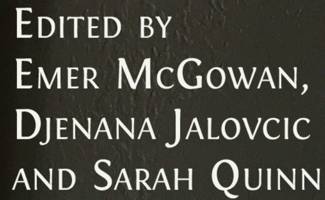
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Interprofessional Approach to Refugee Health

A Practical Guide for Interdisciplinary Health and Social Care Teams

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13. Advocacy and Empowerment in the Context of Refugee Health

Sandra Schiller with Kass Kasadi

Advocacy and empowerment are closely related concepts. Advocacy refers to efforts to support the rights and needs of a particular group or individual, while empowerment involves the process by which individuals or groups acquire the knowledge, skills, and resources necessary to take control of their own lives and advocate for their own needs. The first section of this chapter looks at 'health advocacy'. It emphasizes that a human-rights framework in refugee health requires health and social care professionals to engage in actions that advance the rights of individuals and groups towards social justice objectives. Following this, the next section introduces the concept of empowerment as it is commonly applied in health and social care, highlighting both political-activist and psychosocial perspectives. In order to illustrate the relevance of advocacy and empowerment in practice, the last section of the chapter provides a case example of a current project in which the fight against female genital mutilation (FGM) is closely linked to the empowerment of African women living in the federal state of Lower Saxony in Germany.

Health Advocacy

Following the definition of medical advocacy suggested by Earnest et al. (2010: 63), the concept of health advocacy can be seen as "action by a [healthcare professional] to promote those social, economic, educational and political changes that ameliorate the suffering and threats to

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human health and wellbeing that he or she identifies through his or her professional work and expertise." This requires health professionals to have good knowledge of the rights that individuals are entitled to and why these rights need to be inviolable rights for everyone, regardless of their legal status. Based on this knowledge, professionals also need to be willing to take action to assist persons with refugee experience in achieving these rights.

Article 25 of the Universal Declaration of Human Rights (United Nations 1948: 76) addresses health as a fundamental human right: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Similarly, the Constitution of the World Health Organization (2020/1948: 1) recognizes health as a fundamental human right, stating: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

However, for persons who have experienced forced displacement, health is not a given in many European countries. Current national and international studies show that people who have experienced forced displacement are not only exposed to specific health risks before and during their flight but also to influences from the living conditions in the country of arrival (WHO 2022). Accommodation in a collective accommodation centre, an insecure residence status or an uncertain legal situation, limited access to healthcare, experiences of racist protests including attacks and right-wing populist agitation, discrimination, and a lack of social participation have a negative impact on the health of those affected in many European countries (Nowak & Hornberg 2023; Stevens et al. 2024). Furthermore, refugees and asylum seekers "face legal restrictions with regard to their access to healthcare in many countries of the European Union" although this practice violates their right to health (Bozorgmehr et al. 2017). Against this background, promoting the health and well-being of persons with refugee experience is an ethical challenge that calls on health professionals to advocate for social justice and equity.

The *Advocacy Toolkit for Diaspora Organizations* (Danish Refugee Council 2023: 4) defines advocacy

> as a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities, and explore their choices and options in life. Advocacy, in that sense, can be understood as an organised effort to influence social or policy change, whereby action can be directed towards both political decision-makers or society as a whole.

In refugee health, advocacy typically includes efforts to lobby for persons with refugee experience to have access to quality health services and to ensure that healthcare services are culturally and linguistically appropriate, taking into account the specific living situation of persons with refugee experience.

Advocacy in refugee health cannot be pursued without the strong involvement of persons with refugee experience themselves to avoid the risk that their real interests will be ignored. Legitimacy and accountability are crucial concepts that need to be considered before taking up advocacy work (Danish Refugee Council 2023). Networks and organizations by and for persons with refugee experience have published guidelines and other works offering valuable information on how to prevent the exclusion or tokenization of persons with refugee experience in (health) advocacy (Global Refugee-Led Network 2019).

In this context, it should be noted that although research in the area of refugee health has significantly increased over the last two decades, substantial gaps in the current knowledge base have been criticized. These gaps are considered to stem from a lack of meaningful participation of individuals with refugee experience in this research (James et al. 2021; Kronick et al. 2021; MacFarlane et al. 2024). As MacFarlane et al. (2024) emphasize, explicit, critical attention must be given to the voices that are heard, the voices that are left out, and the voices of those who are ignored because they do not even have a seat at the table.

