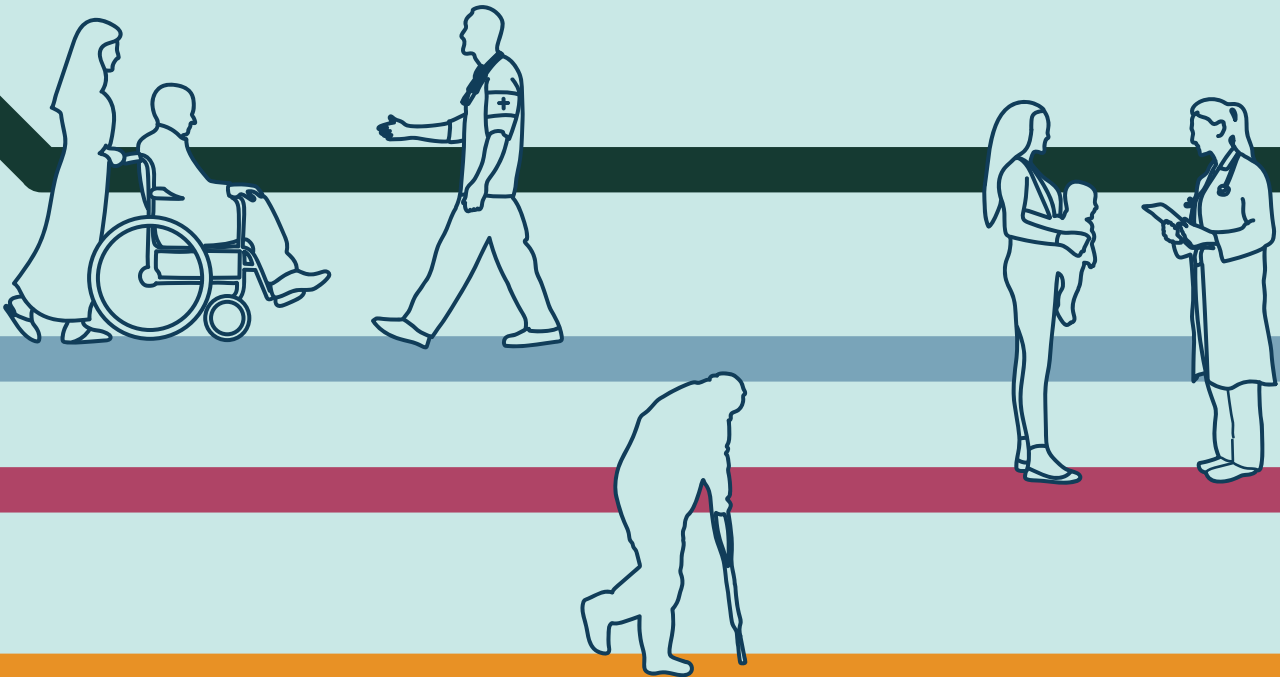




World Health
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Refugee and migrant health: Global Competency Standards for health workers



WHO Health and Migration Programme

The WHO Health and Migration Programme brings together WHO's technical departments, regional and country offices, as well as partners, to secure the health rights of refugees and migrants and achieve universal health coverage. To this end, the Programme has five core functions: to provide global leadership, high-level advocacy, coordination and policy on health and migration; to set norms and standards to support decision-making; to monitor trends, strengthen health information systems and promote tools and strategies; to provide specialized technical assistance, response and capacity-building support to address public health challenges associated with human mobility; and to promote global multilateral action and collaboration.



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Refugee and migrant health: global competency standards for health workers

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Foreword

Refugees and migrants are among the most vulnerable communities in many societies. All too often, they live insecurely on the fringes of society, in fear and without access to a reasonable level of essential services, including health services. They may face discrimination, social exclusion, negative attitudes, and stigmatizing stereotypes.

The COVID-19 pandemic has disrupted health services across the world, putting these already vulnerable and marginalized communities at heightened risk. The pandemic has compromised the ability of health systems to respond to the whole spectrum of health needs, exacerbating existing inequities.

WHO believes that everyone should be able to enjoy the right to health and access to people-centred, high-quality health services without financial impediment, including refugees and migrants, as expressed by our commitment to universal health coverage.

All countries should aspire to build strong health systems, supported by a well-trained, culturally sensitive, and competent health workforce that can respond to the needs of all people. Such health systems must be sensitive to the needs of refugees and migrants, their languages and their unique health problems. This requires comprehensive national health policies underpinned by legislative and financial frameworks.

There is a clear need for consistent standards of practice for health workers providing services to refugees and migrants. These Global Competency Standards are the first of their kind, and are designed to achieve just that. They highlight a range of competencies that can be incorporated into education and practice to help health workers to provide culturally sensitive care to refugees and migrants.

2021 is the International Year of Health and Care Workers, which recognizes the dedication and sacrifice of millions of workers during the COVID-19 pandemic, and thanks them for their critical role in ensuring our health and prosperity. I hope that the Global Competency Standards provides a way of supporting and encouraging health workers to improve the provision of culturally health sensitive care to refugees and migrants, enabling them to live happier, healthier lives.

The Standards will play an important role in strengthening primary care and advancing progress towards universal health coverage for all, including refugees and migrants. Successful roll-out will require the commitment of all countries to support and invest in their health workforces.



A handwritten signature in blue ink, which reads "Tedros Adhanom Ghebreyesus".

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization



Preface

Refugees and migrants have the fundamental right to the enjoyment of the highest attainable standard of health. They may have specific health needs and vulnerabilities that require culturally sensitive, effective and high-quality care that also recognizes the impact of migration on physical and mental health.

Refugees and migrants may face a number of challenges to accessing health care, including language and cultural differences, institutional discrimination and restricted use of health services, which shape their interactions with the host country's health system and health workforce. The health workforce has a vital role in providing people-centred health services and building the resilience of health systems to respond to the health needs of refugees and migrants. This requires health workers with specific competencies.

WHO is committed to promote the health needs of refugees and migrants including through the establishment of the global Health and Migration Programme. WHO's Thirteenth General Programme of Work concentrates on working towards universal health coverage and the achievement of the Sustainable Development Goals, using inclusive health systems that put people at their centre. Ensuring the health and well-being of refugees and migrants is a key priority within this endeavour. The WHO Global Action Plan, Promoting the Health of Refugees and Migrants, aims to both promote refugee and migrant health and leave no one behind.

This Standards document has been developed by the Health and Migration Programme in close collaboration with the Health Workforce Department and is the first set to be developed for health workers who provide health services to refugees and migrants. The Standards highlights the competencies and behaviours needed to provide high-quality care to refugees and migrants. Achieving universal health coverage for these populations requires strong health systems with competent health workers who are trained, supported and empowered to provide the needed care.

