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## EDITORIAL

### Migrants and health – what is the evidence?

**Dr Claudia Stein, Director**

Division of Information, Evidence, Research and Innovation, WHO/Europe

The *WHO European health report 2012: charting the way to well-being* identified migration as an important factor influencing the demographic transition of population growth in Europe. According to reported data, an estimated 73 million migrants currently live in the European Region, accounting for almost 8% of the population. This population inflow reflects a 5 million increase in the Region's population since 2005 and accounts for nearly 70% of the population growth between 2005 and 2010 [1].

The long-term effects of migration on population growth and structure remain somewhat uncertain, however. Some facts are well documented: migrants tend to be younger, less affluent and have poorer access to health services than the rest of the population, but the morbidity and mortality profile of migrants is not well understood, largely due to the fact that not all migrants have legal status in the countries in which they live and information about their health status remains below the official radar. Often, their health issues only come to the fore in the face of trans-border issues in communicable diseases, or when populist movements endeavour to have migrant populations perceived as transmitters of diseases. Even in the case of well-documented notifiable diseases, such as tuberculosis, there is in fact little evidence to show that migrants are a significant factor in transmitting diseases to native populations.

Few efforts have been made to systematically analyse existing health information available on migrants in order to achieve a more complete and differentiated picture. Before such a picture can be assembled, it is important to define what is meant by the term migrant. At the international level, no officially accepted definition exists for a migrant. The International Organization for Migration (IOM) describes migrant status as being “where the decision to migrate was taken freely by the individual concerned for reasons of ‘personal convenience’ and without intervention of an external compelling factor” (thus distinguishing migrants from refugees). The United Nations defines a migrant as “an individual who has resided in a foreign country for more than a year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate” (thus including refugees) (2).

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The term is therefore not clear and definitions may include: individuals who are either documented or “irregular” (also known as illegal) migrants; those who move for economic, political or other reasons; as well as short-term and long-term migrants.



**Meeting of the European Advisory Committee on Health Research, Copenhagen, Denmark, 2013 © WHO**

Migrants constitute a heterogeneous group of people that is likely to differ in its demographic, epidemiological and social profile; it is therefore important to arrive at a definition for the purposes of assembling the best evidence. As a result of a recommendation by the European Advisory Committee on Health Research (EACHR) – which advises the WHO Regional Director for Europe – the Evidence and Information for Policy unit (EIP) within the Division of Information, Evidence, Research and Innovation (DIR) at WHO/Europe in collaboration with Public Health Aspects of Migration in Europe (PHAME) plans to commission several evidence syntheses in the context of the Health Evidence Network

(HEN) in order to summarize the existing evidence in this area. The HEN reports will describe the definitions most widely in use and propose a suitable working definition (which may not include all migration groups). Moreover, it will summarize the health information available on migrants, along with other cross-sectoral indicators that describe the well-being of migrant populations (including access to health services) in alignment with the holistic set of core indicators set out in the European Health 2020 policy. As with all indicators of the Health 2020 policy, the information on migrants requires disaggregation by gender and age groups, and preferably also by socioeconomic status, in order to enhance understanding of the health profile of this group and to identify inequalities within and compared to other population groups.

Such an analysis of existing evidence will inform policy-makers on the steps required to collect, analyse and integrate adequately the information on migrant populations in their national health information systems. This in turn will provide policy-makers with the necessary evidence to hone or establish health policies at the national and international levels. In addition, this work will be a key input to the agenda item on health and migration at the International Conference on Health in the Mediterranean Area convened under the current Presidency of the European Union (EU) by the Italian Ministry of Health in October 2014, thus providing direct evidence to inform the work of the EU.

For as long as human beings have walked the earth, they have migrated, bringing both challenges and new solutions with them. It is therefore high time to reliably describe and synthesize evidence on migrant health, not only for the purposes of European policy-making, but also to inform global policies across all sectors.