To narrow this gap, participatory health research—a research paradigm originating from the Global South—has been promoted as a methodology to follow a human rights advocacy perspective in order to strengthen knowledge translation and promote social justice (Kronick et al. 2021; MacFarlane et al. 2024). However, the intensification of the above-mentioned restrictive refugee policies, as reflected in the asylum

compromise adopted by the European Union (EU) member states in 2023, renders a transformative, evidence-based, and rational design of European healthcare systems a distant prospect (Bozorgmehr & Gottlieb 2023).

Self-reflection exercise:

1. Which refugee associations, networks, or self-help group exist in your local context?
2. How can you support them in acting as advocates for refugee health?

A human rights framework challenges the historical division between systemic change efforts and individual casework in health and social care, advocating for the integration of actions that advance social justice and the rights of individuals and groups in all practices. All health and social care professionals working with persons with refugee experience have a responsibility to advocate for the improvement of the conditions in which care is provided, and advocacy is often written into their ethical code and scope of practice (Gallagher & Little 2017; Stoddart et al. 2020).

However, many health professionals who have not been trained in refugee health are uncertain about what this entails in practice and whether they possess the necessary skills to advocate for the health and well-being of persons with refugee experience. For example, Claire O'Reilly, a physiotherapist working in refugee health, describes the initial feeling of self-doubt: "Probably one of the first challenges was that idea that I didn't necessarily interpret advocacy as part of my role. So, I think there's that element of do I have time to take this on? But it was also much more, do I have the skills? Am I the best person to be doing advocacy?" O'Reilly has experience from various conflict zones and is particularly interested in how humanitarian health responses can be sustainable. In an interview created within the EU-funded project PREP (Physiotherapy and Refugee Education Project) she discusses advocacy strategies: https://soundcloud.com/maria-alme/emer-mcgowan-advocacy-interview?si=4d3a7dfd322f4bab807871fed425cfc5

A transcript of the interview can be found here: https://hvl.instructure.com/courses/19115/pages/Transcript%20of%20discussion%20McGowand%20and%20O%27Reilly?titleize=0

Health advocacy "dictates that practitioners do not shy away from conflict where this is necessary to promote a human rights and agenda" (McAuliffe 2022: 67). Health and social care professionals working in countries where refugees and asylum seekers are not granted access to regular healthcare, or who work in specific settings such as immigration detention centres, are regularly confronted with conflicts between their obligation to act in the best interests of their patients and the demands placed on them in "a system that expects clinicians to deliver diminished standards of care and violate patients' rights to health" (Stoddart et al. 2022). The competing demands of "dual loyalty" towards the patients and the employer (Solomon 2005) make advocacy an important professional role to lessen experiences of moral distress.

An Australian study by Stoddart and colleagues from 2020 documents the personal views and experiences of Australian medical and health professionals advocating for the health of refugee and asylum-seeker populations in mandatory immigration detention. The study provides insights into how advocacy is related to contemporary medical ethics and understandings of core professional roles. It examines which factors have an influence on healthcare professionals' motivation to engage and persevere with advocacy, and what role health advocates can play "in systems that diminish patients' health rights." The participants of this study saw advocacy as both a personal and professional duty in the face of the challenges offered to their obligations as professionals. They identified three key motivations for engaging in advocacy: proximity, readiness, and personal ethics. Proximity involved their awareness and closeness to injustices faced by detained asylum seekers, often stemming from personal or professional experiences. Readiness depended on their ability to advocate given their personal circumstances, such as holding citizenship or permanent resident status. Personal ethics aligned with their core professional responsibilities, leading to two types of advocates: accidental advocates and "jigsaw advocates", the latter seeing advocacy as "a final piece of a personal puzzle" in their pursuit of social justice and humanitarian efforts.

