

OVERVIEW

All sectors can benefit from the International Health Regulations (IHR)

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Current disease outbreaks and public health emergencies show more than ever that our world has become more global, and that the instruments to control such emergencies need to be as strong and global as the threats themselves. The International Health Regulations (IHR) are one such instrument. As one of the 2 legal conventions that WHO serves as secretariat, these regulations were first negotiated in 1969 and then revised in 2005, mainly to take into account the increase in travel and trade, but also the fact that it is no longer possible for a single country to assess and respond to risks on a purely national level. Countries have become increasingly interdependent. The IHR are intended to support the globalized world by avoiding unnecessary interference with international travel and trade, and as such by avoiding economic damage caused by delayed detection of public health threats or by implementing measures that are not proportionate to the problem. The key success of the revised IHR is the establishment of National Focal Points – institutions which serve as a communication hub between State Parties and WHO on a full-time basis. Increasingly more State Parties are also using these multisectoral communication hubs for direct contact with each other, without involving WHO. This information exchange enhances epidemic intelligence and health security. No one will ever be able to prevent health threats from crossing borders, but the mechanisms in the IHR allow countries to function effectively in health terms, despite these threats.

That said, many State Parties are not yet ready to use and apply the IHR on a daily basis, despite having the capacity to do so. In many cases these State Parties began the process with high ambitions and solid implementation plans in 2005. However, while developing and strengthening core capacities in order to support the use of the IHR, the original public health purpose of the IHR faded from focus somewhat, and the IHR became a legal text with little relevance to or bearing

on day-to-day health system functioning. While Annex 1A of the IHR only outlines the minimum requirements to which countries should adhere, at this stage most countries in the WHO European Region do fulfil these requirements. Very few resources are required to share information and consult with WHO and in that sense the IHR provide a very lean approach to managing public events, strengthening the capacity of a country by better informing stakeholders and strengthening links between them.

Later in 2014 the Director-General of WHO will convene an IHR Review Committee, which will review country requests for an extension until 2016 to develop and strengthen capacities. Using this as an opportunity, it has been suggested that the Committee should also discuss and provide advice on how to accelerate the use of the IHR with the capacities that are already available as well as those becoming available beyond 2016. It is necessary to standardize capacities and performance for optimal information sharing. Thus far the monitoring of the IHR has focused more on administration, procedures and equipment (so-called hard capacities), and less on operational and outcome-based (so-called soft) capacities.

The 28 European Union (EU) Member States agreed on Decision No. 1082/2013 on serious cross-border threats to health earlier this year, complementing the IHR. This decision establishes multilateral coordination and consultation mechanisms alongside the bilateral IHR mechanisms. The implementation of the IHR will never be complete – efforts to control public health threats require all stakeholders to continuously improve the way they coordinate, to remain dynamic in their approach and to adapt to new challenges. State Parties are countries which adopted the IHR (to date 196 countries globally), including all 53 Member States of the WHO European Region, plus the Holy See and Lichtenstein (55 in total).

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What is the current evidence on migration and health for better policy-making? Recommendations from the WHO European Advisory Committee on Health Research (EACHR)

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In light of the refugee crisis unfolding on Europe's southern Mediterranean borders, migrant health has risen high on the political agenda in many European countries. Policy-makers across the WHO European Region now have the opportunity to act to save lives, reduce suffering and ill health, and minimize the negative impacts on health systems and societies by implementing public health measures informed by robust, multidisciplinary scientific evidence.

This is easier said than done, however, given the political sensitivity and multifaceted nature of the issue. Indeed, the causes, effects and consequences of mass migration are felt in different ways in different parts of the Region. While southern Mediterranean countries are confronted with the task of managing a massive wave of irregular migration from northern Africa, and northern European WHO Member States are faced with the challenge of integrating asylum seekers, the Russian Federation – which hosts the largest share of the Region's migrant population – is home to a growing number of economic migrants. When providing evidence for informing future policy in this sphere, 3 questions need to be asked: "What is the definition of a migrant?", "Which specific groups are we referring to?" and "What is the definition of 'access to health care' for migrants in different contexts?"

These questions, among others, were discussed in depth at the fifth meeting of the EACHR, which took place in Copenhagen on 7–8 July 2014. The EACHR reports directly to the WHO Regional Director for Europe and is tasked with advising on the formulation of policies for the development of health research, coordinating health research priorities across the Region, and drawing up evidence-based strategies to address priority public health issues. Items on the agenda for the meeting included migrant health, vulnerable groups and health inequalities, health research mapping, public health genomics and knowledge translation.