### References

- 1) The European health report 2012: charting the way to well-being. Copenhagen: WHO Regional Office for Europe; 2013 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/197113/EHR2012-Eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/197113/EHR2012-Eng.pdf?ua=1), accessed 8 September 2014).
- 2) Key migration terms [web site]. Geneva: International Organization for Migration (IOM); 2014 (<http://www.iom.int/cms/en/sites/iom/home/about-migration/key-migration-terms-1.html>, accessed 19 May 2014).

## OVERVIEW

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

**Thomas Dieter Hofmann**, Technical Officer, Country Emergency Preparedness, Division of Communicable Diseases, Health Security & Environment, WHO/Europe

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).

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).

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

**Tim Nguyen**, Unit leader for Evidence and Intelligence for Policy-Making, Division of Information, Evidence, Research and Innovation, WHO/Europe

**Santino Severoni**, Coordinator of the project Public Health Aspects of Migration in Europe, Division of Policy and Governance for Health and Well-being, WHO/Europe

**Sol Richardson**, Intern, Division of Information, Evidence, Research and Innovation, WHO/Europe

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.

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## MIGHEALTHNET – an unfinished story?

**David Ingleby**, Emeritus Professor of Intercultural Psychology at Utrecht University and researcher at the Centre for Social Science and Global Health, University of Amsterdam

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](http://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

Jenny Kremastinou, President of the Hellenic Centre for Disease Control and Prevention

### 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](http://frontex.europa.eu/assets/Publications/Risk_Analysis/Fran_Q1_2014.pdf), accessed 9 September 2014).



## EVENTS

**Who:** WHO

**What:** 64th session of the WHO Regional Committee for Europe

**When:** 15–18 September 2014

**Where:** Copenhagen, Denmark

Ministers and high-level representatives of the 53 Member States of the WHO European Region, along with partner and civil society organizations have taken part in the 64th session of the WHO Regional Committee for Europe, held in Copenhagen, Denmark on 15–18 September 2014. A technical briefing was organized during the first day on the topic of migration and health, where several countries came together to discuss the public health implications of migration in the region, its main challenges and urgent needs. The session was webcast live, and there was real-time coverage on Twitter, using the hashtag #RC64Copenhagen.

**Link:** <http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/64th-session>

**Who:** European Public Health Association

**What:** 7th European Public Health Conference. Mind the gap: reducing inequalities in health and health care

**When:** 19–22 November 2014

**Where:** Glasgow, Scotland, United Kingdom

**Link:** <http://ephconference.eu/>

**Who:** Academy of European Law

**What:** Annual Conference on EU Border Management 2014 – FRONTEX, Schengen evaluations, EUROSUR and visa rules

**When:** 25–26 September 2014

**Where:** ERA Conference Centre, Trier, Germany

**Link:** [https://www.era.int/cgi-bin/cms?\\_SID=new&\\_sprache=en&\\_bereich=artikel&\\_aktion=detail&idartikel=124668](https://www.era.int/cgi-bin/cms?_SID=new&_sprache=en&_bereich=artikel&_aktion=detail&idartikel=124668)

**Who:** Initiatives and Studies on Multi-ethnicity (ISMU) Foundation

**What:** 2014 International Metropolis Conference

**When:** 3–7 November 2014

**Where:** MiCo Milano Congressi convention centre, Milan, Italy

**Link:** <http://www.metropolis2014.eu/page/17/Workshops>

## PUBLICATIONS

### **Jobs for immigrants (vol. 4): labour market integration in Italy**

2014

(<http://www.oecd-ilibrary.org/docserver/download/8114121e.pdf?expires=1405938146&id=id&accname=ocid195767&checksum=48709E17CDF3216AEF32C2A6C1A7129C>)

Until the mid-1990s, the share of migrants in Italy was relatively low in international comparison. With a persistent demand for foreign workers in low-skilled and low-paid jobs, the proximity of conflict areas and the enlargement of the

European Union (EU) to Romania and Bulgaria in 2007, migration to Italy has increased rapidly over the last 15 years. This report presents an overview of the skills and qualifications of immigrants in Italy, their key labour market outcomes in international comparison, and their evolution over time, given the highly segmented Italian labour market and its high share of informal jobs. It analyses the framework for integration and the main integration policy instruments. Special attention is paid to funding issues and to the distribution of competences between national and subnational actors. Finally, this report reviews integration at school and the school-to-work transition of the children of immigrants.