The Standards aims to support a competency-based outcomes approach to education and training for health workers who provide services to refugees and migrants. The Standards focuses on behaviours that are specific and measurable, noting that behaviours are underpinned by knowledge, skills and attitudes that are developed interdependently. It is hoped that Standards described will provide a way forward for health workers to improve and consolidate practices in culturally sensitive care, leading to better outcomes for refugees and migrants. In addition,

the Standards aims to guide the development of a curriculum for training health workers to meet the demands of current and future practice in relation to refugee and migrant health, which is being developed.

Meeting the health needs of refugees and migrants requires the commitment of all countries to support and invest in a health workforce that is competent to provide people-centred health services. What has been achieved so far in development of the Standards is impressive. However, the next stage of rolling this out will be vastly more important. WHO will support the rollout of the Standards regionally and in Member States and will work with countries to build health system capacities and resilience, including a health workforce that provides people-centred quality health service. The development of the learning guide and curriculum and their adaptation to country contexts will help to promote access to high-quality primary care and progress towards universal health coverage for all the population including refugees and migrants. We must commit to achieving equitable access to essential health services for refugees and migrants and remove barriers to quality health services.



A handwritten signature in black ink that reads "Dr. Jakab".

Dr Zsuzsanna Jakab
Deputy Director-General
World Health Organization



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Introduction

The Refugee and Migrant Health: Global Competency Standards for Health Workers (the Standards) highlights the competencies and behaviours of the health workforce in providing quality care to refugee and migrant populations. Achieving universal health coverage for refugee and migrant populations requires strong health systems with competent health workers who are trained, supported and empowered to provide the care needed.

Competence is the state of proficiency to perform work activities to a defined standard. It is multidimensional and dynamic, changing with time, experience and setting, and equates to having the requisite competencies to do this in a given context (1). Competence in an area is durable, trainable and, through the expression of behaviours, measurable. Health workers providing care to refugee and migrant populations are expected to achieve a minimum level of competence and, therefore, to integrate the Standards into their performance of work activities.

The WHO Health and Migration Programme, in collaboration with the Health Workforce Department, identified the need to specifically tailor competencies to address the various differing health needs of refugee and migrant populations. This has led to the development of the Standards. This is strongly aligned with the Global competency framework for universal health coverage being developed by the WHO Health Workforce Department to identify the competencies and areas of practice for health workers through the lens of primary health care but it contains additional specifications for minimum behavioural standards and evidence-informed clinical standards in the context of migration and displacement.

The Standards focuses on the behaviours of health workers while recognizing that health systems also need to be responsive to the needs of refugees and migrants. The health workforce is positioned within a broader landscape, where policy and legal considerations govern access to health services for refugee and migrant populations. Quality health care for all requires structures that are inclusive of refugee and migrant populations as well as an educated health workforce capable of providing culturally sensitive services.

Aims of the Standards

The Standards aims to support a competency-based outcomes approach to education and training for health workers who provide services to refugees and migrants. Competency-based education situates knowledge and skills in

the specific context of practice, in this case refugee and migrant health, while recognizing that the composition and responsibilities of the health workforce are also shaped by the specific health systems and health practices of regions and countries.

The competencies and behaviours in the Standards are organized under five key domains, in line with the competencies within the WHO Global competency framework for universal health coverage but tailored to the specific context of refugee and migrant health. The Standards focuses on behaviours which are specific and measurable, noting that behaviours are underpinned by knowledge, skills and attitudes that are developed interdependently. Together, the Standards represents best practice and builds upon existing efforts of health workers to provide the same high quality of care for refugee and migrant populations as for host populations.

The competencies described here are designed so that they can be tailored to the environments that health workers operate in, taking into consideration the requirements and constraints of local health systems as well as the characteristics of the refugee and migrant populations. Countries with large refugee and migrant populations have adapted their health systems in different ways to accommodate the needs of these populations. Service models for refugees and migrants reflect in part the size of the population, the dynamics and volume of people crossing borders, and the capacity and commitment of the host country to provide for the health needs of its refugee and migrant populations.

Refugees and migrants often have health needs that differ from those of host populations, requiring culturally sensitive and effective care that recognizes the impact of migration on physical and mental health. Refugees and migrants may face a number of challenges to accessing health care, including language and cultural differences, institutional discrimination and restricted use of mainstream health services; these will shape their interactions with the host country's health system and health workforce. Socioeconomic inequities experienced by refugees and migrants are further exacerbated by exclusionary policies and inequitable access to employment and education opportunities, and have a significant influence on health. Particularly vulnerable are migrants who are in situations such as being trafficked for forced work, as unaccompanied children or as irregular migrants.

While the Standards and accompanying Explanatory notes highlight specific areas where refugees and migrants may require additional support, their strengths should also be recognized in the delivery of health services. The Standards prompts health workers to identify vulnerabilities experienced by refugees and migrants when accessing health services, but also to recognize that the empowerment



and agency of refugee and migrant populations in health care remain critical. While refugees and migrants may face additional challenges compared with host populations in their access to, and experience of, health care, it should be recognized that all people have a fundamental right to health regardless of legal status.

Finally, the Standards aims to guide the development of a curriculum to train health professionals to meet the demands of current and future practice in relation to refugee and migrant health. While the behaviours contained within the Standards are designed to be broadly applicable to health workers operating in various environments, there is significant scope for behaviours to be tailored to specific settings. In particular for health workers operating in fragile and conflict settings, it is recognized that competencies and behaviours may need to be further adapted in light of various challenges at operational and systemic levels. These may include severely weakened health systems, limited resources and severe mental health and well-being impacts on health workers themselves.

Development of the Standards

The process of developing the Standards was informed by a multicountry review and an extensive literature review. It was further informed and guided by the technical advice provided by the Strategic Working Group, which was made up of experts in refugee and migrant health (Annex 1). The Strategic Working Group reviewed the draft Standards to ensure its relevance and applicability for health workers in different settings and countries. Additional consultations were also conducted with an expert group drawing from universities, international organizations and nongovernmental organizations.

The multicountry review, Mapping health systems' responsiveness to refugee and migrant health needs, has provided an overview of the levels of health care accessed by refugees and migrants in 18 countries with a significant refugee and migrant population. The review identified four broad models of care adopted by countries to deliver health services to refugees and migrants: (i) mainstream, where the health system accessed by the general population is used; (ii) specialized-focus, where a separate stream of services designed to meet the specific health needs of refugee and migrant populations is the first point of contact; (iii) gateway, where only basic checks may be available but entry to the main health services is provided; and (iv) limited, where basic health services are provided by external actors such as charities and nongovernmental organizations.

The accompanying review, *Health needs of refugees and migrants: a literature review*, explores how the health needs of refugees and migrants may differ from those of the host population over their life course. It covers child health, sexual health, reproductive health, mental health, preventive health, chronic diseases, communicable diseases, oral health, care for elderly people and care for those with disabilities.

