World Health Organization
REGIONAL OFFICE FOR Europe

Public Health Aspects of Migration in Europe
- Newsletter -

PÉCSI TUDOMÁNYEGYETEM
UNIVERSITY OF PÉCS

Issue 7 - December 2015

Content

EDITORIAL

Towards a common public health understanding of migration in the WHO European Region

Dr Piroska Ostlin, Acting Director, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe (WHO/Europe)

On 14 September 2015, senior government officials from the 53 Member States of the WHO European Region came together at the 66th session of the WHO Regional Committee for Europe in Vilnius, Lithuania. Migration and health was among the topics for discussion at a time when the refugee and migrant crisis had escalated in the Region, and its public health challenges were being felt by an increasing number of countries. By that same day in 2015, 411 567 refugees and migrants were estimated to have crossed the Mediterranean sea throughout the year, and the number of people having died or gone missing in the sea reached 2900 *(1).*

Migrant child in a refugee camp in Serbia © WHO

Large influxes of refugees and migrants have arrived to the WHO European Region on a continuous basis since 2011, following the start of political unrest and conflicts in Middle Eastern countries. However, during recent months, changes in the migratory routes have challenged the capacity of a larger number of transit and destination countries across the Region, revealing the need for strategic planning and thorough interventions to cope adequately with the public health implications of potential larger influxes.

About this newsletter: The newsletter has been established within the framework of the WHO Public Health Aspects of Migration in Europe (PHAME) project, based at the WHO European Office for Investment for Health and Development, Venice, Italy, in collaboration with the University of Pécs. The WHO PHAME project is funded by the Italian Ministry of Health. The quarterly newsletter is published by WHO/Europe and archived on its Migration and health website.

In this context, the discussions in Vilnius focused on the need for a regional and comprehensive approach to address adequately the short-, medium- and long-term public health consequences resulting from large-scale migration. The role of WHO/Europe was acknowledged, as was the need for continuous support to provide policy advice and technical assistance to its Member States. Beyond the work at country level, Dr Zsuzsanna Jakab, Regional Director for Europe, highlighted the importance of strengthening intercountry and interregional coordination for the promotion and protection of the health of this mobile population, as well as the host communities.

In order to move towards this goal, she committed to the organization of the High-level Meeting on Refugee and Migrant Health, taking place in Rome on 23–24 November 2015.

The complexity of the topic should be acknowledged. Large-scale movements of refugees and migrants can pose multiple and complex challenges to the health systems of transit and recipient countries, and more so if adequate preparedness measures are not in place. These challenges range from the management of communicable and noncommunicable diseases to the need for health systems to adapt to an increasingly diverse population. Moreover, with migration being a cross-border phenomenon by nature, an adequate and comprehensive response requires coordination across countries of origin, transit and destination. Finally, collaboration must also be strengthened between the multiple international organizations which play an important role in this cross-cutting area.

We need to act together, and we need to act now. Ensuring that the immediate health needs of these vulnerable groups are met is important for the protection of both their health and that of the host community. Furthermore, responding collectively to this common challenge is an opportunity and a responsibility to implement the core values of equity, solidarity and human rights that are central to Health 2020.

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OVERVIEW

Equity in health care for migrants and other vulnerable groups: a project of the Task Force (TF) on Migrant-friendly and Culturally Competent Health Care (MFCCH)

Antonio Chiarenza, Coordinator, International Network of Health Promoting Hospitals & Health Services (HPH) TF on MFCCH

The TF MFCCH was established in 2005 within the HPH to continue the momentum created by the migrant-friendly hospitals (MFH) project (2002–2005) in which 12 European countries developed models of good practice to improve hospital services and promote health and health literacy for migrants in selected pilot hospitals *(1)*. The novelty of the MFH project was to introduce the idea that if responsiveness to the specific needs of migrant groups is to be improved, measures must be addressed to improve not only knowledge and behaviour – of individual patients as well as health care providers – but also the overall organization of service delivery.