### **Access to healthcare for people facing multiple vulnerability factors in 27 cities across 10 countries. Report on the social and medical data gathered in 2013 in eight European countries, Turkey and Canada**

(<http://mdmeuroblog.files.wordpress.com/2014/05/access-to-healthcare-27-cities-10-countries-doctors-of-the-world1.pdf>)

This Médecins du monde (Doctors of the World) report presents the analysis of data collected in 27 cities in 10 countries: 8 European countries, together with Turkey and Canada.

In many countries, groups which were already vulnerable before the crisis (undocumented migrants, asylum seekers, drug users, sex workers, destitute European citizens and homeless people) are seeing a deterioration or even removal of the safety nets and social networks which provided them with basic support.

Almost half the patients seen by Doctors of the World have permission to reside in Europe. For people from both the EU and beyond who do not have permission to reside, the situation is even more difficult. In 2013, 76.3% of those asked reported having had at least one violent experience. The types of violence most frequently reported were hunger and having lived in a country at war. Almost 20% of people reported having experienced violence in the country where they were surveyed.

The 3 barriers to access care most frequently cited by patients were financial problems (25.0%), administrative problems (22.8%) and lack of knowledge or understanding of the health care system and of their rights (21.7%). Personal health only represented 2.3% of the reasons cited for migration. These results clearly contradict the myth that migrants come to Europe for the purpose of using health care services.

## Annual Risk Analysis 2014

([http://frontex.europa.eu/assets/Publications/Risk\\_Analysis/Annual\\_Risk\\_Analysis\\_2014.pdf](http://frontex.europa.eu/assets/Publications/Risk_Analysis/Annual_Risk_Analysis_2014.pdf))

FRONTEX is the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union. FRONTEX Annual Risk Analysis 2014 focuses on describing current challenges that are likely to impact on operations coordinated along the external borders. It presents the latest update regarding the situation before the border, at the border and after the border.

Illegal border crossing along the EU's external borders sharply increased between 2012 and 2013, from approximately 72 500 to 107 000, which represents an annual increase of 48%. While the annual increase is significant, the 2013 level is comparable to the totals reported by Member States in 2009 and 2010 (104 600 and 104 000, respectively), and is still lower than the total reported during the Arab Spring in 2011 (141 000). Most detections of illegal border crossing were of

Syrians, Eritreans, Afghans and Albanians, who together accounted for 52% (55 400) of the total number detected.

Based on FRONTEX Risk Analysis Network data for 2013, the number of asylum applications submitted in the EU have continued to increase. Preliminary data indicate an overall increase of about 28%.

In 2013, there was a steady trend whereby about 159 000 third-country nationals were effectively returned to third countries. This total does not include readmissions between Member States. In 2012 the United Kingdom and Greece were the Member States conducting the largest number of returns.

Looking ahead, everything points to a heightened likelihood of large numbers of illegal border crossings into the EU and an increased number of migrants in need of assistance, not only as regards search and rescue operations but also in terms of international protection, in particular in the southern section of the external border, along the Eastern Mediterranean and central Mediterranean routes.

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## RECOMMENDED READING

United Nations General Assembly 2014

**International migration and development: report of the Secretary-General (A/69/207).** New York: United Nations; 2014

([http://www.un.org/en/development/desa/population/publications/pdf/migration/A-69-207\\_en.pdf](http://www.un.org/en/development/desa/population/publications/pdf/migration/A-69-207_en.pdf))

Nyiri 2012

**A specialist clinic for destitute asylum seekers and refugees in London.** Br J Gen Pract. 2012; 62(604):599–600

(<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3481505/>)

Siyam & Roberto 2014

**Migration of health workers: the WHO Code of Practice and the global economic crisis.** Geneva: World Health Organization; 2014

([http://www.who.int/workforcealliance/knowledge/resources/migration\\_book/en/](http://www.who.int/workforcealliance/knowledge/resources/migration_book/en/))

## OPINION

The following articles represent the opinion of the author(s) and publications and do not necessarily represent the views of WHO, University of Pécs or the Editorial Board of this newsletter.