The overarching conclusion of the discussion on migrant health was that the existing evidence base is underutilized, and that a synthesis of the available evidence is now required. This should take the form of a systematic review, focusing on the issue of migration from different angles, and assessing separately the needs of different migrant groups.

Due to the political sensitivity of migration, both regular and irregular, how these issues are communicated to policy-makers is of the utmost importance. Rather than promoting new research on migration and health, existing evidence needs to be synthesized and packaged for policy-makers. This requires a multisectorial approach in order to adequately address the needs of migrants in a holistic way, and should be able to convince policy-makers who are more likely to approach the issues from an economic or legal perspective, rather than giving full priority to the public health implications.

It was concluded that these reviews should come from a strategic perspective and take an approach underscored by balanced values, recognizing both the human rights aspects and the utilitarian economic arguments that centre around controlling health care costs and creating potential benefits for host populations. In addition, each review should account for the social and economic realities in each country – for example, with regard to access to health care for native citizens, the respective country's health system financing model, the availability of data and any research gaps that might exist. Finally, any future policies will need to recognize the training needs of health care providers to overcome not only the implementation challenges at the country level, but also the other invisible barriers to migrants' access to health care, including cultural determinants of health.

WHO/Europe plans to make migrant health a priority over the coming months and exploit the window of opportunity while it remains high on Member States' political agendas. First, the EACHR will establish a working subgroup and develop terms of reference for the evidence reviews. Secondly, a Health

Evidence Network (HEN) series of synthesis reports can serve as an outlet for disseminating the committee's findings and presenting them to policy-makers and practitioners throughout the Region.

MIGHEALTHNET – an unfinished story?

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The idea for MIGHEALTHNET took shape 2 years before the project started in May 2007, during meetings of the International Migration, Integration and Social Cohesion in Europe (IMISCOE) Network of Excellence. A small group of migration researchers with an interest in the health of migrants realized that the lack of a solid, accessible knowledge base was a major obstacle to developing expertise and good practices.

A project was devised for creating online collections of articles, links and useful information in different countries, which would be easily accessible to anybody. The plan was to use a so-called Wiki – a website that users themselves can edit and add to (the most well-known example being Wikipedia). This website would act as a sort of clearing house for information and would also bring people in touch with each other, thus facilitating the development of networks. At the end of 2005, 2 members of the project team travelled to the head office of the International Organization for Migration (IOM) in Geneva and obtained a promise of help – practical, rather than financial – to realize this idea. As a result, the IMISCOE/IOM European Survey on Migrant Health was born.

Why was it thought necessary to go to all this trouble? Why not use established medical databases, such as PUBMED or MEDLINE? The problem is that information about the health of migrants is tucked away in places that are many and varied and as such is often difficult to unearth. It became important to make a much wider range of information accessible, covering different disciplines (social sciences as well as medicine), different languages, and different types of publication – in particular, “grey” literature areas (reports and

other documents with a less formal status). Lists of activities, organizations and links to useful websites would also be necessary in this context.

It was soon discovered, however, that this task would be by no means easy: even with the help of the IOM, there were simply too few people involved to get the project off the ground. As a network, IMISCOE had no research funds at its disposal, so it soon became clear that more serious financial backing would be needed for the project to succeed or even continue.

As so often happens in the world of research, the next step occurred quite by chance. Ioanna Kotsioni, a researcher at the University of Athens, had heard about the project and realized that it would be ideal for her own department, which was seeking to expand its research programme. The Directorate-General for Health and Consumers (DG-SANCO) had just published a call in which the topic of migrant health figured prominently. The MIGHEALTHNET project was developed and co-financed by the National Kapodistrian University of Athens, with Ioanna as project coordinator and myself (David Ingleby) as the scientific coordinator. The project duration was 2 years (2007–2009) and the total cost was about €650 000.

An enthusiastic team of partners was recruited across 16 different countries. Without the dedication and enthusiasm of its members, the project would never have achieved as much as it did. It was decided to use the same software as Wikipedia (Mediawiki) and a network of websites was set up in the 16 countries, as well as a general website for the whole EU. All these sites can be accessed via the MIGHEALTHNET website (www.mighealth.net).

