways: improving access to required health technologies to treat certain conditions; widening opportunities for employment, training or education, thus enhancing aspects of economic and social wellbeing; providing political freedom to exercise choice and control over one's life; or offering security and safety away from conflict and/or persecution. On the other hand, migration can negatively impact on those who move and those who stay behind, through a whole range of new stresses, pressures and demands. These range from strenuous journeys (for some marked by extreme violence and trauma) to physical and arduous work, to pressures to support families far away and sustain a life in the host country, to challenges with respect to integration, language, social isolation and fears about legal status and security. At another level, health economies and systems can be sustained through certain migratory flows, while simultaneously stretched by new demands and pressures from other forms of migration.

Migration trajectories can thus positively or negatively impact health outcomes at multiple levels, just as health status can affect migration outcomes. However, the interactional relationships between migration and health are not clearly understood, and the policy and practice arena remains largely uncoordinated and inconsistent, with major discrepancies between policy implementation and practical need. Whilst this disjointed and inadequate situation is in part reflective of the politicised and security-focused context in which migration is often played out, it is also the product of a widespread lack of understanding and agreement on how best to promote the

health and wellbeing of increasingly diverse populations. Indeed, recent research has emphasised that international targets, such as the Sustainable Development Goals (SDGs), and in particular, universal health coverage (target 3.8 of the SDGs), are unlikely to be achieved if the dynamics and inter-relations between migration and health are not better understood (Wickramage et al. 2018).

Existing research on health and migration has tended to focus on the barriers migrant communities face in accessing healthcare, and the poor health outcomes that often result from this. Similarly, programmes of health education and health promotion are often conceptualised in quite functional ways, such as mechanisms for facilitating migrant integration or enabling people to achieve the level of health literacy required to access appropriate healthcare and support in their new environment. Much less is known about the sorts of health education and health promotion initiatives that might best respond to different constituents of people arriving in a host country and which take account of their diverse life course experiences and the wider social, psychological, emotional, economic and environmental factors which determine their health and wellbeing and how much control they can have over it. To date, there has been a fairly considerable research focus on education and migration at the level of 'elite' migration, including amongst international students who have moved to pursue educational opportunities elsewhere (e.g. Perkins and Neumayer 2014; Tannock 2013). Rather less attention has been given to understanding the role of education within the lives of migrant people who fall outside of these categories, either in terms of their health or in terms of the potential for education to support social integration, citizenship and wellbeing more generally.

Against this backdrop, this special issue of *Health Education Journal* offers an overview of key debates that underpin and progress understandings of health education and migration in a contemporary global context.

The first two papers focus on the concept of health literacy, and its role in supporting migrant health care. Health literacy is often interpreted as an empowerment strategy to increase control over one's health, through the ability to seek out and apply health information to prevent disease and live a healthy lifestyle (Kickbusch and Maag 2008). However, in reality, many health literacy-related interventions have drawn on Western-led conceptions of what constitutes a health priority, and defer to forms of 'education' in which information deemed by 'experts' to be important, is imparted through top-down interventions and health campaigns. Very often, such interventions show little or no regard for migrants' own health understandings and beliefs, and as a result, do not succeed (WHO 2017). Research in the UK for example, found that the low uptake of cancer screening amongst migrant women was, in part at least, influenced by the health education campaigns that accompanied the promotion of screening. This form of health education was reported by women to be overly didactic, to lack language and cultural sensitivity, and to pay little attention to the social context within which decisions over breast screening were made. Images within educational videos were also considered to

depict crude stereotypes of people from migrant communities, and to reinforce top-down power relations between health providers and patients (Chiu 2009).

There are, however, models and approaches to health education and promotion which, irrespective of the contexts in which they are applied, help guide interventions which are more in keeping with the needs, values, beliefs and circumstances of the lives of people they are intended for. The Ottawa Charter for Health Promotion (WHO 1986) – provides an overarching framework based on a salutogenic, rather than a pathological understanding of health - that is a concern with what keeps people well, rather than what causes their illness. Moreover, the Charter encourages a social ecological analysis of the interacting dimensions of people's lives, at different points in time and space, and how these can simultaneously create factors which enhance or undermine people's wellbeing (see Jack et al, this issue). Hence, such frameworks help widen the lens of analysis of health and wellbeing issues and how we might best respond, while also encouraging critical engagement with issues of inequality and power that perpetuate poor health and wellbeing in complex ways.