### Health data collection and assessment of occupational health-related hazard in Hungarian migrants' reception centres

Zoltán Katz, Assistant professor

Erika Marek, Senior lecturer

István Szilárd, Chief Scientific Adviser

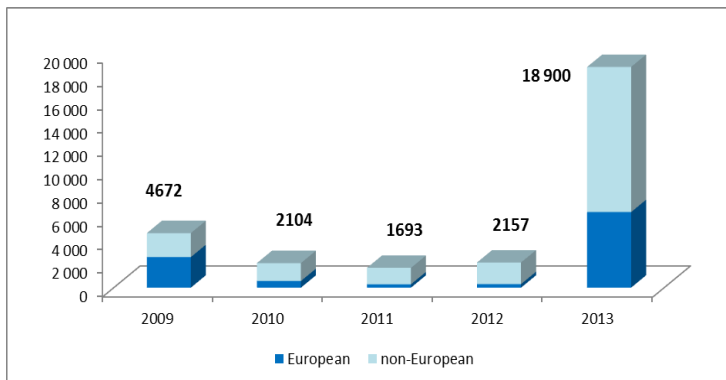
University of Pécs Medical School Chair of Migration Health

#### Background

Hungary joined the European Union (EU) Schengen Area on 21 December 2007. The country covers approximately 1100 km of the EU's Schengen land borders and is faced with an influx of migrants – both regular and irregular – from eastern and south-eastern Europe.

Over the years the number of irregular migrants identified had levelled out, but started increasing sharply between 2012 and 2013 (see Fig. 1).

**Fig. 1. Registered asylum seekers in Hungary by origin, 2009–2013**



**Source:** Statistics of the Hungarian Office of Immigration and Nationality, 2014

([http://www.bmbah.hu/jomla/index.php?option=com\\_k2&view=item&layout=item&id=492&Itemid=1259&lang=en#](http://www.bmbah.hu/jomla/index.php?option=com_k2&view=item&layout=item&id=492&Itemid=1259&lang=en#))

More than 18 000 irregular migrants applied for asylum or refugee status in 2013. Several push factors serve as the background to this trend, such as the side-effect of the Arab Spring and the serious, bloody crisis in Syria.

The composition of the population of asylum seekers according to their country of origin is presented in Fig. 2, comparing 2012 and 2013 data. Aside from the high number of immigrants from

the Balkans (UN Administrative Province of Kosovo (1244)) and Central Asia, numbers entering Hungary from the Middle East and Africa have also increased significantly. In these regions the public health services are either underdeveloped or have been destroyed, and as a consequence the vaccination status of the migrants is uncertain at best. The prevalence of emerging and re-emerging communicable diseases such as poliomyelitis, measles, and tuberculosis is high in these countries, making the recurrence of vaccine-preventable diseases in the EU a real health threat, and it is well understood that the incidence of communicable and vaccine-preventable diseases in the host population can significantly increase as a result (1). The most affected western European countries – namely the United Kingdom, Germany, France, Italy and Spain – have considerable migrant populations as well. During recent years, a growing number of reports have been published on the public health impacts of immigrant populations on the health care indicators in the EU. (See, for example, Suijkerbuijk et al. 2009 (2).)