These two reviews helped to establish the context for the Standards, which also has drawn from the *Competency Standards Framework for Clinicians: Culturally Responsive Clinical Practice – Working with People from Migrant and Refugee Backgrounds (2)*. This was developed in Australia in 2019 by the Migrant and Refugee Health Partnership. This 2019 Competency Standards Framework established recommended and optimal cultural responsiveness competency standards for clinicians working with people from refugee and migrant backgrounds in all health-care settings.

In developing the Standards, care was taken to ensure that the language was reflective of the significant diversity within refugee and migrant populations,¹ as well as the different conditions under which they migrated were displaced or trafficked.

While the Standards provides a high-level overview of the expected behaviours of health workers providing services to refugees and migrants, further work is needed to translate the competencies into work activities. A knowledge guide and curricula guidance will be developed in line with the Standards, focusing on practice activities relating to the provision of health services at an individual level and drawing from the knowledge guides developed as part of the Global competency framework for universal health coverage, but contextualizing for refugee and migrant health in accordance with WHO's Global Action Plan, *Promoting the Health of Refugees and Migrants (2019–2023) (4)*.

1 The term refugee is defined in Article 1 of the 1951 Convention Relating to the Status of Refugees, which states that “For the purposes of present Convention, the term ‘refugee’ shall apply to any person who ... owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (3). By comparison, there is no universally accepted definition of the term migrant (4). Migrants may be granted a different legal status in the country of their stay, which may have different interpretations regarding entitlement and access to essential health-care services within a given national legislation. However, under international law such access remains universal for all in line with the 2030 Agenda for Sustainable Development, in particular with Sustainable Development Goal 3 (ensure healthy lives and promote well-being for all at all ages) (5).



How to use this Standards document

The Standards are organized into five domains with a series of competencies and behaviours within each domain:

domain 1, person-centredness

domain 2, communication

domain 3, collaboration

domain 4, evidence-informed practice

domain 5, personal conduct.

The competencies and behaviours should be read in conjunction with the accompanying explanatory notes, which provide further insight into terms and concepts raised, and draw on peer-reviewed research, grey literature and current guidelines produced by WHO and international organizations.

This document is designed to highlight specific competencies for health workers in relation to refugee and migrant health. For competencies applying to all health workers, please refer to the Global competency framework for universal health coverage.



Refugee and migrant health: Global Competency Standards for health workers

Domain 1: people-centredness

Competency standards under this domain relate to the provision of quality health services to the beneficiaries of health systems.

Competency standard 1: provides people-centred health care to refugees and migrants

Behaviours

- 1.1.** Adapts practice to the needs of the person in view of their migration and displacement experiences, taking into consideration the impact of these experiences on access to health care, including barriers to access.
- 1.2.** Adapts practice to the needs of refugees and migrants in view of their individual characteristics, including the intersection of sex, gender identity, age, disability, sexual orientation and legal status, taking into account social determinants of health throughout migration and displacement transitions – including transit, arrival and possible return – and their impact on individual health needs across the life course.
- 1.3.** Addresses mental health and the psychosocial support needs of refugees and migrants by providing trauma-informed care and interventions sensitive to experiences of chronic hardship, traumatic events, grief and loss, facilitating referrals.
- 1.4.** Supports universal access to quality health care, irrespective of the person's legal status and related legal, administrative and financial barriers to access, recognizing the particular vulnerabilities of children on the move.
- 1.5.** Facilitates continuity of care by supporting the person to hold their own health information and documentation and to understand how to seek further care, recognizing the mobility of refugee and migrant populations.



Competency standard 2: promotes the agency of refugees and migrants at individual and community levels

Behaviours

- 2.1.** Assesses the person's health literacy and health system literacy, including identifying areas of strength and specific areas of risk.
- 2.2.** Supports refugees and migrants to develop their health literacy and their awareness of the right to health.
- 2.3.** Supports refugees and migrants to improve their knowledge of, and ability to navigate, the host country's health system.
- 2.4.** Addresses language and cultural considerations when supporting people to be informed of their options for health care, make decisions about and manage their own health.
- 2.5.** Engages with diaspora communities to promote the agency of refugees and migrants at a community level.
- 2.6.** Identifies processes for safe and appropriate engagement with the person's family or community to facilitate the provision of health care, including when addressing barriers to access.
- 2.7.** Recognizes the impacts of family separation on the health of refugees and migrants, including mental health impacts.

Domain 2: communication

Competency standards under this domain relate to effective communication between health workers and people accessing health services.

Competency standard 3: engages safe and appropriate aids to meet language and communication needs of refugees and migrants

Behaviours

- 3.1.** Recognizes the person's right to timely, gender- and age-appropriate information, including assistance with communication.
- 3.2.** Mitigates language and communication barriers by engaging trained individuals including interpreters and cultural mediators, as appropriate, to facilitate communication between the person and health workers, wherever necessary.
- 3.3.** Uses language and communication aids that are language and culturally appropriate, sensitive and age- and gender-responsive.
- 3.4.** Adapts practice to work effectively with interpreters and cultural mediators, as appropriate, in person or remotely, including by telephone or video link.

Competency standard 4: supports refugees and migrants to understand information about their health care

Behaviours

- 4.1.** Ensures that the person understands information about their health care in view of the language, communication and health literacy barriers to understanding.
- 4.2.** Communicates in plain language, avoiding the use of medical jargon.



Domain 3: collaboration

Competency standards under this domain relate to the practice of teamwork, which underpins culturally sensitive care. Effective communication, collaboration and conflict resolution between health workers and professionals across different sectors is needed to address the impact of non-health-related factors on the person's health.

Competency standard 5: engages in collaborative practice to promote the health of refugees and migrants

Behaviours

- 5.1.** Engages with broader social and community support, including legal, education, employment, housing and other social support services as appropriate, to address the impacts of non-health-related factors on the person's health in the context of migration and displacement and to facilitate specialized care.
- 5.2.** Undertakes effective handover of care to other health workers through verbal and/or written communication, including information about relevant individual, cultural and language considerations and needs as well as migration- and displacement-related factors.
- 5.3.** Utilizes the skills, including language and communication capabilities, of health workers from refugee and migrant backgrounds in supporting people with experiences of migration and displacement.
- 5.4.** Engages effectively with government departments, nongovernmental and civil society organizations, communities and other health workers to provide integrated and coordinated health, mental health and psychosocial support services to refugees and migrants.

Competency standard 6: responds to migration- and displacement-related surges in demand for services

Behaviours

- 6.1.** Responds flexibly and collaboratively to surges in demand for the provision of health-care services in view of increased levels of migration and displacement.

Domain 4: evidence-informed practice

Competency standards under this domain relate to the generation and integration of evidence and information to practice.