MIGHEALTHNET deals with 2 main issues: the state of health of migrants and ethnic minorities, and health services for those groups (entitlement to health care, accessibility and quality). In addition, the websites provide background information on the status of migrants and ethnic minorities in each country, as well as the activities being undertaken to improve services and further research. Translation by Google Translate makes it possible not only to peruse websites in languages one knows, but also to see an image in one's own language of a web page written in another. Although the results can often be hilarious, the translations are usually good enough to find out at least what is being done in each country.

All the websites are structured in the same way, according to the following 6 topics:

- background information concerning migrant and minority populations;
- the state of health of migrants and minorities;
- the health care system and the entitlement of migrants and minorities to health care;
- accessibility of health care;
- quality of care: good practices developed to improve the matching of service provisions to the needs of migrants and minorities;
- mechanisms for achieving change: centres of expertise, general reports and policy documents, journals, training programmes, email groups and so on.

At the end of the 2-year period, almost all of the websites had been populated with relevant material. "State of the Art" reports were produced by most partners and posted on their websites. In some countries, the project was an enormous success: the best example is from Norway, where Thor Inseth and his colleagues at the Norwegian Centre for Minority Health Research (NAKMI) turned their Wiki into a veritable encyclopedia, with specially written articles as well as countless links. At the end of the project they were receiving hundreds of hits a day. By contrast, the team in Germany, despite putting together an excellent website and an energetic dissemination campaign – and having a much larger national population – received only a fraction of this number of hits. Indeed, it was very hard to predict how popular the sites would be.

However, there remained 2 main problems. One was the enormous discrepancies among countries, for example in the United Kingdom and the Netherlands there was almost too much information to handle, whereas in Bulgaria, Hungary and Turkey, the topic was virtually unknown. The other was the difficulty of recruiting voluntary support to develop the websites. The inspiration had come from Wikipedia – an enterprise to which contributors are attracted like bees to a honeypot, willing to devote endless energy to writing new articles and improving those written by others. It was believed that this idea would catch on among people committed to migrant health in Europe, but unfortunately, few bees came along; nearly all the people developing the sites were those who had been paid to do so. It was also discovered that in some countries, the "Wiki" concept had a negative connotation: it was associated with ideas that were subterranean, not respectable, and certainly not scientific. Unfortunately, the grant also ran out just when the sites had started to become useful.

Of course it was realized that sustainability was going to be a problem, and DG-SANCO and project partners had agreed that the teams in each country would do their best to seek support in order to continue the project. Alas, this was easier said than done. The crisis was beginning to bite and most potential sponsors were urgently trying to save money, not to spend it. Only in Norway and the Netherlands was it possible to find subsidies to keep the Wikis up to date. In most other countries, they have become a monument to an enterprise which failed to plan well enough for the future. In spite of this, however, volunteers have added 5 additional Wikis to the network.

It would not be difficult to revitalize the network, or at least parts of it. At the moment, the general Wiki (in English) is being used to host material for the COST Action ADAPT (Adapting European Health Systems to Diversity), and other projects could use it in the same way. In some countries, in which there was little interest at the start of the project, the topic has now been placed on the agenda. The groundwork has already been laid and, if financing could be found, MIGHEALTHNET could still fulfil its promise to play a key role in promoting the health of migrants and ethnic minorities in Europe.

Progress on migration and health during the Greek EU Presidency

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Introduction

In 2011 some 69% of the growth of the population in the EU27 countries came from net migration, accounting for 0.9 million people. The contribution of net migration (taking into account statistical adjustment) to total population growth has exceeded the percentage of natural increase since 1992, peaking in 2003 (at 95% of the total population growth). Migration therefore represents a factor of renovation, strength and growth for the future of the EU labour force.

However, irregular migration towards the EU28 countries continues to present significant challenges to the security, as well as the health systems and public health services of all Member States. An important consideration is that irregular migration presents in different forms among Member States. For example, Member States in the Mediterranean basin frequently face the scenario of the mass arrival of immigrants/refugees through their sea borders, while the main concern of Member States in the centre and north of Europe centres around attempts to enter the countries with fraudulent papers.