**Fig. 2. Composition of asylum seekers in Hungary by country of origin**

Nationality	Number of asylum seekers in 2012	Number of asylum seekers in 2013	Changes
UN Administrative Province of Kosovo (1244)	226	6 212	5 986
Pakistan	327	3 081	2 754
Afghanistan	880	2 328	1 448
Algeria	59	1 116	1 057
Syrian Arabic Republic	145	977	832
Bangladesh	15	679	664
Morocco	47	496	449
Nigeria	27	455	428
Mali	0	305	305
Ghana	1	269	268
Somalia	69	191	122
Others	361	2 791	2 430
<b>Total</b>	<b>2 157</b>	<b>18 900</b>	<b>16 743</b>

**Source:** Statistics of the Hungarian Office of Immigration and Nationality, 2014

([http://www.bmbah.hu/jomla/index.php?option=com\\_k2&view=item&layout=item&id=492&Itemid=1259&lang=en#](http://www.bmbah.hu/jomla/index.php?option=com_k2&view=item&layout=item&id=492&Itemid=1259&lang=en#))

This public health threat simultaneously raises occupational health-related concerns, especially for front-line workers providing assistance for or dealing with migrants. Border guards, health care and non-health care workers in migrant reception centres have first contact with migrants bypassing the standard controls to cross borders.

In 2013 the Chair of Migration Health at the University of Pécs Medical School (UPMS) launched a survey covering 10 Hungarian border-crossing points along the eastern/south-eastern Schengen border and in asylum reception centres, in order to evaluate the preparedness of the staff and the conditions of the infrastructure, including the health-related considerations. This survey was a follow-up to a previous joint project of the International Organization for Migration and the University of Pécs (3).

The project consisted of 4 main items:

- facilitating a self-administered questionnaire survey of the staff (border guards, health and social care workers);
- detailing the public health infrastructure of the border-crossing points and reception centres;
- collecting and analyzing migrant health data from the onsite health records;
- organizing focus group sessions with migrants.

An important – and ongoing – part of the fieldwork is the collection and analysis of the migrants' available health data, including details of their access to health care provision and how their health data is stored. Based on the on-site analysis of the migrant health data (including the means of collection and storage), the conclusion is that currently no standardized, electronic migrant health statistics are available in Hungary. Ongoing health screening takes place in each of the centres

## References

1. Migrant health: infectious diseases in non-UK born populations in the UK. An update to the baseline report. London: Health Protection Agency; 2011 (<http://www.better-health.org.uk/resources/research/migrant-health-infectious-diseases-non-uk-born-populations-uk-update-baseline-rep>, accessed 9 September 2014).
2. Suijkerbuijk AWM, Lindeboom R, van Steenberghe JE, Sonder GJB, Doorduyn Y. Effect of hepatitis A vaccination programs for migrant children on the incidence of hepatitis A in the Netherlands. *Eur J Public Health* 2009; 19(3):240–244.
3. PHBLM Project: increasing public health safety alongside the new eastern European border line. Brussels: International Organization for Migration (IOM) Regional Liaison and Coordination Office to the European Union; 2006 (<http://www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/PHBLM-Project-Summary-Brief-011209.pdf>, accessed 9 September 2014).

visited, and there is at the very least a health consultation room with regular, if not continuous service from physicians. However, there is no standardized screening protocol, health data are stored in paper records and in most cases only symptoms and findings are registered, not diagnoses; neither is there any use of International Classification of Diseases (ICD) coding. No clear channels exist to report focal points of the WHO International Health Regulations (IHR).

## Conclusions

Below is a brief summary of experiences:

Although Hungary is making serious efforts to cope with the rapidly increasing migrant influx, there are areas in which further steps should be taken, as highlighted by the results of the survey.

- Border guard and civil staff training needs to be upgraded in order to cope with the increased occupational health hazards (the UPMS has offered its capacity to assist in this).
- Public health and migration-related training for medical staff should be implemented (UPMS is offering its capacity for such training).
- WHO IHR implementation should be consolidated.
- The health services provided by the reception centres should be further developed (staff, screening protocols, information technology infrastructure, working hours, and so on).

The development of a harmonized electronic migrant health information system and database would be an essential cornerstone in implementing evidence-based planning of health assistance for migrants. The UPMS has started the process of collecting the available data from the existing paper-based health records. As a first step toward data recording and analysis, experiences gained with symptoms- and findings-based surveillance systems could be utilized.