Competency standard 7: promotes evidence-informed health care for refugees and migrants

Behaviours

- 7.1.** Uses evidence-informed guidelines and standards, where they exist, to respond to specific health needs of refugees and migrants in care planning and delivery, including mental health and psychosocial support, psychological first aid, pain management and medication management.
- 7.2.** Recognizes how the health needs of refugees and migrants may differ from those of the general population.
- 7.3.** Identifies where additional evidence is needed to promote the health of refugees and migrants.
- 7.4.** Participates in the generation of evidence, where possible, to inform the development of guidelines and standards to respond to health needs of refugees and migrants.
- 7.5.** Supports the translation of evidence into practice when providing care to refugees and migrants.

Domain 5: personal conduct

Competency standards under this domain relate to the ethical behaviour of health workers, specifically in relation to interactions with refugees and migrants in health-care settings. Competence within ethical conduct of health workers in all settings, including acting with integrity and maintaining ethical boundaries, is extensively addressed in the WHO Global competency framework for universal health coverage.



Competency standard 8: engages in lifelong learning and reflective practice to promote the health of refugees and migrants

Behaviours

- 8.1.** Maintains awareness of own culture, beliefs, values and biases.
- 8.2.** Demonstrates awareness of institutional discrimination experienced by refugees and migrants, in particular its impacts on health status.
- 8.3.** Demonstrates awareness of intersections of systems, structures and patterns of power that determine a person's position of disadvantage and impact their access to, and experience of, health care.
- 8.4.** Addresses the impact of own culture, beliefs, values and biases as well as institutional discrimination on interactions in health-care settings, including by continually adapting practice to respond to the needs of relevant communities.
- 8.5.** Contributes to introducing or improving cultural sensitivity in existing practices by modelling appropriate behaviour and avoiding culturally insensitive practices.

Competency standard 9: contributes to a culture of self-care and mutual support when providing health care in the context of migration and displacement

Behaviours

- 9.1.** Engages in self-care practices to manage own mental health and well-being when working in the context of migration and displacement.
- 9.2.** Contributes to a supportive team environment to manage the mental health and well-being impacts of providing care to refugees and migrants.

Explanatory notes

Competency standard 1: provides people-centred health care to refugees and migrants

Migration and displacement experiences

Experiences of refugees and migrants can be broadly considered in three stages: those taking place in the country of origin, those occurring in transit through one or more countries and those in the country (or place) of destination (6). However, it should be noted that migration and displacement is not always a linear process with consecutive stages; in reality, the trajectory is often more complex. Interception may also form part of the migration and displacement experience.

Country of origin. Pre-migration experiences occur in the country of origin, where the health of refugees and migrants may be shaped by various political, social and environmental factors. These may include climate change, disaster, war, conflict and persecution, poverty and lack of economic opportunity, and existing health-care practices. Lived experiences will also shape experiences, including chronic hardship, daily stressors, potentially traumatic events and the distribution of illnesses that may be commonly found in that country.

Countries of transit. Experiences in transit between countries of origin and destination will depend on the type of journey, the prevalence of illnesses in those countries and the potential limitation in access to health care. Refugees and migrants may be exposed to unhealthy living conditions and may experience disrupted provision of medications, both for existing and for new illnesses. Further, some refugees and migrants may have physical injuries and may experience being trafficked or traumatic/stressful events during transit.

Country (or place) of destination. Experiences in the country of destination – or place of destination for internal migrants – may shape the health of refugees and migrants in various ways. Factors include socioeconomic challenges arising from settlement, integration and, sometimes, a precarious legal status; the ability to access health-care services for ongoing care or new conditions; and the impacts of other experiences, including physical injuries, traumatic or stressful events, chronic hardship and discrimination in the post-migration phase.

Return is generally considered a further stage of the migration cycle, in addition to those outlined above. However, many refugees and migrants may not return to their country of origin or return may not be possible. In the context of health service



delivery, health workers should be aware that refugees and migrants returning to their country of origin may have experienced some of the factors described in this section, which can impact their health.

Social determinants of health

Migration is a fundamental social determinant of health for refugees and migrants. According to the International Organization for Migration, migration cuts across other social determinants of health at individual, community and societal levels (7). While the significant diversity across refugee and migrant populations must be acknowledged, it is recognized that access to health care and the health status of most refugees and migrants are affected by a combination of social, cultural, legal and economic factors. For example, at the individual level, refugees and migrants may experience cultural and linguistic barriers to communication, which limit their access to health information and care (7). At the community level, refugees and migrants may experience discrimination and stigma in the host community, including by the local health workforce. Other cross-cutting influences, such as policy and legislation governing access to health care for refugees and migrants, poor working conditions, insecure housing and limited or lack of access to clean water and sanitation, all have a cumulative impact on the health of refugees and migrants.

Victims of trafficking, migrant smuggling and children on the move

Migrants, in particular irregular migrants, are often the victims of human trafficking and migrant smuggling and enter or stay in a country illegally (8). Many are subjected to sexual exploitation and forced labour. Victims can be children or adults, boys or girls, men or women; they can be trafficked by improper means such as the threat or use of force. Smuggled migrants are often put in dangerous situations (such as being confined for a long period of time or a hazardous sea crossing), which, in addition to being severe human rights violations, are by definition poor health conditions. This is exacerbated by lack of access to quality health services.

Refugee and migrant children (children on the move, often unaccompanied minors) face heightened risks to their physical and mental health. This is particularly critical if they are unaccompanied and separated, have a disability or identify as lesbian, gay, bisexual, transgender or queer. Health workers need to be aware of the special procedures and protection needs that are necessary for these children (9,10).

Culturally sensitive care

Culturally sensitive care is respectful of a person's cultural, religious and linguistic needs, which pays attention to the immense diversity within refugee and migrant populations. Health workers should maintain awareness of the roles that culture and religion play in the person's health beliefs and practices. Religious and cultural considerations may inform the person's preference for gender concordance with their health worker and other professionals involved in their care, such as interpreters and cultural mediators. Health workers should have a basic understanding of the person's culture and the demographics of common countries of origin for refugees and migrants, as this knowledge can help to build trust between the provider and the person and contribute to culturally informed care.

Initiatives that can further support culturally sensitive care include (11):

- engaging a bicultural or bilingual health workforce;
- using universally agreed signage whenever possible, as well as visuals and other displays that are culturally appropriate;
- factoring in cultural and religious considerations when addressing people's accommodation and nutritional and spiritual needs;
- using people's personal models of understanding psychological distress and their preferences for health seeking as a foundation for developing care;
- considering people's preference for gender concordance with clinicians or with language and communication aids where possible;
- developing cultural protocols and display in waiting areas, consulting rooms and pre-admission documentation; and
- using translated resources that are appropriate to people's health literacy and cultural needs.

Trauma- and grief-informed care

Refugees and migrants often experience an accumulation of chronic hardship, daily stressors, significant losses and potentially traumatic events in their countries of origin or destination as well as during transit. These experiences may include gender-based violence, assault, trafficking and other highly distressing events, which may result in stress-related symptoms, including feelings of sadness, helplessness, fear or horror; all of these can impact upon a person's ability to cope (12).