Self-reflection exercise:

1. How well can you relate to the experiences of health professionals described in this section?
2. What are you passionate about? Which aspects of the healthcare system you work in need to be changed in relation to refugee health? Make a plan for an advocacy strategy for working towards this.
3. How do your personal and professional ethics support you in a role as health advocate?
4. Which rewards and challenges are associated with the role of being a health advocate for persons with refugee experience?

> Advocacy is one strategy to raise levels of familiarity with an issue and promote health and access to quality healthcare and public health services at the individual and community levels. When trying to gain political commitment, policy support, social acceptance and systems support for a particular public health goal or programme, a combination of individual and social actions may be used to try to affect change (European Centre for Disease Prevention and Control 2009).

Effective advocacy typically requires a combination of strategies that address both the broader policy context and the needs of individuals. Systems and policy advocacy involve advocating for changes in legislation, regulations, policies, and practices to allow increased funding for refugee healthcare, access to interpreters and other language or cultural support services, and training for healthcare providers on cultural humility and refugee health (MacDonald & Stymiest 2023). This advocacy strategy includes providing information about the healthcare needs of persons with refugee experience and the challenges they face to policymakers and the public to help build support for policies and practices that address these needs. For advocacy to be effective, there is a need to clearly document and define the problem, target a specific audience/group that can affect change, propose a solution, and use evidence and data as a basis for proposed action (MacDonald & Stymiest 2023).

Another type of advocacy is case advocacy, which focuses on providing direct support to individuals and families with refugee experience as they navigate the healthcare system (MacDonald & Stymiest 2023).

Ultimately, advocacy in refugee health needs to be founded on building partnerships and coalitions by working with community organizations, advocacy groups, and other stakeholders as a way to help amplify the voices of persons with refugee experience and increase the impact of individual advocacy efforts.

It is no coincidence that advocacy is one of the three main strategies promoted by the Ottawa Charter for Health Promotion (WHO 1986) as it plays a crucial role in formulating policy programmes or planning for the future, taking into account the social determinants for health that impact health equity. From this perspective, advocacy becomes necessary whenever a group of people or a socio-political goal, such as health, is not considered to be sufficiently articulate and assertive (Lehmann et al. 2020). Approaches to cross-sectoral cooperation can be found at all national and international levels (e.g., federal, state, and local) (Lehmann et al. 2020). An interprofessional and intersectoral approach in health and social care is the basis for effectively designing and planning health promotion programmes for people with refugee experience. Health and social care professionals need to address fundamental issues such as the appropriateness and feasibility of integrating health promotion programmes for refugees into mainstream health promotion structures, the specific needs arising from diverse backgrounds, living conditions, and environments, and how to plan and implement socio-culturally sensitive health promotion in a way that considers the diversity within the refugee population (Kooperationsverbund Gesundheitliche Chancengleichheit 2021).

Community health, or primary healthcare, is promoted by the WHO (2023) as the most promising way to achieve universal health coverage, despite recent setbacks. Primary healthcare is seen as:

> the most inclusive, equitable, cost-effective and efficient approach to enhance people's physical and mental health, as well as social well-being. It enables universal, integrated access to health services as close as possible to people's everyday environments. It also helps deliver the full range of quality services and products that people need for health and well-being, thereby improving coverage and financial protection (WHO 2023).

This point is illustrated by the case example of Carol, an occupational therapist working in the Pathway Homeless team in the UK, who describes how she fulfilled her role as an advocate by assisting a person

with refugee experience to find suitable housing. This case story was created in the EU-funded project PREP (Physiotherapy and Refugee Education Project): https://hvl.instructure.com/courses/19115/pages/case-study-advocacy-for-people-from-a-refugee-background

Self-reflection exercise:

1. How can you collaborate with community health centres or other facilities aiming to increase access to essential primary and preventative care services, particularly for people who experience restricted access to health services?
2. How can you utilize their expertise and support them as part of your professional role? Where do you see the potential of interprofessional collaboration?