The general aim of the TF is to support member organizations in developing policies, systems and competences for the provision and delivery of accessible health care to patients from diverse communities, becoming migrant-friendly and culturally competent health care organizations, as outlined in the 2004 Amsterdam Declaration *(2)* – a set of recommendations for European health systems drawn up at the conclusion of the MFH project. The goals of the TF are to foster cooperation between health care organizations and other networks, share good practices, and stimulate new partnerships for future initiatives in areas of common interest.

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From the very outset, the TF MFCCH struck up a strong alliance with the world of research dedicated to the study of health care for migrants, culminating in the TF participating in the Action projects entitled HOME (2007–2011) *(3)* and ADAPT (2012–2015) *(4)*, financed by COST (European Cooperation in Science and Technology) – a European body focusing on research. Many meetings were held with a strong scientific bias, aiming to analyse existing research and policies in order to identify the challenges facing health services and the policies required to deal with migrants' needs *(5)*. In this context, the TF MFCCH decided to undertake a new initiative to acquire evidence on which interventions are actually effective and implemented within health care organizations.

To this end, in 2011 the TF MFCCH started a new project aimed at developing a comprehensive framework for measuring and monitoring the capacity of health care organizations to improve accessibility and quality of care for migrants and other vulnerable groups. The final product was to be a set of standards for equity in health care that would allow all professionals in health care organizations to carry out their own equity evaluations and to stimulate development in critical areas.

These standards have been developed on the basis of an extensive critical literature review, several expert workshops and consultations *(6)*. 5 main areas were identified that should be addressed to ensure the delivery of equitable services in health care.

1. Equity in policy, which aims to define how organizations should develop policies, governance and performance monitoring systems, in order to promote equity.
2. Equitable access and utilization, which aim to encourage health organizations to address barriers that prevent or limit people accessing and benefiting from health care services.
3. Equitable quality of care, which aims to ensure that organizations develop services that are responsive to the diverse needs of patients and families along the whole care pathway, ensuring a safe environment and continuity of care.
4. Equity in participation, which aims to support organizations in developing equitable participatory processes that respond to the needs and preferences of all service users.
5. Promoting equity, aiming to encourage organizations to do so in equity's wider environment, through cooperation, advocacy, capacity-building, research dissemination and effective practices.

In 2014, these standards were piloted in 55 health care organizations: 7 in Australia, 5 in Canada, 1 in Turkey and 42 in Europe. The aim of the pilot test was to evaluate how health care organizations can utilize the standards and self-assessment process, as well as to explore challenges and opportunities for effective uptake in connection with existing policies and practices. The findings of the pilot test, as illustrated in Fig. 1, show that compliance with the standards was low in 3 main areas: policy, participation and promoting equity outside the organization. In particular, pilot institutions revealed difficulties in establishing specific equity policies and plans at governance level; in promoting the involvement and participation of service users; and in developing forms of collaboration and partnership with relevant stakeholders in the community.

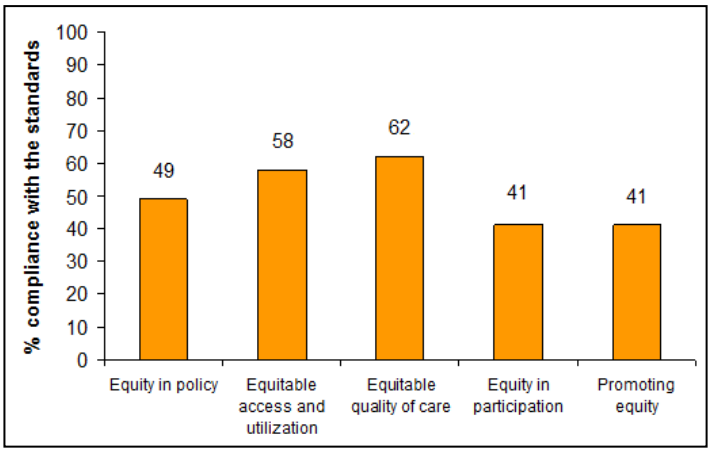

Fig. 1. Analysis of compliance with the standards

The overall evaluation process was considered to have been positive by pilot institutions, as it allowed health care organizations to identify gaps and to develop improvements based on the findings of the self-assessment. Indeed, developing explicit, actionable and measurable equity standards can be a crucial mechanism for operationalizing strategic commitments to equity in health care delivery, as well as enhancing quality improvement and performance measurement initiatives as drivers of change.