It is important that health workers are sensitive to the impacts of the difficult experiences faced by some refugees and migrants and are trained in providing quality, evidence-informed psychological interventions where appropriate (13). Trauma-informed care is a strengths-based framework that focuses on identifying the person's strengths, positive coping strategies and resources for support (12).

Key aspects of trauma-informed care include:

- understanding how different symptoms and behaviours represent responses and adaptations to traumatic experiences;
- emphasizing safety by maintaining awareness of potential triggers and establishing clear roles and boundaries;
- providing opportunities to rebuild control and give the person choice; and
- adopting a strengths-based approach that is focused on the future and building resilience.

Trauma-informed care is based on the knowledge and understanding of how trauma affects people's lives, including their interactions with health services. For example, some people may fear or mistrust authority figures, including health workers (14). It is generally not advised for health workers to ask the person for a detailed trauma and torture history, particularly during their initial health-care visits (14). However, if such incidents are disclosed, health workers should listen supportively and without judgement using basic psychosocial support skills.

Adopting a universal precautions approach to pre-migration traumatizing events, including human rights violations, while providing care to refugee and migrant populations helps to create a safe space for service delivery (15). The failure of health workers to adopt such a trauma-informed approach has been found to impede the delivery of effective care to refugees (16).

Grief in relation to the loss of a family member or loved one is a natural reaction. However, the violent death of a loved one may increase the risk of post-traumatic stress disorder, depression or intense or prolonged grief for survivors, including for refugees and migrants (17). Health workers should respond sensitively to experiences of loss and trauma shared by the person while also being aware of the importance of managing the impacts of disclosures on their own mental health and well-being.

Impact of legal status on health-care access

Access to health care in countries of transit and destination may be limited for people with precarious legal status. Many countries have policies in place that guarantee access to health care for refugees and migrants regardless of legal status; however, in practice, people with tenuous legal status may face numerous challenges in accessing health services. For irregular migrants in particular, access to health care may be patchy or non-existent. For migrant workers, health-care access may depend on their employer arrangements.

The impact of precarious legal status on access to health care may affect a person's ability to follow the advice of health workers, as some individuals may not be in a position to afford the proposed treatments or courses of action.

Continuity of care

The mobility of some refugee and migrant populations can mean that health workers often do not have a full picture of their patient's health or records of their health history. Strategies to improve continuity of care include patient-held records (paper or personal electronic record systems) and effective electronic medical record systems (18). By providing refugees and migrants with patient-held records, which should be updated regularly, health workers can help to ensure that people on the move have continued access to their health information and documentation, including medication and vaccination history.

Competency standard 2: promotes the agency of refugees and migrants at individual and community levels

Health literacy and health system literacy

Health literacy refers to a person's knowledge, skills and confidence in using information to achieve and maintain good health through changes in lifestyle and living conditions (19). Health literacy is relevant for health workers working with refugees and migrants as specific communication skills may be needed to provide the person with information to promote and maintain good health.

Health system literacy refers to the ability to understand how a health system works. This may be even more critical for health outcomes for refugees and migrants than health literacy about their own individual health. In addition to supporting general health literacy, providing education and training regarding the host country's health system is crucial (20). Refugees and migrants may not



understand how to navigate health systems that operate differently from those of their home countries, with studies indicating that those who are unfamiliar with the health system of the host country may underuse primary care services and have increased presentations to emergency care (20).

Poorer health outcomes among some populations, including refugees and migrants, have been partly attributed to lower levels of health literacy in the host environment (21–23). It is important to note, however, that other factors such as different cultural beliefs, attitudes and behaviours also have a significant influence on health. Refugees and migrants may have different health-related attitudes and behaviours, which may diverge from the views of health workers in host countries but nevertheless be effective.

Specific areas of risk

In assessing a person's health literacy and health systems literacy, health workers should also take into consideration specific areas of risk, such as the use of medicines. Provision of medicine is the outcome of many medical encounters. It is a key area of risk for health care, and quality use of medications includes prescribing the right medicine in the right dosage regimen, and the individual, in turn, taking the medicine in the prescribed doses for the prescribed time. For many refugees and migrants, safe use of medicines can be impeded by language and communication barriers, cultural factors and financial barriers, in addition to limited health literacy and health system literacy (24). Particular times of risk include transitions in care (e.g. moving from hospitals to primary care settings (25)) and crossing of state borders. Continuity of medication for migrants with chronic conditions who cross borders may require specific arrangements at borders, or the prescription of medications that are readily accessible in a range of countries (26).

Quality use of medicines for people from refugee and migrant backgrounds may require health workers to:

- ensure effective communication regarding diagnostics, medicines and therapeutic devices, including explanations and demonstrations;
- consider the use of traditional medicines and other medicines that are being taken and potential side-effects (27), noting that health workers' understanding of the use of traditional medicines and healing methods may facilitate mutual respect between the health worker and the individual;
- explain possible adverse effects, risks and benefits of each medicine, and provide clear instructions about dosage and delivery route for the medicines;

- consider the cost implications for individuals and financial assistance options; and
- inform the patient about the safe storage and disposal of medicines, and the importance of not sharing medicines with other family members and friends.

Teach-back strategies, where the health worker specifically asks the person to explain back in their own words the course of action, including the medications prescribed, are useful in clarifying how clearly the plan has been communicated by the health worker (28).

Role of family and community

Many refugees and migrants come from cultures that are collectivist in nature, rather than individualistic. The role of family and community in influencing the person's approach to health and health-related behaviours should be taken into consideration by health workers where appropriate. In particular, community-level discussions on health topics such as safe birthing, nutrition and alcohol use, among others, may help to support individual development of health literacy.

It is also important for health workers to be aware that many refugees and migrants may be separated from their family members. Family separation is a major source of distress for newly arrived refugees and migrants, who fear for the physical safety of family members still living in conflict zones, feel powerless to help distant family members and feel a loss of connection to their culture without the presence of extended family in their host country (29). Family separation is also linked to negative mental health impacts for refugees, including depression and anxiety, post-traumatic stress disorder and lower levels of psychological quality of life (29).

Competency standard 3: engages safe and appropriate aids to meet language and communication needs of refugees and migrants

Communication assistance

Communication assistance, which is provided by interpreters and cultural mediators, helps in overcoming any language and communication barriers that may exist between health workers and refugees and migrants. Interpreters and cultural mediators can play a critical role in language-discordant interactions, where the health worker and the individual do not speak the same language.



Communication barriers between health workers and people from refugee and migrant backgrounds may impact on the person's full understanding of health-care interactions, including the nature and effects of proposed treatments, as well as their ability to access sufficient information and discuss alternatives.

Engaging language and communication aids for refugees and migrants accessing health care can:

- decrease communication errors (30);
- increase patient comprehension (30);
- improve the delivery of person-centred care in health-care settings (31);
- reduce unnecessary tests and treatments;
- increase rates of appropriate informed consent;
- improve clinical outcomes (31);
- raise the quality of care to the same level as that for people without language barriers;
- improve patient satisfaction and understanding of self-care and follow-up plans, leading to reduced errors and better treatment adherence (31); and
- increase the quality of health care and reduce safety risks (32).