Advocacy in refugee health will only be successful if it is not primarily seen as a task for particularly committed 'lone fighters,' but as a collective responsibility supported or initiated by employers in the outpatient, inpatient, or rehabilitation sector, and in the context of intersectoral health promotion, community-oriented work, educational institutions, professional associations, and (inter)professional networks. McAuliffe (2022: 71–72) highlights the critical role played by interprofessional cooperation in such a collective approach:

> Collective action and collaborative partnerships between people of different professional disciplines provide excellent opportunities for strong advocacy and activism through the pooling of intellectual and skills resources. There are many examples across different workplaces of people coming together to work on projects, community action initiatives, research studies and therapeutic interventions with the explicit aim of joining with others and connecting knowledge and know-how. Part of interprofessional education is learning how to find out about what others can offer, and how others position themselves in terms of their value base, ontology and epistemology.

Most importantly, the experiences and expertise of health and social care professionals who have personal experiences of forced displacement are vital as advocates. They can build bridges to local, national, and international refugee communities, organizations, and networks,

ensuring that health advocacy efforts have the legitimacy and the necessary skills to act in the interests of the health and wellbeing of people experiencing displacement.

To further illustrate the importance of advocates who have first-hand experience of the unique healthcare issues with which specific refugee and migrant communities are faced, the last section of this chapter demonstrates how advocacy can be practically applied through community-based initiatives by introducing a real-world example. In recent years, a network dedicated to health and inclusion within African communities living in Germany has increasingly made the fight against female genital mutilation/cutting (FGM/C) the central focus of its work. This case example demonstrates how advocacy is not solely the responsibility of individual health and social care professionals but involves collective community action to ensure equitable healthcare access.

Empowerment in the Context of Refugee Health

Empowerment has become a fashionable concept in various disciplines and can be understood in many different ways (Herriger 2020; Mohseni 2020). In social work or health promotion, empowerment typically signifies a shift from a deficit-oriented, hierarchical, and devaluing view of patients or clients to one that focuses on their resources and strengths. According to Herriger (2022: own translation),

> empowerment describes encouraging processes of self-empowerment in which people in situations of helplessness and powerlessness begin to become aware of their abilities and strengths, actively shape the reality of their lives and learn to use their resources to lead a self-determined life. Empowerment—in a nutshell—aims at (re)establishing self-determination over the circumstances of one's own life.

From an empowerment perspective, people who have experienced displacement are not seen as 'passive victims', but as competent actors who successfully managed their displacement thanks to their significant abilities and resources, their inner strength, and their networks.

Self-reflection exercise:

1. What understanding(s) of empowerment is common in your own profession?
2. What (inter)professional empowerment approaches are applied in your field of work?
3. How well does this apply to refugee health?

Empowerment is originally a strategy used by disadvantaged social groups to defend themselves against unequal opportunities for participation and an unfair distribution of resources resulting from existing social and political power structures. This strategy was developed primarily in the women's and civil rights movements of the 1960s and 1970s and in the self-help movement of the 1970s in the USA. Empowerment stands for the ability to find one's own voice individually and collectively through joint political action, to use one's own resources, and thus to develop agency (Herriger 2020). The empowerment of people with refugee experience is therefore not about the (self-)empowerment of individuals, but about complex, interconnected, individual, collective, and structural power-building processes at the micro, meso and macro levels, the aim of which is to achieve greater democratic participation and political decision-making power. The activist and political engagement of self-organized groups of people with refugee experience—from local initiatives to international movements—play a vital role in bringing public attention to their struggles against exclusion and racism, and their fight for a life free from inhumanity. As a result,

> empowerment benefits not only one group or community, but all citizens. A real perspective for persons with refugee experience also means a new perspective for the respective host country. For us, empowerment means that decisions are made with us, not for us. We want to have a say in all matters that affect us and we want to have a say in the future of the country in which we live. But the basis for this is a level playing field and equal civil rights (Amoah et al. 2023: 15).

Empowerment also plays an important role in health promotion, "the process of enabling people to increase control over, and to improve, their health" (WHO 1986). Empowerment in the health sector often refers to supporting the development of health literacy by making relevant

health information accessible in appropriate ways, for example by working with language and cultural mediators. Good interprofessional and intersectoral networking is important here, including, for example, cooperation with self-help organizations that support migrants and people with refugee experiences. Empowerment in healthcare typically involves support of community-based healthcare initiatives. In refugee health, by supporting the development of initiatives that are led and controlled by persons with refugee experience themselves, healthcare professionals can contribute to empowerment processes that will allow persons with refugee experience to take an active role in their own healthcare and the healthcare of their communities. This is demonstrated, for example, in the interactive, community-based training programme for cross-cultural trauma-informed care described by Im and Swan (2022). Another area is supporting people with refugee experience in accessing services in the healthcare system. Finally, empowerment refers to the implementation of structures and practices in the healthcare system that fundamentally benefit people with refugee experiences. Here, there are many overlaps with advocacy.