Situation in Greece and the EU context

According to the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (FRONTEX), in 2013–2014 the majority of illegal border crossings were at the sea borders, with a massive influx in the central Mediterranean region, mostly at the borders of Italy and Greece, and such crossings are currently at their highest level, even when compared with the initial stages of the Arab Spring in 2011 (1). Concurrent with this influx, there were more applications for international protection in the EU than in any other period since 2010. The effects of the Arab Spring and the civil war in the Syrian Arab Republic have resulted in record asylum applications submitted to the EU, with an increasing concentration in Germany, Sweden and the United Kingdom.

Tragically, there have also been several major incidents involving boats capsizing in the central Mediterranean (for example, the incident in Lampedusa in October 2013) and the

Aegean Sea, resulting in massive loss of life, including women and children. Intelligence gathered by FRONTEX suggests that migration pressure in the central Mediterranean region is expected to remain at a high level, with Greece being the country with the highest migrant inflow within the EU.

In Greece:

- the number of estimated undocumented migrants is currently particularly high, ranging between 150 000 and 400 000 (2.5% of the population);
- more than 17 500 migrants had been detained in Greece before 1 September this year, with authorities expecting the number to reach 31 000 by the end of the year, compared with 10 500 in 2013;
- a threefold increase in the number of immigrants and asylum seekers was recorded this year compared with 2013, with more than half of those entering now coming from the Syrian Arab Republic;
- lack of resources remains a major issue; emergency EU funding was requested officially by the Greek Government on 4 September 2014.

Migration and public health-related activities that have taken place during the Greek EU Presidency

Migration and public health constituted one of the main priorities of the Hellenic Presidency of the EU (January–June 2014), aiming to raise awareness on the impact of migration on health and health systems. In this context, the European Center for Disease Prevention and Control (ECDC), in collaboration with the Hellenic Center for Disease Control and Prevention, and under the auspices of the Hellenic Presidency, organized a technical workshop entitled “Public health benefits of screening for infectious diseases among newly arrived migrants to the EU/European Economic Area (EEA)”. This activity took place in Athens on 19–20 March 2014, involving more than 50 participants, including representatives of the European Commission, WHO, the Centers for Disease Control and Prevention (CDC), the IOM and various nongovernmental organizations (NGOs).

One of the main purposes of the meeting was to highlight the positive aspects of the enhanced cooperation of the EU Member States to face this shared public health challenge. Representatives of the EU/EEA Member States were given the opportunity to exchange experiences and relevant benchmark practices within the workshop, as well as being informed and updated on a selection of ongoing projects (supported by the EU Health Programme and the ECDC), and presented with cost-effectiveness studies on the screening of migrants carried out in some Member States.

During the 2-day meeting a number of common key points of concern among all Member States were raised, including:

- the lack of a systematic approach to certain diseases, as well as to the methodology used;
- the need for European guidance on screening for infectious diseases among migrant populations in the EU;
- the need to connect screening practices with access to health care;
- the need to close gaps in communication and collaboration with other sectors involved with the management of migrants (such as law enforcement).

The priority area of migration and public health was also included in the discussion at the informal meeting of the Council of Health Ministers in Athens on 28–29 April 2014. The ministers agreed on the need for:

- promotion of access to health care for all migrants;

- the development of guidelines and methodology for the control of communicative diseases;
- special health services for particularly vulnerable migrant groups, such as pregnant women and small children;
- the creation of a Special Working Group within the framework of the EU Health Security Committee to address effectively issues at hand;
- enhanced Member State cooperation for the exchange of best practices and mutual support; and
- better information diffusion and more effective exploitation of EU Structural Fund resources, including the new Asylum, Migration and Integration Fund (AMIF).

The follow-up activities on these decisions, of course, remain to be seen, but it is hoped that public health authorities around Europe will be able to agree on the relevant guidance on the screening of newly arrived migrants.

In closing it should be mentioned that in Greece the main public health targets as regards the issue of increased migration remain as follows:

- strengthening the surveillance systems to carry out prompt interventions;
- increasing the awareness of health professionals and the public regarding migrant health; and
- enhancing intersectoral collaboration with the relevant stakeholders (law enforcement, border control, NGOs and so on).

References

1) FRAN Quarterly. Quarter 1 January–March 2014. Risk analysis (18/8/2014). Warsaw: European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (FRONTEX) Risk Analysis Unit; 2014 (http://frontex.europa.eu/assets/Publications/Risk_Analysis/Fran_Q1_2014.pdf, accessed 9 September 2014).