Because of the elevated level of risk involved, providing access to language and communication aids for refugees and migrants is particularly necessary when:

- obtaining informed consent;
- undertaking complex care, for example starting or adjusting the dose of high-risk medications or multiple medications;
- assessing the person's competency; or
- informing the person of bad news.

If the health worker is uncertain as to whether the person is competent to make decisions related to their care at the time, language and communication aids should generally be provided even if they are not requested.

High-quality systems to support communication will include ways of identifying those who are in need of interpreters, the high-risk situations where quality language and communication support will be needed and the appropriate level of communication support for the person and context (33).

Role of interpreters

Interpreters are professionals who are competent in conveying spoken or signed language into another language. The provision, availability and cost of interpreting services differ between countries and may be very limited in some cases. In some countries, interpreters must be registered with a recognized authority. Interpreting services can be provided over the telephone, through video link or face to face. Once the need for an interpreter has been established, it is the health worker's responsibility to ensure that steps are taken to engage an interpreter through established arrangements.

When engaging an interpreter, health workers should be mindful of the person's potential preferences for interpreters, including regarding ethnicity, religion, language or dialect, and gender considerations. The interpreter's ethnicity and religion may be important to some people, for example a worry about bias if the interpreter is from an ethnic group which is or has been in conflict with the person's ethnic group (34).

Some people may request the same interpreter throughout their care or have preference for an interpreter of the same gender. This is particularly likely to occur in consultations related to sexual and reproductive health or, in some cases, mental health, and it may be a high priority for people from some cultural backgrounds. In gender-discordant consultations, where the health worker and the individual are not of the same gender, engaging a gender-concordant interpreter can improve the person's satisfaction with the consultation (35).

People from refugee and migrant backgrounds may prefer interpreting services over the telephone even when an interpreter is available in person, because of concerns about confidentiality if it is likely that the interpreter is from the same small and tight-knit community (36). Telephone interpreting may also be preferred if the consultation involves a sensitive topic, such as mental or sexual health, and particularly if the available interpreter is of the opposite gender. Engaging a telephone interpreter can reduce confidentiality concerns for people with particularly sensitive issues (37).

It may not be possible to accommodate all individual preferences with regard to interpreter requirements (such as ethnicity or religion) in view of the specific service provision policies. Further, in some environments, the availability of interpreters may be limited, with little or no choice regarding their personal characteristics. However, understanding people's concerns and informing them of available options, while clarifying the role of interpreters as facilitators of communication who are bound by confidentiality and impartiality, helps to build trust and effective partnerships.



Health workers may experience communication difficulties while working with interpreters because of a lack of training on how to use interpreting services effectively (38). In the absence of accessible interpreting services, health-care providers often rely on family members, which can create challenges in communication and quality of care. Patients may feel more comfortable in some situations with family members and intimate partners facilitating communication, but this poses the risk of miscommunication, depending on the person's language skills, and may lead to patient frustration in cases of misdiagnosis, error and poor care (38). In particular, health workers have a responsibility not to engage minors to facilitate interpretation, as this is associated with significant risk.

Other risks generally associated with engaging family members and intimate partners to facilitate interpretation include:

- inaccurate and inadequate interpretation because of a lack of interpreting skills, subject matter knowledge and specialized medical terminology;
- possibility of information being withheld or distorted due to the nature of family relationships, including family, domestic or intimate partner violence situations;
- complicating family dynamics, especially parent–child relationships;
- compromised confidentiality; and
- potential trauma caused to family members.

The engagement of language-competent health workers is a possible alternative to using interpreters. However, this option is not risk free, as bilingualism does not necessarily equate to effective interpreting skill and may not be sufficient for providing safe and quality care. If an interpreter or language-competent health worker is not available, health workers are responsible for assessing the risks of proceeding with the consultation without an interpreter compared with that for rescheduling the appointment to allow time to engage an interpreter. In an emergency and when an interpreter is not available, this should be noted in the person's records and an interpreter should be engaged as soon as possible to ensure accurate information is communicated.

The engagement of interpreting services is especially important in situations involving deaf refugees and migrants. There are more than 200 different sign languages used by deaf people around the world (39). Common sign languages include British Sign Language, French Sign Language, American Sign Language and Brazilian Sign Language (40). In situations where the person's sign language may differ from the host country's commonly used sign language, deaf interpreters should be engaged. Deaf interpreters are generally familiar with a national sign language and International Sign, which is a pidgin sign language that combines

the users' national sign languages with internationally recognized signs in situations where a common sign language is not shared (41). Deaf interpreters can use culturally shared ways of communicating with deaf people, including constructing shared gestural meaning; they usually work with an interpreter communicating in a formal sign language.

Role of cultural mediators

While cultural mediators and interpreters share some similarities, cultural mediators generally play a more active, autonomous role in interactions between health workers and a refugee or migrant. Cultural mediators facilitate mutual understanding between people and health workers, not only by interpreting but also by providing cultural context and advice where necessary (42). While interpreters are required to communicate all the information being exchanged between the health worker and the person, cultural mediators will generally convey the main message and provide additional cultural advice and context if needed. This involves clarification on culturally specific concepts, beliefs, values and assumptions in order to avoid misunderstanding (43). Some cultural mediators will go further by providing extra support for the person, for example by filling out forms (42). Additionally, other responsibilities of cultural mediators include preventing conflict in interactions between health workers and people accessing health services, and empowering the person receiving health care to express their own views (44).

Cultural mediators can be engaged in a range of contexts, including humanitarian settings. It should be noted that intercultural mediation is not a registered profession and does not require standardized qualifications (43).

Language and communication aids

Language and communication aids encompass both the engagement of interpreters and cultural mediators, as described above, and the use of other tools to facilitate communication, such as flashcards and translation apps. Machine-automated translation is likely to be increasingly utilized in the future. Google Translate and other automated speech-to-speech translation apps may be of some help in situations where interpreters and cultural mediators are unavailable, but these should not become the default for communication support, especially in interactions that are more complex and pose greater risk to the person. In its current state, artificial intelligence is generally ineffective when translating nuanced and complex information, which is often the case in health and legal settings (45).



Competency standard 4: supports refugees and migrants to understand information about their health care

Ensuring information is genuinely understood

Health workers should seek to ensure that the individual has a genuine understanding of the information conveyed through an interpreter. This can be achieved through the teach-back method, where the health worker asks the person to explain in their own words the health management plan that has been discussed in the consultation (46).

Psychological first aid

Psychological first aid provides rapid practical support for people experiencing acute psychological distress related to a disaster or traumatic event (47). It uses basic principles of support to help people to feel safe, connected to others, calm and hopeful, and to feel able to help themselves. Psychological first aid aims to reduce initial distress and promote flexible coping and natural recovery.