Empowerment refers to a process of collective self-empowerment in which individuals and groups acquire the knowledge, skills, and resources they need to take control of their own lives and advocate for their own needs. As a professional support service, empowerment is inevitably based on a tension between self-determination and heteronomy, autonomy, and dependency (Lindmeier & Meyer 2020). It is therefore important to be clear about what health and social care professionals can and cannot do in relation to their patients' or clients' empowerment processes. Empowerment approaches in the tradition of social movements understand empowerment "as a healing, empowering experience between people with equal rights" (Flory et al. 2020). Health and social care professionals without refugee experience can use their privileged position in society and act in solidarity. This, however, cannot replace empowerment by or with other people who have had similar experiences. Health and social care professionals with refugee experience can both engage in empowerment processes themselves and support others to do so. Their experiences and knowledge are a valuable source for developing the field of refugee health in the future.

Empowerment requires not only “a tireless emancipative, radical and courageous practice by those who protect and defend their human dignity and empower others to do the same. It also requires: listening, openness to learning, allies, power-sharing [...], stepping back from decision-making processes and positions, as well as resources, resources, resources” (Haschemi et al. 2023: 406; own translation). There can be no concrete instructions for the empowerment process, as its goals and elements depend on the specific experiences of the people with refugee experience and their personal coping skills, needs, and demands (Flory et al. 2020). The characteristics of the psychosocial attitude of empowerment, which can form the basis for interprofessional collaboration, include a fundamental trust in the ability to shape one’s own life, a strength- and resource-oriented view, motivational interviewing to enable more self-determination, identifying strengths and resources together, and creating opportunities to experience self-efficacy, recognizing the patients or clients as experts in their own cause, and negotiating and sharing responsibilities as partners (Projekt Kompass F 2018).

Health and social care professionals can support and promote the (individual) development process of empowerment by contributing to the establishment of networks and the creation of spaces where people with refugee experience can create empowerment in exchange with others (Benbrahim 2017). Empowerment processes can only emerge from the needs, interests, and life situations of refugees, and specific content and methods are suitable for initiating these processes with regard to structural disadvantages (Projekt Kompass F 2018). Key elements include creating protected spaces, such as peer-to-peer environments that bring together people with common experiences of discrimination, such as Muslim women refugees or LGBTTIQ* refugees. Additionally, low-threshold activities for refugee groups, such as meeting cafés and creative activities, can strengthen exchange and self-help potential, promote cohesion, and contribute to normalizing everyday life. Providing access to knowledge through workshops and seminars by refugee self-organizations can offer information on legal rights and opportunities for political participation. Establishing, using, and expanding networks by promoting interest- and target-group-specific contacts and cooperation with self-organizations, self-help groups, political groups, NGOs, and regional working groups is also

crucial. Finally, linguistic empowerment involves making marginalized voices and perspectives visible, for example, in local decision-making processes and public relations work. Such an approach calls for sound interprofessional and intersectoral collaboration, which is also reflected by the World Health Organization's (2023) Global Research Agenda on Health, Migration and Displacement.

When empowerment is applied in professional help contexts in the health and social sector, there is a risk of individualizing unequal power relations by focusing on individual patients or clients and their resources. This is why health and social care professionals need to be able to recognize and critique unequal structural and social power relations, and to advocate for structural change that may also challenge their own privileges. Health and social care professionals, who have structural power and institutional access, are called upon to engage in power sharing (in the sense of power distribution and power access, Rosenstreich 2006) when working with people with refugee experience. A fundamental prerequisite for power sharing is to get to know and take seriously the perspectives, problem definitions, positions, and interests of people with refugee experience. This may require a willingness to change one's own actions and attitudes. It is also important to avoid a paternalistic attitude and not to speak for people with refugee experience, but to support them in pursuing their own interests (Rosenstreich 2006).