## Information technology in environmental modelling and developing early warning systems for mitigating health risks (<http://www.eo2heaven.org/>)

Effective prevention of epidemics is based on several factors, such as the preparedness of health care professionals and the health care provision system being in place, but efficiency levels could be raised by implementing the right counter-measures, supported by a forecasting system. The development of a risk modelling system in the health context is essential in our rapidly changing world.

The EU's EO2HEAVEN (Earth observation and environmental modelling for the mitigation of health risks) project contributes to a better understanding of the complex relationships between environmental changes and their impact on human health. It aims to monitor changes induced by human activities, the emphasis being placed on atmospheric, river, lake and coastal marine pollution. The location of a possible disease outbreak may be identified by the risk map that has been developed to correlate environmental and health data. Software architecture for early warning systems has been developed by the Fraunhofer Institute of Optronics, System Technologies and Image Exploitation (IOSB) in Karlsruhe, within the frame of this project. This initiative is examining the effects of various environmental factors on cholera epidemics in Uganda.

Cholera is a bacterial, waterborne disease and has been eradicated in Europe, but it is responsible for thousands of deaths annually in Africa, making it an ideal basis for the development of the project. See the 52north website for more information (<http://www.52north.org/resources/references/sensor-web/eo2heaven>).

### References

1. See the 52north website for more information (<http://www.52north.org/resources/references/sensor-web/eo2heaven>).
2. See the Infection Control Today website for more information (<http://www.infectioncontroltoday.com/news/2014/02/scientists-developing-early-warning-system-for-epidemics.aspx>).

Scientists use sensors to measure environmental parameters, such as rainfall, exposure to solar radiation and pH value, temperature, concentration of nutrients in the water, along with weather and climate forecasts. They also use mobile applications to collect health data on cholera cases from hospitals and doctors, such as where patients have been and what their symptoms are. Using the new software, each case appears as a red dot on a digital map. By correlating this information with the environmental data, scientists can see how fast and how far an outbreak is spreading.

With a functioning early warning system, decision-makers would have the opportunity to deploy medical resources effectively in the affected area and could support the health system in ensuring a more effective and focused response to a disease outbreak. Both regular and irregular forms of migration can contribute to and accelerate the spread of infectious diseases. Today, those diseases – showing strict correlation with migration – could be treated effectively if surveillance data were to be correlated with environmental changes. Malaria, dengue fever and other vector-borne diseases would also be good subjects for further investigation.

The EO2HEAVEN project is being implemented by numerous companies and research institutes, in collaboration with essential WHO support. Successful dissemination and promotion activities contribute to the widespread implementation of the initiative in affected countries and open up the opportunity to establish an early warning system without borders.

### Population projections: why they are often wrong

(<http://www.bmj.com/content/349/bmj.g5184>)

**John Appleby**, chief economist, The King's Fund  
BMJ 2014;349(g5184). doi: 10.1136/bmj.g5184

Predicting the sizes of populations is as important as it is challenging. These projections are used to estimate our future health care needs, government spending or tax revenues amongst other things. Populations generally change for 3 main reasons: births, deaths and migration. John Appleby, economist, sustains that predicting how these will change has proven difficult, and that this is to be recognized in order to construct various alternative futures.

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## INFORMATION SOURCES

### Global Workforce Alliance

(<http://www.who.int/workforcealliance/en/>)

Health workers are the heart and soul of health systems. And yet, the world is faced with a chronic shortage. A new progress report under the title *A universal truth: no health without a workforce* (2013) estimates a global shortage of 7.2

million health workers, with 83 countries facing a health worker crisis.

The relative shortages of doctors, nurses and midwives are still most acute in sub-Saharan Africa. This is currently one of the major obstacles to achieving the Millennium Development Goals (MDGs) and other international health goals, including universal health coverage.

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### Humanitarian Health Action – technical guidance in emergencies

([http://www.who.int/hac/techguidance/health\\_of\\_migrants/en/](http://www.who.int/hac/techguidance/health_of_migrants/en/))

This section of the Health Action in Crises web pages contains technical information for crises and crises management, useful templates and training information, as well as tools to facilitate work in the field.

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