European health care organizations are invited to participate in the strategic implementation of the equity standards by joining the TF MFCCH; any interested institutions should contact Antonio Chiarenza at the Local Health Authority of Reggio Emilia, Italy (antonio.chiarenza@ausl.re.it).

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Strengthening health care systems capacity in an era of migration crisis

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The capacity of health care systems to predict, segment, reduce, divert and circulate the escalated flow of irregular migration is highly reliant on the effectiveness of the multisectoral coalitions involved in migration-related crisis management *(1, 2)*.

The lack of a caring and proactive approach in attracting and engaging multisectoral stakeholders during the pre-crisis and crisis stages of irregular migration could be seen as a primary inducing factor for escalated emergencies and breakdowns, spreading across all subsystems of the economies hit by crisis. In terms of crisis governance, these problems may accelerate crisis, owing to the resulting asymmetry of information and miscommunication among those involved *(3, 4)*.

In terms of managing the stages, cycles and processes of crisis, several major areas for attention can be highlighted within the general recommended crisis management procedures *(4, 5)*.

- First, it is suggested to establish an infrastructure capable of acting as an early-warning system, before the situation escalates to crisis phase.
- Second, it is useful to call on the systematic actions of crisis management liaison (involving individuals, groups or institutions as necessary) to ensure coordinated, timely action, especially during the pre-crisis stage.
- Third, capacity-building programmes that educate and train multidisciplinary experts to plan and manage the complete cycle and process of crisis ought to receive special attention and increased co-investment. The very thoroughly thought-out CHANCE MSc in Migrant Health programme curriculum – which was an outcome of the joint research of six academic institutions across six disciplines – is a unique example in the area of professional capacity-building at the public health level for responding to migration management *(6–8)*.
- Finally, aligned and coordinated stakeholder action demands a proactive, strategic and systematic role to be played by volunteers and the third sector, complementing the efforts of renowned professional organizations such as Red Crescent and Red Cross, through communication and mentoring.

The formation of the Global Migration Group (GMG) in 2013 – with 18 members, including WHO, the International Organization for Migration (IOM) and many influential international institutions in the field – has been an important response to the aforementioned need for joint effort in building multi-stakeholder capacities, to jointly prevent and manage crisis *(9)*. The ongoing international exchanges aiming to arrive at aligned regulations, under the International Health Regulations (IHR) initiated by WHO, are another example of this coordinated approach *(10)*.

From a policy planning perspective at the European Union (EU) level, awareness-building of the significance of a joint migrant health management system has become a high-priority area *(2)*.

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The European Agenda on Migration clearly refers to a similar understanding of and emphasis on the need for joint effort at multiple levels. Migration management is a shared responsibility, not only among EU Member States, but also vis-à-vis non-EU countries of transit and origin of migrants. By combining both internal and external policies, the Agenda provides a new, comprehensive approach grounded in mutual trust and solidarity among EU Member States and institutions. However, despite the many existing policy frameworks, aligned participation has become even more challenging *(11)*.

The United Nations Regional Refugee and Resilience Plan, which groups a number of humanitarian agencies and provides development aid for the countries bordering the Syrian Arab Republic, expresses serious concerns. The United Nations Refugee Agency (UNHCR)'s funding for the Syrian Arab Republic is only at 43% of budgeted requirements for 2015; the High Commissioner for Refugees, António Guterres had made it clear that his agency's budget would be 10% less than in 2014 *(12)*. In an interview with the *New York Times* in late September 2015 *(13)*, Madeline Garlick of the Migration Policy Institute stated that refugees have a right to work under the 1951 United Nations Convention, and nearly all of the countries in Europe have signed the Convention. However, in practice, not every country honors this obligation.