Empowerment in the context of forced migration has particularly been criticized with regard to the following points: Firstly, empowerment becomes a diversionary tactic when the same problems are named over and over again while their causes are only sought in people with refugee experience themselves, and a self-critical public discussion of "inadequate and outdated structures, legal situations or blatant violations of humanity" in the host country is avoided (Amoah et al. 2023: 14; own translation). Secondly, the establishment of parallel and inexpensive alternative structures in the form of voluntary support groups or peer offers of psychosocial support carries the risk that such services do not come close to the professional care to which persons with refugee experience are entitled (Flory et al. 2020). Thirdly, there should be no illusion that the empowerment approach can lead to cooperation on an equal footing with people with refugee experience, whose life situations are largely determined by their residence status,

who experience a wide range of discrimination and who are dependent on support, but often face long waiting lists (Flory et al. 2020). Taking this criticism into consideration, the aim in European countries should be to enable the empowerment of persons with refugee experience within the structures of an established healthcare system that is sensitive to the needs of diverse groups in society and that promotes strong intersectoral collaboration as a crucial means to enhance the health and well-being of persons with refugee experience.

Self-reflection exercise:

1. What can you contribute to power sharing and empowerment in refugee health?
2. How can the empowerment of persons with refugee experience be supported within the context of your country's health and social care system?

Empowerment in refugee health necessitates collaborative, context-sensitive and nuanced approaches. The following section underscores how empowerment is operationalized within African communities through peer-to-peer health promotion and active engagement against practices like female genital mutilation/cutting (FGM/C). This case highlights the intersection between empowerment and advocacy, illustrating that empowerment efforts are most effective when they are community-driven and culturally resonant. By directly involving community members in health initiatives and advocacy projects, the case study exemplifies how participatory approaches can promote health equity and provide individuals with the tools necessary for self-advocacy and self-determination.

The Need for Networking to Promote the Health of African Migrants and Refugees

In order to illustrate the concepts explored in the previous two sections, Kass Kasadi, the founder of baobab—zusammensein e.V., an association focused on advocacy and the empowerment of women and families from the African community, provides a practical case example describing the

association's work. Among other things, he works as a project manager for the project Elikia.

The association baobab—zusammensein ('zusammensein' means 'being together'), founded in 2013, emerged from the heterogeneous African communities in the German federal states of Lower Saxony and Bremen. In the course of its existence, it has increasingly developed from a project in the field of disease prevention to a network for health and participation. Baobab—zusammensein e.V. offers a low-threshold counselling service for basic questions on the topics of childrearing, integration, health, education, work, and assistance with everyday issues, e.g., housing and living. Many women and families from the African community are looking for support, counselling, and advice, particularly with regard to female genital mutilation/cutting (FGM/C), as there is currently no appropriate contact point for the community.

Due to the strong desire and commitment of the community members to become involved in the areas of health and integration, the need for exchange, training programmes, participation, and support has increased. This is provided by means of:

1. participatory, emancipatory and eye-level (peer-to-peer) health promotion by and for Africans in the federal state of Lower Saxony;
2. establishing and anchoring self-help groups in the African community;
3. the fight against female genital mutilation/cutting (FGM/C) by combining community-based awareness-raising, direct support for affected individuals, intersectoral networking, and preventive protection work, all within a framework of empowerment and cultural sensitivity;
4. HIV/AIDS/hepatitis prevention through multilingual education, culturally sensitive outreach, peer mediation, support in health system navigation, and cooperation with professional agencies, all tailored to the specific needs of migrant and refugee communities in Hannover;

5. support during medical treatment and therapy to increase patient adherence to advice and treatment in the German healthcare system;
6. promoting the participation of communities in the development and organisation of services and approaches that promote health, integration, and transculturality;
7. training and further education programmes for professionals working in the health and integration sector on African lifestyles and societies;
8. promoting empowerment and combating stigmatisation;
9. supporting the continuation of health promotion in African communities;
10. social services/social mediators.