Adopting this broader framing of health education and promotion has evident relevance to responding to health needs in the context of migration. As Ingleby (2012) has noted, migrant people are not 'empty vessels' to be filled by Western expertise, but have their own beliefs, understandings and values, as well as their own forms of health literacy, and it is vital that this is recognised in any attempt to develop appropriate health education initiatives. Research amongst Pakistani people moving to Denmark for example, has demonstrated how 'one-size fits all' public health campaigns around diet have failed to be fully effective when they have not attempted to incorporate diverse cultural norms and values (Halkier and Jensen 2011). Such work demonstrates the need for public health policies and interventions to shift from a deficit-based model (seeking to redress assumed deficiencies in people's knowledge, motivation and resources) to an approach that recognises how social and cultural norms and values are embedded in the social practices, relations and realities of people's everyday lives. Attempts to promote health through education which fail to recognise and engage with these perspectives are likely to be, at best, ineffectual. More importantly, however, they run the risk of perpetuating inequalities, marginalisation and discrimination through generating top-down, normative ideas about what people 'should' do in pursuit of their own health and wellbeing. Understanding the institutional and structural constraints which may inhibit people's control over their health is part of the critical analysis required to inform appropriate policy and practice for health education and promotion

The papers in this special issue provide concrete examples of how this more expansive conceptualisation of health and health education might be achieved. In the first paper, Hyojin Im and Laura Swan provide a detailed analysis of the concept of health literacy, and critique the limited way in which it tends to be applied in research on migrant people's health. Examining the various levels at which health literacy operates, the authors explain how much existing research has

overemphasised functional health literacy, which focuses on the basic skills used to gain and understand health information, whilst *underestimating* the more complex role of interactive and critical health literacy skills which involve capacity to analyse and engage with health information, and to maintain self-management and control over life events. Exploring four key domains of critical health literacy, namely, critical appraisal; self-efficacy and confidence; empowerment; and problem solving and collective action, Im and Swan analyse the ways that people process and action health information within the context of existing cultural knowledge and community experience. Within this discussion, the authors call for health education interventions to move away from overly simplistic notions of functional health literacy towards more complex and multidimensional aspects of critical health literacy.

Recognising the challenges that exist from high levels of migration into the European Region, the second paper in this special issue explores the evidence on migrant health literacy to mobilise and facilitate appropriate action to help reduce systemic health and wellbeing inequalities. Here, Markia Ward et al. identify the lack of consistency across the region over the ways that different 'types' of migrant people are categorised and how such categorisation impacts adversely on data collection and analysis, the generalisability of research findings and their potential for positively affecting policy and action. In emphasising the limited nature of evidence across health topics and how they differentially affect the health of people from different origins and backgrounds, Ward et al. call for national and international guidance for professionals working to promote health with migrant communities. Such guidance, they argue, could assist professionals in setting priorities for health literacy and thus improve the quality of healthcare delivery in Europe.

The following three papers demonstrate some of the diversity of settings in which forms of health education take place. Underpinning all of these chapters is a recognition that understanding the values and expectations that people attach to health and wellbeing is necessary before it is possible to respond effectively to their needs. If people are not consulted and involved in the design of their own health services, then these services will not be optimally accessible, relevant or inclusive. Undertaking this kind of work *with* rather than *on* migrant groups can therefore help to give voice to subjectively defined expectations, needs and priorities and, importantly, can help to build trust, empowerment and ownership of health processes and interventions.

Antonio Chiarenza et al. emphasise the challenges facing practitioners in healthcare settings who are working with increasingly diverse migrant populations. Focusing on Europe, Chiarenza et al. report a startling lack of appraisal of either content or quality of training programmes designed to support cultural competence amongst health care practitioners. Their evaluation of related training programmes between 2004 - 2013, found that the design, delivery and evaluation of such programmes have been characterised by low levels of engagement with migrant men and women and other minority ethnic members of the communities for whom they are intended. As a result, notions of cultural competence have tended to remain limited

in scope, with little recognition of the importance of how factors such as age, gender, ethnicity, sexual orientation, class, caste (and other social cleavages) intersect with culture to determine people's health opportunities and outcomes. Nor have these programmes adequately taken into account central tenets of health care provision including equity and person-centred care. Furthermore, training programmes have lacked an explicit pedagogical approach, have been narrowly targeted at specific health personnel and poorly linked to wider organisational or policy level support. The lack of formal assessment for those completing the training also suggests that the systemic buy-in so vital for such initiatives to gain acceptance and kudos among the communities for whom they are designed has been lacking.