Using plain language

To support the person's understanding of information related to their health care, health workers should avoid using technical clinical terms or colloquialisms. Complex concepts should be explained in simple language, particularly if interpreters or cultural mediators are involved, as their understanding of medical terminology may be limited. Where appropriate, visual aids or culturally sensitive non-verbal cues and gestures may be used to help in communicating with the person.

Competency standard 5: engages in collaborative practice to promote the health of refugees and migrants

Impacts of other determinants on health

While migration and displacement are key determinants of health, it is important for health workers to maintain awareness of other interacting factors that may impact on health, including housing, education, employment and legal status. Housing, in particular, is of importance to refugees and migrants as it influences physical and mental health, perceptions of safety and belonging, and the security

of their stay in the host country (48). Education and employment also shape health outcomes for refugees and migrants, while legal status generally remains a critical factor in determining health-care access for refugees and migrants. Health workers should be aware of the interactions between these areas and their impact on health.

Handover of care

For refugees and migrants, effective handover of care is important, particularly at the interface of primary and tertiary services, as the person may be less likely to correct errors or misunderstandings in relation to their health, or even ask about them. Failure to communicate new treatment plans can result in medication errors or gaps in follow-up. Failure to communicate the full history to specialist service providers can result in repetition of treatment or investigations, representing a waste of resources. Further, missing key elements of patient history exposes the person to danger and may result in key areas of risk being underappreciated.

Competency standard 6: responds to migration- and displacement-related surges in demand for services

Surges in demand for services

Periodic surge in demand is a feature of refugee and migrant health services for a range of reasons. People move across borders or within countries for work on seasonal or temporary contracts, when returning home for key periods such as holidays or if they are being forcibly returned. Surges in planned permanent intake or influxes of refugees and migrants can also occur as a result of government policies, for example humanitarian programmes in response to conflicts, wars or environmental disasters. Surges in temporary intake or influxes also occur at border crossings initiated when routes for people flows open up.

Health workers need to be familiar with systems that enable rapid expansion of health care to meet a temporary or permanent increase in need, including:

- expansion of health-care assessment points;
- expansion of treatment distribution; and
- focus of health-care delivery on critical needs.

While organizations are responsible for anticipating, planning, operationalizing and monitoring a surge response, health workers must be able to demonstrate flexibility



and the ability to collaborate with fellow health workers, nongovernmental and civil society organizations and local communities. Surge responses often require that the clinicians function in accordance with an organizational plan, including being deployed to areas where needs are greatest. Surge response is often stressful because of the rapid increase in workload and the sometimes distressing circumstances or experiences that may surround the surge. Strategies to help in avoiding a negative spiral of burnout and disengagement include providing mutual support, conscious respect for the surge population, attention to professional roles and boundaries and mindful reflection on one's own adaptive responses (49,50).

Competency standard 7: promotes evidence-informed health care for refugees and migrants

Evidence-informed guidelines and standards

All health-care workers should follow evidence-informed guidelines where they exist and are applicable to the circumstances of the refugees and migrants to whom they provide care. However, there are often gaps in knowledge regarding refugee and migrant health care, for example in relation to the prevalence of illnesses from particular regions or the availability and effectiveness of treatment for certain conditions. It may be necessary for health workers to identify where evidence does not exist and be prepared to seek advice from others on the most appropriate responses.

Competency standard 8: engages in lifelong learning and reflective practice to promote the health of refugees and migrants

Reflective practice

It is important for health workers to maintain awareness of their own often unacknowledged views in relation to culture and values, and how they may impact upon health-care delivery. Cultural beliefs and ways of thinking can shape how health workers interpret or prioritize symptoms.

Reflective practice is a useful tool that can take various forms. Essentially, it requires health workers to consider a situation that has occurred, whether positive or negative, and make sense of it by examining their role, what they could have done differently and what changes they may make to their practice in the future (51). While reflective practice, when done effectively, can benefit all health workers and

those they provide care to, it is particularly important in the context of refugee and migrant health. Health workers should consider how their approach to health and health service delivery is influenced by their own culture and beliefs, as well as by unconscious bias and institutional discrimination, and what impact, if any, this may have on the refugees and migrants receiving care.

Competency standard 9: contributes to a culture of self-care and mutual support when providing health care in the context of migration and displacement

Mental health and well-being impacts

Health workers providing care to refugees and migrants may be affected by the challenging environments in which they work, particularly in fragile and conflict settings, as well as by second-hand exposure to stressful and potentially traumatic events experienced by their patients. Listening to stories of hardship, human rights violations and stressful or potentially traumatic experiences while also working in a challenging environment (e.g. high workload, insecure location) can have negative impacts on the mental health of health workers (52). Health workers providing services to refugees and migrants should be aware of potential signs of stress, such as feelings of helplessness and hopelessness, changes in beliefs (e.g. perceiving the world as less safe) and somatic responses such as nausea and numbness (53).

Health workers coping with the emotional impact of their work can adopt a range of self-care behaviours in response, including exercise, meditation, watching films, listening to music and engaging in some activity to delineate work from personal life (53). Health workers should also have access to psychological support and mental health care if needed.

Experiencing professional or personal development and growth can also occur as a result of working with survivors of torture and other traumatic events (54). Health workers may feel empowered and personally motivated from working alongside refugees and migrants, drawing lessons from their perseverance and determination (54).



Supportive team environment

At an organizational level, it is important for health workers to contribute to a safe and supportive team environment where the emotional and social aspects of providing health care to refugees and migrants can be discussed among colleagues. Having a space where stressful experiences are debriefed and positive interactions are celebrated helps to foster a compassionate work culture; this, in turn, benefits the recipients of health care.

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Annex. Membership of the Strategic Working Group

Dr Aula Abbara

Dr Abbara is a consultant in Infectious Diseases/General Internal Medicine at Imperial College NHS Healthcare Trust, London, and an Honorary Clinical Senior Lecturer at Imperial College. She teaches and supervises students on the Global Health Bachelor of Sciences course at Imperial College and the Tropical Medicine and International Health course at the London School of Hygiene & Tropical Medicine. She has volunteered in different humanitarian and refugee settings, including direct clinical work, teaching health-care workers and building capacity.

Associate Professor Jill Benson

Dr Benson is a general practitioner and Director of the Health in Human Diversity Unit at the University of Adelaide. In addition to her work at Adelaide City General Practice, she has worked at Doctors' Health SA since 2000. Dr Benson also works at Pangula Mannamurna Aboriginal health service in Mt Gambier and is the founding Medical Director of Kakarrara Wilurrara Health Alliance in the remote Aboriginal communities at Yalata, Oak Valley and Tjuntjuntjara. Dr Benson is a medical educator at GPEx, the general practice training organization for South Australia and is a researcher in the Discipline of General Practice at the University of Adelaide.