Currently, the association is run from three offices: the main office in Hanover, and a small one in Walsrode and Osnabrück, respectively; and has five full-time employees. Most importantly, the network is supported by a large number of volunteers, the majority of whom are women, representing the diverse African communities in Lower Saxony.

These volunteers are of such a great importance because they are part of their communities, hence they are heard—and they hear what issues are being discussed; they know what the main problems are, because these are their problems as well. These volunteers are trusted, so they can put forth and discuss solutions. In other words, the problems discussed in baobab—zusammensein are problems of daily life, not problems drawn from theoretical discussions.

The following languages are spoken in the network: Kabwe, Ewe, Kotokoli, Twi, Medumbe (Bamileke), Lingala, Lari, Kikongo, Kizombo, Swahili, Tshiluba, Tetela, Peul, Yoruba, Ibo, Wolof, Djoula, Bete, Kreol, Mandingue, Arabic, Tigrini, Somali, Kinyarwanda, Kirundi, Shona, Ndebele, Twi, Bambara, Abron, Haoussa, Baoulé, German, French, English, Portuguese, and Spanish.

With the project 'Elikia', which was launched in the spring of 2024, baobab—zusammensein aims to take up the fight against FGM/C in Lower Saxony in order to offer those affected a contact point so that they can come to terms with the suffering inflicted on them. Elikia also aims

to carry out low-threshold prevention and awareness-raising work in the communities. In this context, 'contact point' must also be understood as a place that can change. Not only is a fixed counselling centre offered where people can go, but the staff of baobab—zusammensein go to the people, i.e., they move around in the communities. This outreach work is time-consuming and labour-intensive, but it also serves to build trust, which is the basis for any collaboration. It is only from this position of trust that effective cooperation can take place with those affected, those at risk, and husbands or fathers.

Baobab—zusammensein has already implemented two projects focusing on FGM/C, both of which, however, have regional or spatial limitations. With funding from the state capital of Hanover, the 'Mouharaba' project has been implemented for Africans living in Hanover since 2019. At state level, the project 'Ntafe' was launched in 2021, which aims to help overcome FGM/C through awareness-raising at the Lower Saxony state reception centre for asylum seekers.

The project 'Elikia' has three target groups: African women; African men; and finally a group made up of educators, primary school teachers, professionals in projects and institutions, and medical doctors.

The first target group is African women and in particular mothers. This is about educational work. Education and discussion about this rite are necessary, because the reasons for its practice lie in tradition. Circumcision is part of cultural identity and is deeply rooted in it. Female genital mutilation is a tradition that primarily underpins the strong role of men. Since, depending on the type of circumcision, the woman has little or no sexual desire afterwards, and often experiences severe pain during sex, FGM/C is also intended to 'protect' her from being unfaithful.

However, women and mothers are often responsible for forcing their daughters to undergo this cruel practice. Girls are often circumcised at a very young age so that they cannot defend themselves or refuse the practice, and so that the circumcisions are protected from state persecution—as female genital mutilation is now banned in many countries.

In modern Africa, however, there are already many awareness campaigns by various groups, organisations, and governments. But people who have emigrated find it harder to give up their customs. They

are more likely to cling to the traditions and associated values of their home country.

The second target group is African men. A lot of educational work and persuasion is needed here. Many men from countries with a tradition of FGM/C who live here bring their traditional way of thinking with them to Europe. They do not want an uncircumcised woman because they have been brought up with the idea that if a woman is not circumcised, she is not pure. If she is not circumcised, she is considered a whore. Most immigrants from Africa are convinced that an uncircumcised woman cannot lead a good life. No one wants to marry her; her community shuns her. This is ingrained in them. These attitudes need to be addressed and clarified.

Both African men and African women need to be made aware of the social and legal values that also determine their lives in Germany.

The third target group (educators, primary school teachers, professionals in projects and institutions and medical doctors) are to be reached through events and workshops. The initial aim here is to raise awareness of the problem of FGM/C: how can I tell if a girl is about to be circumcised, what happens during the procedure, why do mothers (especially), but also fathers, do this to their daughters?