The authors make a number of recommendations for future training programmes including the adoption of a health-system approach in defining training objectives; involving service users and stakeholders in programme development, delivery, and evaluation; widening the target of training programmes to include health managers and key decision-makers; developing a clear rationale and pedagogical approach for the training programme; and ensuring there is a clear focus on outcomes for all stakeholders in training design, implementation and evaluation.

In the fourth paper of this special issue, Odette Jack et al. examine the health and wellbeing of refugee students in a higher education institute in the UK. Education has been shown to help protect the psychosocial, physical and cognitive wellbeing of refugees and to facilitate economic independence and integration into the host society (Betts 2016). For the participants in this research, education was seen as a key motivator, with huge potential to enhance their lives. However, whilst the university had an established service structure to support the health and wellbeing of all students, participants identified a number of barriers to access for refugee students. This included a lack of awareness of the service by students, a reluctance to talk to people who they did not know, cultural attitudes which stigmatised mental health issues, and a perceived lack of cultural competence within services, leading students to question the reliability of the service, and the ability of its staff to understand and respond appropriately to the student's specific backgrounds and circumstances. The authors recommend a range of strategies to develop and embed a more culturally competent service that is meaningful and relevant to refugee students.

The following paper examines the potential for health education within the more everyday and personal settings of people's lives. Here, Catrin Evans et al. explore the potential for mobile phone interventions to encourage HIV testing amongst migrant groups who are known to face difficulties in accessing mainstream health services in the UK. Using data from a feasibility study undertaken with African migrant communities, the authors show how, when designed with stakeholders, mobile phone messaging can be a feasible and acceptable intervention to promote both HIV testing and lifestyle behaviours which are conducive to sustaining health and wellbeing.

The final two papers in this special issue focus on the role of methodology in influencing the shape and likely success of health education initiatives. At present, much of the dominant evidence base around migrant health upholds a Western, biomedical notion of health, and privileges the use of particular methodologies, such as epidemiological surveys, to assess health 'problems', and their causes and consequences. The current preference for these types of data elicitation can, in turn, shape the way that forms of health education are identified, developed and implemented. Yet in overlooking the relevance of diverse cultural frames of reference for understanding and promoting health, such approaches offer only a partial insight into people's health-related concerns, experiences and priorities. Research that engages with more participatory and narrative methods of enquiry can open up important spaces for more nuanced insights and perspectives that may offer a different starting point for health education, the development of meaningful and respectful partnerships, and opportunities for the co-creation of health education initiatives with their intended beneficiaries.

Expanding upon this approach, the paper by Grace Spencer et al. examines how notions of health and health education play out within the daily lives and settings of migrant children. Drawing on work from within the WHO Western Pacific region, the authors highlight how a dominant focus on adults' (often negative) health experiences and outcomes can limit rather than aid the understanding of migrant children's health and in so doing, overlook their agency and resilience. They argue that the tendency to conflate children's experience with that of their parents promotes particular forms of health education *for*, rather than *with* children and young people. Demonstrating how participatory approaches can provide crucial insights into the experiences, concerns and priorities of migrant children and young people, they argue for the development of health education that is in line with children's own understandings of health and wellbeing. In so doing, they draw attention to how children and young people prioritise and value elements of their own health and wellbeing which may have been overlooked by more normative research methods, such as the central importance of the social aspects of their health and migration experiences.

The final paper in this special issue serves as a reminder of the wide array of contexts in which forms of health education can take place, as well as the insights that can be gained through participatory and narrative methods of enquiry. In it, Oscar Millar and Ian Warwick explain how participatory observation and interviews enabled them to identify the positive impact of music practice on the wellbeing of young Iraqi and Syrian refugees in Greece. Using group work to share and perform music and songs, participants reported improved social relations and the development of emotional expression, self-knowledge and positive self-identity, as well as a sense of agency. The approach used in this research also provided a supportive environment for enabling participants to work as teachers for other young migrants in the refugee camp, helping them to develop further skills to act as agents of community development.

Taken together, the papers included here demonstrate something of the vibrancy and urgency of the field, as well as the value of diverse disciplinary and methodological approaches within this. As these papers make clear, effective health education does not mean the top-down imparting of knowledge, and is by no means limited to formal educational settings. Instead, effective health education takes into account the diverse life course experiences of migrant people, and the wider range of social, cultural, economic, environmental and political factors that determine their health and wellbeing. It also involves working with migrant groups to ensure that health education is designed and developed in a way that fosters ownership and responds to their subjectively defined understandings, priorities and needs. As migration increases in scale and diversity, it is clear that this is an area that can no longer be ignored within health education.

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