Dr Fouad M. Fouad

Dr Fouad is an Associate Professor of Public Health Practice at the Faculty of Health and Sciences at the American University of Beirut and Co-Director of the Refugee Health Programme at the Global Health Institute. His current research focuses on the displaced population, with a special interest in the Syrian refugee crisis, as well as the impact of this crisis on the health and the well-being of the Syrian population. Dr Fouad has carried out extensive research on health workforces in humanitarian settings and the weaponization of health care in armed conflicts.

Professor Indika Karunathilake

Professor Karunathilake is the first Professor in Medical Education at the University of Colombo. He is currently the Head of the Department of Medical Education, Faculty of Medicine, University of Colombo and the WHO Collaborating Centre for Medical Education, Faculty of Medicine.

Professor Elsie Kiguli-Malwadde

Professor Kiguli-Malwadde is the Director of Health Workforce and Development at the African Centre for Global Health and Social Transformation. She was the Director of the Medical Education Partnership Initiative, African Coordinating Centre at the African Centre for Global Health and Social Transformation. She is a radiologist and was formerly Associate Professor and Head of the Radiology Department at Makerere University in Kampala.

Professor Allan Krasnik

Professor Krasnik is a Professor of Health Services Research at the Department of Public Health and the Danish Centre for Migration, Ethnicity and Health at the University of Copenhagen. His main interest lies in health services research, with special attention to prevention, evaluation of innovations and changes and the effect on the structure of the health service as to access and health-care utilization for different social and ethnic groups.

Dr Paul Spiegel

Dr Spiegel is a physician by training. Before becoming Director of the Johns Hopkins Center for Humanitarian Health, he was the Deputy Director of the Division of Programme Management and Support Services for the United Nations High Commissioner for Refugees. Prior to joining the United Nations in 2002, Dr Spiegel worked as a medical epidemiologist in the International Emergency and Refugee Health Branch at the United States Centers for Disease Control and Prevention. He has also worked as a medical coordinator with Médecins Sans Frontières and Médecins du Monde in refugee emergencies, as well as acting as a consultant for numerous organizations.



Professor István Szilárd

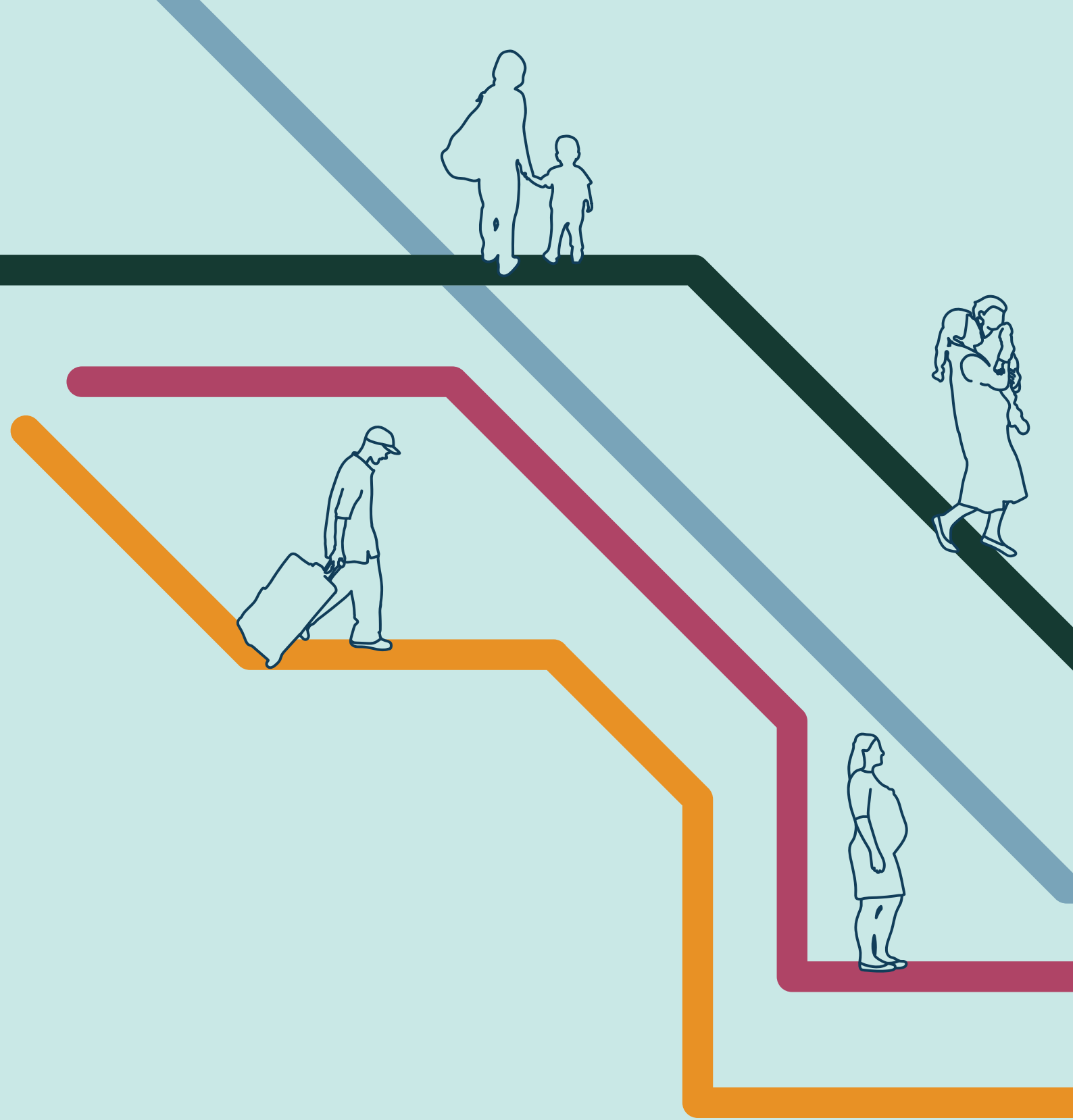
Professor Szilárd is a specialist in internal medicine and public health medicine. He is the Co-Head of the WHO Collaborating Centre for Migration Health Training and Research at the University of Pécs. Previously, he worked with the International Organization for Migration, participating in emergency and post-conflict humanitarian operations in the Balkans and was the Senior Migration Health Adviser in charge of Europe.

Associate Professor Jo Vearey

Jo Vearey is an Associate Professor and Director of the African Centre for Migration and Society at the University of the Witwatersrand, Johannesburg. She is an Honorary Fellow of the School of Social and Political Science at the University of Edinburgh, and is Vice-Chair of the global Migration Health and Development Research Initiative (MHADRI).

Professor Cynthia Whitehead

Professor Whitehead is a Professor in the Department of Family and Community Medicine at the University of Toronto; Director and Scientist at the Wilson Centre for Research in Education at the Temerty Faculty of Medicine at University of Toronto and University Health Network. She is the BMO Financial Group Chair in Health Professions Education Research at University Health Network and has held many education leadership positions at the University of Toronto.



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