The project is implemented through two main strands: counselling/support and awareness-raising/prevention, with the latter targeting communities and professionals in authorities and institutions. The primary aim is to prevent FGM/C among African women living in Germany—in particular, among young girls between the ages of 3 and 12, as this is the age group in which most of the victims of this practice are found.

Another key objective is to raise awareness of the issue. This includes the third group of educators, primary school teachers, professionals in projects and institutions, and medical doctors. Further training programmes and campaigns are implemented to educate this target group on this sensitive topic and to ensure their commitment to fight against this ritual.

In order to successfully combat this serious violation of girls' and women's rights, the education of African women and men should be carried out by an African network that has proven access to the communities, enjoys their trust, and has a proven track record in disease

prevention and health promotion. There is a need for an intensive, personal outreach approach by African women to African women for the purpose of education and prevention in the various communities: this is indispensable.

The project started with a needs assessment of the target group, from which specific educational activities were then derived. The process accompanying the needs assessment phase included the following steps:

1. Promoting the acceptance of the project among the communities.
2. Involving as many volunteers as possible.
3. Promoting the project and cooperation with day-care centres, schools, medical doctors, independent churches, mosques, counselling centres, youth welfare offices, and health authorities, etc.
4. Training sessions for the full-time and volunteer staff of the project by various specialists.
5. Training sessions for professionals on transcultural competence in dealing with those affected or at risk.

Indicators of goal achievement:

1. Ability to act independently.
2. Contact and cooperation with the further help systems of state institutions and welfare organisations (KSD/Johanniter/AWO/Caritas/Diakonie, Red Cross, etc.).
3. Involvement as multipliers within the communities—people who have sought counselling become counsellors themselves.
4. Those affected take responsibility for themselves and others; they become health mediators.

The multipliers should carry out low-threshold education and prevention work in their respective place of residence/district (this is known as 'the baobab principle') and receive ongoing training and further education.

In principle, there are two strands to the implementation phase: the first is the organisation and implementation of both the further training programmes for African communities, and the further training

programmes as well as the continuous provision of information for the schools, kindergartens, advice centres etc., and the medical sector. Contacts with the medical sector are also intended to serve the subsequent medical care of the women concerned. The second strand aims to strengthen the existing African networks. Future participants and multipliers will be recruited from these contacts to the African communities.

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Conclusion

This chapter highlighted the intricate relationship between advocacy, empowerment, and the health of persons with refugee experience, demonstrating how these elements are essential for promoting health equity in diverse societies. Through the exploration of health advocacy, professionals are encouraged to incorporate a human rights framework into their practices, ensuring that they engage in concrete action towards social justice and equity. This involves understanding the social and political challenges faced by refugee communities and actively working to influence change at systemic and policy levels.

In parallel, the empowerment of persons with refugee experience was described as a vital component of effective health and social care delivery. By shifting the focus to the strengths and resources of individuals, health and social care professionals can facilitate processes that enable persons with refugee experience to advocate for their healthcare needs. Lastly, the case example included in the chapter underscored that meaningful empowerment can only come from collaborative efforts and community-driven initiatives, where individuals with lived experiences lead and shape the interventions

that affect them. The work of the association baobab—zusammensein provides a practical illustration of how advocacy and empowerment can be operationalized through community networks. This initiative exemplifies how integrated approaches can effectively address pressing issues such as female genital mutilation/cutting (FGM/C) while promoting broader health improvements and social integration. The empowerment strategies employed by baobab—zusammensein, such as fostering self-help groups and training for community leaders, align with the empowerment approaches discussed in this chapter, demonstrating the transformative potential of enabling migrants and persons with refugee experience to advocate for themselves. Ultimately, this showcases the necessity of an interprofessional and intersectoral approach to refugee health. Without strong connections between health and social care professionals, community organizations, and individuals with lived experiences, inclusive and equitable healthcare environments cannot be created.

Advocacy by healthcare professionals and advocacy by associations by and for persons with refugee experience must therefore go hand in hand. Furthermore, empowerment within the context of refugee health means first and foremost that health and social care professionals acknowledge their role in supporting and facilitating opportunities for persons with refugee experience to influence their own health matters through collective political and societal engagement.

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