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NEWS

WHO/Europe and the Ministry of Health of Hungary conduct a joint assessment of refugee and migrant health in Hungary, 27 October 2015

http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2015/10/whoeurope-and-the-ministry-of-health-of-hungary-conduct-a-joint-assessment-of-refugee-and-migrant-health-in-hungary

WHO and Ministry of Health assess health system capacity to manage large migration in Albania, 21 October 2015

http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2015/10/who-and-ministry-of-health-assess-health-system-capacity-to-manage-large-migration-in-albania

EVENTS

Within the frame of the IX Conference of the Hungarian Association of Public Health Training and Research Institutions, entitled "**Hungarian Health – European Health", 26–28 August 2015 in Pécs, Hungary**, an **international symposium on migrant health** took place, with keynote speeches from Dr Santino Severoni and Prof. Allan Krasnik
http://nke2015.pte.hu/index2_en.html

First MediPIET Annual Scientific Conference (ASC), 18–19 November 2015, Skopje, The former Yugoslav Republic of Macedonia
http://medipiet.eu/event/first-medipiet-annual-scientific-conference-asc/

High-level meeting on refugee and migrant health (WHO/Europe), 23–25 November 2015, Rome, Italy
http://www.euro.who.int/en/media-centre/events/events/2015/11/high-level-meeting-on-refugee-and-migrant-health-announcement

106th Session of the International Organization for Migration (IOM) Council, 24–27 November 2015, Geneva, Switzerland
https://governingbodies.iom.int/106th-session-council

6th European Conference on Migrant and Ethnic Minority Health: "Equity – the Policy Practice Gap in Health", 23–25 June 2016, Oslo, Norway
http://www.nakmi.no/Details.asp?article=6th+European+Conference+on+Migrant+and+Ethnic+Minority+Health&aid=287
Abstract submission deadline: 20 December 2015
http://www.nakmi.no/NewsArticle.asp?news=EUPHA+MEMH+2016+Call+for+abstract&nid=294

European Public Health Association (EUPHA)'s 9th European Public Health Conference: "All for Health – Health for All", 9–12 November 2016, Milan, Italy
http://www.ephconference.eu/

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OPINION

This article represents the opinion of the author(s) and publications and does not necessarily represent the views of WHO, the University of Pécs or the Editorial Board of this newsletter.

Duration of residence and disease occurrence among refugees and family-reunified immigrants: test of the "healthy migrant effect" hypothesis

Marie Nørredam (1,2), Charles Agyemang (3), Oluf K Hoejbjerg Hansen (4), Jørgen Holm Petersen (4), Stine Byberg (1), Allan Krasnik (1), Anton E Kunst (3)

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(2) Section of Immigrant Medicine, Department of Infectious Disease, Copenhagen University Hospital, Hvidovre
(3) Department of Public Health, Amsterdam Medical Centre (AMC), Amsterdam University, Amsterdam
(4) Section for Biostatistics, Department of Public Health, University of Copenhagen, Copenhagen

Introduction

Studies have shown that levels of all-cause mortality are relatively low in many migrant populations *(1–5)*. The lower overall mortality rates have been attributed – among other things – to the "healthy migrant effect" (HME) hypothesis, which implies that the health advantages of migrant populations can be explained by the selection of the healthiest individuals upon migration *(6, 7)*. The hypothesis originally compared migrants to those remaining in the country of origin, but it is now often applied as an explanation for favourable health outcomes among migrants relative to local-born individuals in host countries. This has been difficult to investigate, owing to lack of data on the health of populations in the countries of origin. As an alternative, some studies have tried to examine the HME in host countries. The few studies that followed this approach originated from the United States and provided only weak support to the hypothesis *(8–10)*. Recently, the HME has been challenged by Agyemang et al. *(6)*, because it seeks to explain health outcomes for a number of very different diseases, with a number of different risk factors, and also because it tends to be applied to all migrants, without acknowledging that people migrate for very different reasons. To gain insight into the potential role of the HME, the association between residence duration and disease occurrence was examined in a new study.

Methods

A historical prospective cohort study was carried out, for which the study cohort was established in collaboration with the Danish Immigration Service. The immigration authority provided data on immigrants by age, sex, and nationality upon arrival, along with migrant status (refugee versus family reunification). Migrants who obtained residence permits in Denmark between 1 January 1993 and 31 December 2010 (n=114 331) were included. Occurrence of severe conditions was identified through the Danish National Patient Register and hazard ratios (HRs) were modelled for disease incidence by residence duration since arrival (0–5 years; 0–10 years; 0–18 years), adjusting for age and sex.

Results

Compared to Danish-born individuals, refugees and family-reunified immigrants had lower HRs for stroke and breast cancer within 5 years after arrival; however, HRs increased at longer follow-up periods. For example, HRs for stroke among refugees increased from 0.77 (95% CI:0.66;0.91) to 0.96 (95% CI:0.88;1.05). For ischaemic heart disease (IHD) and diabetes, refugees and family-reunified migrants already had higher HRs within 5 years after arrival, and most HRs had increased by the end of the follow-up period. For example, HRs for IHD among family-reunified migrants increased from 1.29 (95% CI:1.17;1.42) to 1.43 (95% CI:1.39;1.52). In contrast, HRs for tuberculosis (TB) and HIV/AIDS showed a consistent decrease over time.

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Discussion

Gaining insight into the HME is important because it is often invoked to explain the lower mortality of migrants. Using unique data on a cohort of refugees and family-reunified migrants and Danish-born individuals, this study explored how the occurrence of various disease outcomes was related to the duration of residence of recently arrived migrants in the host country. Results showed that migrants already had significantly or non-significantly higher HRs for most disease outcomes within the first 5 years after arrival, relative to Danish-born individuals. Moreover, the occurrence of stroke, IHD, diabetes, and breast cancer increased with increasing duration of residence, while the occurrence of HIV/AIDS, TB and lung cancer decreased. Analysis of the effect of duration of residence on disease occurrence among migrants implies that, when explaining migrants' advantageous health outcomes, the ruling theory of the HME should be used with caution and other explanatory models should be included. At policy level, the results of this study imply that preventative and diagnostic health efforts in the immigration country should target relevant migrant groups from arrival onwards and should include noncommunicable as well as communicable diseases.

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RECOMMENDED READING

De Vito E, de Waure C, Speccia ML, Ricciardi W. **Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region (2015)**. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network Synthesis Report 42)

(http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2015/public-health-aspects-of-migrant-health-a-review-of-the-evidence-on-health-status-for-undocumented-migrants-in-the-european-region-2015)

Simon J, Kiss N, Laszewska A, Mayer S. **Public health aspects of migrant health: a review of the evidence on health status for labour migrants in the European Region (2015)**. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network Synthesis Report 43)

(http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2015/public-health-aspects-of-migrant-health-a-review-of-the-evidence-on-health-status-for-labour-migrants-in-the-european-region-2015)

Bradby H, Humphris R, Newall D, Phillimore D. **Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region (2015)**. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network Synthesis Report 44)

(http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2015/public-health-aspects-of-migrant-health-a-review-of-the-evidence-on-health-status-for-refugees-and-asylum-seekers-in-the-european-region-2015)

Risk of importation and spread of malaria and other vector-borne diseases associated with the arrival of migrants to the EU – 21 October 2015. Stockholm: European Centre for Disease Prevention and Control; 2015

(http://ecdc.europa.eu/en/publications/Publications/risk-malaria-vector-borne-diseases-associated-with-migrants-october-2015.pdf)

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